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

FORM 10-Q

(MARK ONE)

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

For the quarterly period ended March 31, 2019

OR

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

For the transition period from to

Commission file number 1-10765

UNIVERSAL HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

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

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

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

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

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

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

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

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

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

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

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

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date. Common shares outstanding, as of April 30, 2019:

Class A	6,577,100
Class B	82,882,673
Class C	661,688
Class D	18,573

UNIVERSAL HEALTH SERVICES, INC.

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This Quarterly Report on Form 10-Q is for the quarter ended March 31, 2019. This Report modifies and supersedes documents filed prior to this Report. Information that we file with the Securities and Exchange Commission (the "SEC") in the future will automatically update and supersede information contained in this Report.

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

PART I. FINANCIAL INFORMATION

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

	Three months ended March 31,	
	2019	2018
Net revenues	$ 2,804,391	$ 2,687,516
Operating charges:		
Salaries, wages and benefits	1,365,546	1,300,148
Other operating expenses	644,780	620,819
Supplies expense	307,463	292,929
Depreciation and amortization	120,040	113,103
Lease and rental expense	26,125	26,703
	2,463,954	2,353,702
Income from operations	340,437	333,814
Interest expense, net	39,640	37,576
Other (income) expense, net	4,501	-
Income before income taxes	296,296	296,238
Provision for income taxes	58,898	67,569
Net income	237,398	228,669
Less: Net income attributable to noncontrolling interests	3,230	4,837
Net income attributable to UHS	$ 234,168	$ 223,832
Basic earnings per share attributable to UHS	$ 2.57	$ 2.37
Diluted earnings per share attributable to UHS	$ 2.57	$ 2.36
Weighted average number of common shares - basic	90,776	94,226
Add: Other share equivalents	191	457
Weighted average number of common shares and equivalents - diluted	90,967	94,683

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

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

	Three months ended March 31,	
	2019	2018
Net income	$ 237,398	$ 228,669
Other comprehensive income (loss):		
Unrealized derivative gains (losses) on cash flow hedges	(2,917)	2,124
Foreign currency translation adjustment	(14,262)	(4,341)
Other	-	2,367
Other comprehensive income (loss) before tax	(17,179)	150
Income tax expense (benefit) related to items of other comprehensive income (loss)	(2,466)	1,077
Total other comprehensive income (loss), net of tax	(14,713)	(927)
Comprehensive income	222,685	227,742
Less: Comprehensive income attributable to noncontrolling interests	3,230	4,837
Comprehensive income attributable to UHS	$ 219,455	$ 222,905

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

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

	March 31, 2019	December 31, 2018
Assets		
Current assets:		
Cash and cash equivalents	$ 62,726	$ 105,220
Accounts receivable, net	1,602,405	1,509,909
Supplies	149,928	148,206
Other current assets	145,382	174,467
Total current assets	1,960,441	1,937,802
Property and equipment	8,733,367	8,563,455
Less: accumulated depreciation	(3,818,529)	(3,715,515)
	4,914,838	4,847,940
Other assets:		
Goodwill	3,856,664	3,844,628
Deferred income taxes	5,350	5,280
Right of use assets-operating leases	342,032	0
Deferred charges	8,207	8,772
Other	633,745	621,058
Total Assets	$ 11,721,277	$ 11,265,480
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 71,991	$ 63,446
Accounts payable and accrued liabilities	1,355,717	1,253,714
Legal reserves	128,294	129,150
Operating lease liabilities	56,136	0
Federal and state taxes	44,628	2,428
Total current liabilities	1,656,766	1,448,738
Other noncurrent liabilities	364,334	361,809
Operating lease liabilities noncurrent	286,101	0
Long-term debt	3,821,938	3,935,187
Deferred income taxes	35,984	49,661
Redeemable noncontrolling interests	3,843	4,292
Equity:		
UHS common stockholders' equity	5,482,415	5,389,262
Noncontrolling interest	69,896	76,531
Total equity	5,552,311	5,465,793
Total Liabilities and Stockholders' Equity	$ 11,721,277	$ 11,265,480

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Three Months Ended March 31, 2019
(amounts in thousands, unaudited)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2019	$ 4,292	$ 66	$ 841	$ 7	$ 0	$ (409,156)	$ 5,793,262	$ 4,242	$ 5,389,262	$ 76,531	$ 5,465,793
Common Stock											
Issued/(converted)	—	—	6	—	—	—	2,720	—	2,726	—	2,726
Repurchased	—	—	(10)	—	—	—	(137,219)	—	(137,229)	—	(137,229)
Restricted share-based compensation expense	—	—	—	—	—	—	1,523	—	1,523	—	1,523
Dividends paid	—	—	—	—	—	(9,081)	—	—	(9,081)	—	(9,081)
Stock option expense	—	—	—	—	—	—	15,759	—	15,759	—	15,759
Distributions to noncontrolling interests	(500)	—	—	—	—	—	—	—	—	(9,814)	(9,814)
Comprehensive income:											
Net income to UHS / noncontrolling interests	51	—	—	—	—	—	234,168	—	234,168	3,179	237,347
Foreign currency translation adjustments, net of income tax	—	—	—	—	—	—	—	(12,489)	(12,489)	—	(12,489)
Unrealized derivative losses on cash flow hedges, net of income tax	—	—	—	—	—	—	—	(2,224)	(2,224)	—	(2,224)
Subtotal - comprehensive income	51	—	—	—	—	—	234,168	(14,713)	219,455	3,179	222,634
Balance, March 31, 2019	$ 3,843	$ 66	$ 837	$ 7	$ —	$ (418,237)	$ 5,910,213	$ (10,471)	$ 5,482,415	$ 69,896	$ 5,552,311

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Three Months Ended March 31, 2018
(amounts in thousands, unaudited)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2018	$ 6,702	$ 66	$ 869	$ 7	$ 0	$ (371,814)	$ 5,353,209	$ 7,177	$ 4,989,514	$ 61,922	$ 5,051,436
Common Stock											
Issued/(converted)	—	—	2	—	—	—	2,664	—	2,666	—	2,666
Repurchased	—	—	(1)	—	—	—	(9,440)	—	(9,441)	—	(9,441)
Restricted share-based compensation expense	—	—	—	—	—	—	545	—	545	—	545
Dividends paid	—	—	—	—	—	(9,422)	—	—	(9,422)	—	(9,422)
Stock option expense	—	—	—	—	—	—	18,879	—	18,879	—	18,879
Distributions to noncontrolling interests	(500)	—	—	—	—	—	—	—	—	(3,717)	(3,717)
Purchase of noncontrolling interest	—	—	—	—	—	—	—	—	—	7,213	7,213
Comprehensive income:											
Net income to UHS / noncontrolling interests	(121)	—	—	—	—	—	223,832	—	223,832	4,958	228,790
Foreign currency translation adjustments	—	—	—	—	—	—	—	(4,341)	(4,341)	—	(4,341)
Other, net of income tax	—	—	—	—	—	—	—	1,795	1,795	—	1,795
Unrealized derivative gains on cash flow hedges, net of income tax	—	—	—	—	—	—	—	1,619	1,619	—	1,619
Subtotal - comprehensive income	(121)	—	—	—	—	—	223,832	(927)	222,905	4,958	227,863
Balance, March 31, 2018	$ 6,081	$ 66	$ 870	$ 7	$ —	$ (381,236)	$ 5,589,689	$ 6,250	$ 5,215,646	$ 70,376	$ 5,286,022

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

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

	Three months ended March 31,	
	2019	**2018**
Cash Flows from Operating Activities:		
Net income	$ 237,398	$ 228,669
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	120,040	113,134
Stock-based compensation expense	17,591	19,700
Gain on sale of assets and businesses	0	(703)
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(101,619)	(72,526)
Accrued interest	(2,687)	(6,209)
Accrued and deferred income taxes	52,291	61,674
Other working capital accounts	107,878	59,032
Other assets and deferred charges	(3,771)	(5,438)
Other	(38,298)	8,211
Accrued insurance expense, net of commercial premiums paid	24,398	23,125
Payments made in settlement of self-insurance claims	(22,320)	(18,765)
Net cash provided by operating activities	390,901	409,904
Cash Flows from Investing Activities:		
Property and equipment additions, net of disposals	(169,848)	(189,041)
Acquisition of property and businesses	0	(20,931)
Inflows (outflows) from foreign exchange contracts that hedge our net U.K. investment	12,895	(45,853)
Proceeds received from sales of assets and businesses	0	839
Costs incurred for purchase and implementation of information technology applications	(9,678)	(8,570)
Decrease in capital reserves of commercial insurance subsidiary	0	100
Investment in, and advances to, joint ventures and other	(879)	(8,675)
Net cash used in investing activities	(167,510)	(272,131)
Cash Flows from Financing Activities:		
Reduction of long-term debt	(114,540)	(140,676)
Additional borrowings	8,700	20,500
Repurchase of common shares	(143,785)	(9,441)
Dividends paid	(9,081)	(9,422)
Issuance of common stock	2,726	2,545
Profit distributions to noncontrolling interests	(10,314)	(4,217)
Net cash used in financing activities	(266,294)	(140,711)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	794	1,857
Decrease in cash, cash equivalents and restricted cash	(42,109)	(1,081)
Cash, cash equivalents and restricted cash, beginning of period	199,685	167,297
Cash, cash equivalents and restricted cash, end of period	$ 157,576	$ 166,216
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$ 41,050	$ 41,539
Income taxes paid, net of refunds	$ 5,087	$ 2,749
Noncash purchases of property and equipment	$ 71,987	$ 84,708
Right-of-use assets obtained in exchange for lease obligations	$ 355,981	$ -

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

(1) General

This Quarterly Report on Form 10-Q is for the quarterly period ended March 31, 2019. In this Quarterly Report, "we," "us," "our" "UHS" and the "Company" refer to Universal Health Services, Inc. and its subsidiaries.

The condensed consolidated interim financial statements include the accounts of our majority-owned subsidiaries and partnerships and limited liability companies controlled by us, or our subsidiaries, as managing general partner or managing member. The condensed consolidated interim financial statements included herein have been prepared by us, without audit, pursuant to the rules and regulations of the Securities and Exchange Commission ("SEC") and reflect all adjustments (consisting only of normal recurring adjustments) which, in our opinion, are necessary to fairly state results for the interim periods. Certain information and footnote disclosures normally included in audited consolidated financial statements prepared in accordance with accounting principles generally accepted in the United States of America have been condensed or omitted pursuant to such rules and regulations, although we believe that the accompanying disclosures are adequate to make the information presented not misleading. These condensed consolidated interim financial statements should be read in conjunction with the audited consolidated financial statements, significant accounting policies and the notes thereto included in our Annual Report on Form 10-K for the year ended December 31, 2018.

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

Relationship with Universal Health Realty Income Trust:

At March 31, 2019, we held approximately 5.7% of the outstanding shares of Universal Health Realty Income Trust (the "Trust"). We serve as Advisor to the Trust under an annually renewable advisory agreement, which is scheduled to expire on December 31st of each year, pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. The advisory agreement was Amended and Restated effective January 1, 2019. Among other things, the Amended and Restated Advisory Agreement (the "Agreement") eliminated the 20% annual incentive fee clause which we were previously entitled to under certain conditions (the incentive fee requirements have never been achieved). The advisory agreement was renewed by the Trust for 2019 at the same rate as the prior three years. During 2018, 2017 and 2016, the advisory fee was computed at 0.70% of the Trust's average invested real estate assets. During the three-month periods ended March 31, 2019 and 2018, we earned an advisory fee from the Trust, which was computed at 0.70% of the Trust's average invested real estate assets, and is included in net revenues in the accompanying consolidated statements of income, of approximately $1.0 million and $904,000, respectively.

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

Our pre-tax share of income from the Trust, which is included in other income in the accompanying consolidated statements of income, was approximately $300,000 and $284,000 during the three-month periods ended March 31, 2019 and 2018, respectively. We received dividends from the Trust amounting to $531,000 and $524,000 during the three month periods ended March 31, 2019 and 2018, respectively. The carrying value of our investment in the Trust was approximately $7.3 million and $7.5 million at March 31, 2019 and December 31, 2018, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $59.6 million at March 31, 2019 and $48.3 million at December 31, 2018, based on the closing price of the Trust's stock on the respective dates.

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

Total rent expense under the operating leases on the three hospital facilities reflected in the table below was approximately $4 million during each of the three months ended March 31, 2019 and 2018. Pursuant to the terms of the three hospital leases with the Trust, we have the option to renew the leases at the lease terms described above and below by providing notice to the Trust at least 90 days prior to the termination of the then current term. We also have the right to purchase the respective leased hospitals at the end of the lease terms or any renewal terms at their appraised fair market value as well as purchase any or all of the three leased hospital properties at the appraised fair market value upon one month's notice should a change of control of the Trust occur. In addition, we have rights of first refusal to: (i) purchase the respective leased facilities during and for 180 days after the lease terms at the same price, terms and

conditions of any third-party offer, or; (ii) renew the lease on the respective leased facility at the end of, and for 180 days after, the lease term at the same terms and conditions pursuant to any third-party offer.

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

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

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

In addition, certain of our subsidiaries are tenants in several medical office buildings and two FEDs owned by the Trust or by limited liability companies in which the Trust holds 95% to 100% of the ownership interest.

Other Related Party Transactions:

In December, 2010, our Board of Directors approved the Company's entering into supplemental life insurance plans and agreements on the lives of Alan B. Miller (our chief executive officer ("CEO") and his wife. As a result of these agreements, as amended in October, 2016, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $28 million in premiums, and certain trusts owned by our CEO, would pay approximately $9 million in premiums. Based on the projected premiums mentioned above, and assuming the policies remain in effect until the death of the insureds, we will be entitled to receive death benefit proceeds of no less than approximately $37 million representing the $28 million of aggregate premiums paid by us as well as the $9 million of aggregate premiums paid by the trusts. In connection with these policies, we will pay/we paid approximately $1.1 million, net, in premium payments during each of the 2019 and 2018 years.

In August, 2015, Marc D. Miller, our President and member of our Board of Directors, was appointed to the Board of Directors of Premier, Inc. ("Premier"), a healthcare performance improvement alliance. During 2013, we entered into a new group purchasing organization agreement ("GPO") with Premier. In conjunction with the GPO agreement, we acquired a minority interest in Premier for a nominal amount. During the fourth quarter of 2013, in connection with the completion of an initial public offering of the stock of Premier, we received cash proceeds for the sale of a portion of our ownership interest in the GPO. Also in connection with this GPO agreement, we received shares of restricted stock of Premier which vest ratably over a seven-year period (2014 through 2020), contingent upon our continued participation and minority ownership interest in the GPO. We have elected to retain a portion of the previously vested shares of Premier, the market value of which is included in other assets on our consolidated balance sheet. Based upon the closing price of Premier's stock on each respective date, the market value of our shares of Premier on which the restrictions have lapsed was $51 million as of March 31, 2019 and $56 million as of December 31, 2018. In connection with our adoption of ASU 2016-01, "Recognition and Measurement of Financial Assets and Financial Liabilities", since our vested shares of Premier are held for investment and classified as available for sale, the $4 million decrease in market value of these shares since December 31, 2018 was recorded as an unrealized loss and included in "Other (income) expense, net" on our condensed consolidated statements of income for the three-month period ended March 31, 2019.

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

(3) Other Noncurrent liabilities and Redeemable/Noncontrolling Interests

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

As of March 31, 2019, outside owners held noncontrolling, minority ownership interests of: (i) 20% in an acute care facility located in Washington, D.C.; (ii) approximately 11% in an acute care facility located in Texas; (iii) 20% and 30% in two behavioral health care facilities located in Pennsylvania and Ohio, respectively; (iv) approximately 5% in an acute care facility located in Nevada, and; (v) approximately 20% in a behavioral health care facility located in Spokane, Washington. The noncontrolling interest and redeemable noncontrolling interest balances of $70 million and $4 million, respectively, as of March 31, 2019, consist primarily of the third-party ownership interests in these hospitals.

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

(4) Treasury

Credit Facilities and Outstanding Debt Securities:

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

The Sixth Amendment amended the Senior Credit Agreement to, among other things: (i) increase the aggregate amount of the revolving credit facility to $1 billion (increase of $200 million over the $800 million previous commitment); (ii) increase the aggregate amount of the tranche A term loan commitments to $2 billion (increase of approximately $290 million over the $1.71 billion of outstanding borrowings prior to the amendment), and; (iii) extended the maturity date of the revolving credit and tranche A term loan facilities to October 23, 2023 from August 7, 2019.

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

As of March 31, 2019, we had no borrowings outstanding pursuant to our $1 billion revolving credit facility and we had $973 million of available borrowing capacity net of $12 million of outstanding letters of credit and $15 million of outstanding borrowings pursuant to a short-term credit facility.

Pursuant to the terms of the Sixth Amendment, the tranche A term loan, which had $1.988 billion of borrowings outstanding as of March 31, 2019, provides for eight installment payments of $12.5 million per quarter, covering the period of March of 2019 through December of 2020, followed by payments of $25 million per quarter, commencing in March of 2021 until maturity in October of 2023, when all outstanding amounts will be due.

The tranche B term loan, which had $499 million of borrowings outstanding as of March 31, 2019, provides for installment payments of $1.25 million per quarter, which commenced on March 31, 2019 until maturity in October of 2025, when all outstanding amounts will be due.

Borrowings under the Senior Credit Agreement bear interest at our election at either (1) the ABR rate which is defined as the rate per annum equal to the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.375% to 0.625% for revolving credit and term loan A borrowings and 0.75% for tranche B borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.375% to 1.625% for revolving credit and term loan A borrowings and 1.75% for the tranche B term loan. As of March 31, 2019, the applicable margins were 0.50% for ABR-based loans and 1.50% for LIBOR-based loans under the revolving credit and term loan A facilities. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Senior Credit Agreement is secured by certain assets of the Company and our material subsidiaries (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

The Senior Credit Agreement includes a material adverse change clause that must be represented at each draw. The Senior Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage. We were in compliance with all required covenants as of March 31, 2019 and December 31, 2018.

In late April, 2018, we entered into the sixth amendment to our accounts receivable securitization program ("Securitization") dated as of October 27, 2010 with a group of conduit lenders, liquidity banks, and PNC Bank, National Association, as administrative agent, which provides for borrowings outstanding from time to time by certain of our subsidiaries in exchange for undivided security interests in their respective accounts receivable. The sixth amendment, among other things, extended the term of the Securitization program through April 26, 2021 and increased the borrowing capacity to $450 million (from $440 million previously). Although the program fee and certain other fees were adjusted in connection with the sixth amendment, substantially all other provisions of the Securitization program remained unchanged. Pursuant to the terms of our Securitization program, substantially all of the patient-

related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At March 31, 2019, we had $290 million of outstanding borrowings pursuant to the terms of the Securitization and $160 million of available borrowing capacity.

As of March 31, 2019, we had combined aggregate principal of $1.1 billion from the following senior secured notes:

- $700 million aggregate principal amount of 4.75% senior secured notes due in August, 2022 ("2022 Notes") which were issued as follows:
  - $300 million aggregate principal amount issued on August 7, 2014 at par.
  - $400 million aggregate principal amount issued on June 3, 2016 at 101.5% to yield 4.35%.

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

Interest on the 2022 Notes is payable on February 1 and August 1 of each year until the maturity date of August 1, 2022. Interest on the 2026 Notes is payable on June 1 and December 1 until the maturity date of June 1, 2026. The 2022 Notes and 2026 Notes were offered only to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended (the "Securities Act"). The 2022 Notes and 2026 Notes have not been registered under the Securities Act and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements.

On November 26, 2018 we redeemed the $300 million aggregate principal, 3.75% Senior Notes due in 2019. The 2019 Notes were redeemed for an aggregate price equal to 100.485% of the principal amount, resulting in a premium paid of approximately $1 million, plus accrued interest to the redemption date.

At March 31, 2019, the carrying value and fair value of our debt were each approximately $3.9 billion. At December 31, 2018, the carrying value and fair value of our debt were each approximately $4.0 billion. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Cash Flow Hedges:

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

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

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

The fair value of interest rate swap agreements approximates the amount at which they could be settled, based on estimates obtained from the counterparties. We assess the effectiveness of our hedge instruments on a quarterly basis. We performed periodic assessments of the cash flow hedge instruments during the first three months of 2019 and the full year of 2018 and determined the hedges to be highly effective. Although we do not anticipate nonperformance by our counterparties to interest rate swap agreements,

the counterparties expose us to credit risk in the event of nonperformance. We do not hold or issue derivative financial instruments for trading purposes.

During 2015, we entered into nine forward starting interest rate swaps whereby we paid a fixed rate on a total notional amount of $1.0 billion and received one-month LIBOR. The average fixed rate payable on these swaps, all of which matured on April 15, 2019, was 1.31%. These interest rates swaps consisted of:

- Four forward starting interest rate swaps, entered into during the second quarter of 2015, whereby we paid a fixed rate on a total notional amount of $500 million and received one-month LIBOR. Each of the four swaps became effective on July 15, 2015 and matured on April 15, 2019. The average fixed rate payable on these swaps was 1.40%;
- Four forward starting interest rate swaps, entered into during the third quarter of 2015, whereby we paid a fixed rate on a total notional amount of $400 million and received one-month LIBOR. One swap on a notional amount of $100 million became effective on July 15, 2015, two swaps on a total notional amount of $200 million became effective on September 15, 2015 and another swap on a notional amount of $100 million became effective on December 15, 2015. All of these swaps matured on April 15, 2019 and the average fixed rate payable was 1.23%, and;
- One interest rate swap, entered into during the fourth quarter of 2015, whereby we paid a fixed rate on a total notional amount of $100 million and received one-month LIBOR. The swap became effective on December 15, 2015 and matured on April 15, 2019. The fixed rate payable on this swap was 1.21%.

Foreign Currency Forward Exchange Contracts:

In August 2017, the FASB issued new guidance on hedge accounting (ASU 2017-12) that is intended to more closely align hedge accounting with companies' risk management strategies, simplify the application of hedge accounting, and increase transparency as to the scope and results of hedging programs. The new guidance amends the presentation and disclosure requirements, and changes how companies assess effectiveness. The Company adopted this guidance as of January 1, 2019 and applied to all existing hedges as of the adoption date.

We use forward exchange contracts to hedge our net investment in foreign operations against movements in exchange rates. The effective portion of the unrealized gains or losses on these contracts is recorded in foreign currency translation adjustment within accumulated other comprehensive income and remains there until either the sale or liquidation of the subsidiary. In conjunction with the January 1, 2019 adoption of ASU 2017-12, "Targeted Improvements to Accounting for Hedging Activities", we reclassified our presentation of the net cash inflows or outflows, which were received or paid in connection with foreign exchange contracts that hedge our net investment in foreign operations against movements in exchange rates, to investing cash flows on the consolidated statements of cash flows. As previously disclosed within our footnotes, these cash flows were formerly reported as operating activities. Prior period amounts have been reclassified from net cash provided by operating activities to net cash used in investing activities to conform with the current year presentation on the consolidated statements of cash flows. In connection with these forward exchange contracts, we recorded net cash inflows of $13 million during the three-month period ended March 31, 2019 and net cash outflows of $46 million during the three-month period ended March 31, 2018.

Derivatives Hedging Relationships:

The following table presents the effects of our interest rate swap agreements and our foreign currency foreign exchange contracts on our results of operations for the three month periods ended March 31, 2019 and 2018 (in thousands):

	Gain/(Loss) recognized in AOCI	
	March 31, 2019	March 31, 2018
Cash Flow Hedge relationships		
Interest rate swap agreements (a)	$ (2,917)	$ 2,124
Net Investment Hedge relationships		
Foreign currency foreign exchange contracts (b)	$ 5,221	$ (45,853)

(a) The amount of gain reclassified out of AOCI into Interest expense, net was $2.9 million and $709,000 during the three month periods ended March 31, 2019 and 2018, respectively.

(b) The amount reclassified out of AOCI into Other (income) expense, net includes the net effect of a $3.8 million gain offset by a $3.8 million loss recorded on repatriation of cash related to our net investment in the U.K. for the three month period ended March 31, 2019. There were no amounts reclassified out of AOCI for the three month period ended March 31, 2018.

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

Cash, Cash Equivalents and Restricted Cash:

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

	March 31, 2019	December 31, 2018
Cash and cash equivalents	$ 62,726	$ 105,220
Restricted cash and cash equivalents (a)	94,850	94,465
Total cash, cash equivalents and restricted cash	$ 157,576	$ 199,685

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

(5) Fair Value Measurement

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

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

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

	Balance at		Basis of Fair Value Measurement		
(in thousands)	March 31, 2019	Balance Sheet Location	Level 1	Level 2	Level 3
Assets:					
Money market mutual funds	$ 106,916	Other assets	$ 106,916	$	
Certificates of deposit	5,415	Other assets	5,415		
Available for sale securities	51,337	Other assets	51,337		
Deferred compensation assets	33,778	Other assets	33,778		
Interest rate swap agreements	1,008	Accounts receivable, net		1,008	
Foreign currency exchange contracts	(2,579)	Other current assets		(2,579)	
	$ 195,875		$ 197,446	$ (1,571)	-
Liabilities:					
Deferred compensation liabilities	$ 33,778	Other noncurrent liabilities	$ 33,778		
	$ 33,778		$ 33,778	-	-

	Balance at		Basis of Fair Value Measurement		
(in thousands)	December 31, 2018	Balance Sheet Location	Level 1	Level 2	Level 3
Assets:					
Money market mutual funds	$ 106,530	Other assets	$ 106,530	$	
Certificates of deposit	5,415	Other assets	5,415		
Available for sale securities	55,594	Other assets	55,594		
Deferred compensation assets	32,998	Other assets	32,998		
Interest rate swap agreements	3,925	Accounts Receivable, net		3,925	
Foreign currency exchange contracts	8,908	Other current assets		8,908	
	$ 213,370		$ 200,537	$ 12,833	-
Liabilities:					
Deferred compensation liabilities	$ 32,998	Other noncurrent liabilities	$ 32,998		
	$ 32,998		$ 32,998	-	-

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

(6) Commitments and Contingencies

Professional and General Liability, Workers' Compensation Liability

Effective January, 2017, the vast majority of our subsidiaries are self-insured for professional and general liability exposure up to $5 million and $3 million per occurrence, respectively, subject to certain aggregate limitations. Prior to January, 2017, the vast majority of our subsidiaries were self-insured for professional and general liability exposure up to $10 million and $3 million per occurrence, respectively. These subsidiaries are provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence self-insured retention or underlying policy limits up to $250 million per occurrence and in the aggregate for claims incurred after 2013 and up to $200 million per occurrence and in the aggregate for claims incurred from 2011 through 2013. We remain liable for 10%, up to an annual aggregate limitation of $5 million ($8.5 million for facilities located in the U.K.), of the claims paid pursuant to the commercially insured excess coverage. In addition, from time to time based upon marketplace conditions, we may elect to purchase additional commercial coverage for certain of our facilities or businesses. Our behavioral health care facilities located in the U.K. have policies through a commercial insurance carrier located in the U.K. that provides for £10 million of professional liability coverage and £25 million of general liability coverage.

As of March 31, 2019, the total accrual for our professional and general liability claims was $246 million, of which $42 million was included in current liabilities. As of December 31, 2018, the total accrual for our professional and general liability claims was $243 million, of which $42 million was included in current liabilities.

As of March 31, 2019, the total accrual for our workers' compensation liability claims was $71 million, of which $40 million was included in current liabilities. As of December 31, 2018, the total accrual for our workers' compensation liability claims was $72 million, of which $40 million was included in current liabilities.

Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimates of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Given our significant self-insured exposure for professional and general liability claims, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations. Although we are unable to predict whether or not our future financial statements will include adjustments to our prior year reserves for self-insured general and professional and workers' compensation claims, given the relatively unpredictable nature of the these potential liabilities and the factors impacting these reserves, as discussed above, it is reasonably likely that our future financial results may include material adjustments to prior period reserves.

Property Insurance:

We have commercial property insurance policies for our properties covering catastrophic losses, including windstorm damage, up to a $1 billion policy limit, subject to a deductible ranging from $50,000 to $250,000 per occurrence. Losses resulting from named windstorms are subject to deductibles between 3% and 5% of the total insurable value of the property. In addition, we have commercial property insurance policies covering catastrophic losses resulting from earthquake and flood damage, each subject to aggregated loss limits (as opposed to per occurrence losses). Commercially insured earthquake coverage for our facilities is subject to various deductibles and limitations including: (i) $500 million limitation for our facilities located in Nevada; (ii) $130 million limitation for our facilities located in California; (iii) $100 million limitation for our facilities located in fault zones within the United States; (iv) $40 million limitation for our facility located in Puerto Rico, and; (v) $250 million limitation for many of our facilities located in other states. Deductibles for flood losses vary in amount, up to a maximum of $500,000, based upon location of the facility. Since certain of our facilities have been designated by our insurer as flood prone, we have elected to purchase policies from The National Flood Insurance Program. Property insurance for our behavioral health facilities located in the U.K. are provided on an all risk basis up to a £1.29 billion policy limit, with coverage caps per location, that includes coverage for real and personal property as well as business interruption losses.

Other

Our accounts receivable as of March 31, 2019 and December 31, 2018 include amounts due from Illinois of approximately $34 million and $32 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $19 million as of March 31, 2019 and $18 million as of December 31, 2018, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. Although the accounts receivable due from Illinois could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois. Failure to ultimately collect all outstanding amounts due to us from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

Legal Proceedings

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

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

Certain legal matters are described below:

Government Investigations:

UHS Behavioral Health

In February, 2013, the Office of Inspector General for the United States Department of Health and Human Services ("OIG") served a subpoena requesting various documents from January, 2008 to the date of the subpoena directed at Universal Health Services, Inc. ("UHS") concerning it and UHS of Delaware, Inc., and certain UHS owned behavioral health facilities including: Keys of Carolina, Old Vineyard Behavioral Health, The Meadows Psychiatric Center, Streamwood Behavioral Health, Hartgrove Hospital, Rock River Academy and Residential Treatment Center, Roxbury Treatment Center, Harbor Point Behavioral Health Center, f/k/a The Pines Residential Treatment Center, including the Crawford, Brighton and Kempsville campuses, Wekiva Springs Center and River Point Behavioral Health. Prior to receipt of this subpoena, some of these facilities had received independent subpoenas from state or federal agencies. Subsequent to the February 2013 subpoenas, some of the facilities above have received additional, specific subpoenas or other document and information requests. In addition to the OIG, the DOJ and various U.S. Attorneys' and state Attorneys' General Offices are also involved in this matter. Since February 2013, additional facilities have also received subpoenas and/or document and information requests or we have been notified are included in the omnibus investigation. Those facilities include: National Deaf Academy, Arbour-HRI Hospital, Behavioral Hospital of Bellaire, St. Simons By the Sea, Turning Point Care Center, Salt Lake Behavioral Health, Central Florida Behavioral Hospital, University Behavioral Center, Arbour Hospital, Arbour-Fuller Hospital, Pembroke Hospital, Westwood Lodge, Coastal Harbor Health System, Shadow Mountain Behavioral Health, Cedar Hills Hospital, Mayhill Hospital, Southern Crescent Behavioral Health (Anchor Hospital and Crescent Pines campuses), Valley Hospital (AZ), Peachford Behavioral Health System of Atlanta, University Behavioral Health of Denton, El Paso Behavioral Health System, Newport News Behavioral Health Center, The Hughes Center and Forest View Hospital.

In October, 2013, we were advised that the DOJ's Criminal Frauds Section had opened an investigation of River Point Behavioral Health and Wekiva Springs Center. Since that time, we have been notified that the Criminal Frauds section has opened investigations of National Deaf Academy, Hartgrove Hospital and UHS as a corporate entity. In April 2017, the DOJ's Criminal Division issued a subpoena requesting documentation from Shadow Mountain Behavioral Health. In August 2017, Kempsville Center of Behavioral Health (a part of Harbor Point Behavioral Health previously identified above) received a subpoena requesting documentation.

In April, 2014, the Centers for Medicare and Medicaid Services ("CMS") instituted a Medicare payment suspension at River Point Behavioral Health in accordance with federal regulations regarding suspension of payments during certain investigations. The Florida Agency for Health Care Administration ("AHCA") subsequently issued a Medicaid payment suspension for the facility. River Point Behavioral Health submitted a rebuttal statement disputing the basis of the suspension and requesting revocation of the suspension. Notwithstanding, CMS continued the payment suspension. River Point Behavioral Health provided additional information to CMS in an effort to obtain relief from the payment suspension but the Medicare suspension remains in effect. In June 2017, AHCA advised that while they were maintaining the suspension for dual eligible and cross-over Medicare beneficiaries, the Medicaid payment suspension was lifted effective June 27, 2017. We cannot predict if and/or when the facility's remaining suspended payments will resume in total. From inception through March 31, 2019, the aggregate funds withheld from us in connection with the River Point Behavioral Health payment suspension amounted to approximately $9 million. Although the operating results of River Point Behavioral Health did not have a material impact on our consolidated results of operations during the three-month period ended March 31, 2019 or the year ended December 31, 2018, the payment suspension has had a material adverse effect on the facility's results of operations and financial condition.

The DOJ has advised us that the civil aspect of the coordinated investigation referenced above is a False Claims Act investigation focused on billings submitted to government payers in relation to services provided at those facilities. While there have been various matters raised by DOJ during the pendency of this investigation, DOJ Civil has advised that the focus of their investigation is on medical necessity issues and billing for services not eligible for payment due to non-compliance with regulatory requirements relating to, among other things, admission eligibility, discharge decisions, length of stay and patient care issues. It is our understanding that the DOJ Criminal Fraud Section is investigating issues similar to those focused on by the DOJ Civil Division and the other related agencies involved in this matter. UHS denies any fraudulent billings were submitted to government payers; however, we are involved in settlement discussions with the DOJ Civil Division in an attempt to resolve this matter. During 2018, we recorded pre-tax increases to the reserve established in connection with the civil aspects of these matters amounting to $102 million (including $13 million recorded during the first quarter of 2018) increasing the aggregate pre-tax reserve to $123 million as of December 31, 2018 from $22 million as of December 31, 2017. The aggregate pre-tax reserve remained at $123 million as of March 31, 2019. Changes in the reserve may be required in future periods as discussions with the DOJ continue and additional information becomes available. We cannot predict the ultimate resolution of these matters and therefore can provide no assurance that final amounts paid in settlement or otherwise, if any, or associated costs, as well as the income tax deductibility of payments, will not differ materially from our established reserve and assumptions related to income tax deductibility.

DOJ investigation of Turning Point Hospital.

During the fourth quarter of 2018, we were notified that the DOJ Civil Division in conjunction with the U.S. Attorney's Office for the Northern District of Georgia and the Georgia Attorney General's Office have opened an investigation of Turning Point Hospital in Moultrie, GA. The DOJ Civil Division has advised us that they are primarily investigating transportation and housing financial assistance provided to patients receiving treatment at the facility. The DOJ issued a civil investigative demand to the facility requesting various documents and other information. At this time, we are unable to assess potential liability or damages, if any.

Litigation:

U.S. ex rel Escobar v. Universal Health Services, Inc. et.al.

This is a False Claims Act case filed against Universal Health Services, Inc., UHS of Delaware, Inc. and HRI Clinics, Inc. d/b/a Arbour Counseling Services in U.S. District Court for the District of Massachusetts. This qui tam action primarily alleges that Arbour Counseling Services failed to appropriately supervise certain clinical providers in contravention of regulatory requirements and the submission of claims to Medicaid were subsequently improper. Relators make other claims of improper billing to Medicaid associated with alleged failures of Arbour Counseling to comply with state regulations. The U.S. Attorney's Office and the Massachusetts Attorney General's Office initially declined to intervene. UHS filed a motion to dismiss and the trial court originally granted the motion dismissing the case. The First Circuit Court of Appeals ("First Circuit") reversed the trial court's dismissal of the case. The United States Supreme Court subsequently vacated the First Circuit's opinion and remanded the case for further consideration under the new legal standards established by the Supreme Court for False Claims Act cases. During the 4th quarter of 2016, the First Circuit issued a revised opinion upholding their reversal of the trial court's dismissal. The case was then remanded to the trial court for further proceedings. In January 2017, the U.S. Attorney's Office and Massachusetts Attorney General's Office advised of the potential for intervention in the case. The Massachusetts Attorney General's Office subsequently filed its motion to intervene which was granted and, in April 2017, filed their Complaint in Intervention. We are defending this case vigorously. At this time, we are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter.

Shareholder Class Action

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

Shareholder Derivative Cases

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

Disproportionate Share Hospital Payment Matter:

In late September, 2015, many hospitals in Pennsylvania, including seven of our behavioral health care hospitals located in the state, received letters from the Pennsylvania Department of Human Services (the "Department") demanding repayment of allegedly excess Medicaid Disproportionate Share Hospital payments ("DSH") for the federal fiscal year ("FFY") 2011 amounting to approximately $4 million in the aggregate. Since that time, we have received similar requests for repayment for alleged DSH overpayments for FFYs 2012, 2013 and 2014. For FFY 2012, the claimed overpayment amounts to approximately $4 million. For FFY 2013, the claimed overpayments were initially approximately $7 million but have since been reduced to approximately $2 million due to a change in the Department's calculations of the hospital specific DSH upper payment limit. For FFY 2014, the claimed overpayments were approximately $7 million. We filed administrative appeals for all of our facilities contesting the recoupment efforts for FFYs 2011 through 2014 as we believe the Department's calculation methodology is inaccurate and conflicts with applicable federal and state laws and regulations. The Department has agreed to postpone the recoupment of the state's share of the DSH payments until all hospital appeals are resolved but started recoupment of the federal share. Due to a change in the Pennsylvania Medicaid State Plan and implementation of a CMS-approved Medicaid Section 1115 Waiver, we do not believe the methodology applied by the Department to FFYs 2011 through 2014 is applicable to reimbursements received for Medicaid services provided after January 1, 2015 by our behavioral health care facilities located in Pennsylvania. We can provide no assurance that we will ultimately be successful in our legal and administrative appeals related to the Department's repayment demands. If our legal and administrative appeals are unsuccessful, our future consolidated results of operations and financial condition could be adversely impacted by these repayments.

Other Matters:

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

(7) Segment Reporting

Our reportable operating segments consist of acute care hospital services and behavioral health care services. The "Other" segment column below includes centralized services including, but not limited to, information technology, purchasing, reimbursement, accounting and finance, taxation, legal, advertising and design and construction. The chief operating decision making group for our acute care services and behavioral health care services is comprised of our Chief Executive Officer, the President and the Presidents of each operating segment. The Presidents for each operating segment also manage the profitability of each respective segment's various facilities. The operating segments are managed separately because each operating segment represents a business unit that offers different types of healthcare services or operates in different healthcare environments. The accounting policies of the operating segments are the same as those described in the summary of significant accounting policies included in our Annual Report on Form 10-K for the year ended December 31, 2018. The corporate overhead allocations, as reflected below, are utilized for internal reporting purposes and are comprised of each period's projected corporate-level operating expenses (excluding interest expense). The overhead expenses are captured and allocated directly to each segment to the extent possible, and overhead expenses incurred on behalf of both segments are captured and allocated to each segment based upon each segment's respective percentage of total operating expenses.

	Three months ended March 31, 2019			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 7,163,714	$ 2,483,999	$ 0	$ 9,647,713
Gross outpatient revenues	$ 4,257,614	$ 266,546	$ 0	$ 4,524,160
Total net revenues	$ 1,514,844	$ 1,286,383	$ 3,164	$ 2,804,391
Income/(loss) before allocation of corporate overhead and income taxes	$ 192,213	$ 244,168	$ (140,085)	$ 296,296
Allocation of corporate overhead	$ (57,500)	$ (41,647)	$ 99,147	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 134,713	$ 202,521	$ (40,938)	$ 296,296
Total assets as of March 31, 2019	$ 4,372,628	$ 6,972,929	$ 375,720	$ 11,721,277

	Three months ended March 31, 2018			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$ 6,361,766	$ 2,402,258	$ 0	$ 8,764,024
Gross outpatient revenues	$ 3,714,661	$ 255,181	$ 0	$ 3,969,842
Total net revenues	$ 1,445,632	$ 1,237,996	$ 3,888	$ 2,687,516
Income/(loss) before allocation of corporate overhead and income taxes	$ 203,711	$ 238,748	$ (146,221)	$ 296,238
Allocation of corporate overhead	$ (49,891)	$ (40,332)	$ 90,223	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 153,820	$ 198,416	$ (55,998)	$ 296,238
Total assets as of March 31, 2018	$ 3,924,302	$ 6,649,732	$ 449,483	$ 11,023,517

(a) Includes net revenues generated from our behavioral health care facilities located in the U.K. amounting to approximately $137 million and $115 million for the three-month periods ended March 31, 2019 and 2018, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.237 billion and $1.176 billion as of March 31, 2019 and 2018, respectively.

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

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

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

	Three months ended March 31,	
	2019	2018
Basic and Diluted:		
Net income attributable to UHS	$ 234,168	$ 223,832
Less: Net income attributable to unvested restricted share grants	(515)	(104)
Net income attributable to UHS – basic and diluted	$ 233,653	$ 223,728
Weighted average number of common shares - basic	90,776	94,226
Net effect of dilutive stock options and grants based on the treasury stock method	191	457
Weighted average number of common shares and equivalents - diluted	90,967	94,683
Earnings per basic share attributable to UHS:	$ 2.57	$ 2.37
Earnings per diluted share attributable to UHS:	$ 2.57	$ 2.36

The "Net effect of dilutive stock options and grants based on the treasury stock method", for all periods presented above, excludes certain outstanding stock options applicable to each period since the effect would have been anti-dilutive. The excluded weighted-average stock options totaled 7.0 million for the three months ended March 31, 2019 and 2.9 million for the three months ended March 31, 2018. All classes of our common stock have the same dividend rights.

The decrease in our basic and diluted weighted number of common shares outstanding for the three months ended March 31, 2019, as compared to the comparable prior year quarter, was due primarily to the impact of shares repurchased by us since January 1, 2018.

Stock-Based Compensation:

During the three-month periods ended March 31, 2019 and 2018, pre-tax compensation cost of $15.8 million and $18.9 million, respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended March 31, 2019 and 2018, pre-tax compensation cost of approximately $1.5 million and $545,000 (net of cancellations), respectively, was recognized related to restricted stock. As of March 31, 2019 there was approximately $175.7 million of unrecognized compensation cost related to unvested options and restricted stock which is expected to be recognized over the remaining weighted average vesting period of 3.1 years. There were 2,390,390 stock options granted during the first three months of 2019 with a weighted-average grant date fair value of $30.43 per share. There were 142,288 shares of restricted shares granted during the first three months of 2019 with a weighted-average grant date fair value of $134.23 per share.

The expense associated with stock-based compensation arrangements is a non-cash charge. In the Condensed Consolidated Statements of Cash Flows, stock-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities and aggregated to $17.6 million and $19.7 million during the three-month periods ended March 31, 2019 and 2018, respectively.

(9) Dispositions and acquisitions

Three-month period ended March 31, 2019:

Acquisitions:

During the first quarter of 2019, there were no acquisitions.

Divestitures:

During the first quarter of 2019, there were no divestitures.

Three-month period ended March 31, 2018:

Acquisitions:

During the first quarter of 2018, we paid approximately $21 million to acquire businesses and property consisting primarily of the acquisition of a 109-bed behavioral health care facility located in Gulfport, Mississippi.

Divestitures:

During the first quarter of 2018, there were no divestitures.

(10) Dividends

We declared and paid dividends of $9.1 million, or $.10 per share, during the first quarter of 2019 and $9.4 million or $.10 per share during the first quarter of 2018.

(11) Income Taxes

Our effective income tax rate was 19.9% for the three months ended March 31, 2019, compared with 22.8% for the three months ended March 31, 2018. The decrease in the effective tax rate during the three months ended March 31, 2019, compared with the same period in 2018, was primarily due to a $9 million decrease in our provision for income taxes attributable to employee share-based payment accounting, which decreased our provision for income taxes by $11 million during the first quarter of 2019 as compared to $2 million during the first quarter of 2018.

The global intangible low-taxed income ("GILTI") provisions from the TCJA-17 require the inclusion of the earnings of certain foreign subsidiaries in excess of an acceptable rate of return on certain assets of the respective subsidiaries in our U.S. tax return for tax years beginning after December 31, 2017. An accounting policy election was made during 2018 to treat taxes related to GILTI as a period cost when the tax is incurred. We recorded a GILTI tax provision of less than $1 million for the three months ended March 31, 2019 and 2018, respectively.

As of January 1, 2019, our unrecognized tax benefits were approximately $2 million. The amount, if recognized, that would favorably affect the effective tax rate is approximately $1 million. During the three months ended March 31, 2019, changes to the estimated liabilities for uncertain tax positions (including accrued interest) relating to tax positions taken during prior and current periods did not have a material impact on our financial statements.

We recognize accrued interest and penalties associated with uncertain tax positions as part of the tax provision. As of March 31, 2019, we have less than $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for 2015 and subsequent years. Foreign and U.S. state and local jurisdictions have statutes of limitations generally ranging from 3 to 4 years. The statute of limitations on certain jurisdictions could expire within the next twelve months. It is reasonably possible that the amount of uncertain tax benefits will change during the next 12 months, however, it is anticipated that any such change, if it were to occur, would not have a material impact on our results of operations.

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

(12) Revenue

In May 2014 and March 2016, the FASB issued ASU 2014-09 and ASU 2016-08, "Revenue from Contracts with Customers (Topic 606)" and "Revenue from Contracts with Customers: Principal versus Agent Considerations (Reporting Revenue Gross versus Net)", respectively, which provides guidance for revenue recognition. The standard's core principle is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. Under the new standards, our estimate for amounts not expected to be collected based on historical experience will continue to be recognized as a reduction to net revenue. However, subsequent changes in estimate of collectability due to a change in the financial status of a payer, for example a bankruptcy, will be recognized as bad debt expense in operating charges.

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

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

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

The following table disaggregates our revenue by major source for the three month periods ended March 31, 2019 and 2018 (in thousands):

	For the three months ended March 31, 2019					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 335,909	22%	$ 137,456	11%		$ 473,365	17%
Managed Medicare	209,103	14%	52,259	4%		261,362	9%
Medicaid	104,510	7%	172,916	13%		277,426	10%
Managed Medicaid	133,731	9%	267,273	21%		401,004	14%
Managed Care (HMO and PPOs)	570,383	38%	347,882	27%		918,265	33%
UK Revenue	0	0%	136,702	11%		136,702	5%
Other patient revenue and adjustments, net	51,883	3%	123,478	10%		175,361	6%
Other non-patient revenue	109,325	7%	48,417	4%	3,164	160,906	6%
Total Net Revenue	$ 1,514,844	100%	$ 1,286,383	100%	$ 3,164	2,804,391	100%

	For the three months ended March 31, 2018					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 342,718	24%	$ 142,527	12%		$ 485,245	18%
Managed Medicare	176,957	12%	44,995	4%		221,952	8%
Medicaid	105,966	7%	177,336	14%		283,302	11%
Managed Medicaid	111,277	8%	230,776	19%		342,053	13%
Managed Care (HMO and PPOs)	497,780	34%	358,062	29%		855,842	32%
UK Revenue	0	0%	114,741	9%		114,741	4%
Other patient revenue and adjustments, net	112,570	8%	116,985	9%		229,555	9%
Other non-patient revenue	98,364	7%	52,574	4%	3,888	154,826	6%
Total Net Revenue	$ 1,445,632	100%	$ 1,237,996	100%	$ 3,888	2,687,516	100%

(13) Lease Accounting

In February 2016, the FASB issued ASU 2016-02 (Topic 842) "Leases." Topic 842 supersedes the lease requirements in Accounting Standards Codification Topic 840, "Leases." Under Topic 842, lessees are required to recognize assets and liabilities on the balance sheet for most leases and provide enhanced disclosures. Leases will be classified as either finance or operating.

We adopted Topic 842 effective January 1, 2019. We applied Topic 842 to all leases as of January 1, 2019 with comparative periods continuing to be reported under Topic 840. We have elected the practical expedient package to not reassess at adoption (i) expired or existing contracts for whether they are or contain a lease, (ii) the lease classification of any existing leases or (iii) initial indirect costs for existing leases. We have also elected the policy exemption that allows lessees to choose to not separate lease and non-lease components by class of underlying asset and are applying this expedient to all relevant asset classes.

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

Our operating leases are primarily for real estate, including certain acute care facilities, off-campus outpatient facilities, medical office buildings, and corporate and other administrative offices. Our real estate lease agreements typically have initial terms of five to 10 years. These real estate leases may include one or more options to renew, with renewals that can extend the lease term from five to 10

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

The components of lease expense for the three month period ended March 31, 2019 are as follows (in thousands):

	Three months ended March 31, 2019
Operating lease cost	$ 18,079
Variable and short term lease cost (a)	8,046
Total lease cost	$ 26,125
Finance lease cost:	
Amortization of right-of-use-assets	$ 481
Interest on lease liabilities	484
Total finance lease cost	$ 965

(a) Includes equipment, month-to-month and leases with a maturity of less than 12 months.

Supplemental cash flow information related to leases for the three month period ended March 31, 2019 are as follows (in thousands):

	Three months ended March 31, 2019
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows from operating leases	$ 25,884
Operating cash flows from finance leases	$ 575
Financing cash flows from finance leases	$ 433
Right-of-use assets obtained in exchange for lease obligations:	
Operating leases	$ 355,981
Finance leases	0

Included in the $356 million of right-of-use assets obtained in exchange for operating lease obligations is $6 million of new operating leases entered into during the three month period ended March 31, 2019.

Supplemental balance sheet information related to leases as of March 31, 2019 are as follows (in thousands):

	March 31, 2019
Operating Leases	
Right of use assets-operating leases	$ 342,032
Operating lease liabilities	$ 56,136
Operating lease liabilities noncurrent	286,101
Total operating lease liabilities	$ 342,237
Finance Leases	
Property and equipment	$ 23,250
Accumulated depreciation	(9,882)
Property and equipment, net	$ 13,368
Current maturities of long-term debt	$ 1,737
Long-term debt	17,612
Total finance lease liabilities	$ 19,349
Weighted Average remaining lease term, years	
Operating leases	10.4
Finance leases	7.8
Weighted Average discount rate	
Operating leases	4.7%
Finance leases	10.5%

Future maturities of lease liabilities are as follows (in thousands):

	Operating Leases	Finance Leases
Year ending December 31,		
2019 (remaining 9 months)	$ 52,447	$ 2,842
2020	62,920	3,375
2021	55,817	3,257
2022	45,404	3,559
2023	41,277	3,654
Later years	183,572	12,096
Total lease payments	441,437	28,783
less imputed interest	(99,200)	(9,434)
Total	$ 342,237	$ 19,349

Future minimum rental payments under lease commitments with a term of more than one year as of December 31, 2018, prior to our adoption of ASU 2016-02 are as follows (amounts in thousands):

Year	Capital Leases	Operating Leases
2019	$ 3,996	$ 72,353
2020	3,345	59,492
2021	3,227	48,891
2022	3,508	35,233
2023	3,624	28,839
Later years	12,070	123,039
Total minimum rental	$ 29,770	$ 367,847
Less: Amount representing interest	(9,829)	
Present value of minimum rental commitments	19,941	
Less: Current portion of capital lease obligations	(2,128)	
Long-term portion of capital lease obligations	$ 17,813	

(14) Recent Accounting Standards

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

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

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

Overview

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

As of March 31, 2019, we owned and/or operated 353 inpatient facilities and 38 outpatient and other facilities including the following located in 37 states, Washington, D.C., the United Kingdom and Puerto Rico:

Acute care facilities located in the U.S.:

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

Behavioral health care facilities (327 inpatient facilities and 21 outpatient facilities):

Located in the U.S.:

- 188 inpatient behavioral health care facilities, and;
- 19 outpatient behavioral health care facilities.

Located in the U.K.:

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

Located in Puerto Rico:

- 3 inpatient behavioral health care facilities.

As a percentage of our consolidated net revenues, net revenues from our acute care hospitals, outpatient facilities and commercial health insurer accounted for 54% during each the three-month periods ended March 31, 2019 and 2018. Net revenues from our behavioral health care facilities and commercial health insurer accounted for 46% of our consolidated net revenues during each of three-month periods ended March 31, 2019 and 2018.

Our behavioral health care facilities located in the U.K. generated net revenues of approximately $137 million and $115 million during the three-month periods ended March 31, 2019 and 2018, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.237 billion as of March 31, 2019 and $1.224 billion as of December 31, 2018.

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

Forward-Looking Statements and Risk Factors

You should carefully review the information contained in this Quarterly Report, and should particularly consider any risk factors that we set forth in this Quarterly Report and in other reports or documents that we file from time to time with the Securities and Exchange Commission (the "SEC"). In this Quarterly Report, we state our beliefs of future events and of our future financial performance. This Quarterly Report contains "forward-looking statements" that reflect our current estimates, expectations and projections about our future results, performance, prospects and opportunities. Forward-looking statements include, among other things, the information concerning our possible future results of operations, business and growth strategies, financing plans, expectations that regulatory developments or other matters will not have a material adverse effect on our business or financial condition, our competitive position and the effects of competition, the projected growth of the industry in which we operate, and the benefits and synergies to be obtained from our completed and any future acquisitions, and statements of our goals and objectives, and other similar expressions concerning matters that are not historical facts. Words such as "may," "will," "should," "could," "would," "predicts," "potential," "continue," "expects," "anticipates," "future," "intends," "plans," "believes," "estimates," "appears," "projects" and similar expressions, as well as statements in future tense, identify forward-looking statements. In evaluating those statements, you should specifically consider various factors, including the risks related to healthcare industry trends and those detailed in our filings with the SEC including those set forth herein and in our Annual Report on Form 10-K for the year ended December 31, 2018 in *Item 1A. Risk Factors* and in *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations-Forward Looking Statements and Risk Factors*. Those factors may cause our actual results to differ materially from any of our forward-looking statements.

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

- our ability to comply with the existing laws and government regulations, and/or changes in laws and government regulations;
- an increasing number of legislative initiatives have been passed into law that may result in major changes in the health care delivery system on a national or state level. Legislation has already been enacted that has eliminated the penalty for failing to maintain health coverage that was part of the original Legislation. President Trump has already taken executive actions: (i) requiring all federal agencies with authorities and responsibilities under the Legislation to "exercise all authority and discretion available to them to waiver, defer, grant exemptions from, or delay" parts of the Legislation that place "unwarranted economic and regulatory burdens" on states, individuals or health care providers; (ii) the issuance of a final rule in June, 2018 by the Department of Labor to enable the formation of association health plans that would be exempt from certain Legislation requirements such as the provision of essential health benefits; (iii) the issuance of a final rule in August, 2018 by the Department of Labor, Treasury, and Health and Human Services to expand the availability of short-term, limited duration health insurance, (iv) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level; (v) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and lead to additional enrollment in short-term, limited duration insurance and association health plans; and (vi) the issuance of a proposed rule by the Department of Labor, Treasury, and Health and Human Services that would be incentivize the use of health reimbursement accounts by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these Executive Branch policies has led to reduced Exchange enrollment in 2018 and 2019 and is expected to further worsen the individual and small group market risk pools in future years. It is also anticipated that these and future policies may create additional cost and reimbursement pressures on hospitals, including ours. In addition, while attempts to repeal the entirety of the Affordable Care Act ("ACA") have not been successful to date, a key provision of the ACA was repealed as part of the Tax Cuts and Jobs Act and on December 14, 2018, a federal U.S. District Court Judge in Texas ruled the entire ACA is unconstitutional. While that ruling is stayed and has been appealed, it has caused greater uncertainty regarding the future status of the ACA. If all or any parts of the ACA are found to be unconstitutional, it could have a material adverse effect on our business, financial condition and results of operations. See below in *Sources of Revenue and Health Care Reform* for additional disclosure;
- possible unfavorable changes in the levels and terms of reimbursement for our charges by third party payers or government based payers, including Medicare or Medicaid in the United States, and government based payers in the United Kingdom;
- our ability to enter into managed care provider agreements on acceptable terms and the ability of our competitors to do the same, including contracts with United/Sierra Healthcare in Las Vegas, Nevada;
- the outcome of known and unknown litigation, government investigations, false claim act allegations, and liabilities and other claims asserted against us and other matters as disclosed in *Item 1. Legal Proceedings,* and the effects of adverse publicity relating to such matters*;*
- the potential unfavorable impact on our business of deterioration in national, regional and local economic and business conditions, including a worsening of unfavorable credit market conditions;
- competition from other healthcare providers (including physician owned facilities) in certain markets;
- technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for healthcare;
- our ability to attract and retain qualified personnel, nurses, physicians and other healthcare professionals and the impact on our labor expenses resulting from a shortage of nurses and other healthcare professionals;
- demographic changes;
- the availability of suitable acquisition and divestiture opportunities and our ability to successfully integrate and improve our acquisitions since failure to achieve expected acquisition benefits from certain of our prior or future acquisitions could result in impairment charges for goodwill and purchased intangibles;
- the impact of severe weather conditions, including the effects of hurricanes;

- as discussed below in *Sources of Revenue,* we receive revenues from various state and county based programs, including Medicaid in all the states in which we operate (we receive Medicaid revenues in excess of $100 million annually from each of Texas, California, Nevada, Washington, D.C., Pennsylvania and Illinois); CMS-approved Medicaid supplemental programs in certain states including Texas, Mississippi, Illinois, Oklahoma, Nevada, Arkansas, California and Indiana, and; state Medicaid disproportionate share hospital payments in certain states including Texas and South Carolina. We are therefore particularly sensitive to potential reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. We can provide no assurance that reductions to revenues earned pursuant to these programs, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations;
- our ability to continue to obtain capital on acceptable terms, including borrowed funds, to fund the future growth of our business;
- our inpatient acute care and behavioral health care facilities may experience decreasing admission and length of stay trends;
- our financial statements reflect large amounts due from various commercial and private payers and there can be no assurance that failure of the payers to remit amounts due to us will not have a material adverse effect on our future results of operations;
- in August, 2011, the Budget Control Act of 2011 (the "2011 Act") was enacted into law. The 2011 Act imposed annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Select Committee on Deficit Reduction (the "Joint Committee"), which was tasked with making recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year with a uniform percentage reduction across all Medicare programs. The Bipartisan Budget Act of 2015, enacted on November 2, 2015, continued the 2% reductions to Medicare reimbursement imposed under the 2011 Act. We cannot predict whether Congress will restructure the implemented Medicare payment reductions or what other federal budget deficit reduction initiatives may be proposed by Congress going forward;
- uninsured and self-pay patients treated at our acute care facilities unfavorably impact our ability to satisfactorily and timely collect our self-pay patient accounts;
- changes in our business strategies or development plans;
- in June, 2016, the United Kingdom affirmatively voted in a non-binding referendum in favor of the exit of the United Kingdom from the European Union (the "Brexit") and it has been approved by vote of the British legislature. On March 29, 2017, the United Kingdom triggered Article 50 of the Lisbon Treaty, formally starting negotiations regarding its exit from the European Union, scheduled for October 31, 2019. The actual exit of the United Kingdom from the European Union could cause disruptions to and create uncertainty surrounding our business. Any of these effects of Brexit (and the announcement thereof), and others we cannot anticipate, could harm our business, financial condition and results of operations;
- fluctuations in the value of our common stock, and;
- other factors referenced herein or in our other filings with the Securities and Exchange Commission.

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

Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. We consider our critical accounting policies to be those that require us to make significant judgments and estimates when we prepare our consolidated financial statements. For a summary of our significant accounting policies, please see *Note 1 to the Consolidated Financial Statements* as included in our Annual Report on Form 10-K for the year ended December 31, 2018.

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

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

Charity Care, Uninsured Discounts and Other Adjustments to Revenue: Collection of receivables from third-party payers and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. We estimate our revenue adjustments for implicit price concessions based on general factors such as payer mix, the agings of the receivables and historical collection experience, consistent with our estimates for provisions for doubtful accounts under ASC 605. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts and make adjustments to our allowances as warranted. At our acute care hospitals, third party liability accounts are pursued until all payment and adjustments are posted to the patient account. For those accounts with a patient balance after third party liability is finalized or accounts for uninsured patients, the patient receives statements and collection letters.

Under ASC 605, our hospitals established a partial reserve for self-pay accounts in the allowance for doubtful accounts for both unbilled balances and those that have been billed and were under 90 days old. All self-pay accounts were fully reserved at 90 days from the date of discharge. Third party liability accounts were fully reserved in the allowance for doubtful accounts when the balance aged past 180 days from the date of discharge. Patients that express an inability to pay were reviewed for potential sources of financial assistance including our charity care policy. If the patient was deemed unwilling to pay, the account was written-off as bad debt and transferred to an outside collection agency for additional collection effort. Under ASC 606, while similar processes and methodologies are considered, these revenue adjustments are considered at the time the services are provided in determination of the transaction price.

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

A portion of the accounts receivable at our acute care facilities are comprised of Medicaid accounts that are pending approval from third-party payers but we also have smaller amounts due from other miscellaneous payers such as county indigent programs in certain states. Our patient registration process includes an interview of the patient or the patient's responsible party at the time of registration. At that time, an insurance eligibility determination is made and an insurance plan code is assigned. There are various pre-established insurance profiles in our patient accounting system which determine the expected insurance reimbursement for each patient based on the insurance plan code assigned and the services rendered. Certain patients may be classified as Medicaid pending at registration based upon a screening evaluation if we are unable to definitively determine if they are currently Medicaid eligible. When a patient is registered as Medicaid eligible or Medicaid pending, our patient accounting system records net revenues for services provided to that patient based upon the established Medicaid reimbursement rates, subject to the ultimate disposition of the patient's Medicaid eligibility. When the patient's ultimate eligibility is determined, reclassifications may occur which impacts net revenues in future periods. Although the patient's ultimate eligibility determination may result in adjustments to net revenues, these adjustments do not have a material impact on our results of operations during the first quarter ended March 31, 2019 or the year ended December 31, 2018 since our facilities make estimates at each financial reporting period to adjust revenue based on historical collections. Under ASC 605, these estimates were reported in the provision for doubtful accounts.

We also provide discounts to uninsured patients (included in "uninsured discounts" amounts below) who do not qualify for Medicaid or charity care. Because we do not pursue collection of amounts classified as uninsured discounts, the transaction price is fully

adjusted and there is no impact in our net revenues or in our net accounts receivable. In implementing the discount policy, we first attempt to qualify uninsured patients for governmental programs, charity care or any other discount program. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

The following tables show the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the three-month periods ended March 31, 2019 and 2018:

Uncompensated care:

Amounts in millions	Three Months Ended			
	March 31, 2019	%	March 31, 2018	%
Charity care	$ 146	31%	$ 146	36%
Uninsured discounts	328	69%	263	64%
Total uncompensated care	$ 474	100%	$ 409	100%

Estimated cost of providing uncompensated care:

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

	Three Months Ended	
Amounts in millions	March 31, 2019	March 31, 2018
Estimated cost of providing charity care	$ 17	$ 18
Estimated cost of providing uninsured discounts related care	37	32
Estimated cost of providing uncompensated care	$ 54	$ 50

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

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

The total accrual for our professional and general liability claims and workers' compensation claims was $317 million as of March 31, 2019, of which $82 million is included in current liabilities. The total accrual for our professional and general liability claims and workers' compensation claims was $315 million as of December 31, 2018, of which $82 million is included in current liabilities.

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

Results of Operations

Three-month periods ended March 31, 2019 and 2018:

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended March 31, 2019 and 2018 (dollar amounts in thousands):

	Three months ended March 31, 2019		Three months ended March 31, 2018	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 2,804,391	100.0%	$ 2,687,516	100.0%
Operating charges:				
Salaries, wages and benefits	1,365,546	48.7%	1,300,148	48.4%
Other operating expenses	644,780	23.0%	620,819	23.1%
Supplies expense	307,463	11.0%	292,929	10.9%
Depreciation and amortization	120,040	4.3%	113,103	4.2%
Lease and rental expense	26,125	0.9%	26,703	1.0%
Subtotal-operating expenses	2,463,954	87.9%	2,353,702	87.6%
Income from operations	340,437	12.1%	333,814	12.4%
Interest expense, net	39,640	1.4%	37,576	1.4%
Other (income) expense, net	4,501	0.2%	-	—
Income before income taxes	296,296	10.6%	296,238	11.0%
Provision for income taxes	58,898	2.1%	67,569	2.5%
Net income	237,398	8.5%	228,669	8.5%
Less: Income attributable to noncontrolling interests	3,230	0.1%	4,837	0.2%
Net income attributable to UHS	$ 234,168	8.4%	$ 223,832	8.3%

Net revenues increased 4.3%, or $117 million, to $2.80 billion during the three-month period ended March 31, 2019 as compared to $2.69 billion during the first quarter of 2018. The net increase was primarily attributable to: (i) a $103 million or 3.9% increase in net revenues generated from our acute care hospital services and behavioral health services operated during both periods (which we refer to as "same facility"), and; (ii) $14 million of other combined net increases due primarily to the revenues generated at 25 behavioral health facilities located in the U.K. acquired during the third quarter of 2018 in connection with our acquisition of The Danshell Group.

Income before income taxes (before deduction for income attributable to noncontrolling interests) remained unchanged amounting to $296 million during each of the three-month periods ended March 31, 2019 and 2018. Noted below are certain changes to income before income taxes during the first quarter of 2019, as compared to the comparable quarter of 2018:

- a decrease of $11 million at our acute care facilities as discussed below in Acute Care Hospital Services;
- an increase of $5 million at our behavioral health care facilities, as discussed below in Behavioral Health Services;
- an increase of $13 million due to an increase recorded during the first quarter of 2018 to the reserve established in connection with the civil aspects of the government's investigation of certain of our behavioral health care facilities (see *Item 1 - Legal Proceedings* for additional disclosure);
- a decrease of $4 million from an unrealized loss recorded during the first quarter of 2019 resulting from a decrease in the market value of shares of certain marketable securities held for investment and classified as available for sale, and;
- $3 million of other combined net decreases.

Net income attributable to UHS increased $10 million to $234 million during the three-month period ended March 31, 2019 as compared to $224 million during the comparable prior year quarter. Changes to our net income attributable to UHS during the first quarter of 2019, as compared to the comparable prior year quarter, included:

- no net change in income before income taxes, as discussed above;
- an increase of $2 million due to an decrease in income attributable to noncontrolling interests, and;
- an increase of $9 million resulting from a decrease in the provision for income taxes resulting from a net decrease to our provision for income taxes resulting from ASU 2016-09 which decreased our provision for income taxes by $11 million during the first three months of 2019 as compared to $2 million during the first quarter of 2018.

Acute Care Hospital Services

Same Facility Basis Acute Care Hospital Services

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

The following table summarizes the results of operations for our acute care facilities on a same facility basis and is used in the discussion below for the three-month periods ended March 31, 2019 and 2018 (dollar amounts in thousands):

	Three months ended March 31, 2019		Three months ended March 31, 2018	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,490,862	100.0%	$ 1,423,777	100.0%
Operating charges:				
Salaries, wages and benefits	618,691	41.5%	581,768	40.9%
Other operating expenses	331,885	22.3%	308,181	21.6%
Supplies expense	257,711	17.3%	243,153	17.1%
Depreciation and amortization	74,228	5.0%	72,150	5.1%
Lease and rental expense	14,256	1.0%	14,283	1.0%
Subtotal-operating expenses	1,296,771	87.0%	1,219,535	85.7%
Income from operations	194,091	13.0%	204,242	14.3%
Interest expense, net	279	0.0%	531	0.0%
Other (income) expense, net	-	—	0	—
Income before income taxes	$ 193,812	13.0%	$ 203,711	14.3%

Three-month periods ended March 31, 2019 and 2018:

During the three-month period ended March 31, 2019, as compared to the comparable prior year quarter, net revenues from our acute care hospital services, on a same facility basis, increased $67 million or 4.7%. Income before income taxes (and before income attributable to noncontrolling interests) decreased $10 million, or 5%, amounting to $194 million or 13.0% of net revenues during the first quarter of 2019 as compared to $204 million or 14.3% of net revenues during the first quarter of 2018.

During the three-month period ended March 31, 2019, net revenue per adjusted admission decreased 0.4% while net revenue per adjusted patient day remained unchanged, as compared to the comparable quarter of 2018. During the three-month period ended March 31, 2019, as compared to the comparable prior year quarter, inpatient admissions to our acute care hospitals increased 5.2% and adjusted admissions (adjusted for outpatient activity) increased 4.9%. Patient days at these facilities increased 4.8% and adjusted patient days increased 4.4% during the three-month period ended March 31, 2019 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 4.6 days during each of the three-month periods ended March 31, 2019 and 2018. The occupancy rate, based on the average available beds at these facilities, was 66% during each of the three-month periods ended March 31, 2019 and 2018.

All Acute Care Hospitals

The following table summarizes the results of operations for all our acute care operations during the three-month periods ended March 31, 2019 and 2018. These amounts include: (i) our acute care results on a same facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iii) certain other amounts including, if applicable, the results of recently acquired/opened ancillary businesses. Dollar amounts below are reflected in thousands.

	Three months ended March 31, 2019		Three months ended March 31, 2018	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,514,844	100.0%	$ 1,445,632	100.0%
Operating charges:				
Salaries, wages and benefits	619,317	40.9%	581,768	40.2%
Other operating expenses	356,231	23.5%	330,036	22.8%
Supplies expense	258,144	17.0%	243,153	16.8%
Depreciation and amortization	74,361	4.9%	72,150	5.0%
Lease and rental expense	14,299	0.9%	14,283	1.0%
Subtotal-operating expenses	1,322,352	87.3%	1,241,390	85.9%
Income from operations	192,492	12.7%	204,242	14.1%
Interest expense, net	279	0.0%	531	0.0%
Other (income) expense, net	-	—	0	—
Income before income taxes	$ 192,213	12.7%	$ 203,711	14.1%

Three-month periods ended March 31, 2019 and 2018:

During the three-month period ended March 31, 2019, as compared to the comparable prior year quarter, net revenues from our acute care hospital services increased $69 million or 4.8% to $1.51 billion as compared to $1.45 billion due to: (i) a $67 million, or 4.7%, increase same facility revenues, as discussed above, and; (ii) other combined net increase of $2 million due primarily to increased provider taxes incurred during the first quarter of 2019 as compared to the first quarter of 2018.

Income before income taxes decreased $11 million, or 6%, to $192 million or 12.7% of net revenues during the first quarter of 2019 as compared to $204 million or 14.1% of net revenues during the first quarter of 2018. The decrease resulted primarily from the $10 million decrease in income before income taxes from our acute care hospital services, on a same facility basis, as discussed above.

Behavioral Health Services

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

The following table summarizes the results of operations for our behavioral health care facilities, on a same facility basis, and is used in the discussions below for the three-month periods ended March 31, 2019 and 2018 (dollar amounts in thousands):

Same Facility—Behavioral Health

	Three months ended March 31, 2019		Three months ended March 31, 2018	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,241,225	100.0%	$ 1,205,048	100.0%
Operating charges:				
Salaries, wages and benefits	655,586	52.8%	630,831	52.3%
Other operating expenses	234,424	18.9%	230,586	19.1%
Supplies expense	48,618	3.9%	48,743	4.0%
Depreciation and amortization	39,872	3.2%	36,738	3.0%
Lease and rental expense	10,917	0.9%	11,696	1.0%
Subtotal-operating expenses	989,417	79.7%	958,594	79.5%
Income from operations	251,808	20.3%	246,454	20.5%
Interest expense, net	375	0.0%	427	0.0%
Other (income) expense, net	-	—	0	—
Income before income taxes	$ 251,433	20.3%	$ 246,027	20.4%

Three-month periods ended March 31, 2019 and 2018:

On a same facility basis during the first quarter of 2019, as compared to the first quarter of 2018, net revenues generated from our behavioral health services increased $36 million, or 3.0%, to $1.24 billion from $1.21 billion. Income before income taxes increased $5 million, or 2%, to $251 million or 20.3% of net revenues during the three-month period ended March 31, 2019, as compared to $246 million or 20.4% of net revenues during the comparable quarter of 2018.

During the three-month period ended March 31, 2019, net revenue per adjusted admission increased 0.4% and net revenue per adjusted patient day increased 2.5%, as compared to the comparable quarter of 2018. On a same facility basis, inpatient admissions and adjusted admissions to our behavioral health facilities increased 2.8% and 2.9%, respectively, during the three-month period ended March 31, 2019 as compared to the comparable quarter of 2018. Patient days and adjusted patient days increased 0.8% and 0.9% during the three-month period ended March 31, 2019 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 12.9 days and 13.1 days during the three-month periods ended March 31, 2019 and 2018, respectively. The occupancy rate, based on the average available beds at these facilities, was 77% during each of the three-month periods ended March 31, 2019 and 2018.

All Behavioral Health Care Facilities

The following table summarizes the results of operations for all our behavioral health care services during the three-month periods ended March 31, 2019 and 2018. These amounts include: (i) our behavioral health care results on a same facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iii) certain other amounts including the results of facilities acquired or opened during the past year as well as the results of certain facilities that were closed or restructured during the past year. Dollar amounts below are reflected in thousands.

	Three months ended March 31, 2019		Three months ended March 31, 2018	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,286,383	100.0%	$ 1,237,996	100.0%
Operating charges:				
Salaries, wages and benefits	675,699	52.5%	642,128	51.9%
Other operating expenses	262,137	20.4%	256,402	20.7%
Supplies expense	49,131	3.8%	49,536	4.0%
Depreciation and amortization	42,552	3.3%	38,454	3.1%
Lease and rental expense	11,644	0.9%	12,301	1.0%
Subtotal-operating expenses	1,041,163	80.9%	998,821	80.7%
Income from operations	245,220	19.1%	239,175	19.3%
Interest expense, net	375	0.0%	427	0.0%
Other (income) expense, net	677	0.1%	0	—
Income before income taxes	$ 244,168	19.0%	$ 238,748	19.3%

Three-month periods ended March 31, 2019 and 2018:

During the three-month period ended March 31, 2019, as compared to the comparable prior year quarter, net revenues generated from our behavioral health services increased $48 million or 3.9% due to primarily to: (i) the above-mentioned $36 million or 3.0% increase in net revenues on a same facility basis, and; (ii) an $12 million other combined net increase due primarily to the revenues generated at 25 behavioral health facilities located in the U.K. acquired during the third quarter of 2018 in connection with our acquisition of The Danshell Group.

Income before income taxes increased $5 million, or 2%, to $244 million or 19.0% of net revenues during the first quarter of 2019 as compared to $239 million or 19.3% during the first quarter of 2018. The increase resulted from the $5 million increase in income before income taxes generated at our behavioral health facilities, on a same facility basis, as discussed above.

Sources of Revenue

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

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

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

Sources of Revenues and Health Care Reform: Given increasing budget deficits, the federal government and many states are currently considering additional ways to limit increases in levels of Medicare and Medicaid funding, which could also adversely affect future payments received by our hospitals. In addition, the uncertainty and fiscal pressures placed upon the federal government as a result of, among other things, economic recovery stimulus packages, responses to natural disasters, and the federal 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.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (the "ACA"). The Healthcare and Education Reconciliation Act of 2010 (the "Reconciliation Act"), which contains a number of amendments to the ACA, was signed into law on March 30, 2010. Two primary goals of the ACA, combined with the Reconciliation Act (collectively referred to as the "Legislation"), are to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses.

The Legislation revises reimbursement under the Medicare and Medicaid programs to emphasize the efficient delivery of high quality care and contains a number of incentives and penalties under these programs to achieve these goals. The Legislation provides for decreases in the annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the market basket update beginning October 1, 2011 for Medicare Part B reimbursable items and services and beginning October 1, 2012 for Medicare inpatient hospital services. The Legislation and subsequent revisions provide for reductions to both Medicare DSH and Medicaid DSH payments. The Medicare DSH reductions began in October, 2013 while the Medicaid DSH reductions are scheduled to begin in 2020. The Legislation implements a value-based purchasing program, which will reward the delivery of efficient care. Conversely, certain facilities will receive reduced reimbursement for failing to meet quality parameters; such hospitals will include those with excessive readmission or hospital-acquired condition rates.

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

Medicaid expansion program by reducing their existing Medicaid funding. Therefore, states can choose to accept or not to participate without risking the loss of federal Medicaid funding. As a result, many states, including Texas, have not expanded their Medicaid programs without the threat of loss of federal funding. CMS has granted, and is expected to grant additional, section 1115 demonstration waivers providing for work and community engagement requirements for certain Medicaid eligible individuals. It is anticipated this will lead to reductions in coverage, and likely increases in uncompensated care, in states where these demonstration waivers are granted.

On December 14, 2018, a Texas Federal District Court deemed the ACA to be unconstitutional in its entirety. The Court concluded that the Individual Mandate is no longer permissible under Congress's taxing power as a result of the Tax Cut and Jobs Act of 2017 ("TCJA") reducing the Individual Mandate's tax to $0 (i.e., it no longer produces revenue, which is an essential feature of a tax), rendering the ACA unconstitutional. The court also held that because the individual mandate is "essential" to the ACA and is inseverable from the rest of the law, the entire ACA is unconstitutional. Because the court issued a declaratory judgment and did not enjoin the law, the ACA remains in place pending its appeal. The District Court for the Northern District of Texas ruling has been appealed to the U.S. Court of Appeals for the Fifth Circuit, and will likely be appealed to the United States Supreme Court. We are unable to predict the final outcome of this legal challenge and its financial impact on our future results of operation.

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

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

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

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

In addition to legislative changes, the Legislation can be significantly impacted by executive branch actions. In relevant part, President Trump has already taken executive actions: (i) requiring all federal agencies with authorities and responsibilities under the

Legislation to "exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay" parts of the Legislation that place "unwarranted economic and regulatory burdens" on states, individuals or health care providers; (ii) the issuance of a final rule in June, 2018 by the Department of Labor to enable the formation of health plans that would be exempt from certain Legislation essential health benefits requirements; (iii) the issuance of a final rule in August, 2018 by the Department of Labor, Treasury, and Health and Human Services to expand the availability of short-term, limited duration health insurance; (iv) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level, (v) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and lead to additional enrollment in short-term, limited duration insurance and association health plans, and; (vi) the issuance of a proposed rule by the Department of Labor that would incentivize the use of health reimbursement accounts by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these Executive Branch policies led to reduced Exchange enrollment in 2018 with final CMS reported data for 2019 indicating further decline and is expected to further worsen the individual and small group market risk pools in future years. In May, 2019, The Congressional Budget Office projected that 32 million people will be uninsured in 2020. It is also anticipated that these and future policies may create additional cost and reimbursement pressures on hospitals.

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

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

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

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

In April, 2019, CMS published its IPPS 2020 proposed payment rule which provides for a 3.2% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments ACA-mandated adjustments are considered, without consideration for changes related to the required Medicare DSH payment changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 3.2%. Including DSH payments (where no change is projected) and certain other adjustments, we estimate our overall increase from the proposed IPPS 2020 rule (covering the period of October 1, 2019 through September 30, 2020) will approximate 2.7%. This projected impact from the IPPS 2020 proposed rule includes an increase of approximately 0.5% to partially restore cuts made as a result of the American Taxpayer Relief Act of 2012 ("ATRA"), as required by the 21st Century Cures Act but excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, Bipartisan Budget Act of 2015, and Bipartisan Budget Act of 2018, as discussed below. CMS completed its full phase-in to use uncompensated care data from the 2015 Worksheet S-10 hospital cost reports to allocate approximately $8.5 billion in the DSH Uncompensated Care Pool.

In August, 2018, CMS published its IPPS 2019 final payment rule which provides for a 2.9% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments ACA-mandated adjustments are considered, without consideration for the decreases related to the required Medicare DSH payment changes and decrease to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 0.5%. Including the estimated increase to our DSH payments (approximating 2.1%) and certain other adjustments, we estimate our overall increase from the final IPPS 2019 rule (covering the period of October 1, 2018 through September 30, 2019) will approximate 2.7%. This projected impact from the IPPS 2019 final rule includes an increase of approximately 0.5% to partially restore cuts made as a result of the ATRA, as required by the 21st Century Cures Act but excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, Bipartisan Budget Act of 2015, and Bipartisan Budget Act of 2018, as discussed below. CMS continued to phase-in the use of uncompensated care data from both the 2014 and 2015 Worksheet S-10 hospital cost reports, two-third weighting as part of the proxy methodology to allocate approximately $8 billion in the DSH Uncompensated Care Pool. This final rule change will continue to result in wide variations among all hospitals nationwide in the distribution of these DSH funds compared to previous years until the full phase-in of worksheet S-10 is completed by CMS.

In August, 2017, CMS published its IPPS 2018 final payment rule which provides for a 2.9% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and ACA-mandated adjustments are considered, without consideration for the decreases related to the required Medicare DSH payment changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments would approximate 2.3%. Including the estimated decrease to our DSH payments (approximating 0.1%) and certain other adjustments, we estimate our overall increase from the final IPPS 2018 rule (covering the period of October 1, 2017 through September 30, 2018) will approximate 1.8%. This projected impact from the IPPS 2018 final rule includes an increase of approximately 0.5% to partially restore cuts made as a result of the ATRA, as required by the 21st Century Cures Act but excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, Bipartisan Budget Act of 2015, and Bipartisan Budget Act of 2018, as discussed below. CMS began using uncompensated care data from the 2014 hospital cost report Worksheet S-10, one-third weighting as part of the proxy methodology to allocate approximately $7 billion in the DSH Uncompensated Care Pool. This final rule change resulted in wide variations among all hospitals nationwide in the distribution of these DSH funds compared to previous years.

In August, 2011, the Budget Control Act of 2011 (the "2011 Act") was enacted into law. Included in this law are the imposition of annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Committee, which was responsible for developing recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year. The Bipartisan Budget Act of 2015, enacted on November 2, 2015, and the Bipartisan Budget Act of 2018, enacted on February 9, 2018, continued the 2% reductions to Medicare reimbursement imposed under the 2011 Act.

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

In April, 2019, CMS published its Psych PPS proposed rule for the federal fiscal year 2020. Under this proposed rule, payments to our psychiatric hospitals and units are estimated to increase by 1.85% compared to federal fiscal year 2019. This amount includes the effect of the 3.1% market basket update less a 0.75% adjustment as required by the ACA and a 0.5% productivity adjustment.

In August, 2018, CMS published its Psych PPS final rule for the federal fiscal year 2019. Under this final rule, payments to our psychiatric hospitals and units are estimated to increase by 1.35% compared to federal fiscal year 2018. This amount includes the effect of the 2.90% market basket update less a 0.75% adjustment as required by the ACA and a 0.8% productivity adjustment.

In August, 2017, CMS published its Psych PPS final rule for the federal fiscal year 2018. Under this final rule, payments to our psychiatric hospitals and units are estimated to increase by 1.25% compared to federal fiscal year 2017. This amount includes the effect of the 2.6% market basket update less a 0.75% adjustment as required by the ACA and a 0.6% productivity adjustment.

In December, 2018, the U.S. District Court for the District of Columbia ruled that the U.S. Department of Health and Human Services ("HHS") did not have statutory authority to implement the 2018 Medicare OPPS rate reduction related to hospitals that qualify for drug discounts under the federal 340B Drug Discount Program and granted a permanent injunction against the payment reduction.

However, recognizing both the complexity of the OPPS payment system as well as its budget neutral rate setting system, the Court refrained from imposing a remedy. Instead the Judge in the case called for additional briefing from the Plaintiffs and Defendants on the proper scope and implementation for relief. The case has been appealed by HHS. We are unable to predict the ultimate outcome of any appeal and the type of relief that may be ordered by the Courts. We estimate that the CMS 2018 change in the 340B payment policy increased our 2018 Medicare OPPS payments by approximately $8 million, which has been fully reserved in our results of operations for the year, and estimate that a comparable amount was scheduled to be earned during 2019.

In November, 2018, CMS published its OPPS final rule for 2019. The hospital market basket increase is 2.9%. The Medicare statute requires a productivity adjustment reduction of 0.8% and 0.75% reduction to the 2019 OPPS market basket resulting in a 2019 update to OPPS payment rates by 1.35%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2019 will aggregate to a net increase of 1.1% which includes a 5.7% increase to behavioral health division partial hospitalization rates. When the behavioral health division's partial hospitalization rate impact is excluded, we estimate that our Medicare 2019 OPPS payments will result in a 0.4% increase in payment levels for our acute care division, as compared to 2018.

In November, 2017, CMS published its OPPS final rule for 2018. The hospital market basket increase is 2.7%. The Medicare statute requires a productivity adjustment reduction of 0.6% and 0.75% reduction to the 2018 OPPS market basket resulting in a 2018 OPPS market basket update at 1.35%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2018 will aggregate to a net increase of 4.2% which includes a 0.8% increase to behavioral health division partial hospitalization rates. When the behavioral health division's partial hospitalization rate impact is excluded, we estimate that our Medicare 2018 OPPS payments will result in a 4.8% increase in payment levels for our acute care division, as compared to 2017. Additionally, the Medicare inpatient-only (IPO) list includes procedures that are only paid under the Hospital Inpatient Prospective Payment System. Each year, CMS uses established criteria to review the IPO list and determine whether or not any procedures should be removed from the list. CMS removed total knee arthroplasty (TKA) from the IPO list effective January 1, 2018. Additionally, CMS redistributed $1.6 billion in cost savings within the OPPS system attributable to changes in the federal 340B hospital drug pricing payment methodology in 2018 but, as discussed above, this 340B-related payment methodology is currently under legal challenge. The impact of these IPO and 340B changes are reflected in the above noted estimated acute care division percentage change in OPPS reimbursement.

In November, 2016, CMS published its OPPS final rule for 2017. The hospital market basket increase is 2.7%. The Medicare statute requires a productivity adjustment reduction of 0.3% and 0.75% reduction to the 2017 OPPS market basket resulting in a 2017 OPPS market basket update at 1.65%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2017 resulted in a net increase of 1.5% which included a -1.3% decrease to behavioral health division partial hospitalization rates. When the behavioral health division's partial hospitalization rate impact is excluded, we estimate that our Medicare 2017 OPPS payments resulted in a 2.1% increase in payment levels for our acute care division, as compared to 2016.

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

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

The ACA substantially increases the federally and state-funded Medicaid insurance program, and authorizes states to establish federally subsidized non-Medicaid health plans for low-income residents not eligible for Medicaid starting in 2014. However, the Supreme Court has struck down portions of the ACA requiring states to expand their Medicaid programs in exchange for increased federal funding. Accordingly, many states in which we operate have not expanded Medicaid coverage to individuals at 133% of the federal poverty level. Facilities in states not opting to expand Medicaid coverage under the ACA may be additionally penalized by

corresponding reductions to Medicaid disproportionate share hospital payments beginning in 2020, as discussed below. We can provide no assurance that further reductions to Medicaid revenues, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations.

Various State Medicaid Supplemental Payment Programs:

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

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

Texas Uncompensated Care/Upper Payment Limit Payments:

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

For state fiscal year 2017, Texas Medicaid continued to operate under a CMS-approved Section 1115 five-year Medicaid waiver demonstration program extended by CMS for fifteen months to December 31, 2017. During the first five years of this program that started in state fiscal year 2012, the THHSC transitioned away from UPL payments to new waiver incentive payment programs, UC and DSRIP payments. During demonstration periods ending December 31, 2017, THHSC continued to, make incentive payments under the program after certain qualifying criteria were met by hospitals. Supplemental payments are also subject to aggregate statewide caps based on CMS approved Medicaid waiver amounts.

On December 21, 2017, CMS approved the 1115 Waiver for the period January 1, 2018 to September 30, 2022. The Waiver continued to include UC and DSRIP payment pools with modifications and new state specific reporting deadlines that if not met by THHSC will result in material decreases in the size of the UC and DSRIP pools. For UC during the initial two years of this renewal, the UC program will remain relatively the same in size and allocation methodology. For year three of this waiver renewal, FFY 2020, and through FFY 2022, the size and distribution of the UC pool will be determined based on charity care costs reported to HHSC in accordance with Medicare cost report Worksheet S-10 principles. For FFY 2020 and forward, we are unable to estimate the impact on of these UC program changes on our future operating results.

Effective April 1, 2018, certain of our acute care hospitals located in Texas began to receive Medicaid managed care rate enhancements under the Uniform Hospital Rate Increase Program ("UHRIP"). The non-federal share component of these UHRIP rate enhancements are financed by Provider Taxes. The Texas 1115 Waiver rules require UHRIP rate enhancements be considered in the Texas UC payment methodology which results in a reduction to our UC payments. The UC amounts reported in the State Medicaid Supplemental Payment Program Table below reflect the impact of this new UHRIP program.

On November 16, 2018, THHSC published a final rule effective in federal fiscal years 2018 and 2019 that changes the definition of a rural hospital for the purposes of determining Texas UC payments and the applicable UC payment reduction. The application of UC payment reduction allows the THHSC to comply with the overall statewide UC payment cap required under the special terms and condition of the approved 1115 Waiver. Two of our acute care hospitals, which have been designated as a Rural Referral Center by CMS and which are located in an urban Metropolitan Statistical Area, recorded: (i) increased UC payments/revenue for the federal fiscal year ending September 30, 2018, and; (ii) decreased UC payments/revenue for the federal fiscal year beginning October 1, 2018. The net impact of these changes had a favorable impact on our 2018 results of operations and are included in the amounts reflected below in the *State Medicaid Supplemental Payment Program* table.

Texas Delivery System Reform Incentive Payments:

In addition, the Texas Medicaid Section 1115 Waiver includes a DSRIP pool to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness. DSRIP pool payments are incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. In May, 2014, CMS formally approved specific DSRIP projects for certain of our hospitals for demonstration years 3 to 5 (our facilities did not materially participate in the DSRIP pool during demonstration years 1 or 2). DSRIP payments are contingent on the hospital meeting certain pre-determined milestones, metrics and clinical outcomes. Additionally, DSRIP payments are contingent on a governmental entity providing an IGT for the non-federal share component of the DSRIP payment. THHSC generally approves DSRIP reported metrics, milestones and clinical outcomes on a semi-annual basis in June and December. Under the CMS approval noted above, the Waiver renewal requires the transition of the DSRIP program to one focused on "health system performance measurement and improvement." THHSC must submit a transition plan describing "how it will further develop its delivery system reforms without DSRIP funding and/or phase out DSRIP funded activities and meet mutually agreeable milestones to demonstrate its ongoing progress." The size of the DSRIP pool will remain unchanged for the initial two years of the waiver renewal with unspecified decreases in years three and four of the renewal, FFY 2020 and 2021, respectively. In FFY 2022, DSRIP funding under the waiver is eliminated. For FFY 2020 and 2021, we are unable to estimate the impact of these DSRIP program changes on its operating results. For FFY 2022, we will no longer receive DSRIP funds due to the elimination of this funding source by CMS in the Waiver renewal.

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

The following table summarizes the revenues, Provider Taxes and net benefit related to each of the above-mentioned Medicaid supplemental programs for the three-month periods ended March 31, 2019 and 2018. The Provider Taxes are recorded in other operating expenses on the Condensed Consolidated Statements of Income as included herein.

	(amounts in millions)	
	Three Months Ended	
	March 31, 2019	March 31, 2018
Texas UC/UPL:		
Revenues	$ 26	$ 21
Provider Taxes	(10)	(6)
Net benefit	$ 16	$ 15
Texas DSRIP:		
Revenues	$ 0	$ 0
Provider Taxes	0	0
Net benefit	$ 0	$ 0
Various other state programs:		
Revenues	$ 61	$ 56
Provider Taxes	(34)	(36)
Net benefit	$ 27	$ 20
Total all Provider Tax programs:		
Revenues	$ 87	$ 77
Provider Taxes	(44)	(42)
Net benefit	$ 43	$ 35

We estimate that our aggregate net benefit from the Texas and various other state Medicaid supplemental payment programs will approximate $178 million (net of Provider Taxes of $186 million) during the year ending December 31, 2019. This estimate is based upon various terms and conditions that are out of our control including, but not limited to, the states'/CMS's continued approval of the programs and the applicable hospital district or county making IGTs consistent with 2018 levels. Future changes to these terms and conditions could materially reduce our net benefit derived from the programs which could have a material adverse impact on our future consolidated results of operations. In addition, Provider Taxes are governed by both federal and state laws and are subject to future legislative changes that, if reduced from current rates in several states, could have a material adverse impact on our future consolidated results of operations.

Texas and South Carolina Medicaid Disproportionate Share Hospital Payments:

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

Upon meeting certain conditions and serving a disproportionately high share of Texas' and South Carolina's low income patients, five of our facilities located in Texas and one facility located in South Carolina received additional reimbursement from each state's DSH fund. The South Carolina and Texas DSH programs were renewed for each state's 2019 DSH fiscal year (covering the period of October 1, 2018 through September 30, 2019).

In connection with these DSH programs, included in our financial results was an aggregate of approximately $9 million and $10 million during the three-month periods ended March 31, 2019 and 2018, respectfully. We expect the aggregate reimbursements to our hospitals pursuant to the Texas and South Carolina 2019 fiscal year programs to be approximately $33 million.

The ACA and subsequent federal legislation provides for a significant reduction in Medicaid disproportionate share payments beginning in federal fiscal year 2020 (see below in *Sources of Revenues and Health Care Reform-Medicaid Revisions* for additional disclosure). The U.S. Department of Health and Human Services is to determine the amount of Medicaid DSH payment cuts imposed on each state based on a defined methodology. As Medicaid DSH payments to states will be cut, consequently, payments to Medicaid-participating providers, including our hospitals in Texas and South Carolina, will be reduced in the coming years. Based on the CMS proposed rule published in July, 2017, Medicaid DSH payments in South Carolina and Texas could be reduced by approximately 20% and 14%, respectively, from projected 2018 DSH payment levels beginning in FFY 2020.

Nevada SPA:

In Nevada, CMS approved a state plan amendment ("SPA") in August, 2014 that implemented a hospital supplemental payment program retroactive to January 1, 2014. This SPA has been approved for additional state fiscal years including the 2019 fiscal year covering the period of July 1, 2018 through June 30, 2019.

In connection with this program, included in our financial results was approximately $7 million and $6 million during the three-month periods ended March 31, 2019 and 2018, respectively. We estimate that our reimbursements pursuant to this program will approximate $26 million during the year ended December 31, 2019.

California SPA:

In California, CMS issued formal approval of the 2017-19 Hospital Fee Program in December, 2017 retroactive to January 1, 2017 through June 30, 2019. This approval included the Medicaid inpatient and outpatient fee-for-service supplemental payments and the overall provider tax structure but did not yet include the approval of the managed care payment component. Upon approval by CMS, the managed care payment component will consist of two categories of payments, "pass-through" payments and "directed" payments. The pass-through payments will be similar in nature to the prior Hospital Fee Program payment method whereas the directed payment method will be based on actual concurrent hospital Medicaid managed care in-network patient volume. In March, 2018, CMS approved the "directed" payment component methodology for the period of July 1, 2017 through September 30, 2018. The timing of CMS approval of the "pass through" component and the remaining "directed" payment periods is uncertain. We estimate that the managed care component of the Hospital Fee Program will result in a favorable impact on our operating results of $6 million in 2019 while this program favorably impacted our 2018 results of operations by $16 million, $7 million of which related to prior years. The aggregate impact of the California supplemental payment program, as outlined above, is included in the above *State Medicaid Supplemental Payment Program* table.

Risk Factors Related To State Supplemental Medicaid Payments:

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

In April, 2016, CMS published its final Medicaid Managed Care Rule which explicitly permits but phases out the use of pass-through payments (including supplemental payments) by Medicaid Managed Care Organizations ("MCO") to hospitals over ten years but

allows for a transition of the pass-through payments into value-based payment structures, delivery system reform initiatives or payments tied to services under a MCO contract. Since we are unable to determine the financial impact of this aspect of the final rule, we can provide no assurance that the final rule will not have a material adverse effect on our future results of operations. In November, 2018, CMS issued a proposed rule that would permit pass-through supplemental provider payments during a time-limited period when states transition populations or services from fee-for-service Medicaid to managed care.

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

Pursuant to HITECH Act regulations, hospitals that do not qualify as a meaningful user of EHR by 2015 are subject to a reduced market basket update to the IPPS standardized amount in 2015 and each subsequent fiscal year. We believe that all of our acute care hospitals have met the applicable meaningful use criteria and therefore are not subject to a reduced market basked update to the IPPS standardized amount in federal fiscal year 2015. However, under the HITECH Act, hospitals must continue to meet the applicable meaningful use criteria in each fiscal year or they will be subject to a market basket update reduction in a subsequent fiscal year. Failure of our acute care hospitals to continue to meet the applicable meaningful use criteria would have an adverse effect on our future net revenues and results of operations.

Federal regulations require that Medicare EHR incentive payments be computed based on the Medicare cost report that begins in the federal fiscal period in which a hospital meets the applicable "meaningful use" requirements. Since the annual Medicare cost report periods for each of our acute care hospitals ends on December 31st, we will recognize Medicare EHR incentive income for each hospital during the fourth quarter of the year in which the facility meets the "meaningful use" criteria and during the fourth quarter of each applicable subsequent year.

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

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

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

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

Other Sources: Our hospitals provide services to individuals that do not have any form of health care coverage. Such patients are evaluated, at the time of service or shortly thereafter, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other state assistance programs, as well as our local hospitals' indigent and charity care policy. Patients

without health care coverage who do not qualify for Medicaid or indigent care write-offs are offered substantial discounts in an effort to settle their outstanding account balances.

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

Implemented Medicare Reductions and Reforms:

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

Medicaid Revisions:

- Expanded Medicaid eligibility and related special federal payments, effective in 2014.
- The ACA (as amended by subsequent federal legislation) requires annual aggregate reductions in federal DSH funding from federal fiscal year ("FFY") 2020 through FFY 2025. The aggregate annual reduction amounts are $4.0 billion for FFY 2020 and $8.0 billion for FFY 2021 through FFY 2025.

Health Insurance Revisions:

- Large employer insurance reforms, effective in 2015.
- Individual insurance mandate and related federal subsidies, effective in 2014. As noted above in *Health Care Reform,* the Tax Cuts and Jobs Act enacted into law in December, 2017 eliminated the individual insurance federal mandate penalty after December 31, 2018.
- Federally mandated insurance coverage reforms, effective in 2010 and forward.

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

Value-Based Purchasing:

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

The ACA required HHS to implement a value-based purchasing program for inpatient hospital services which became effective on October 1, 2012. The ACA requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1% in FFY 2013 and increasing by 0.25% each fiscal year up to 2% in FFY 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions. In its fiscal year 2016 IPPS final rule, CMS funded the value-based purchasing program by reducing base operating DRG payment amounts to participating hospitals by 1.75%. For FFY 2017, this reduction was increased to its maximum of 2%.

Hospital Acquired Conditions:

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

Readmission Reduction Program:

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

Accountable Care Organizations:

The ACA requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("ACOs"). The ACO program allows providers (including hospitals), physicians and other designated professionals and suppliers to voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. CMS is also developing and implementing more advanced ACO payment models, such as the Next Generation ACO Model, which require ACOs to assume greater risk for attributed beneficiaries. On December 21, 2018, CMS published a final rule that, in general, requires ACO participants to take on additional risk associated with participation in the program. It remains unclear to what extent providers will pursue federal ACO status or whether the required investment would be warranted by increased payment.

Bundled Payments for Care Improvement Advanced:

The Center for Medicare & Medicaid Innovation ("CMMI") is responsible for establishing demonstration projects and other initiatives aimed to develop, test and encourage the adoption of new methods for delivery and payment for health care that create savings under the Federal Medicare and state Medicaid programs while improving quality of care. For example, providers participating in bundled payment initiatives agree to receive one payment for services provided to Medicare beneficiaries for certain medical conditions or episodes of care, accepting accountability for costs and quality of care across the continuum of care. By rewarding providers for increasing quality and reducing costs, and penalizing providers if costs exceed a set amount, these models are intended to lead to higher quality and more coordinated care at a lower cost to the Medicare beneficiary and overall program. The CMMI has previously implemented a voluntary bundled payment program known as the Bundled Payment for Care Improvement ("BPCI"). Substantially all of our acute care hospitals were participants in the BPCI program, which ended September 30, 2018.

CMMI implemented a new, second generation voluntary episode payment model, Bundled Payments for Care Improvement Advanced (BPCI-Advanced or the Program), with the first performance period beginning October 1, 2018. BPCI-Advanced is designed to test a new iteration of bundled payments for 32 Clinical Episodes (29 inpatient and 3 outpatient) with an aim to align incentives among participating health care providers to reduce expenditures and improve quality of care for traditional Medicare beneficiaries. The first cohort of participants entered BPCI-Advanced on October 1, 2018, and agreed to an initial performance period that will run through December 31, 2023. We have elected to participate in BPCI-Advanced at seventeen (17) of our acute care hospitals across almost two hundred (200) clinical episodes in collaboration with a third-party convener which has extensive experience and success in BPCI. The ultimate success and financial impact of the BPCI-Advanced program is contingent on multiple variables so we are unable to estimate the impact. However, given the breadth and scope of participation of our acute care hospitals in BPCI-Advanced, the impact could be significant (either favorably or unfavorably) depending on actual program results.

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 payers could have a material adverse effect on our financial position and our results.

Other Operating Results

Interest Expense:

As reflected on the schedule below, interest expense was $40 million and $38 million during the three-month periods ended March 31, 2019 and 2018, respectively (amounts in thousands):

	Three Months Ended March 31, 2019	Three Months Ended March 31, 2018
Revolving credit & demand notes (a.)	$ 745	$ 3,235
$300 million, 3.75% Senior Notes due 2019 (b.)	0	2,813
$700 million, 4.75% Senior Notes due 2022, net (c.)	8,069	8,069
$400 million, 5.00% Senior Notes due 2026 (d.)	5,000	5,000
Term loan facility A (a.)	19,334	13,746
Term loan facility B (a.)	5,318	-
Accounts receivable securitization program (e.)	3,192	2,659
Subtotal-revolving credit, demand notes, Senior Notes, term loan facility and accounts receivable securitization program	41,658	35,522
Interest rate swap income, net	(2,944)	(709)
Amortization of financing fees	1,278	2,247
Other combined interest expense	691	1,040
Capitalized interest on major projects	(774)	(421)
Interest income	(269)	(103)
Interest expense, net	$ 39,640	$ 37,576

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

As of March 31, 2019, we had: (i) no outstanding borrowings under the $1 billion revolving credit facility; (ii) $1.988 billion of borrowings outstanding under the term loan A facility, and; (iii) $499 million of borrowings outstanding under the term loan B facility.

(b.) On November 26, 2018 we redeemed the $300 million aggregate principal, 3.75% Senior Notes due 2019. The 2019 Notes were redeemed for an aggregate price equal to 100.485% of the principal amount (premium of approximately $1 million) plus accrued interest to the redemption date.

(c.) In June, 2016, we completed the offering of an additional $400 million aggregate principal amount of 4.75% Senior Notes due in 2022 (issued at a yield of 4.35%), the terms of which were identical to the terms of our $300 million aggregate principal amount of 4.75% Senior Notes due in 2022, issued in August, 2014. These Senior Notes, combined, are referred to as $700 million, 4.75% Senior Notes due in 2022.

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

(e.) In April, 2018, we amended our accounts receivable securitization program, which was scheduled to expire in December, 2018. Pursuant to the amendment, the term has been extended through April 26, 2021, and the borrowing limit has been increased to $450 million from $440 million ($290 million outstanding as of March 31, 2019).

Interest expense increased $2 million during the three-month period ended March 31, 2019, as compared to the comparable period of 2018, due primarily to: (i) a net $6 million increase in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facility and accounts receivable securitization program resulting from an increase in our aggregate average cost of borrowings pursuant to these facilities (4.2% during the three months ended March 31, 2019 as compared to 3.6% in the comparable quarter of 2018), slightly offset by a decrease in the aggregate average outstanding borrowings ($3.99 billion during the three months ended March 31, 2019 as compared to $4.00 billion in the comparable 2018 quarter), partially offset by; (ii) $4 million of other combined decreases in interest expense consisting primarily of a $2 million increase in interest rate swap income. The average effective interest rate on these facilities, including amortization of deferred financing costs and original issue discounts and designated interest rate swap expense was 4.0% and 3.7% during the three-month periods ended March 31, 2019 and 2018, respectively.

Provision for Income Taxes and Effective Tax Rates:

The effective tax rates, as calculated by dividing the provision for income taxes by income before income taxes, were as follows for the three-month periods ended March 31, 2019 and 2018 (dollar amounts in thousands):

	Three months ended	
	March 31, 2019	March 31, 2018
Provision for income taxes	$ 58,898	$ 67,569
Income before income taxes	296,296	296,238
Effective tax rate	19.9%	22.8%

The decrease in the provision for income taxes and effective tax rate during the three-month period ended March 31, 2019, as compared to the comparable quarter of 2018, was due primarily to a favorable change of $9 million resulting from our adoption of ASU 2016-09. As a result of ASU 2016-09, our provision for income taxes was decreased by approximately $11 million during the first quarter of 2019, as compared to a decrease of approximately $2 million during the first quarter of 2018.

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $391 million during the three-month period ended March 31, 2019 and $410 million during the comparable quarter of 2018. The net decrease of $19 million was primarily attributable to the following:

- a favorable change of $14 million due to an increase in net income plus/minus depreciation and amortization expense, stock-based compensation, and a net gain on sales of assets;
- an unfavorable change of $29 million in accounts receivable;
- a favorable change of $49 million in other working capital accounts resulting primarily from changes in accounts payable due to timing of disbursements;
- an unfavorable change of $9 million in accrued and deferred income taxes, and;
- $44 million of other combined net unfavorable changes.

Days sales outstanding ("DSO"): Our DSO are calculated by dividing our net revenue by the number of days in the three-month periods. The result is divided into the accounts receivable balance at March 31st of each year to obtain the DSO. Our DSO were 51 days and 53 days at March 31, 2019 and 2018, respectively.

Our accounts receivable as of March 31, 2019 and December 31, 2018 include amounts due from Illinois of approximately $34 million and $32 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $19 million as of March 31, 2019 and $18 million as of December 31, 2018, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. Although the accounts receivable due from Illinois could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois. Failure to ultimately collect all outstanding amounts due to us from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

Net cash used in investing activities

During the first three months of 2019, we used $168 million of net cash in investing activities as follows:

- $170 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $13 million received in connection with net cash inflows from forward exchange contracts that hedge our investment in the U.K. against movements in exchange rates;
- $10 million spent on the purchase and implementation of information technology applications, and;
- $1 million spent to fund investments in and advances to joint ventures and other.

During the first three months of 2018, we used $272 million of net cash in investing activities as follows:

- $189 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $46 million paid in connection with net cash outflows from forward exchange contracts that hedge our investment in the U.K. against movements in exchange rates;
- $20 million spent to acquire businesses and property consisting primarily of the acquisition of a 109-bed behavioral health care facility located in Gulfport, Mississippi;
- $9 million spent on the purchase and implementation of information technology application, and;
- $9 million spent to fund construction costs of a new behavioral health care facility which will be jointly owned by us and a third-party.

In conjunction with the January 1, 2019 adoption of ASU 2017-12, "Targeted Improvements to Accounting for Hedging Activities", we reclassified our presentation of the net cash inflows or outflows, which were received or paid in connection with foreign exchange

contracts that hedge our net investment in foreign operations against movements in exchange rates, to investing cash flows on the consolidated statements of cash flows. As previously disclosed within our footnotes, these cash flows were formerly reported as operating activities. Prior period amounts have been reclassified from net cash provided by operating activities to net cash used in investing activities to conform with the current year presentation on the consolidated statements of cash flows.

Net cash used in financing activities

During the first three months of 2019, we used $266 million of net cash in financing activities as follows:

- spent $115 million on net repayments of debt as follows: (i) $100 million related to our accounts receivable securitization program; (ii) $13 million related to our term loan A facility; (iii) $1 million related to our term loan B facility, and; (iv) $1 million related to other debt facilities;
- generated $9 million of proceeds related to new borrowings pursuant to a short-term, on-demand credit facility;
- spent $144 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our $1.7 billion stock repurchase program ($113 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($31 million);
- spent $10 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- spent $9 million to pay quarterly cash dividends of $.10 per share, and;
- generated $3 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

During the first three months of 2018, we used $141 million of net cash in financing activities as follows:

- spent $141 million on net repayments of debt as follows: (i) $22 million related to our term loan A facility; (ii) $118 million related to our revolving credit facility, and; (iii) $1 million related to other debt facilities;
- generated $20 million of proceeds related to new borrowings pursuant to our accounts receivable securitization program;
- spent $9 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our $1.2 billion stock repurchase program ($5 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($4 million);
- spent $4 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- spent $9 million to pay quarterly cash dividends of $.10 per share, and;
- generated $3 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

During the remaining nine months of 2019, we expect to spend approximately $505 million to $555 million on capital expenditures which includes expenditures for capital equipment, renovations and new projects at existing hospitals. We believe that our capital expenditure program is adequate to expand, improve and equip our existing hospitals. We expect to finance all capital expenditures and acquisitions with internally generated funds and/or additional funds, as discussed below.

Capital Resources

Credit Facilities and Outstanding Debt Securities

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

The Sixth Amendment amended the Senior Credit Facility to, among other things: (i) increase the aggregate amount of the revolving credit facility to $1 billion (increase of $200 million over the $800 million previous commitment); (ii) increase the aggregate amount of the tranche A term loan commitments to $2 billion (increase of approximately $290 million over the $1.71 billion of outstanding borrowings prior to the amendment), and; (iii) extended the maturity date of the revolving credit and tranche A term loan facilities to October 23, 2023 from August 7, 2019.

On October 31, 2018, we added a seven-year tranche B term loan facility in the aggregate principal amount of $500 pursuant to the Senior Credit Agreement. The tranche B term loan matures on October 31, 2025. We used the proceeds to repay borrowings under the

revolving credit facility, the Securitization, to redeem our $300 million, 3.75% Senior Notes that were scheduled to mature in 2019 and for general corporate purposes.

As of March 31, 2019, we had no borrowings outstanding pursuant to our $1 billion revolving credit facility and we had $973 million of available borrowing capacity net of $12 million of outstanding letters of credit and $15 million of outstanding borrowings pursuant to a short-term credit facility.

Pursuant to the terms of the Sixth Amendment, the tranche A term loan, which had $1.988 billion of borrowings outstanding as of March 31, 2019, provides for eight installment payments of $12.5 million per quarter, covering the period of March of 2019 through December of 2020, followed by payments of $25 million per quarter, commencing in March of 2021 until maturity in October of 2023, when all outstanding amounts will be due.

The tranche B term loan, which had $499 million of borrowings outstanding as of March 31, 2019, provides for installment payments of $1.25 million per quarter, which commenced on March 31, 2019 until maturity in October of 2025, when all outstanding amounts will be due.

Borrowings under the Senior Credit Agreement bear interest at our election at either (1) the ABR rate which is defined as the rate per annum equal to the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.375% to 0.625% for revolving credit and term loan A borrowings and 0.75% for tranche B borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.375% to 1.625% for revolving credit and term loan A borrowings and 1.75% for the tranche B term loan. As of March 31, 2019, the applicable margins were 0.50% for ABR-based loans and 1.50% for LIBOR-based loans under the revolving credit and term loan A facilities. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Senior Credit Agreement is secured by certain assets of the Company and our material subsidiaries (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

The Senior Credit Agreement includes a material adverse change clause that must be represented at each draw. The Senior Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage. We are in compliance with all required covenants as of March 31, 2019 and December 31, 2018.

In late April, 2018, we entered into the sixth amendment to our accounts receivable securitization program ("Securitization") dated as of October 27, 2010 with a group of conduit lenders, liquidity banks, and PNC Bank, National Association, as administrative agent, which provides for borrowings outstanding from time to time by certain of our subsidiaries in exchange for undivided security interests in their respective accounts receivable. The sixth amendment, among other things, extended the term of the Securitization program through April 26, 2021 and increased the borrowing capacity to $450 million (from $440 million previously). Although the program fee and certain other fees were adjusted in connection with the sixth amendment, substantially all other provisions of the Securitization program remained unchanged. Pursuant to the terms of our Securitization program, substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At March 31, 2019, we had $290 million of outstanding borrowings pursuant to the terms of the Securitization and $160 million of available borrowing capacity.

As of March 31, 2019, we had combined aggregate principal of $1.1 billion from the following senior secured notes:

- $700 million aggregate principal amount of 4.75% senior secured notes due in August, 2022 ("2022 Notes") which were issued as follows:
  - $300 million aggregate principal amount issued on August 7, 2014 at par.
  - $400 million aggregate principal amount issued on June 3, 2016 at 101.5% to yield 4.35%.

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

Interest on the 2022 Notes is payable on February 1 and August 1 of each year until the maturity date of August 1, 2022. Interest on the 2026 Notes is payable on June 1 and December 1 until the maturity date of June 1, 2026. The 2022 Notes and 2026 Notes were offered only to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended (the "Securities Act"). The 2022 Notes and 2026 Notes have not been registered under the Securities Act and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements.

On November 26, 2018 we redeemed the $300 million aggregate principal, 3.75% Senior Notes due in 2019. The 2019 Notes were redeemed for an aggregate price equal to 100.485% of the principal amount, resulting in a premium paid of approximately $1 million, plus accrued interest to the redemption date.

At March 31, 2019, the carrying value and fair value of our debt were each approximately $3.9 billion. At December 31, 2018, the carrying value and fair value of our debt were each approximately $4.0 billion. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Our total debt as a percentage of total capitalization was approximately 42% at March 31, 2019 and 43% at December 31, 2018.

During 2015, we entered into nine forward starting interest rate swaps whereby we paid a fixed rate on a total notional amount of $1.0 billion and received one-month LIBOR. The average fixed rate payable on these swaps, all of which matured on April 15, 2019, was 1.31%. Although we can provide no assurance that we will ultimately do so, we are currently monitoring the interest rate environment and evaluating the terms of potential replacement interest rate swaps that we may enter into for a large portion, or potentially all, of the $1 billion total notional amount that expired on April 15, 2019.

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

Off-Balance Sheet Arrangements

During the three months ended March 31, 2019, there have been no material changes in the off-balance sheet arrangements consisting of standby letters of credit and surety bonds. Effective January 1, 2019, we adopted ASU 2016-02 which requires companies to, among other things, recognize lease assets and lease liabilities on the balance sheet. As a result of our adoption of ASU 2016-02, our consolidated balance sheet as of March 31, 2019 includes right of use assets-operating leases ($342.0 million) and operating lease liabilities ($56.1 million current and $286.1 million noncurrent). Prior period financial statements were not adjusted for the effects of this new standard. Reference is made to *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations – Contractual Obligations and Off-Balance Sheet Arrangements,* in our Annual Report on Form 10-K for the year ended December 31, 2018.

As of March 31, 2019 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $116 million consisting of: (i) $111 million related to our self-insurance programs, and; (ii) $5 million of other debt and public utility guarantees.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

There have been no material changes in the quantitative and qualitative disclosures during the three months ended March 31, 2019. 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, 2018.

Item 4. Controls and Procedures

As of March 31, 2019, under the supervision and with the participation of our management, including our Chief Executive Officer ("CEO") and Chief Financial Officer ("CFO"), we performed an evaluation of the effectiveness of our disclosure controls and procedures, as defined in Rule 13a-15(e) or Rule 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "1934 Act"). Based on this evaluation, the CEO and CFO have concluded that our disclosure controls and procedures are effective to ensure that

material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the 1934 Act and the SEC rules thereunder.

Changes in Internal Control Over Financial Reporting

On January 1, 2019, we adopted ASC 842. In connection with our adoption of ASC 842 we did implement changes to our internal controls relating to leases. These changes included the development of new policies, enhanced contract review requirements and other ongoing monitoring activities. These controls were designed to provide assurance at a reasonable level of the fair presentation of our condensed consolidated financial statements and related disclosures.

There have been no other changes in our internal control over financial reporting or in other factors during the first quarter of 2019 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

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

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

Certain legal matters are described below:

Government Investigations:

UHS Behavioral Health

In February, 2013, the Office of Inspector General for the United States Department of Health and Human Services ("OIG") served a subpoena requesting various documents from January, 2008 to the date of the subpoena directed at Universal Health Services, Inc. ("UHS") concerning it and UHS of Delaware, Inc., and certain UHS owned behavioral health facilities including: Keys of Carolina, Old Vineyard Behavioral Health, The Meadows Psychiatric Center, Streamwood Behavioral Health, Hartgrove Hospital, Rock River Academy and Residential Treatment Center, Roxbury Treatment Center, Harbor Point Behavioral Health Center, f/k/a The Pines Residential Treatment Center, including the Crawford, Brighton and Kempsville campuses, Wekiva Springs Center and River Point Behavioral Health. Prior to receipt of this subpoena, some of these facilities had received independent subpoenas from state or federal agencies. Subsequent to the February 2013 subpoenas, some of the facilities above have received additional, specific subpoenas or other document and information requests. In addition to the OIG, the DOJ and various U.S. Attorneys' and state Attorneys' General Offices are also involved in this matter. Since February 2013, additional facilities have also received subpoenas and/or document and information requests or we have been notified are included in the omnibus investigation. Those facilities include: National Deaf Academy, Arbour-HRI Hospital, Behavioral Hospital of Bellaire, St. Simons By the Sea, Turning Point Care Center, Salt Lake Behavioral Health, Central Florida Behavioral Hospital, University Behavioral Center, Arbour Hospital, Arbour-Fuller Hospital, Pembroke Hospital, Westwood Lodge, Coastal Harbor Health System, Shadow Mountain Behavioral Health, Cedar Hills Hospital, Mayhill Hospital, Southern Crescent Behavioral Health (Anchor Hospital and Crescent Pines campuses), Valley

Hospital (AZ), Peachford Behavioral Health System of Atlanta, University Behavioral Health of Denton, El Paso Behavioral Health System, Newport News Behavioral Health Center, The Hughes Center and Forest View Hospital.

In October, 2013, we were advised that the DOJ's Criminal Frauds Section had opened an investigation of River Point Behavioral Health and Wekiva Springs Center. Since that time, we have been notified that the Criminal Frauds section has opened investigations of National Deaf Academy, Hartgrove Hospital and UHS as a corporate entity. In April 2017, the DOJ's Criminal Division issued a subpoena requesting documentation from Shadow Mountain Behavioral Health. In August 2017, Kempsville Center of Behavioral Health (a part of Harbor Point Behavioral Health previously identified above) received a subpoena requesting documentation.

In April, 2014, the Centers for Medicare and Medicaid Services ("CMS") instituted a Medicare payment suspension at River Point Behavioral Health in accordance with federal regulations regarding suspension of payments during certain investigations. The Florida Agency for Health Care Administration ("AHCA") subsequently issued a Medicaid payment suspension for the facility. River Point Behavioral Health submitted a rebuttal statement disputing the basis of the suspension and requesting revocation of the suspension. Notwithstanding, CMS continued the payment suspension. River Point Behavioral Health provided additional information to CMS in an effort to obtain relief from the payment suspension but the Medicare suspension remains in effect. In June 2017, AHCA advised that while they were maintaining the suspension for dual eligible and cross-over Medicare beneficiaries, the Medicaid payment suspension was lifted effective June 27, 2017. We cannot predict if and/or when the facility's remaining suspended payments will resume in total. From inception through March 31, 2019, the aggregate funds withheld from us in connection with the River Point Behavioral Health payment suspension amounted to approximately $9 million. Although the operating results of River Point Behavioral Health did not have a material impact on our consolidated results of operations during the three-month period ended March 31, 2019 or the year ended December 31, 2018, the payment suspension has had a material adverse effect on the facility's results of operations and financial condition.

The DOJ has advised us that the civil aspect of the coordinated investigation referenced above is a False Claims Act investigation focused on billings submitted to government payers in relation to services provided at those facilities. While there have been various matters raised by DOJ during the pendency of this investigation, DOJ Civil has advised that the focus of their investigation is on medical necessity issues and billing for services not eligible for payment due to non-compliance with regulatory requirements relating to, among other things, admission eligibility, discharge decisions, length of stay and patient care issues. It is our understanding that the DOJ Criminal Fraud Section is investigating issues similar to those focused on by the DOJ Civil Division and the other related agencies involved in this matter. UHS denies any fraudulent billings were submitted to government payers; however, we are involved in settlement discussions with the DOJ Civil Division in an attempt to resolve this matter. During 2018, we recorded pre-tax increases to the reserve established in connection with the civil aspects of these matters amounting to $102 million (including $13 million recorded during the first quarter of 2018) increasing the aggregate pre-tax reserve to $123 million as of December 31, 2018 from $22 million as of December 31, 2017. The aggregate pre-tax reserve remained at $123 million as of March 31, 2019. Changes in the reserve may be required in future periods as discussions with the DOJ continue and additional information becomes available. We cannot predict the ultimate resolution of these matters and therefore can provide no assurance that final amounts paid in settlement or otherwise, if any, or associated costs, as well as the income tax deductibility of payments, will not differ materially from our established reserve and assumptions related to income tax deductibility.

DOJ investigation of Turning Point Hospital.

During the fourth quarter of 2018, we were notified that the DOJ Civil Division in conjunction with the U.S. Attorney's Office for the Northern District of Georgia and the Georgia Attorney General's Office have opened an investigation of Turning Point Hospital in Moultrie, GA. The DOJ Civil Division has advised us that they are primarily investigating transportation and housing financial assistance provided to patients receiving treatment at the facility. The DOJ issued a civil investigative demand to the facility requesting various documents and other information. At this time, we are unable to assess potential liability or damages, if any.

Litigation:

U.S. ex rel Escobar v. Universal Health Services, Inc. et.al.

This is a False Claims Act case filed against Universal Health Services, Inc., UHS of Delaware, Inc. and HRI Clinics, Inc. d/b/a Arbour Counseling Services in U.S. District Court for the District of Massachusetts. This qui tam action primarily alleges that Arbour Counseling Services failed to appropriately supervise certain clinical providers in contravention of regulatory requirements and the submission of claims to Medicaid were subsequently improper. Relators make other claims of improper billing to Medicaid associated with alleged failures of Arbour Counseling to comply with state regulations. The U.S. Attorney's Office and the Massachusetts Attorney General's Office initially declined to intervene. UHS filed a motion to dismiss and the trial court originally granted the motion dismissing the case. The First Circuit Court of Appeals ("First Circuit") reversed the trial court's dismissal of the case. The United States Supreme Court subsequently vacated the First Circuit's opinion and remanded the case for further consideration under the new legal standards established by the Supreme Court for False Claims Act cases. During the 4th quarter of 2016, the First Circuit issued a revised opinion upholding their reversal of the trial court's dismissal. The case was then remanded to

the trial court for further proceedings. In January 2017, the U.S. Attorney's Office and Massachusetts Attorney General's Office advised of the potential for intervention in the case. The Massachusetts Attorney General's Office subsequently filed its motion to intervene which was granted and, in April 2017, filed their Complaint in Intervention. We are defending this case vigorously. At this time, we are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter.

Shareholder Class Action

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

Shareholder Derivative Cases

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

Disproportionate Share Hospital Payment Matter:

In late September, 2015, many hospitals in Pennsylvania, including seven of our behavioral health care hospitals located in the state, received letters from the Pennsylvania Department of Human Services (the "Department") demanding repayment of allegedly excess Medicaid Disproportionate Share Hospital payments ("DSH") for the federal fiscal year ("FFY") 2011 amounting to approximately $4 million in the aggregate. Since that time, we have received similar requests for repayment for alleged DSH overpayments for FFYs 2012, 2013 and 2014. For FFY 2012, the claimed overpayment amounts to approximately $4 million. For FFY 2013, the claimed overpayments were initially approximately $7 million but have since been reduced to approximately $2 million due to a change in the Department's calculations of the hospital specific DSH upper payment limit. For FFY 2014, the claimed overpayments were approximately $7 million. We filed administrative appeals for all of our facilities contesting the recoupment efforts for FFYs 2011 through 2014 as we believe the Department's calculation methodology is inaccurate and conflicts with applicable federal and state laws and regulations. The Department has agreed to postpone the recoupment of the state's share of the DSH payments until all hospital appeals are resolved but started recoupment of the federal share. Due to a change in the Pennsylvania Medicaid State Plan and implementation of a CMS-approved Medicaid Section 1115 Waiver, we do not believe the methodology applied by the Department to FFYs 2011 through 2014 is applicable to reimbursements received for Medicaid services provided after January 1, 2015 by our behavioral health care facilities located in Pennsylvania. We can provide no assurance that we will ultimately be successful in our legal and administrative appeals related to the Department's repayment demands. If our legal and administrative appeals are unsuccessful, our future consolidated results of operations and financial condition could be adversely impacted by these repayments.

Other Matters:

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

Item 1A. Risk Factors

Our Annual Report on Form 10-K for the year ended December 31, 2018 includes a listing of risk factors to be considered by investors in our securities. There have been no material changes in our risk factors from those set forth in our Annual Report on Form 10-K for the year ended December 31, 2018.

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

In December, 2018, our Board of Directors authorized a $500 million increase to our stock repurchase program, which increased the aggregate authorization to $1.7 billion from the previous $1.2 billion authorization approved during 2017, 2016 and 2016. Pursuant to this program, we may purchase shares of our Class B Common Stock, from time to time as conditions allow, on the open market or in negotiated private transactions. There is no expiration date for our stock repurchase program.

As reflected below, during the three-month period ended March 31, 2019, 840,699 shares ($106.3 million in the aggregate) were repurchased pursuant to the terms of our stock repurchase program and 223,339 shares were repurchased in connection with income tax withholding obligations resulting from the exercise of stock options and the vesting of restricted stock grants.

During the period of January 1, 2019 through March 31, 2019, we repurchased the following shares:

	Additional Dollars Authorized For Repurchase (in thousands)	Total number of shares purchased (a.)	Total number of shares cancelled	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid for shares purchased as part of publicly announced program (in thousands)	Maximum number of shares that may yet be purchased under the program	Maximum number of dollars that may yet be purchased under the program (in thousands)
January, 2019	—	596,632	2,709	$ 0.01	592,141	$ 123.28	$ 72,997	—	$ 389,347
February, 2019	—	105,800	—	$ 0.01	—	N/A	—	—	$ 389,347
March, 2019	—	361,606	1,017	$ 0.01	248,558	$ 134.07	$ 33,325	—	$ 356,022
Total January through March, 2019	—	1,064,038	3,726	$ 0.01	840,699	$ 126.47	$ 106,322		

(a.) Includes 3,726 of restricted shares that were forfeited by former employees pursuant to the terms of our restricted stock purchase plan during the first quarter of 2019.

Dividends

During the quarter ended March 31, 2019, we declared and paid dividends of $.10 per share.

Item 6. Exhibits

(a) Exhibits:

10.1	Universal Health Services, Inc. Supplemental Executive Retirement Income Plan effective as of June 1, 2018, dated as of July 18, 2018.
11	Statement re computation of per share earnings is set forth in Note 7 of the Notes to Condensed Consolidated Financial Statements.
31.1	Certification of the Company's Chief Executive Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
31.2	Certification of the Company's Chief Financial Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
32.1	Certification of the Company's Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of the Company's Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema Document
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

EXHIBIT INDEX

Exhibit No.	Description
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101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

Signatures

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

Universal Health Services, Inc.
(Registrant)

Date: May 8, 2019

/s/ Alan B. Miller

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

/s/ Steve Filton

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

Exhibit 10.1

UNIVERSAL HEALTH SERVICES, INC.
SUPPLEMENTAL EXECUTIVE RETIREMENT INCOME PLAN

Universal Health Services, Inc.
Supplemental Executive Retirement Income Plan

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Universal Health Services, Inc.
Supplemental Executive Retirement Income Plan

Universal Health Services, Inc. hereby adopts this Supplemental Executive Retirement Income Plan (the "Plan") for the benefit of a select group of management or highly compensated employees. The Plan is an unfunded arrangement and is intended to be exempt from the participation, vesting, funding, and fiduciary requirements set forth in Title I of the Employee Retirement Income Security Act of 1974, as amended. The Plan is intended to comply with Internal Revenue Code Section 409A.

Article 1 Definitions

1.1 Account
The bookkeeping account(s) as may be established for each Participant as provided in Section 5.1 hereof.

1.2 Administrator
An individual or a committee of individuals appointed by the Sponsor to act in the capacity of the Administrator pursuant to the terms hereof.

1.3 Board
The Board of Directors of the Sponsor.

1.4 Change-in-Control
Provided that such term shall be interpreted within the meaning of regulations promulgated under Code Section 409A, a "Change-in-Control" shall mean the first to occur of any of the following:

(a) the date that any one person or persons acting as a group acquires ownership of Sponsor stock constituting more than fifty percent (50%) of the total fair market value or total voting power of the stock of the Sponsor;

(b) the date that any one person or persons acting as a group acquires (or has acquired during the 12-month period ending on the date of the most recent acquisition by such person or persons) ownership of the stock of the Sponsor possessing thirty percent (30%) or more of the total voting power of the stock of the Sponsor;

(c) the date that any one person or persons acting as a group acquires (or has acquired during the 12-month period ending on the date of the most recent acquisition by such person or persons) assets from the Sponsor that have a total gross fair market value equal to or more than forty percent (40%) of the total gross fair market value of all of the assets of the Sponsor immediately prior to such acquisition; or

(d) the date that a majority of the members of the Board is replaced during any 12-month period by directors whose appointment or election is not endorsed by a majority of the members of the Board prior to the date of the appointment or election.

1.5 Code
The Internal Revenue Code of 1986, as amended.

1.6 Disability
Provided that such term shall be interpreted within the meaning of regulations promulgated under Code Section 409A, a Participant shall be considered to have incurred a Disability if: (i) the Participant is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months; (ii) the Participant is, by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months, receiving income replacement benefits for a period of not less than 3

months under an accident and health plan covering employees of the Participant's Participating Employer; or (iii) determined to be totally disabled by the Social Security Administration.

1.7 Effective Date
June 1, 2018

1.8 Eligible Employee
An Employee shall be considered an Eligible Employee if such Employee is a member of a "select group of management or highly compensated employees," within the meaning of Sections 201, 301 and 401 of ERISA, and is designated as an Eligible Employee by the Administrator. The Administrator may at any time, in its sole discretion, change the eligible criteria for an Eligible Employee or determine that one or more Participants will cease to be an Eligible Employee. The designation of an Employee as an Eligible Employee in any Plan Year shall not confer upon such Employee any right to be designated as an Eligible Employee in any future Plan Year.

1.9 Employee
Any person employed by a Participating Employer.

1.10 Employer Discretionary Contribution
A discretionary contribution made by a Participating Employer that is credited to one or more Participants' Account(s) in accordance with the terms of Section 3.1.

1.11 Employer Supplemental Discretionary Contribution
A discretionary contribution made by a Participating Employer that is credited to one or more Participants' Account(s) in accordance with the terms of Section 3.2.

1.12 ERIP
The Universal Health Services, Inc. Executive Retirement Income Plan maintained by the Sponsor.

1.13 ERIP Conversion Contribution
An amount equal to the [present value] of the Participant's ERIP benefit that is credited to the Account of the Participant in accordance with Section 3.3.

1.14 ERISA
The Employee Retirement Income Security Act of 1974, as amended.

1.15 Investment Fund
Each hypothetical investment which serves as a means to measure any increases or decreases in the value of a Participant's Account in accordance with Article 5.

1.16 Participant
An Eligible Employee who is a Participant as provided in Article 2.

1.17 Participating Employer
The Sponsor, UHS of Delaware, Inc., any other business organization that succeeds either of the foregoing entities, or any other business entity that adopts the Plan with the consent of the Board.

1.18 Plan Year
For the initial Plan Year, Effective Date through December 31, 2018. For each Plan Year thereafter, January 1 through December 31.

1.19 Retirement
Retirement (including the terms "Retires" or "Retired") shall mean, (i) with respect to the portion of a Participant's Account related to Employer Discretionary Contribution and Employer Supplemental Discretionary Contribution, a Participant's Separation from Service on, or subsequent to, the Participant attaining age fifty-five (55) with at least five (5) Years of Service, (ii) with respect to the portion of a Participant's Account related to an ERIP Conversion Contribution, for a Participant designated as a "Group

1 Participant" in the attached Appendix A, such Participant's Separation from Service on, or subsequent to, the Participant attaining age sixty-two (62), or (iii) with respect to the portion of a Participant's Account related to an ERIP Conversion Contribution, for a Participant designated as a "Group 2 Participant" in the attached Appendix A, such Participant's Separation from Service on, or subsequent to, the Participant attaining age sixty-five (65).

1.20 Separation from Service

Provided that such term shall be interpreted within the meaning of regulations promulgated under Code Section 409A, a Participant shall incur a Separation from Service with the Service Recipient due to death, retirement or other termination of employment with the Service Recipient unless the employment relationship is treated as continuing intact while the individual is on military leave, sick leave, or other bona fide leave of absence if the period of such leave does not exceed six months, or if longer, so long as the individual retains a right to reemployment with the Service Recipient under an applicable statute or by contract. Upon a sale or other disposition of the assets of the Participating Employer to an unrelated purchaser, the Administrator reserves the right, to the extent permitted by Code Section 409A, to determine whether Participants providing services to the purchaser after and in connection with the purchase transaction have experienced a Separation from Service.

1.21 Service Recipient

Provided that such term shall be interpreted within the meaning of regulations promulgated under Code Section 409A, Service Recipient shall mean the Participating Employer or person for whom the services are performed and with respect to whom the legally binding right to compensation arises, and all persons with whom such person would be considered a single employer under Code Section 414(b) (employees of controlled group of corporations), and all persons with whom such person would be considered a single employer under Code Section 414(c) (employees of partnerships, proprietorships, etc., under common control).

1.22 Specified Employee

Provided that such term shall be interpreted within the meaning of regulations promulgated under Code Section 409A, a "Specified Employee" shall mean a Participant who is considered a "key employee" (as defined in Code Section 416(i) without regard to Code Section 416(i)(5)) on the Identification Date (as defined below) and for the period beginning April 1 of the year subsequent to the Identification Date and ending March 31 of the following year. The Identification Date for the Plan is December 31 of each year. Notwithstanding anything to the contrary, a Participant is not a Specified Employee unless any stock of the Service Recipient is publicly traded on an established securities market or otherwise.

1.23 Sponsor

Universal Health Services, Inc.

1.24 Trust

The agreement between the Sponsor and the Trustee under which the assets of the Plan are held, administered and managed, which shall conform to the terms of Rev. Proc. 92-64.

1.25 Trustee

Reliance Trust Company or such other successor that shall become trustee pursuant to the terms of the Plan.

1.26 Years of Service

A Participant's "Years of Service," as of the applicable determination date, shall be the number of full twelve (12) month periods commencing with the Participant's date of hire during which the Participant was an Employee.

Article 2 **Participation**

2.1 Commencement of Participation

Each Eligible Employee shall become a Participant on the date an Employer Discretionary Contribution and/or Employer Supplemental Discretionary Contribution and/or ERIP Conversion Contribution is first credited to his or her Account.

2.2 Loss of Eligible Employee Status

Amounts previously credited to the Account of a Participant who is no longer an Eligible Employee shall continue to be held pursuant to the terms of the Plan and shall be distributed as provided in Article 6; provided that no additional contributions shall be credited to such Account while the Participant is not an Eligible Employee.

Article 3 **Contributions**

3.1 Employer Discretionary Contribution

A Participating Employer may make a discretionary contribution(s) to one or more Participants' Accounts in such amount, at such time and in such manner as may be determined by the Participating Employer in its sole discretion. Such Employer Discretionary Contribution will be credited to a Participant's Account and will be payable in accordance with Article 6.

3.2 Employer Supplemental Discretionary Contribution

A Participating Employer may make a supplemental discretionary contribution(s) to one or more Participants' Accounts in such amount, at such time and in such manner as may be determined by the Participating Employer in its sole discretion. Such Employer Supplemental Discretionary Contribution will be credited to a Participant's Account and will be payable in accordance with Article 6.

3.3 ERIP Conversion Contributions

A Participating Employer shall make, as applicable, a one-time ERIP Conversion Contribution to the Account of the Participants who formerly participated in the ERIP and are designated as a "Group 1 Participant" or "Group 2 Participant" (see Appendix A). The amount of the ERIP Conversion Contribution shall be determined by the Participating Employer in its sole discretion and communicated to the applicable Participants. Such ERIP Conversion Contribution shall be credited to the applicable Participants' Accounts and will be payable in accordance with Article 6.

3.4 Crediting of Contributions

(a) Employer Discretionary Contributions, if any, shall be credited to a Participant's Account, and if applicable, transferred to the Trust at such time as the Participating Employer shall determine.

(b) Employer Supplemental Discretionary Contributions shall be credited to a Participant's Account, and if applicable, transferred to the Trust at such time as the Participating Employer shall determine.

(c) The ERIP Conversion Contribution shall be credited to a Participant's Account, and if applicable, transferred to the Trust at such time as the Participating Employer shall determine.

Article 4 **Vesting**

4.1 Vesting of Employer Discretionary Contributions

Subject to Sections 4.4 and 4.5, a Participant shall have a vested right to the portion of his or her Account attributable to an Employer Discretionary Contribution, adjusted for any earnings or losses thereon, upon the first to occur of (i) the fifth anniversary of the date on which such Employer Discretionary Contribution is credited to his or her Account or (ii) the date on which the Participant attains age sixty-five (65). Notwithstanding the foregoing, subject to Sections 4.4 and 4.5, a Participant who is a former ERIP participant and is designated as a "Group 1 Participant", as provided for in Appendix A attached hereto,

shall have a vested right to the portion of his or her Account attributable to an Employer Discretionary Contribution, adjusted for any earnings or losses thereon, upon the first to occur of (i) the fifth anniversary of the date on which such Employer Discretionary Contribution is credited to his or her Account or (ii) the date on which the Participant attains age sixty-two (62).

4.2 Vesting of Employer Supplemental Discretionary Contributions

Subject to Sections 4.4 and 4.5, and except as otherwise provided in an award letter or offer letter between a Participant and the Sponsor or any other Participating Employer, a Participant shall have a vested right to the portion of his or her Account attributable to an Employer Supplemental Discretionary Contribution, adjusted for any earnings or losses thereon, upon the first to occur of (i) the fifth anniversary of the date on which such Employer Supplemental Discretionary Contribution is credited to his or her Account or (ii) the date on which the Participant attains age sixty-five (65). Notwithstanding the foregoing, subject to Sections 4.4 and 4.5, a Participant who is a former ERIP participant and is designated as a "Group 1 Participant", as provided for in Appendix A attached hereto, shall have a vested right to the portion of his or her Account attributable to an Employer Supplemental Discretionary Contribution, adjusted for any earnings or losses thereon, upon the first to occur of (i) the fifth anniversary of the date on which such Employer Supplemental Discretionary Contribution is credited to his or her Account or (ii) the date on which the Participant attains age sixty-two (62).

4.3 Vesting of ERIP Conversion Contributions

A Participant shall have a vested right to the portion of his or her Account attributable to the ERIP Conversion Contribution upon attainment of age sixty-two (62) if the Participant is designated as a "Group 1 Participant" (see Appendix A), or upon attainment of age sixty-five (65) if the Participant is designated as a "Group 2 Participant" (see Appendix A), in either case, provided that such Participant has not incurred a Separation from Service and has not ceased to be an Eligible Employee at any time before the applicable vesting date. For the avoidance of doubt, if such Participant incurs a Separation from Service for any reason, including death, or such Participant ceases to be an Eligible Employee, in either case, at any time prior to his or her 62nd birthday or 65th birthday, as applicable, then the portion of his or her Account attributable to the ERIP Conversion Contribution shall be forfeited immediately with no compensation or other payment due to such Participant.

4.4 Vesting due to Certain Events

(a) Notwithstanding anything to the contrary contained herein, upon a Participant's Disability while employed by a Participating Employer, the Participant shall be fully vested in the Employer Discretionary Contributions and/or Employer Supplemental Discretionary Contributions (adjusted for any earnings or losses thereon) credited to his or her Account as of the date of Disability. This vesting provision is not applicable to any ERIP Conversion Contribution credited to a Participant's Account.

(b) Notwithstanding anything to the contrary contained herein, upon a Participant's death while employed by a Participating Employer, the Participant shall be fully vested in the Employer Discretionary Contributions and/or Employer Supplemental Discretionary Contributions (adjusted for any earnings or losses thereon) credited to his or her Account as of the date of death. This vesting provision is not applicable to any ERIP Conversion Contribution credited to a Participant's Account.

(c) Notwithstanding anything to the contrary contained herein, upon a Participant's Retirement, the Participant shall be fully vested in all of the amounts credited to his or her Account as of the date of Retirement; provided that, for purposes of this Section 4.4(c), a Participant designated as a "Group 1 Participant" on Appendix A shall not be vested in any portion of his or her Account attributable to an ERIP Conversion Contribution until such Participant Retires on or after his or her 62nd birthday, and a Participant designated as a "Group 2 Participant" on Appendix A shall not be vested in any portion of his or her Account attributable to an ERIP Conversion Contribution until such Participant Retires on or after his or her 65th birthday.

(d) Notwithstanding anything to the contrary contained herein, upon a Change-in-Control, all Participants shall be fully vested in the Employer Discretionary Contributions and/or Employer Supplemental Discretionary Contributions (adjusted for any earnings or losses thereon) credited to their

respective Accounts as of the date of the Change-in-Control. This vesting provision is not applicable to any ERIP Conversion Contribution credited to a Participant's Account.

4.5 Amounts Not Vested

Any amounts credited to a Participant's Account that are not vested at the time of his or her Separation from Service (after giving effect to full vesting upon a Retirement as provided in Section 4.4(c)) shall be forfeited.

4.6 Forfeitures

At the discretion of the Participating Employer, any forfeitures from a Participant's Account (i) may continue to be held in the Trust, may be separately invested, and may be used to reduce any future Participating Employer contribution(s), or (ii) may be used to pay Plan administrative expense(s) or (iii) may be returned to the Participating Employer as soon as administratively feasible.

Article 5 Accounts

5.1 Accounts

Each Participant's Account shall be credited with any Employer Discretionary Contribution(s) and/or any Employer Supplemental Discretionary Contribution(s), and an ERIP Conversion Contribution, as applicable. A Participant's Account shall be adjusted with the allocable share of any earnings or losses on the aforementioned Employer Discretionary Contribution(s) and/or Employer Supplemental Discretionary Contribution(s) that are deemed invested in one or more Investment Fund(s), as described in Section 5.2. Each Participant's Account shall be reduced by any distributions made plus any federal, state and local tax withholdings, and any payroll, social security and other employment withholding taxes as may be required by law.

5.2 Investments, Gains and Losses

(a) A Participant may direct balances within his or her Account associated with Employer Discretionary Contribution(s) and/or Employer Supplemental Discretionary Contribution(s) to be valued as if they were invested in one or more Investment Funds as selected by the Participating Employer in multiples of one percent (1%). The Sponsor may, from time to time, change the Investment Funds for purposes of the Plan. Participant Account balances associated with an ERIP Conversion Contribution will not be permitted to be hypothetically invested in the Investment Funds.

(b) The Administrator shall adjust the amounts credited to each Participant's Account to reflect any Employer Discretionary Contributions, Employer Supplemental Discretionary Contributions, ERIP Conversion Contribution, hypothetical investment experience (i.e., earnings and losses), if applicable, distributions and any other appropriate adjustments. Such adjustments shall be made as frequently as is administratively feasible.

(c) A Participant may change his or her selection of Investment Funds an unlimited number of times each Plan Year with respect to his or her Account by filing a new election in accordance with procedures established by the Administrator. An election shall be effective as soon as administratively feasible following the date a properly completed change is submitted in accordance with procedures prescribed by the Administrator.

(d) Notwithstanding the Participant's ability to designate the Investment Fund(s) in which his or her Account shall be deemed invested, the Participating Employer shall have no obligation to actually invest the Participant's Account in any Investment Funds in accordance with the Participant's election. Participants' Accounts shall merely be bookkeeping entries on the Participating Employer's books, and no Participant shall obtain any property right or interest in any Investment Fund.

Article 6 **Distributions**

6.1 Distributions upon a Retirement

(a) Upon a Participant's Retirement, the balance within a Participant's Account associated with the Employer Discretionary Contribution(s) and/or the Employer Supplemental Discretionary Contribution(s) shall be distributed in annual installments over a period of ten (10) years following the Participant's Retirement, with the first such installment to be paid as soon as administratively feasible, but no later than sixty (60) days, following the Participant's Retirement, and each of the nine subsequent installments to be paid as soon as administratively feasible, but no later than sixty (60) days, following each of the first nine anniversaries of the date of the Participant's Retirement, in all cases, subject to Section 6.6 (Distributions to Specified Employees).

(b) Upon a Participant's Retirement, the balance within a Participant's Account associated with an ERIP Conversion Contribution shall be distributed in monthly installments over a period of five (5) years following the Participant's Retirement, with the first such installment to be paid on the first day of the month immediately following the Participant's Retirement, subject to Section 6.6 (Distributions to Specified Employee).

6.2 Annual Installments

(a) The amount of the first annual installment paid pursuant to Section 6.1(a) shall be determined by multiplying the Participant's applicable Account or sub-account by a fraction, the denominator of which equals the total number of years over which benefits are to be paid, and the numerator of which is one (1). The amount of each succeeding installment payment shall be determined by multiplying the Participant's applicable Account or sub-account by a fraction, the denominator of which equals the number of remaining years over which benefits are to be paid, and the numerator of which is one (1).

(b) For purposes of the Plan, pursuant to Code Section 409A and regulations thereunder, each payment in a series of installments shall be considered a separate payment.

6.3 Distributions due to Disability

Upon a Participant's Separation from Service due to Disability that occurs prior to his or her Retirement (or upon a Participant's Disability that occurs on or after his or her Retirement but before any distributions under Section 6.1 have commenced), all vested amounts credited to his or her Account, other than any amounts related to an ERIP Conversion Contribution, shall be paid to the Participant in a lump sum as soon as administratively feasible, but no later than sixty (60) days, following the date of Disability. No balance within a Participant's Account related to an ERIP Conversion Contribution will be distributed upon a Participant's Disability.

6.4 Distributions upon Death

(a) Upon the death of a Participant that occurs prior to his or her Retirement (or on or after his or her Retirement but before any distributions under Section 6.1 have commenced), all vested amounts credited to his or her Account, other than any amounts related to an ERIP Conversion Contribution, shall be paid, as soon as administratively feasible, but no later than sixty (60) days, following Participant's date of death, to his or her beneficiary or beneficiaries, as determined under Article 7 hereof, in a lump sum. If a Participant dies after distributions under Section 6.1 have commenced and before such distributions have been fully paid, then the Participant's beneficiary or beneficiaries will be entitled to receive the unpaid value of the Participant's Account balance (including any portion attributable to an ERIP Conversion Contribution) in the form of a lump sum payment equal to the then present value of the installment payments that would have otherwise been paid to the Participant.

(b) If a Participant dies prior to his or her 62nd birthday (in the case of a Participant designated as "Group 1 Participant" on Appendix A) or his or her 65th birthday (in the case of a Participant designated as "Group 2 Participant" on Appendix A), all amounts credited to his or her Account that are attributable to an ERIP Conversion Contribution shall be forfeited immediately and none of such amounts shall be paid to

his or her beneficiary or beneficiaries. If a Group 1 Participant dies on or after his or her 62nd birthday or a Group 2 Participant dies on or after his or her 65th birthday, and in either case, before such Participant's Separation from Service, then such Participant's beneficiary or beneficiaries will be entitled to receive the monthly installments of the ERIP Conversion Contribution credited to such Participant's Account that would have been payable to his or her beneficiary or beneficiaries if such Participant Retired on the day preceding his or her death, became entitled to receive a 60-month payout under Section 6.1(b), and died immediately before the first payment.

6.5 Acceleration or Delay in Payments

To the extent permitted by Code Section 409A, and notwithstanding any provision of the Plan to the contrary, the Administrator, in its sole discretion, may elect to (i) accelerate the time or form of payment of a benefit owed to a Participant hereunder in accordance with the terms and subject to the conditions of Treasury Regulations Section 1.409A-3(j)(4), or (ii) delay the time of payment of a benefit owed to a Participant hereunder in accordance with the terms and subject to the conditions of Treasury Regulations Section 1.409A-2(b)(7). By way of example, and at the sole discretion of the Administrator, if a Participant's entire Account balance is less than the applicable Code Section 402(g) annual limit, the Participating Employer may distribute the Participant's Account in a lump sum provided that the distribution results in the termination of the Participant's entire interest in the Plan, subject to the plan aggregation rules of Code Section 409A and regulations thereunder. By way of example, the Administrator may permit such acceleration of the time or schedule of a payment under the Plan to an individual other than a Participant as may be necessary to fulfill a domestic relations order (as defined in Code Section 414(p)(1)(B)).

6.6 Distributions to Specified Employee

Notwithstanding anything herein to the contrary, if any Participant is a Specified Employee upon a Separation from Service for any reason other than death, distributions to such Participant shall commence no earlier than six months following Separation from Service (or, if earlier, the date of death of the Participant) and no later than seven months following Separation from Service. If distributions are to be made in installments pursuant to the terms of the Plan (such as when distributions are triggered by a Retirement), and such distributions are subject to the six-month delay described in this Section 6.6, then the first installment payable to the Participant shall include the amount of all payments so delayed and the second installment and all subsequent installments will be paid at such time as if no such delay had occurred.

6.7 Distributions due to Separation other than Retirement

Upon a Participant's Separation from Service for any reason other than Retirement, all vested amounts credited to his or her Account shall be paid to the Participant in a lump-sum, as soon as administratively feasible, but no later than sixty (60) days following Participant's effective date of Separation from Service, subject to Section 6.6 (Distributions to Specified Employees).

6.8 Form of Payment

All distributions shall be made in the form of cash.

6.9 Separation from Service for Cause

Notwithstanding anything to the contrary contained herein, in the event a Participant has an involuntary Separation from Service for Cause at any time, all amounts (whether or not vested) credited to the Participant's Account relating to Employer Discretionary Contribution(s), Employer Supplemental Discretionary Contribution(s), ERIP Conversion Contribution, including the Participant's allocable share of any earnings or losses credited on the foregoing pursuant to Section 5.2, above, shall be forfeited with no compensation or other payment due to the Participant. For purposes of the Plan, (x) "Cause" shall have the meaning set forth in any employment, severance or other similar agreement between the Participant and the Participating Employer or (y) if such agreement does not define the term "Cause" or no such agreement exists, then "Cause shall mean: (i) engaging in willful or grossly negligent misconduct that is, or would reasonably be expected to be, materially injurious (monetarily or otherwise) to the Participating Employer and/or any of its affiliates, (ii) embezzlement or misappropriation of funds or property of the Participating Employer and/or any of its affiliates, (iii) commission, indictment or conviction of a felony or the entrance of a plea of guilty or nolo contendere to a felony, (iv) commission, indictment or conviction of any crime involving fraud, dishonesty or breach of trust or the entrance of a plea of guilty or nolo contendere

to such a crime, (v) failure or refusal by the Participant to devote full business time and attention to the performance of his or her duties and responsibilities if such failure or refusal has not been cured within fifteen (15) days after notice is given to the Participant, (vi) a violation by the Participant of any policy or code of conduct of the Participating Employer and/or any of its affiliates, including, without limitation, any such policy or code of conduct relating to sexual harassment, or (vii) a material breach by the Participant of the terms of any agreement between the Participant and the Participating Employer (or any affiliate thereof), including, without limitation, any employment agreement or any restrictive covenant agreement, if such breach has not been cured within fifteen (15) days after notice is given to the Participant.

6.10 Forfeiture upon Competitive Activity

If a Participant engages in competition with the Sponsor, any other Participating Employer or any of their respective affiliates after reaching the age at which he or she is first eligible for Retirement and before the Participant's Account balance is fully paid, then the Board, in its sole and absolute discretion, may declare that the Participant's total interest in the Plan be forfeited and, in such event, no further amounts will be paid under the Plan to or with respect to such Participant.

Article 7 Beneficiaries

7.1 Beneficiaries

Each Participant may from time to time designate one or more persons (who may be any one or more members of such Participant's family or other persons, administrators, trusts, foundations or other entities) as his or her beneficiary or beneficiaries under the Plan. Such designation shall be made in a form prescribed by the Administrator. Each Participant may, at any time and from time to time, change any previous beneficiary designation, without notice to or consent of any previously designated beneficiary, by amending his or her previous designation in a form prescribed by the Administrator. If no beneficiary survives the Participant (or is otherwise available to receive payment), or if no beneficiary is validly designated, then the amounts payable under the Plan shall be paid to the Participant's estate. If more than one person is the beneficiary of a deceased Participant, each such person shall receive a pro rata share of any death benefit payable unless otherwise designated in the applicable form. If a beneficiary who is receiving benefits dies, all benefits that were payable to such beneficiary shall then be payable to the estate of that beneficiary.

7.2 Lost Beneficiary

Each Participant and each beneficiary shall have the obligation to keep the Administrator informed of his, her or its current address until such time as all benefits due to him, her or it under the Plan have been paid. If a Participant or beneficiary cannot be located by the Administrator exercising due diligence, then, in its sole discretion, the Administrator may presume that the Participant or beneficiary is deceased for purposes of the Plan and all unpaid amounts (net of due diligence expenses) owed to the Participant or beneficiary shall be paid according to Section 7.1 or, if a beneficiary cannot be so located, then such amounts may be forfeited. Any such presumption of death shall be final, conclusive and binding on all persons and entities.

Article 8 Funding

8.1 Prohibition against Funding

Should any assets be acquired or any investment be made in connection with the liabilities assumed under the Plan, it is expressly understood and agreed that the Participants and beneficiaries shall not have any right with respect to, or claim against, such assets or investment nor shall any such acquisition or investment be construed to create a trust of any kind or a fiduciary relationship between the Participating Employer and the Participants, their beneficiaries or any other person. Any such assets or investment shall be and remain a part of the general, unpledged, unrestricted assets of the Participating Employer, subject to the claims of its general creditors. It is the express intention of the Sponsor, other Participating Employers and all Participants and beneficiaries that this Plan shall be unfunded for tax purposes and for purposes of Title I of the ERISA. Each Participant and beneficiary shall be required to look to the provisions of the Plan and to the Participating Employer itself for enforcement of any and all benefits due under the Plan, and to the extent any such person acquires a right to receive payment under the Plan, such right shall be no

greater than the right of any unsecured general creditor of the Participating Employer. The Participating Employer or the Trust shall be designated the owner and beneficiary of any assets acquired or investment made in connection with its obligation under the Plan.

8.2 Deposits in Trust

Notwithstanding Section 8.1 or any other provision of the Plan to the contrary, the Participating Employer may deposit into the Trust any amounts it deems appropriate to pay benefits under the Plan. The amounts so deposited may include all or any portion of the Employer Discretionary Contribution(s), Employer Supplemental Discretionary Contribution(s), and ERIP Conversion Contribution.

Article 9 Claims Administration

9.1 General

If a Participant, beneficiary or his or her representative is denied all or a portion of an expected Plan benefit for any reason and the Participant, beneficiary or his or her representative desires to dispute the decision of the Administrator, he or she must file a written notification of his or her claim with the Administrator. The Plan Administrator shall ensure that all written claims and appeals for benefits are judged in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. All notices provided to individuals pursuant to this Article 9 are to be provided in a culturally and linguistically appropriate manner (as described in Department of Labor Regulation Section 2560.503-1(o)).

9.2 Claims Procedure

Upon receipt of any written claim for benefits, the Administrator shall be notified and shall give due consideration to the claim presented. If any Participant or beneficiary claims to be entitled to benefits under the Plan and the Administrator determines that the claim should be denied in whole or in part, the Administrator shall, in writing, notify such claimant within ninety (90) days (forty-five (45) days if the claim is on account of Disability) of receipt of the claim that the claim has been denied. The Administrator may extend the period of time for making a determination with respect to any claim for a period of up to ninety (90) days (thirty (30) days if claim is on account of Disability), provided that the Administrator determines that such an extension is necessary because of special circumstances and notifies the claimant, prior to the expiration of the initial ninety (90) day (or forty-five (45) day) period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the claim is denied to any extent by the Administrator, the Administrator shall furnish the claimant with a written notice setting forth:

(a) the specific reason or reasons for denial of the claim;

(b) a specific reference to the Plan provisions on which the denial is based;

(c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) an explanation of the provisions of this Article;

(e) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review, and a description of any time limit that applies under the Plan for bringing such an action;

(f) in the event of a claim based on account of Disability, a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented by the claimant of health care professionals treating the claimant and vocational professionals who evaluated the claimant, (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination and (3) a disability determination regarding the claimant presented by the claimant made by the Social Security Administration;

(g) in the event of a claim based on account of Disability and as applicable in the event of an adverse benefit determination either an explanation of the scientific or clinical judgment for the

determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(h) in the event of a claim based on account of Disability, either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(i) in the event of a claim based on account of Disability, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits (whether a document, record, or other information is relevant to a claim for benefits shall be determined by Department of Labor Regulation Section 2560.503-1(m)(8)).

9.3 Right of Appeal

A claimant who has a claim denied wholly or partially under Section 9.2 may appeal to the Administrator for reconsideration of that claim. A request for reconsideration under this Section must be filed by written notice within sixty (60) days (one-hundred and eighty (180) days if the claim is on account of Disability) after receipt by the claimant of the notice of denial under Section 9.2.

9.4 Review of Appeal

Upon receipt of an appeal, the Administrator shall promptly take action to give due consideration to the appeal. Such consideration may include a hearing of the parties involved, if the Administrator feels such a hearing is necessary. Prior to and in preparing for this appeal, the claimant shall be given, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination in connection with the claim, or any new or additional rationale, as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, to give the claimant a reasonable opportunity to respond prior to that date. Claimant shall be given the opportunity to submit issues and written comments to the Plan Administrator, as well as to review and receive, without charge, all relevant (as defined in applicable ERISA regulations) documents, records and other information relating to the claim. In considering the review, the Plan Administrator (or reviewer other than the Plan Administrator) shall take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. A claim on account of Disability will be reviewed by an individual or committee who did not make the initial determination that is subject of the appeal, nor by a subordinate of the individual who made the determination, and the review shall be made without deference to the initial adverse benefit determination. If the initial adverse benefit determination was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional with appropriate training and experience in the field of medicine involving the medical judgment. The health care professional who is consulted on appeal will not be the same individual who was consulted during the initial determination or the subordinate of such individual. If the Plan Administrator obtained the advice of medical or vocational experts in making the initial adverse benefits determination (regardless of whether the advice was relied upon), the Plan Administrator will identify such experts.

After consideration of the merits of the appeal, the Administrator shall issue a written decision, which shall be binding on all parties. The decision shall specifically state its reasons and pertinent Plan provisions on which it relies. The Administrator's decision shall be issued within sixty (60) days (forty-five (45) days if the claim is on account of Disability) after the appeal is filed, except that the Administrator may extend the period of time for making a determination with respect to any claim for a period of up one-hundred and twenty (120) days (ninety (90) days if the claim is on account of Disability), provided that the Administrator determines that such an extension is necessary because of special circumstances and notifies the claimant, prior to the expiration of the initial sixty (60) day (or, if the claim is on account of Disability, initial forty-five (45) day) period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

In the case of an adverse benefit determination with respect to a claim on account of Disability, the Plan Administrator will provide a notification that shall set forth:

(a) the Plan Administrator's decision;

(b) the specific reasons for the denial;

(c) a reference to the specific provisions of the Plan or insurance contract on which the decision is based;

(d) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant (as defined in applicable ERISA regulations) to the claimant's claim for benefits;

(e) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures;

(f) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) which shall describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

(g) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented by the claimant of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (3) a disability determination regarding the claimant presented by the claimant made by the Social Security Administration,

(h) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(i) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

9.5 Miscellaneous

Under no circumstances shall any failure by the Administrator to comply with the provisions of this Article 9 be considered to constitute an allowance of the claimant's claim. A claimant must follow the claims procedures under this Plan and exhaust his or her administrative remedies before taking any further action with respect to a claim for benefits. The Administrator may designate any other person of its choosing to make any determination otherwise required under this Article. Any person so designated shall have the same authority and discretion granted to the Administrator hereunder. In the case of a claim for benefits on account of Disability, if the Plan fails to strictly adhere to all the requirements of this claims procedure with respect to a Disability based claim, the claimant shall be deemed to have exhausted the administrative remedies available under the Plan, and shall be entitled to pursue any available remedies under ERISA Section 502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim, except where the violation was: (a) de minimis; (b) non-prejudicial; (c) attributable to good cause or matters beyond the Plan's control; (d) in the context of an ongoing good-faith exchange of information; and (e) not reflective of a pattern or practice of noncompliance. The claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies to be deemed exhausted. If a court rejects the claimant's request for immediate review on the basis that the Plan met the standards for the exception, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within

a reasonable time after the receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

Article 10 General Provisions

10.1 Administrator

(a) The Administrator is expressly empowered to interpret the Plan, and to determine all questions arising in the administration, interpretation and application of the Plan; to employ actuaries, accountants, counsel, and other persons it deems necessary in connection with the administration of the Plan; to request any information from the Participating Employer it deems necessary to determine whether the Participating Employer would be considered insolvent or subject to a proceeding in bankruptcy; and to take all other necessary and proper actions to fulfill its duties as Administrator.

(b) The Administrator shall not be liable for any actions by it hereunder, unless due to its own negligence, willful misconduct or lack of good faith.

(c) The Administrator shall be indemnified and saved harmless by the Participating Employer from and against all personal liability to which it may be subject by reason of any act done or omitted to be done in its official capacity as Administrator in good faith in the administration of the Plan, including all expenses reasonably incurred in its defense in the event the Participating Employer fails to provide such defense upon the request of the Administrator. The Administrator is relieved of all responsibility in connection with its duties hereunder to the fullest extent permitted by law, short of breach of duty to the Participants and their beneficiaries.

(d) The Administrator (or any individual member thereof) may be removed by the Sponsor at any time. The Administrator (or any individual member thereof) may resign at any time by submitting his or her resignation in writing to the Sponsor. Notwithstanding the foregoing, any individual who is designated as the Administrator (or as a member thereof) and who is an Employee shall be deemed to have resigned as the Administrator (or as a member thereof) effective upon his or her termination of employment. A new Administrator (or, if applicable, a new individual member thereof) shall be appointed as soon as possible in the event the Administrator (or any individual member thereof) is removed or resigns from the Administrator position. The Administrator shall serve as the agent for the Participating Employer with respect to the Trust.

10.2 No Assignment

Benefits or payments under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, attachment, or garnishment by creditors of the Participant or the Participant's beneficiary, whether voluntary or involuntary, and any attempt to so anticipate, alienate, sell, transfer, assign, pledge, encumber, attach or garnish the same shall not be valid, nor shall any such benefit or payment be in any way liable for or subject to the debts, contracts, liabilities, engagement or torts of any Participant or beneficiary, or any other person entitled to such benefit or payment pursuant to the terms of the Plan, except to such extent as may be required by law. If any Participant or beneficiary or any other person entitled to a benefit or payment pursuant to the terms of the Plan becomes bankrupt or attempts to anticipate, alienate, sell, transfer, assign, pledge, encumber, attach or garnish any benefit or payment under the Plan, in whole or in part, or if any attempt is made to subject any such benefit or payment, in whole or in part, to the debts, contracts, liabilities, engagements or torts of the Participant or beneficiary or any other person entitled to any such benefit or payment pursuant to the terms of the Plan, then such benefit or payment, in the discretion of the Administrator, shall cease and terminate with respect to such Participant or beneficiary, or any other such person.

10.3 No Employment Rights

Participation in the Plan shall not be construed to confer upon any Participant the legal right to be retained in the employ of the Participating Employer, or give a Participant or beneficiary, or any other person, any right to any payment whatsoever, except to the extent of the benefits provided for hereunder. Each Participant shall remain subject to discharge to the same extent as if the Plan had never been adopted.

10.4 Incompetence

If the Administrator determines that any person to whom a benefit is payable under the Plan is incompetent by reason of physical or mental disability, the Administrator shall have the power to cause the payments becoming due to such person to be made to another person for his or her benefit without responsibility of the Administrator or the Participating Employer to see to the application of such payments. Any payment made pursuant to such power shall, as to such payment, operate as a complete discharge of the Participating Employer, the Administrator and the Trustee.

10.5 Identity

If, at any time, any doubt exists as to the identity of any person entitled to any payment hereunder or the amount or time of such payment, the Administrator shall be entitled to hold such sum until such identity or amount or time is determined or until an order of a court of competent jurisdiction is obtained. The Administrator shall also be entitled to pay such sum to such court in accordance with the appropriate rules of law. Any expenses incurred by the Participating Employer, Administrator, and/or Trustee incident to such proceeding or litigation shall be charged against the Account of the affected Participant.

10.6 Other Benefits

The benefits of each Participant or beneficiary hereunder shall be in addition to any benefits paid or payable to or on account of the Participant or beneficiary under any other pension, disability, annuity or retirement plan or policy whatsoever.

10.7 Expenses

All expenses incurred in the administration of the Plan, whether incurred by the Sponsor, any other Participating Employer or the Plan, shall be paid by the Sponsor or such other Participating Employer (as applicable).

10.8 Insolvency

Should a Participating Employer be considered insolvent (as defined by the Trust), the Participating Employer, through its board of directors and/or chief executive officer, shall give immediate written notice of such to the Administrator of the Plan and the Trustee. Upon receipt of such notice, the Administrator or Trustee shall cease to make any payments to Participants who were Employees of the Participating Employer or their beneficiaries or estates and shall hold any and all assets attributable to the Participating Employer for the benefit of the general creditors of the Participating Employer.

10.9 Amendment or Modification

The Sponsor may, at any time, in its sole discretion, amend or modify the Plan in whole or in part, except that no such amendment or modification shall have any retroactive effect to reduce any amounts allocated to a Participant's Accounts, and provided that such amendment or modification complies with Code Section 409A and related regulations thereunder.

10.10 Plan Suspension

The Sponsor further reserves the right to suspend the Plan in whole or in part, except that no such suspension shall have any retroactive effect to reduce any amounts allocated to a Participant's Accounts, and provided that the distribution of the vested Participant Accounts shall not be accelerated but shall be paid at such time(s) and in such manner as determined under the terms of the Plan immediately prior to such suspension as if the Plan had not been suspended.

10.11 Plan Termination

The Sponsor further reserves the right to terminate the Plan in whole or in part, in the following manner, except that no such termination shall have any retroactive effect to reduce any amounts allocated to a Participant's Accounts, and provided that such termination (and the related liquidation of the Plan) complies with Code Section 409A and related regulations thereunder:

(a) The Sponsor, in its sole discretion, may terminate the Plan and distribute all vested Participants' Accounts no earlier than twelve (12) calendar months after the date of the Plan termination and no later than twenty-four (24) calendar months after the date of the Plan termination, provided however that all other similar arrangements are also terminated by the Sponsor or any other Participating Employer

for any affected Participant and no other similar arrangements are adopted by the Sponsor or any other Participating Employer for any affected Participant within a three (3) year period after the date of the Plan termination; or

(b) The Sponsor may decide, in its sole discretion, to terminate the Plan in the event of a corporate dissolution taxed under Code Section 331, or with the approval of a bankruptcy court, provided that the Participants' vested Account balances are distributed to Participants and are included in the Participants' gross income in the latest of: (i) the calendar year in which the Plan termination occurs; (ii) the calendar year in which the amounts deferred are no longer subject to a substantial risk of forfeiture; or (iii) the first calendar year in which payment is administratively practicable.

10.12 Plan Termination due to a Change-in-Control

The Sponsor may decide, in its discretion, to terminate the Plan in the event of a Change-in-Control and distribute all vested Participants' Account balances no earlier than thirty (30) days prior to the Change-in-Control and no later than twelve (12) months after the effective date of the Change-in-Control, provided however that the Sponsor and the other applicable Participating Employers terminate all other similar arrangements for any affected Participant, provided further that such termination and liquidation of the Plan complies with Code Section 409A and related regulations thereunder.

10.13 Construction

All questions of interpretation, construction or application arising under or concerning the terms of the Plan shall be decided by the Administrator, in its sole and final discretion, whose decision shall be final, binding and conclusive upon all persons and entities.

10.14 Governing Law

The Plan shall be governed by, construed and administered in accordance with the applicable provisions of ERISA, Code Section 409A, and any other applicable federal law, provided, however, that, to the extent not preempted by federal law, the Plan shall be governed by, construed and administered under the laws of the Commonwealth of Pennsylvania, other than its laws respecting choice of law.

10.15 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan and the Plan shall be construed and enforced as if such provision had not been included therein. If the inclusion of any Employee (or Employees) as a Participant(s) under the Plan would cause the Plan to fail to comply with the requirements of Sections 201(2), 301(a)(3) and 401(a)(1) of ERISA, then the Plan shall be severed with respect to such Employee or Employees, who shall be considered to be participating in a separate arrangement.

10.16 Headings

The Article headings contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall they affect the Plan or the construction of any provision thereof.

10.17 Terms

Capitalized terms shall have meanings as defined herein. Singular nouns shall be read as plural, masculine pronouns shall be read as feminine, and vice versa, as appropriate.

10.18 Code Section 409A Fail Safe Provision

If any provision of the Plan violates Code Section 409A, the regulations promulgated thereunder, regulatory interpretations, announcements or mandatory judicial precedents construing Code Section 409A (collectively "Applicable Law"), then such provision shall be void and have no effect. At all times, the Plan shall be interpreted in such manner that it complies with Applicable Law.

10.19 No Guarantee of Tax Consequences

While the Plan is intended to provide tax deferral for **Participants, the Plan is not a guarantee that the intended tax deferral will be achieved. Participants are solely responsible and liable for the satisfaction of all taxes, penalties and interest that may arise in connection with the Plan (including any**

taxes, penalties or interest arising under Section 409A of the Code). Neither the Sponsor, any other Participating Employer or any of their respective affiliates, nor any of the directors, officers or employees of any of the foregoing shall have any obligation to indemnify or otherwise hold any Participant harmless from any such taxes, penalties or interest.

10.20 Limitation on Actions.

Any Participant or beneficiary who disagrees with a denial of his, her or its appealed claim under Article 9 of the Plan must file any complaint in the federal District Court located in Philadelphia, Pennsylvania to dispute such determination by no later than the first anniversary of the date on which such claim was denied upon appeal.

IN WITNESS WHEREOF, Universal Health Services, Inc. has caused this instrument to be executed by its duly authorized officer, effective as of this 18th day of July, 2018.

Universal Health Services, Inc.

By: /s/ Steve Filton

Title: Executive Vice President and Chief Financial Officer

Appendix A

List of “Group 1 Participants”

List of “Group 2 Participants”

Exhibit 31.1

CERTIFICATION—Chief Executive Officer

I, Alan B. Miller, certify that:

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

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

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

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

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

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

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

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

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

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

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

Date: May 8, 2019

/s/ Alan B. Miller
Chief Executive Officer

Exhibit 31.2

CERTIFICATION—Chief Financial Officer

I, Steve Filton, certify that:

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

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

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

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

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

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

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

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

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

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

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

Date: May 8, 2019

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

Exhibit 32.1

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

In connection with the Quarterly Report of Universal Health Services, Inc. (the "Company") on Form 10-Q for the quarter ended March 31, 2019, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Alan B. Miller, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and to the best of my knowledge, that:

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

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

/s/ Alan B. Miller
Chief Executive Officer
May 8, 2019

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, 2019, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Steve Filton, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, and to the best of my knowledge, that:

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

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

/s/ Steve Filton
Executive Vice President and Chief Financial Officer
May 8, 2019

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.