UNIVERSAL HEALTH SERVICES INC
Form 10-Q
May 09, 2018

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, 2018

OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to

Commission file number 1-10765

UNIVERSAL HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

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

UNIVERSAL CORPORATE CENTER

367 SOUTH GULPH ROAD

KING OF PRUSSIA, PENNSYLVANIA 19406

(Address of principal executive offices) (Zip Code)

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

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

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

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

Large accelerated filer Accelerated filer

Non-accelerated filer Smaller reporting company
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, 2018:

Class A	6,577,100
Class B	87,149,150
Class C	661,688
Class D	18,673

UNIVERSAL HEALTH SERVICES, INC.

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This Quarterly Report on Form 10-Q is for the quarter ended March 31, 2018. 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,	
	2018	2017
Net revenues before provision for doubtful accounts		$2,825,472
Less: Provision for doubtful accounts		212,614
Net revenues	$2,687,516	2,612,858
Operating charges:		
Salaries, wages and benefits	1,300,148	1,237,964
Other operating expenses	620,819	607,360
Supplies expense	292,929	277,614
Depreciation and amortization	113,103	110,798
Lease and rental expense	26,703	25,189
	2,353,702	2,258,925
Income from operations	333,814	353,933
Interest expense, net	37,576	35,507
Income before income taxes	296,238	318,426
Provision for income taxes	67,569	107,899
Net income	228,669	210,527
Less: Net income attributable to noncontrolling interests	4,837	4,472
Net income attributable to UHS	$223,832	$206,055
Basic earnings per share attributable to UHS	$2.37	$2.13
Diluted earnings per share attributable to UHS	$2.36	$2.12
Weighted average number of common shares - basic	94,226	96,585
Add: Other share equivalents	457	787
Weighted average number of common shares and equivalents - diluted	94,683	97,372

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,	
	2018	2017
Net income	$228,669	$210,527
Other comprehensive income (loss):		
Unrealized derivative gains on cash flow hedges	2,124	3,066
Foreign currency translation adjustment	(4,341)	7,236
Other	2,367	1,094
Other comprehensive income before tax	150	11,396
Income tax expense related to items of other comprehensive income	1,077	1,551
Total other comprehensive income (loss), net of tax	(927)	9,845
Comprehensive income	227,742	220,372
Less: Comprehensive income attributable to noncontrolling interests	4,837	4,472
Comprehensive income attributable to UHS	$222,905	$215,900

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, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$73,053	$74,423
Accounts receivable, net	1,569,803	1,500,898
Supplies	137,246	136,177
Other current assets	104,624	86,504
Total current assets	1,884,726	1,798,002
Property and equipment	8,144,555	7,921,126
Less: accumulated depreciation	(3,444,003)	(3,349,289)
	4,700,552	4,571,837
Other assets:		
Goodwill	3,843,126	3,825,157
Deferred charges	8,882	9,787
Deferred income taxes	3,072	3,007
Other	583,159	554,038
Total Assets	$11,023,517	$10,761,828
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$126,248	$545,619
Accounts payable and accrued liabilities	1,366,333	1,284,081
Federal and state taxes	86,996	18,334
Total current liabilities	1,579,577	1,848,034
Other noncurrent liabilities	311,900	306,304
Long-term debt	3,795,087	3,494,390
Deferred income taxes	44,850	54,962
Redeemable noncontrolling interests	6,081	6,702
Equity:		
UHS common stockholders' equity	5,215,646	4,989,514
Noncontrolling interest	70,376	61,922
Total equity	5,286,022	5,051,436
Total Liabilities and Stockholders' Equity	$11,023,517	$10,761,828

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,	
	2018	2017
Cash Flows from Operating Activities:		
Net income	$228,669	$210,527
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	113,134	110,798
Stock-based compensation expense	19,700	15,348
Gain on sale of assets and businesses	(703)	0
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(72,526)	(5,362)
Accrued interest	(6,209)	(6,123)
Accrued and deferred income taxes	61,674	102,269
Other working capital accounts	59,032	66,877
Other assets and deferred charges	(5,438)	(7,654)
Other	(37,642)	(229)
Accrued insurance expense, net of commercial premiums paid	23,125	22,007
Payments made in settlement of self-insurance claims	(18,765)	(25,349)
Net cash provided by operating activities	364,051	483,109
Cash Flows from Investing Activities:		
Property and equipment additions, net of disposals	(189,041)	(144,338)
Acquisition of property and businesses	(20,931)	(17,832)
Proceeds received from sales of assets and businesses	839	0
Costs incurred for purchase and implementation of information technology application	(8,570)	(9,456)
Decrease (increase) in capital reserves of commercial insurance subsidiary	100	(3,000)
Investment in, and advances to, joint venture	(8,675)	0
Net cash used in investing activities	(226,278)	(174,626)
Cash Flows from Financing Activities:		
Reduction of long-term debt	(140,676)	(260,633)
Additional borrowings	20,500	21,600
Repurchase of common shares	(9,441)	(29,167)
Dividends paid	(9,422)	(9,662)
Issuance of common stock	2,545	2,540
Profit distributions to noncontrolling interests	(4,217)	(4,118)
Net cash used in financing activities	(140,711)	(279,440)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	1,857	285
(Decrease) increase in cash, cash equivalents and restricted cash	(1,081)	29,328
Cash, cash equivalents and restricted cash, beginning of period	167,297	121,950

Cash, cash equivalents and restricted cash, end of period	$166,216	$151,278
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$41,539	$39,404
Income taxes paid, net of refunds	$2,749	$5,253
Noncash purchases of property and equipment	$84,708	$56,427

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(1) General

This Quarterly Report on Form 10-Q is for the quarterly period ended March 31, 2018. 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, 2017.

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

Relationship with Universal Health Realty Income Trust:

At March 31, 2018, 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, pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $900,000 during each of the three-month periods ended March 31, 2018 and 2017.

Our pre-tax share of income from the Trust was approximately $284,000 and $1.8 million during the three-month periods ended March 31, 2018 and 2017, respectively. Included in our share of the Trust's income for the three months ended March 31, 2017, is our share of a gain realized by the Trust in connection with the divestiture of property that was completed during the first quarter of 2017. The carrying value of this investment was approximately $8.5 million and $8.2 million at March 31, 2018 and December 31, 2017, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $47.3 million at March 31, 2018 and $59.2 million at December 31, 2017, 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, 2018 and 2017. 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 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, 2021	10(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 two 5-year renewal options 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) 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 chief executive officer ("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 and $1.2 million in premium payments during each of 2018 and 2017, respectively.

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 $35 million as of March 31, 2018 and $33 million as of December 31, 2017.

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. This Board member also provides 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, 2018, 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 an under-construction behavioral health care facility located in Spokane, Washington with an expected October 2018 opening. The noncontrolling interest and redeemable noncontrolling interest balances of $70 million and $6 million, respectively, as of March 31, 2018, 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

Debt:

On June 7, 2016, we entered into a Fifth Amendment (the "Fifth Amendment") to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012, May 16, 2013 and August 7, 2014, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders ("Credit Agreement"). The Fifth Amendment increased the size of the term loan A facility by $200 million and those proceeds were utilized to repay outstanding borrowings under the revolving credit facility of the Credit Agreement. The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility ($285 million of borrowings outstanding as of March 31, 2018), and; (ii) a term loan A facility with $1.753 billion of borrowings outstanding as of March 31, 2018.

Borrowings under the 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 0.50% to 1.25% for revolving credit and term loan-A 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 1.50% to 2.25% for revolving credit and term loan-A borrowings. As of March 31, 2018, 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.

As of March 31, 2018, we had $285 million of borrowings outstanding pursuant to the terms of our $800 million revolving credit facility and we had $446 million of available borrowing capacity net of $34 million of outstanding letters of credit and $35 million of outstanding borrowings pursuant to a short-term, on demand-credit facility. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, certain real estate assets and assets held in joint-ventures with third-parties) and our material subsidiaries and guaranteed by our material subsidiaries.

Pursuant to the terms of the Credit Agreement, term loan-A quarterly installment payments of approximately $22 million commenced during the fourth quarter of 2016 and are scheduled through June, 2019. Previously, approximately $11 million of quarterly installment payments were made from the fourth quarter of 2014 through the third quarter of 2016.

The Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of March 31, 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, 2018, we had $440 million of outstanding borrowings pursuant to the terms of the Securitization and no available borrowing capacity, before giving effect to the $10 million increase in borrowing capacity effective in April, 2018 pursuant to the terms of the sixth amendment.

As of March 31, 2018, we had combined aggregate principal of $1.4 billion from the following senior secured notes:

- $300 million aggregate principal amount of 3.75% senior secured notes due in August, 2019 ("2019 Notes") which were issued on August 7, 2014.

- $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 is payable on the 2019 Notes and the 2022 Notes on February 1 and August 1 of each year until the maturity date of August 1, 2019 for the 2019 Notes and August 1, 2022 for the 2022 Notes. Interest on the 2026 Notes is payable on June 1 and December 1 until the maturity date of June 1, 2026. The 2019 Notes, 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 2019 Notes, 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.

At March 31, 2018, the carrying value and fair value of our debt were each approximately $3.9 billion. At December 31, 2017, the carrying value and fair value of our debt were approximately $4.0 billion and $4.1 billion, respectively. The fair value of our debt was computed based upon quotes received from financial institutions. We consider these to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

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 derivative instruments designated as cash flow hedges, the ineffective portion of the change in expected cash flows of the hedged item are recognized currently in the income statement.

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

The fair value of interest rate swap agreements approximates the amount at which they could be settled, based on estimates obtained from the counterparties. We assess the effectiveness of our hedge instruments on a quarterly basis. We performed periodic assessments of the cash flow hedge instruments during the first three months of 2018 and the

full year of 2017 and determined the hedges to be highly effective. We also determined that any portion of the hedges deemed to be ineffective was de minimis and therefore there was no material effect on our consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose us to credit risk in the event of nonperformance. We do not anticipate nonperformance by our counterparties. We do not hold or issue derivative financial instruments for trading purposes.

Seven interest rate swaps on a total notional amount of $825 million matured in May, 2015. During 2015, we entered into nine forward starting interest rate swaps whereby we pay a fixed rate on a total notional amount of $1.0 billion and receive one-month LIBOR. The average fixed rate payable on these swaps, which are scheduled to mature on April 15, 2019, is 1.31%. These interest rates swaps consist of:

- Four forward starting interest rate swaps, entered into during the second quarter of 2015, whereby we pay a fixed rate on a total notional amount of $500 million and receive one-month LIBOR. Each of the four swaps became effective on July 15, 2015 and are scheduled to mature on April 15, 2019. The average fixed rate payable on these swaps is 1.40%;

- Four forward starting interest rate swaps, entered into during the third quarter of 2015, whereby we pay a fixed rate on a total notional amount of $400 million and receive 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 are scheduled to mature on April 15, 2019. The average fixed rate payable on these four swaps is 1.23%, and;

- One interest rate swap, entered into during the fourth quarter of 2015, whereby we pay a fixed rate on a total notional amount of $100 million and receive one-month LIBOR. The swap became effective on December 15, 2015 and is scheduled to mature on April 15, 2019. The fixed rate payable on this swap is 1.21%.

We measure our interest rate swaps at fair value on a recurring basis. The fair value of our interest rate swaps is based on quotes from our counterparties. We consider those inputs to be “level 2” in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with derivative instruments and hedging activities. At March 31, 2018, the fair value of our interest rate swaps was a net asset of $9 million, $8 million of which is included in net accounts receivable and $1 million of which is included in other assets on the accompanying balance sheet. At December 31, 2017, the fair value of our interest rate swaps was a net asset of $7 million, $4 million of which is included in net accounts receivable and $3 million of which is included in other assets on the accompanying consolidated balance sheet.

Foreign Currency Forward Exchange Contracts:

We use forward exchange contracts to hedge our net investment in foreign operations against movements in exchange rates. The effective portion of the unrealized gains or losses on these contracts is recorded in foreign currency translation adjustment within accumulated other comprehensive income and remains there until either the sale or liquidation of the subsidiary. The cash flows from these contracts are reported as operating activities in the consolidated statements of cash flows. In connection with these forward exchange contracts, we recorded net cash outflows of $46 million and $8 million during the three-month periods ended March 31, 2018 and 2017, respectively.

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, 2018	December 31, 2017
Cash and cash equivalents	$73,053	$74,423
Restricted cash (a)	93,163	92,874
Total cash, cash equivalents and restricted cash	$166,216	$167,297

(a) Restricted cash, associated with an insurance subsidiary, is included in other assets on the accompanying consolidated balance sheet.

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

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(5) 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, 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. The coverage for the facilities located in the U.K. acquired in late December, 2016 in connection with our acquisition of the Cambian Group, PLC's adult services division is similar to the above-mentioned U.K. insurance program.

As of March 31, 2018, the total accrual for our professional and general liability claims was $232 million, of which $54 million was included in current liabilities. As of December 31, 2017, the total accrual for our professional and general liability claims was $229 million, of which $54 million was included in current liabilities.

At each of March 31, 2018 and December 31, 2017, the total accrual for our workers' compensation liability claims was $70 million, of which $35 million is 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, 2018 and December 31, 2017 include amounts due from Illinois of approximately $35 million and $25 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $15 million as of March 31, 2018 and $8 million as of December 31, 2017, 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.

As of March 31, 2018 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $117 million consisting of: (i) $108 million related to our self-insurance programs, and; (ii) $9 million of other debt and public utility guarantees.

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, and El Paso Behavioral Health System.

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, 2018, the aggregate funds withheld from us in connection with the River Point Behavioral Health payment suspension amounted to approximately $10 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, 2018 or the year ended December 31, 2017, 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 payors in relation to services provided at those facilities. During the first quarter of 2018, we recorded a $13 million pre-tax increase to the reserve established in connection with the civil aspects of these matters increasing the aggregate pre-tax reserve to $35 million. 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, will not differ materially from our established reserve.

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. Plaintiff alleges that defendants violated federal securities laws relating to the disclosures made in public filings associated with practices at our behavioral health facilities. 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. 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. The suit alleges breaches of fiduciary duties and other allegedly wrongful conduct by the members of the Board of Directors and certain officers of Universal Health Services, Inc. relating to practices at our behavioral health facilities. UHS has been named as a nominal defendant in the case. 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 Amalgamated Bank Longview Funds as the lead plaintiff and their counsel as lead counsel. 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. These additional cases make substantially similar allegations and claims based upon alleged violations of federal securities laws as well common law causes of action against the individual defendants. All of these additional cases have also named members of the UHS Board of Directors as well as certain officers of the Company. 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.

Chowdary v. Universal Health Services, Inc., et. al.

This is a lawsuit filed in 1999 in state court in Hidalgo County, Texas by a physician and his professional associations alleging tortious interference with contractual relationships and retaliation against McAllen Medical Center in McAllen, Texas as well as Universal Health Services, Inc. The state court has entered a summary judgment order awarding plaintiff $3.85 million in damages. With prejudgment interest, the total amount of the order amounts to approximately $9 million, for which a reserve is included in our financial statements as of December 31, 2017. A trial on punitive damages, emotional distress and attorneys' fees remains to be conducted if the summary judgment order is not vacated. The case has been removed to federal court. Plaintiffs filed a motion to remand. In February 2018, the federal court denied plaintiffs' motion to remand and retained the case in federal court. Plaintiffs have filed a writ of mandamus with the 5th Circuit Court of Appeals seeking to overturn the federal court's decision denying remand. We have filed a motion for reconsideration of state court's summary judgment order in the federal court proceeding.

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 2011 ("FFY2011") 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 and 2013 aggregating to approximately $11 million. We filed administrative appeals for all of our facilities contesting the recoupment efforts for FFYs 2011 through 2013 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. The Department will likely make similar repayment demand for FFY 2014. 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 2013 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.

Matters Relating to Psychiatric Solutions, Inc. ("PSI"):

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

Department of Justice Investigation of Riveredge Hospital

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our

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

Department of Justice Investigation of Friends Hospital

In October, 2010, Friends Hospital in Philadelphia, Pennsylvania, received a subpoena from the DOJ requesting certain documents from the facility. The requested documents were collected and provided to the DOJ for review and examination. Another subpoena was issued to the facility in July, 2011 requesting additional documents, which have also been delivered to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

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.

(6) Segment Reporting

Our reportable operating segments consist of acute care hospital services and behavioral health care services. The "Other" segment column below includes centralized services including, 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, 2017. 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, 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

	Three months ended March 31, 2017			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Amounts in thousands)			
Gross inpatient revenues	$5,597,850	$2,183,002	$0	$7,780,852
Gross outpatient revenues	$3,294,177	$246,460	$0	$3,540,637
Total net revenues	$1,389,547	$1,218,122	$5,189	$2,612,858
Income/(loss) before allocation of corporate overhead and	$187,804	$251,931	$(121,309)	$318,426

income taxes				
Allocation of corporate overhead	$(45,676)	$(39,661)	$85,337	$0
Income/(loss) after allocation of corporate overhead and before income taxes	$142,128	$212,270	$(35,972)	$318,426
Total assets as of March 31, 2017	$3,757,311	$6,517,608	$173,340	$10,448,259

(a) Includes net revenues generated from our behavioral health care facilities located in the U.K. amounting to approximately $115 million and $100 million for the three-month periods ended March 31, 2018 and 2017, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.176 billion and $992 million as of March 31, 2018 and 2017, respectively.

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

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

The following table sets forth the computation of basic and diluted earnings per share for classes A, B, C and D common stockholders for the periods indicated (in thousands, except per share data):

	Three months ended March 31,	
	2018	2017
Basic and Diluted:		
Net income attributable to UHS	$223,832	$206,055
Less: Net income attributable to unvested restricted share grants	(104)	(94)
Net income attributable to UHS – basic and diluted	$223,728	$205,961
Weighted average number of common shares - basic	94,226	96,585
Net effect of dilutive stock options and grants based on the treasury stock method	457	787
Weighted average number of common shares and equivalents - diluted	94,683	97,372
Earnings per basic share attributable to UHS:	$2.37	$2.13
Earnings per diluted share attributable to UHS:	$2.36	$2.12

The “Net effect of dilutive stock options and grants based on the treasury stock method”, for all periods presented above, excludes certain outstanding stock options applicable to each period since the effect would have been anti-dilutive. The excluded weighted-average stock options totaled 2.9 million for the three months ended March 31, 2018. The excluded weighted-average stock options totaled 5.7 million for the three months ended March 31, 2017. All classes of our common stock have the same dividend rights.

Stock-Based Compensation:

During the three-month periods ended March 31, 2018 and 2017, pre-tax compensation cost of $18.9 million and $14.9 million, respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended March 31, 2018 and 2017, pre-tax compensation cost of approximately $545,000 and $150,000 (net of cancellations), respectively, was recognized related to restricted stock. As of March 31, 2018 there was approximately $87.0 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 2.4 years. There were 4,000 stock options granted during the first three months of 2018 with a weighted-average grant date fair value of $29.6425 per share. There were 16,926 shares of restricted shares granted during the first three months of 2018 with a weighted-average grant date fair value of $117.98 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 $19.7 million and $15.3 million during the three-month periods ended March 31, 2018 and 2017, respectively.

(8) Dispositions and acquisitions

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 significant divestitures.

Three-month period ended March 31, 2017:

Acquisitions:

During the first quarter of 2017, we paid approximately $18 million to acquire various property assets.

Divestitures:

During the first quarter of 2017, there were no divestitures.

(9) Dividends

We declared and paid dividends of $9.4 million, or $.10 per share, during the first quarter of 2018 and $9.7 million or $.10 per share during the first quarter of 2017.

(10) Income Taxes

Our effective income tax rate was 22.8% for the three months ended March 31, 2018, compared with 33.9% for the three months ended March 31, 2017. The decrease in the effective tax rates for the three months ended March 31, 2018, compared with the same period in 2017, was primarily due to the Tax Cuts and Jobs Act of 2017 (the "TCJA-17"), which reduced the U.S. federal corporate tax rate from 35% to 21% effective January 1, 2018, partially offset by a $5 million increase in our provision for income taxes due to an unfavorable change resulting from our January 1, 2017 adoption of ASU 2016-09,"Compensation – Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting", which decreased our provision for income taxes by $2 million during the first quarter of 2018 as compared to $7 million during the first quarter 2017.

The TCJA-17 enacted on December 22, 2017 makes broad and complex changes to the U.S. tax code, including, but not limited to, (1) reducing the U.S. federal corporate tax rate from 35% to 21%; (2) requiring companies to pay a one-time transition tax on certain unrepatriated earnings of foreign subsidiaries; (3) generally eliminating U.S. federal income taxes on dividends from foreign subsidiaries; (4) requiring a current inclusion in U.S. federal taxable income of certain earnings of controlled foreign corporations through the implementation of a territorial tax system; and (5) creating a new limitation on deductible interest expense. Due to the complexities involved in accounting for the TCJA-17, the SEC issued Staff Accounting Bulletin No. 118 ("SAB 118"), which allows a measurement period of up to one year after the enactment date of the TCJA-17 to finalize the recording of the related tax impacts. We applied the guidance in SAB 118 and at December 31, 2017, recorded provisional estimates to re-measure our deferred taxes using the new 21% rate ($30 million tax benefit) and to record an estimated transition tax ($11.3 million expense). During the three months ended March 31, 2018, we have not made any additional measurement period adjustments related to the provisional estimates recorded at December 31, 2017. However, we are continuing to gather additional information to complete our accounting for these items and expect to complete our accounting within the prescribed measurement period.

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. We recorded an estimate in our effective tax rate for the three months ended March 31, 2018. Due to the complexities around the calculation we have not recorded any provisional deferred tax effects related to the GILTI tax and will not make an accounting policy election at this time with respect to deferred tax effects of GILTI for our consolidated financial statements three months ended March 31, 2018.

As of January 1, 2018, our unrecognized tax benefits were approximately $1 million. The amount, if recognized, that would favorably affect the effective tax rate is approximately $1 million. During the three months ended March 31,

2018, 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, 2018, we have less than $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for 2014 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.

(11) 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 payor, 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 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 payor or group of payors, will result in the recognition of the same amount of revenue as applying the analysis at the individual patient level.

On January 1, 2018, we adopted the new accounting standard using the modified retrospective method. The information in comparative periods have not been restated and continues to be reported under the accounting standards in effect for those periods. In accordance with the new revenue standard requirements, the disclosure of the impact of adoption on our condensed consolidated income statement was as follows (in thousands):

2018	As Reported	Balances Without Adoption ASC 606	Effect of Change
Net Revenue before provision for doubtful accounts		$2,931,527	
Less: Provision for doubtful accounts		246,543	
Net Revenues	$2,687,516	$2,684,984	$ 2,532
Other operating expenses	$620,819	$618,287	$ 2,532

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, 2018 and 2017 (in thousands):

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	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	%

2017	Acute Care			Behavioral Health			Other	Total		
Medicare	$316,385	23	%	$146,645	12	%		$463,030	18	%
Managed Medicare	144,047	10	%	36,674	3	%		180,721	7	%
Medicaid	92,657	7	%	180,949	15	%		273,606	10	%
Managed Medicaid	114,552	8	%	217,645	18	%		332,197	13	%
Managed Care (HMO and PPOs)	477,266	34	%	355,338	29	%		832,604	32	%
UK Revenue	0	0	%	100,022	8	%		100,022	4	%
Other patient revenue	123,374	9	%	124,798	10	%		248,172	9	%
Other non-patient revenue	121,266	9	%	56,051	5	%	5,189	182,506	7	%
Total Net Revenue	$1,389,547	100	%	$1,218,122	100	%	$5,189	2,612,858	100	%

(12) Recent Accounting Standards

On January 1, 2018, we adopted ASU No. 2016-15, Classification of Certain Cash Receipts and Cash Payments, which adds or clarifies guidance of the classification of certain cash receipts and payments in the statement of cash flows, and ASU 2016-18, Restricted Cash, which requires an entity to show the changes in total cash, cash equivalents, restricted cash and restricted cash equivalents in the statement of cash flows. We adopted these ASUs by applying a retrospective transition method which requires a restatement of our Consolidated Statement of Cash Flows for all periods presented.

In February, 2016, the FASB issued ASU 2016-02, “Leases (Topic 842): Amendments to the FASB Accounting Standards Codification (“Update 2016-02”), which requires an entity to recognize lease assets and lease liabilities on the balance sheet and to disclose key qualitative and quantitative information about the entity’s leasing arrangements. This update is effective for annual reporting periods beginning after December 15, 2018 with early adoption permitted. A modified retrospective approach is required. Upon adoption of this new standard, we will recognize significant right of use assets and lease obligation liabilities on the consolidated balance sheet as a result of our operating lease obligations. Operating lease expense will still be recognized on a straight-line basis over the remaining life of the lease within lease and rental expense in the consolidated statements of income. We are currently evaluating the effect that ASU 2016-02 will have on our consolidated financial statements and related disclosures.

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.

In August, 2017, the FASB issued ASU 2017-12, “Targeted Improvements to Accounting for Hedging Activities", which amends the accounting and presentation of certain hedging activities outlined in ASC 815 and is intended to more accurately present economic results of hedging activities. This update is effective for annual reporting periods beginning after December 15, 2018 with early adoption permitted. The adoption is required prospectively with a cumulative-effect adjustment. We are currently evaluating the impact of this ASU on our financial statements.

In February, 2018, the FASB issued ASU 2018-02, “Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income”, which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the Tax Cuts and Jobs Act of 2017. This update is effective for annual reporting periods beginning after December 15, 2018 with early adoption permitted. We are currently evaluating the impact of this ASU 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, 2018, we owned and/or operated 327 inpatient facilities and 32 outpatient and other facilities including the following located in 37 states, Washington, D.C., the United Kingdom, Puerto Rico and the U.S. Virgin Islands:

Acute care facilities located in the U.S.:

- 26 inpatient acute care hospitals;
- 4 free-standing emergency departments, and;
- 4 outpatient surgery/cancer care centers & 1 surgical hospital.

Behavioral health care facilities (301 inpatient facilities and 23 outpatient facilities):

Located in the U.S.:

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

Located in the U.K.:

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

Located in Puerto Rico and the U.S. Virgin Islands:

- 4 inpatient behavioral health care facilities, and;
- 1 outpatient behavioral health care facility.

As a percentage of our consolidated net revenues, net revenues from our acute care hospitals, outpatient facilities and commercial health insurer accounted for 54% and 53% during the three-month periods ended March 31, 2018 and 2017, respectively. Net revenues from our behavioral health care facilities and commercial health insurer accounted for 46% and 47% of our consolidated net revenues during the three-month periods ended March 31, 2018 and 2017, respectively.

Our behavioral health care facilities located in the U.K. generated net revenues amounting to approximately $115 million and $100 million during the three-month periods ended March 31, 2018 and 2017, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.176 billion as of March 31, 2018 and $1.098 billion as of December 31, 2017.

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 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," "predict "potential," "continue," "expects," "anticipates," "future," "intends," "plans," "believes," "estimates," "appears," "projects" an 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, 2017 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. No assurances can be given that the implementation of these laws will not have a material adverse effect on our business, financial condition or 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 payors or government based payors, including Medicare or Medicaid in the United States, and government based payors 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;
- 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;
- our ability to successfully integrate and improve our recent acquisitions and the availability of suitable acquisitions and divestiture opportunities;
- 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 California, Texas, Washington, D.C., Nevada, 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 payors and there can be no assurance that failure of the payors to remit amounts due to us will not have a material adverse effect on our future results of operations;

- 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 (annual reduction of approximately $36 million to our Medicare net revenues) 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;
- 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, 2017.

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 payor, 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 11 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 Revenues: Collection of receivables from third-party payors and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. We routinely review accounts receivable balances in conjunction with general factors such as payor mix, the agings of the receivables and historical collection as well as other economic conditions which might ultimately affect the collectability of the patient accounts and make adjustments to our net revenues 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. Our hospitals establish a partial reserve for self-pay accounts for both unbilled balances and those that have been billed and are under 90 days old. All self-pay accounts are fully reserved at 90 days from the date of discharge. Third party liability accounts are fully reserved when the balance ages past 180 days from the date of discharge. Patients that express an inability to pay are reviewed for potential sources of financial assistance including our charity care policy. If the patient is deemed unwilling to pay, the account is written-off and transferred to an outside collection agency for additional collection effort.

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. Generally, 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. Our hospitals in certain states in which we operate reduced the charity care eligibility threshold to less than the federal poverty guidelines. Because we do not pursue collection of amounts that qualify as charity care, they are not reported 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 payors but we also have smaller amounts due from other miscellaneous payors 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 the reported amounts in future periods for the provision for doubtful accounts and other accounts such as Medicaid pending. Although the patient's ultimate eligibility determination may result in amounts being reclassified among these accounts from period to period, these reclassifications did not have a material impact on our results of operations during the three-month periods ended March 31, 2018 or 2017 since our facilities make estimates at each financial reporting period to reserve for amounts that are deemed to be uncollectible.

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, they are not reported 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. Our accounts receivable are recorded net of allowance for doubtful accounts of $480 million at December 31, 2017.

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, 2018 and 2017:

Uncompensated care:

Amounts in millions	Three Months Ended					
	March 31, 2018	%		March 31, 2017	%	
Charity care	$146	36	%	$ 225	53	%

Uninsured discounts	263	64 %	197	47 %
Total uncompensated care	$409	100%	$ 422	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, 2018	March 31, 2017
Estimated cost of providing charity care	$20	$ 31
Estimated cost of providing uninsured discounts related care	36	26
Estimated cost of providing uncompensated care	$56	$ 57

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 5 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 $303 million as of March 31, 2018, of which $89 million is included in current liabilities. The total accrual for our professional and general liability claims and workers' compensation claims was $298 million as of December 31, 2017, of which $89 million is included in current liabilities.

Recent Accounting Standards: For a summary of accounting standards, please see Note 12 to the Consolidated Financial Statements, as included herein.

Results of Operations

Three-month periods ended March 31, 2018 and 2017:

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended March 31, 2018 and 2017 (dollar amounts in thousands):

	Three months ended March 31, 2018		Three months ended March 31, 2017	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts			$2,825,472	
Less: Provision for doubtful accounts			212,614	
Net revenues	$2,687,516	100.0 %	2,612,858	100.0 %
Operating charges:				
Salaries, wages and benefits	1,300,148	48.4 %	1,237,964	47.4 %
Other operating expenses	620,819	23.1 %	607,360	23.2 %
Supplies expense	292,929	10.9 %	277,614	10.6 %
Depreciation and amortization	113,103	4.2 %	110,798	4.2 %
Lease and rental expense	26,703	1.0 %	25,189	1.0 %
Subtotal-operating expenses	2,353,702	87.6 %	2,258,925	86.5 %
Income from operations	333,814	12.4 %	353,933	13.5 %
Interest expense, net	37,576	1.4 %	35,507	1.4 %
Income before income taxes	296,238	11.0 %	318,426	12.2 %
Provision for income taxes	67,569	2.5 %	107,899	4.1 %
Net income	228,669	8.5 %	210,527	8.1 %
Less: Income attributable to noncontrolling interests	4,837	0.2 %	4,472	0.2 %
Net income attributable to UHS	$223,832	8.3 %	$206,055	7.9 %

Net revenues increased 2.9%, or $75 million, to $2.69 billion during the three-month period ended March 31, 2018 as compared to $2.61 billion during the first quarter of 2017. The net increase was primarily attributable to: (i) a $87 million or 3.4% 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”), partially offset by; (ii) $12 million of other combined net decreases due primarily to the closure or restructuring of three behavioral health care facilities.

Income before income taxes (before deduction for income attributable to noncontrolling interests) decreased $22 million to $296 million during the three-month period ended March 31, 2018 as compared to $318 million during the comparable quarter of 2017. The net decrease in our income before income taxes during the first quarter of 2018, as compared to the comparable quarter of 2017, was due to:

- an increase of $16 million at our acute care facilities as discussed below in Acute Care Hospital Services;
- a decrease of $13 million at our behavioral health care facilities, as discussed below in Behavioral Health Services;
- a decrease of $13 million due to 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 (reserve increased to $35 million from $22 million; see Item 1 - Legal Proceedings for additional disclosure);
- a decrease of $2 million due to an increase in interest expense, as discussed below in Other Operating Results, and;

- $10 million of other combined net decreases.

Net income attributable to UHS increased $18 million to $224 million during the three-month period ended March 31, 2018 as compared to $206 million during the comparable prior year quarter. Changes to our net income attributable to UHS during the first quarter of 2018, as compared to the comparable prior year quarter, included:

- a decrease of $22 million in income before income taxes, as discussed above, and;
- an increase of $40 million resulting from a decrease in the provision for income taxes resulting primarily from: (i) a decrease in the provision for income taxes resulting from the Tax Cuts and Jobs Act of 2017 which, among other things, reduced the U.S. federal corporate tax rate from 35% to 21%; (ii) a decrease in the provision for income taxes resulting from the $22 million decrease in pre-tax income, partially offset by; (iii) a $5 million increase to our provision for income taxes due to an unfavorable change resulting from our January 1, 2017 adoption of ASU 2016-09, “Compensation-Stock

Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting" ("ASU 2016-09"), which decreased our provision for income taxes by $2 million during the first quarter of 2018 as compared to $7 million during the first quarter of 2017.

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 impact of the EHR applications, 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 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, 2018 and 2017 (dollar amounts in thousands):

	Three months ended March 31, 2018		Three months ended March 31, 2017	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts			$1,553,467	
Less: Provision for doubtful accounts			180,983	
Net revenues	$1,423,653	100.0 %	1,372,484	100.0 %
Operating charges:				
Salaries, wages and benefits	581,573	40.9 %	554,902	40.4 %
Other operating expenses	307,397	21.6 %	315,223	23.0 %
Supplies expense	243,153	17.1 %	228,485	16.6 %
Depreciation and amortization	72,150	5.1 %	63,049	4.6 %
Lease and rental expense	14,283	1.0 %	13,916	1.0 %
Subtotal-operating expenses	1,218,556	85.6 %	1,175,575	85.7 %
Income from operations	205,097	14.4 %	196,909	14.3 %
Interest expense, net	531	0.0 %	745	0.1 %
Income before income taxes	$204,566	14.4 %	$196,164	14.3 %

Three-month periods ended March 31, 2018 and 2017:

During the three-month period ended March 31, 2018, as compared to the comparable prior year quarter, net revenues from our acute care hospital services, on a same facility basis, increased $51 million or 3.7%. Excluding the impact of our commercial health insurer headquartered in Nevada, net revenues from our acute care hospital services increased $76 million or 5.8%. Income before income taxes (and before income attributable to noncontrolling interests) increased $8 million, or 4%, amounting to $205 million or 14.4% of net revenues during the first quarter of 2018 as compared to $196 million or 14.3% of net revenues during the first quarter of 2017.

During the three-month period ended March 31, 2018, net revenue per adjusted admission increased 3.4% while net revenue per adjusted patient day increased 0.4%, as compared to the comparable quarter of 2017. During the three-month period ended March 31, 2018, as compared to the comparable prior year quarter, inpatient admissions to our acute care hospitals increased 3.1% and adjusted admissions (adjusted for outpatient activity) increased 2.3%. Patient days at these facilities increased 6.0% and adjusted patient days increased 5.4% during the three-month period ended March 31, 2018 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 4.6 days and 4.5 days during the three-month periods ended March 31, 2018 and 2017, respectively. The occupancy rate, based on the average available beds at these facilities, was 66% and 62% during the three-month periods ended March 31, 2018 and 2017, respectively.

All Acute Care Hospitals

The following table summarizes the results of operations for all our acute care operations during the three-month periods ended March 31, 2018 and 2017. These amounts include: (i) our acute care results on a same facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iii) certain other amounts including the impact of the implementation of EHR applications at our acute care hospitals (beginning in 2018, the EHR impact is included in our same facility results as well as all acute care hospitals) and the results of recently acquired/opened ancillary businesses. Dollar amounts below are reflected in thousands.

	Three months ended March 31, 2018			Three months ended March 31, 2017		
	Amount	% of Net Revenues		Amount	% of Net Revenues	
Net revenues before provision for doubtful accounts				$1,570,530		
Less: Provision for doubtful accounts				180,983		
Net revenues	$1,445,632	100.0	%	1,389,547	100.0	%
Operating charges:						
Salaries, wages and benefits	581,768	40.2	%	554,960	39.9	%
Other operating expenses	330,036	22.8	%	332,299	23.9	%
Supplies expense	243,153	16.8	%	228,485	16.4	%
Depreciation and amortization	72,150	5.0	%	71,338	5.1	%
Lease and rental expense	14,283	1.0	%	13,916	1.0	%
Subtotal-operating expenses	1,241,390	85.9	%	1,200,998	86.4	%
Income from operations	204,242	14.1	%	188,549	13.6	%
Interest expense, net	531	0.0	%	745	0.1	%
Income before income taxes	$203,711	14.1	%	$187,804	13.5	%

Three-month periods ended March 31, 2018 and 2017:

During the three-month period ended March 31, 2018, as compared to the comparable prior year quarter, net revenues from our acute care hospital services increased $56 million or 4.0% to $1.45 billion as compared to $1.39 billion due to: (i) a $51 million, or 3.7%, increase same facility revenues, as discussed above, and; (ii) other combined net increase of $5 million due primarily to provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes.

Income before income taxes increased $16 million, or 9%, to $204 million or 14.1% of net revenues during the first quarter of 2018 as compared to $188 million or 13.5% of net revenues during the first quarter of 2017.

Included in these results are the following:

- the $8 million increase in income before income taxes from our acute care hospital services, on a same facility basis, as discussed above, and;
- other combined net increase of $8 million consisting primarily of the depreciation and amortization expense incurred in connection with the implementation of EHR applications at our acute care hospitals (this expense, which amounted to approximately $8 million during the first quarter of 2017, was excluded from our same facility basis results prior to January 1, 2018, however, the impact is included in our same facility basis results thereafter since the amount no longer materially impacts our results of operations).

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, impacts of settlements, legal judgments and lawsuits, impairments of long-lived 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 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, 2018 and 2017 (dollar amounts in thousands):

Same Facility—Behavioral Health

	Three months ended March 31, 2018		Three months ended March 31, 2017	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts			$1,205,077	
Less: Provision for doubtful accounts			30,636	
Net revenues	$1,209,937	100.0 %	1,174,441	100.0 %
Operating charges:				
Salaries, wages and benefits	630,568	52.1 %	597,092	50.8 %
Other operating expenses	230,347	19.0 %	229,888	19.6 %
Supplies expense	48,769	4.0 %	47,747	4.1 %
Depreciation and amortization	36,743	3.0 %	35,316	3.0 %
Lease and rental expense	12,008	1.0 %	10,761	0.9 %
Subtotal-operating expenses	958,435	79.2 %	920,804	78.4 %
Income from operations	251,502	20.8 %	253,637	21.6 %
Interest expense, net	427	0.0 %	723	0.1 %
Income before income taxes	$251,075	20.8 %	$252,914	21.5 %

Three-month periods ended March 31, 2018 and 2017:

On a same facility basis during the first quarter of 2018, as compared to the first quarter of 2017, net revenues generated from our behavioral health services increased $35 million, or 3.0%, to $1.21 billion from $1.17 billion. Income before income taxes decreased $2 million, or 1%, to $251 million or 20.8% of net revenues during the three-month period ended March 31, 2018, as compared to $253 million or 21.5% of net revenues during the comparable quarter of 2017.

During the three-month period ended March 31, 2018, net revenue per adjusted admission increased 2.0% and net revenue per adjusted patient day increased 3.2%, as compared to the comparable quarter of 2017. On a same facility basis, inpatient admissions and adjusted admissions to our behavioral health facilities increased 2.1% and 1.6%, respectively, during the three-month period ended March 31, 2018 as compared to the comparable quarter of 2017. Patient days and adjusted patient days increased 0.9% and 0.4%, respectively, during the three-month period ended March 31, 2018 as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 13.1 days and 13.3 days during the three-month periods ended March 31, 2018 and 2017, 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, 2018 and 2017.

In certain markets in which we operate, the ability of our behavioral health facilities to fully meet the demand for their services has been unfavorably impacted by a shortage of clinicians which includes psychiatrists, nurses and mental health technicians which has, at times, caused the closure of a portion of available bed capacity. As a result, we have instituted certain initiatives at the impacted facilities designed to enhance recruitment and retention of clinical staff. Although we believe the impact on these facilities is temporary, we can provide no assurance that these factors will not continue to unfavorably impact our patient volumes.

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, 2018 and 2017. 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 three facilities that were closed or restructured during the past year. Dollar amounts below are reflected in thousands.

	Three months ended March 31, 2018		Three months ended March 31, 2017	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts			$1,249,748	
Less: Provision for doubtful accounts			31,626	
Net revenues	$1,237,996	100.0 %	1,218,122	100.0 %
Operating charges:				
Salaries, wages and benefits	642,128	51.9 %	613,849	50.4 %
Other operating expenses	256,402	20.7 %	254,478	20.9 %
Supplies expense	49,536	4.0 %	49,036	4.0 %
Depreciation and amortization	38,454	3.1 %	36,945	3.0 %
Lease and rental expense	12,301	1.0 %	11,160	0.9 %
Subtotal-operating expenses	998,821	80.7 %	965,468	79.3 %
Income from operations	239,175	19.3 %	252,654	20.7 %
Interest expense, net	427	0.0 %	723	0.1 %
Income before income taxes	$238,748	19.3 %	$251,931	20.7 %

Three-month periods ended March 31, 2018 and 2017:

During the three-month period ended March 31, 2018, as compared to the comparable prior year quarter, net revenues generated from our behavioral health services increased $20 million or 1.6% due to: (i) the above-mentioned $35 million or 3.0% increase in net revenues on a same facility basis, partially offset by; (ii) $15 million of other combined net decreases resulting primarily from the closure or restructuring of three facilities during the past year.

Income before income taxes decreased $13 million, or 5%, to $239 million or 19.3% of net revenues during the first quarter of 2018 as compared to $252 million or 20.7% during the first quarter of 2017. Included in these results are the following:

- a $2 million decrease at our behavioral health care facilities on a same facility basis, as discussed above, and;
- other combined net decrease of $11 million consisting primarily of the losses sustained at three facilities that were closed or restructured during the past year as well as the loss incurred at a facility acquired during the first quarter of 2018 that is awaiting completion of its Medicare certification.

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 payors 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.

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 has repealed the individual mandate to obtain health insurance penalty that was part of the original Legislation. In addition, Congress is considering legislation that would, in material part: (i) eliminate the large employer mandate to obtain or provide health insurance coverage, respectively; (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 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 proposed rule by the Department of Labor to enable the formation of health plans that would be exempt from certain Legislation essential health benefits requirements, and; (iii) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level. The uncertainty resulting from these Executive Branch policies has led to reduced Exchange enrollment in 2018 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.

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 11 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, 2018, CMS published its IPPS 2019 proposed payment rule which provides for a 2.8% 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 increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 0.7%. Including the estimated increase to our DSH payments (approximating 1.1%) and certain other adjustments, we estimate our overall increase from the proposed IPPS 2019 rule (covering the period of October 1, 2018 through September 30, 2019) will approximate 1.6%. This projected impact from the IPPS 2019 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 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, 2016, CMS published its IPPS 2017 final payment rule which provides for a 2.7% 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 DSH payment changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments would approximate 0.95%. Including the estimated decreases to our DSH payments (approximating -0.8%) and certain other adjustments, we estimate our overall decrease from the final IPPS 2017 rule (covering the period of October 1, 2016 through September 30, 2017) would approximate -0.2%. This projected impact from the IPPS 2017 final rule includes both the impact of ATRA documentation and coding adjustment and the required changes to the DSH payments related to the traditional Medicare fee for service, however, it excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, and Bipartisan Budget Act of 2015, as discussed below.

In August, 2013, CMS published its final IPPS 2014 payment rule which expanded CMS's policy under which it defines inpatient admissions to include the use of an objective time of care standard. Specifically, it would require Medicare's external review contractors to presume that hospital inpatient admissions are reasonable and necessary when beneficiaries receive a physician order for admission and receive medically necessary services for at least two midnights (the "Two Midnight" rule). In October, 2015 as part of the 2016 Medicare Outpatient Prospective Payment System ("OPPS") final rule (additional related disclosure below), CMS will allow payment for one-midnight stays under the Medicare Part A benefit on a case-by case basis for rare and unusual exceptions based the presence of certain clinical factors. CMS also announced in the final rule that, effective October 1, 2015, Quality Improvement Organizations ("QIOs") will conduct reviews of short inpatient stay reviews rather than Medicare Administrative Contractors. Additionally, CMS also announced that Recovery Audit Contractors ("RACs") resumed patient status

reviews for claims with admission dates of January 1, 2016 or later, and the agency indicates that RACs will conduct these reviews focused on providers with high denial rates that are referred by the QIOs. In its IPPS 2017 final payment rule, CMS: (i) reversed the Two-Midnight rule's 0.2% reduction in hospital payments, and; (ii) implemented a temporary one-time increase of 0.8% in FFY2017 payments to offset cuts in the preceding fiscal years affected by the prior 0.2% reduction.

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.

On January 2, 2013 ATRA was enacted which, among other things, includes a requirement for CMS to recoup $11 billion from hospitals from Medicare IPPS rates during federal fiscal years 2014 to 2017. The recoupment relates to IPPS documentation and coding adjustments for the period 2008 to 2013 for which adjustments were not previously applied by CMS. Both the 2014 and 2015 IPPS final rules include a -0.8% recoupment adjustment. CMS has included the same 0.8% recoupment adjustment in fiscal year 2016, a 1.5% recoupment adjustment in federal fiscal year 2017, and a 0.45% positive adjustment in fiscal year 2018 in order to recover the entire $11 billion. This adjustment is reflected in the IPPS estimated impact amounts noted above. On April 16, 2015, the Medicare Access and CHIP Reauthorization Act of 2015 was enacted and an anticipated 3.2% payment increase in 2018 is scheduled to be phased in at approximately 0.5% per year over 6 years beginning in fiscal year 2018.

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, 2018, CMS published its Psych PPS proposed rule for the federal fiscal year 2019. Under this proposed 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 2.8% 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 July, 2016, CMS published its Psych PPS final rule for the federal fiscal year 2017. Under this final rule, payments to psychiatric hospitals and units are estimated to increase by 2.3% compared to federal fiscal year 2016. This amount includes the effect of the 2.8% market basket update less a 0.2% adjustment as required by the ACA and a 0.3% productivity adjustment.

In July, 2015, CMS published its Psych PPS final rule for the federal fiscal year 2016. This final rule, among other things, updated the Inpatient Psychiatric Quality Reporting Program, which requires psychiatric facilities to report on quality measures or incur a reduction in their annual payment update.

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 2017 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. 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.

In October, 2015, CMS published its OPPS final rule for 2016. The hospital market basket increase is 2.8%. The Medicare statute requires a productivity adjustment reduction of 0.5% and 0.2% reduction to the 2016 OPPS market basket. Additionally, CMS also included a reduction of 2.0%, which the CMS claimed was necessary to eliminate $1 billion in excess laboratory payments that CMS

packaged into OPPS payment rates in 2014 resulting in a 2016 OPPS market basket update at -0.3%. When other statutorily required adjustments and hospital patient service mix are considered, our overall Medicare OPPS update for 2016 aggregated to a net decrease of approximately -0.2% which includes a 7.0% increase to behavioral health division partial hospitalization rates. When the behavioral health division's partial hospitalization rate impact is excluded, our Medicare 2016 OPPS payments resulted in a -1.6% decrease in payment levels for our acute care division, as compared to 2015.

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

We receive revenues from various state and county based programs, including Medicaid in all the states in which we operate (we receive Medicaid revenues in excess of $100 million annually from each of California, Texas, Washington, D.C., Nevada, 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 FFY2020 and forward, we are unable to estimate the impact on of these UC program changes on our future operating results.

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 FFY2020 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, 2018 and 2017. 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, 2018	March 31, 2017
Texas UC/UPL:		
Revenues	$21	$ 16
Provider Taxes	(6)	(3)
Net benefit	$15	$ 13
Texas DSRIP:		
Revenues	$0	$ 0
Provider Taxes	0	0
Net benefit	$0	$ 0
Various other state programs:		
Revenues	$56	$ 54
Provider Taxes	(36)	(32)
Net benefit	$20	$ 22
Total all Provider Tax programs:		
Revenues	$77	$ 70
Provider Taxes	(42)	(35)
Net benefit	$35	$ 35

We estimate that our aggregate net benefit from the Texas and various other state Medicaid supplemental payment programs will approximate $156 million (net of Provider Taxes of $172 million) during the year ended December 31, 2018. 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 2017 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 2018 DSH fiscal year (covering the period of October 1, 2017 through September 30, 2018).

In connection with these DSH programs, included in our financial results was an aggregate of approximately $10 million during each of the three-month periods ended March 31, 2018 and 2017. We expect the aggregate reimbursements to our hospitals pursuant to the Texas and South Carolina 2018 fiscal year programs to be approximately $36 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 2018 fiscal year covering the period of July 1, 2017 through June 30, 2018.

In connection with this program, included in our financial results was approximately $6 million and $5 million during the three-month periods ended March 31, 2018 and 2017, respectively. Assuming the program is approved for the

state's 2019 fiscal year, we estimate that our reimbursements pursuant to this program will approximate $22 million during the year ended December 31, 2018.

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. The timing of CMS approval of the managed care payment component is uncertain. We are unable to estimate the impact of the managed care component of the Hospital Fee program but it could result in a material favorable impact on our operating results in 2018 and 2019. The 2017 impact of the California supplemental payment program 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.

Massachusetts Health Safety Net Care Pool ("SNCP")

Included in our 2017 financial results was a $7 million pre-tax charge incurred to establish a reserve related to Massachusetts Health SNCP payments received by certain of our behavioral health facilities during the period October, 2014 through December, 2016. SNCP payments are made by Massachusetts under the current CMS approved Section 1115 Medicaid Waiver available to Institutions of Medical Disease. During the second quarter of 2017, we received notification that such payments are subject to a retroactively applied uncompensated care cost limit protocol.

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.

The pre-tax charges in connection with the implementation of EHR applications at our acute care hospitals did not have a material impact on our consolidated results of operations during the three-month period ended March 31, 2018. During the three-month period ended March 31, 2017, we incurred an $8 million pre-tax charge consisting of depreciation and amortization expense related to the costs incurred for the purchase and development of the EHR applications.

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 proposed rule, CMS proposed to overhaul 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 proposed changes, if implemented, 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 payors

than we do from traditional indemnity insurers, however, during the past few years we have secured price increases from many of our commercial payors including managed care companies.

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

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

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

Health Care Reform: Listed below are the Medicare, Medicaid and other health care industry changes which are 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 and 2018.
- 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 will remove the individual insurance federal mandate 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 payors currently require hospitals to report quality data, and several commercial payors 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 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.

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

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

Other Operating Results

Interest Expense:

As reflected on the schedule below, interest expense was $38 million and $36 million during the three-month periods ended March 31, 2018 and 2017, respectively (amounts in thousands):

	Three Months Ended March 31, 2018	Three Months Ended March 31, 2017
Revolving credit & demand notes (a.)	$ 3,235	$ 2,504
$300 million, 3.75% Senior Notes due 2019	2,813	2,813
$700 million, 4.75% Senior Notes due 2022, net (b.)	8,069	8,069
$400 million, 5.00% Senior Notes due 2026 (c.)	5,000	5,000
Term loan facility A (a.)	13,746	10,633
Accounts receivable securitization program (d.)	2,659	1,620
Subtotal-revolving credit, demand notes, Senior Notes, term loan facility and accounts receivable securitization program	35,522	30,639
Interest rate swap expense, net	(709)	1,318
Amortization of financing fees	2,247	2,226
Other combined interest expense	1,040	1,480
Capitalized interest on major projects	(421)	(143)
Interest income	(103)	(13)
Interest expense, net	$ 37,576	$ 35,507

(a.) In June, 2016, we entered into a fifth amendment to our credit agreement dated November 15, 2010, as amended, to increase the size of the Term Loan A facility by $200 million. Interest rates were not impacted by this amendment. The credit agreement, as amended, which is scheduled to expire in August, 2019, consists of: (i) an $800 million revolving credit facility ($285 million of outstanding borrowings as of March 31, 2018), and; (ii) a Term Loan A facility with $1.75 billion outstanding as of March 31, 2018.

(b.) 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.

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

(d.) 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 ($440 million of borrowings outstanding as of March 31, 2018).

Interest expense increased $2 million during the three-month period ended March 31, 2018, as compared to the comparable period of 2017, due primarily to: (i) a net $5 million increase in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facility and accounts receivable securitization program resulting from a decrease in the aggregate average outstanding borrowings ($4.00 billion during the three months ended March 31, 2018 as compared to $4.05 billion in the comparable 2017 period), offset by an increase in our aggregate average cost of borrowings pursuant to these facilities (3.6% during the three months ended March 31, 2018 as compared to 3.0% in the comparable period of 2017), partially offset by; (ii) a $2 million decrease in the interest rate swap expense, and (iii) other combined net decreases of $1 million. 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 3.7% and 3.4% during the three month periods ended March 31, 2018 and 2017, 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, 2018 and 2017 (dollar amounts in thousands):

	Three months ended	
	March 31, 2018	March 31, 2017
Provision for income taxes	$67,569	$107,899
Income before income taxes	296,238	318,426
Effective tax rate	22.8 %	33.9 %

The decrease in the effective tax rates during the first quarter of 2018, as compared to the first quarter of 2017, was primarily due to the TCJA-17 which, among other things, reduced the U.S. federal corporate tax rate from 35% to 21%, partially offset by a $5 million increase to our provision for income taxes due to an unfavorable change resulting from our January 1, 2017 adoption of ASU 2016-09 which decreased our provision for income taxes by $2 million during the first quarter of 2018 as compared to $7 million during the first quarter of 2017.

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $364 million during the three-month period ended March 31, 2018 and $483 million during the comparable quarter of 2017. The net decrease of $119 million was primarily attributable to the following:

- an unfavorable change of $67 million in accounts receivable;
- an unfavorable change of $41 million in accrued and deferred income taxes;
- an unfavorable change of $38 million in cash flows from forward exchange contracts related to our investments in the United Kingdom;
- a favorable change of $24 million due to an increase in net income plus/minus depreciation and amortization expense, stock-based compensation, and a net gain on the sale of an asset, and;
- $3 million of other combined net favorable changes.

Days sales outstanding (“DSO”): Our DSO are calculated by dividing our net revenue by the number of days in the three-month periods. The result is divided into the accounts receivable balance at March 31st of each year to obtain the DSO. Our DSO were 53 days and 50 days at March 31, 2018 and 2017, respectively.

Our accounts receivable as of March 31, 2018 and December 31, 2017 include amounts due from Illinois of approximately $35 million and $25 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $15 million as of March 31, 2018 and $8 million as of December 31, 2017, 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 2018, we used $226 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;

- $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.

During the first three months of 2017, we used $175 million of net cash in investing activities as follows:

- $144 million spent on capital expenditures;

- $18 million spent to acquire a business and property;

- $9 million spent on the purchase and implementation of an information technology application, and;

- $3 million spent to increase the statutorily required capital reserves of our commercial insurance subsidiary.

Net cash used in financing activities

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 first three months of 2017, we used $279 million of net cash in financing activities as follows:

- spent $261 million on net repayments of debt as follows: (i) $238 million related to our revolving credit facility; (ii) $22 million related to our term loan A facility, and; (v) $1 million related to other debt facilities;
- generated $22 million of proceeds related to new borrowings pursuant to our on demand credit facility ($20 million) and accounts receivable securitization program ($1 million);
- spent $29 million to repurchase shares of our Class B Common Stock in connection with: (i) income tax withholding obligations related to stock-based compensation programs ($10 million), and; (ii) open market purchases pursuant to our $800 million stock repurchase program ($19 million);
- spent $4 million to pay profit distributions related to noncontrolling interests in majority owned businesses;
- spent $10 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 2018, we expect to spend approximately $411 million to $436 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 June 7, 2016, we entered into a Fifth Amendment (the “Fifth Amendment”) to our credit agreement dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012, May 16, 2013 and August 7, 2014, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders (“Credit Agreement”). The Fifth Amendment increased the size of the term loan A facility by $200 million and those

proceeds were utilized to repay outstanding borrowings under the revolving credit facility of the Credit Agreement. The Credit Agreement, as amended, which is scheduled to mature in August, 2019, consists of: (i) an $800 million revolving credit facility ($285 million of borrowings outstanding as of March 31, 2018), and; (ii) a term loan A facility with $1.753 billion of borrowings outstanding as of March 31, 2018.

Borrowings under the 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 0.50% to 1.25% for revolving credit and term loan-A 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 1.50% to 2.25% for revolving credit and term loan-A borrowings. As of March 31, 2018, 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.

As of March 31, 2018, we had $285 million of borrowings outstanding pursuant to the terms of our $800 million revolving credit facility and we had $446 million of available borrowing capacity net of $34 million of outstanding letters of credit and $35 million of outstanding borrowings pursuant to a short-term, on demand-credit facility. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, certain real estate assets and assets held in joint-ventures with third-parties) and our material subsidiaries and guaranteed by our material subsidiaries.

Pursuant to the terms of the Credit Agreement, term loan-A quarterly installment payments of approximately $22 million commenced during the fourth quarter of 2016 and are scheduled through June, 2019. Previously, approximately $11 million of quarterly installment payments were made from the fourth quarter of 2014 through the third quarter of 2016.

The Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage and minimum interest coverage ratios. We are in compliance with all required covenants as of March 31, 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, 2018, we had $440 million of outstanding borrowings pursuant to the terms of the Securitization and no available borrowing capacity, before giving effect to the $10 million increase in borrowing capacity effective in April, 2018 pursuant to the terms of the sixth amendment.

As of March 31, 2018, we had combined aggregate principal of $1.4 billion from the following senior secured notes:

- $300 million aggregate principal amount of 3.75% senior secured notes due in August, 2019 (“2019 Notes”) which were issued on August 7, 2014.

- $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 is payable on the 2019 Notes and the 2022 Notes on February 1 and August 1 of each year until the maturity date of August 1, 2019 for the 2019 Notes and August 1, 2022 for the 2022 Notes. Interest on the 2026 Notes is payable on June 1 and December 1 until the maturity date of June 1, 2026. The 2019 Notes, 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 2019 Notes, 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.

At March 31, 2018, the carrying value and fair value of our debt were each approximately $3.9 billion. At December 31, 2017, the carrying value and fair value of our debt were approximately $4.0 billion and $4.1 billion, respectively. The fair value of our debt was

computed based upon quotes received from financial institutions. We consider these to be “level 2” in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with debt instruments.

Our total debt as a percentage of total capitalization was approximately 43% at March 31, 2018 and 45% at December 31, 2017.

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 revolving 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, available borrowing capacity under our $800 million revolving credit facility and $450 million accounts receivable securitization program, as well as access to the capital markets, provide us with sufficient capital resources to fund our operating, investing and financing requirements for the next twelve months. However, in the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

Off-Balance Sheet Arrangements

During the three months ended March 31, 2018, there have been no material changes in the off-balance sheet arrangements consisting of operating leases and standby letters of credit and surety bonds. Reference is made to Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations – Contractual Obligations and Off-Balance Sheet Arrangements, in our Annual Report on Form 10-K for the year ended December 31, 2017.

As of March 31, 2018 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $117 million consisting of: (i) $108 million related to our self-insurance programs, and; (ii) $9 million of other debt and public utility guarantees.

We have various obligations under operating leases or master leases for real property and under operating leases for equipment. The real property master leases are leases for buildings on or near hospital property for which we guarantee a certain level of rental income. We sublease space in these buildings and any amounts received from these subleases are offset against the expense. In addition, we lease three hospital facilities from Universal Health Realty Trust (the “Trust”) with terms expiring in 2021. These leases contain up to two 5-year renewal options. We also lease two free-standing emergency departments and space in certain medical office buildings which are owned by the Trust. In addition, we lease the real property of certain other facilities from non-related parties.

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, 2018. 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, 2017.

Item 4. Controls and Procedures

As of March 31, 2018, under the supervision and with the participation of our management, including our Chief Executive Officer (“CEO”) and Chief Financial Officer (“CFO”), we performed an evaluation of the effectiveness of our disclosure controls and procedures, as defined in Rule 13a-15(e) or Rule 15d-15(e) under the Securities Exchange Act of 1934, as amended (the “1934 Act”). Based on this evaluation, the CEO and CFO have concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the 1934 Act and the SEC rules thereunder.

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting or in other factors during the first quarter of 2018 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, and El Paso Behavioral Health System.

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, 2018, the aggregate funds withheld from us in connection with the River Point Behavioral Health payment suspension amounted to approximately $10 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, 2018 or the year ended December 31, 2017, 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 payors in relation to services provided at those facilities. During the first quarter of 2018, we recorded a $13 million pre-tax increase to the reserve established in connection with the civil aspects of these matters increasing the aggregate pre-tax reserve to $35 million. 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, will not differ materially from our established reserve.

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. Plaintiff alleges that defendants violated federal securities laws relating to the disclosures made in public filings associated with practices at our behavioral health facilities. 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. 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. The suit alleges breaches of fiduciary duties and other allegedly wrongful conduct by the members of the Board of Directors and certain officers of Universal Health Services, Inc. relating to practices at our behavioral health facilities. UHS has been named as a nominal defendant in the case. 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 Amalgamated Bank Longview Funds as the lead plaintiff and their counsel as lead counsel. 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. These additional cases make substantially similar allegations and claims based upon alleged violations of federal securities laws as well common law causes of action against the individual defendants. All of these additional cases have also named members of the UHS Board of Directors as well as certain officers of the Company. 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.

Chowdary v. Universal Health Services, Inc., et. al.

This is a lawsuit filed in 1999 in state court in Hidalgo County, Texas by a physician and his professional associations alleging tortious interference with contractual relationships and retaliation against McAllen Medical Center in McAllen, Texas as well as Universal Health Services, Inc. The state court has entered a summary judgment order awarding plaintiff $3.85 million in damages. With prejudgment interest, the total amount of the order amounts to approximately $9 million, for which a reserve is included in our financial statements as of December 31, 2017. A trial on punitive damages, emotional distress and attorneys' fees remains to be conducted if the summary judgment order is not vacated. The case has been removed to federal court. Plaintiffs filed a motion to remand. In February 2018, the federal court denied plaintiffs' motion to remand and retained the case in federal court. Plaintiffs have filed a writ of mandamus with the 5th Circuit Court of Appeals seeking to overturn the federal court's decision denying remand. We have filed a motion for reconsideration of state court's summary judgment order in the federal court proceeding.

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 2011 ("FFY2011") 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 and 2013 aggregating to approximately $11 million. We filed administrative appeals for all of our facilities contesting the recoupment efforts for FFYs 2011 through 2013 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. The Department will likely make similar repayment demand for FFY 2014. 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 2013 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.

Matters Relating to Psychiatric Solutions, Inc. (“PSI”):

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

Department of Justice Investigation of Riveredge Hospital

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI’s ownership prior to our acquisition. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

Department of Justice Investigation of Friends Hospital

In October, 2010, Friends Hospital in Philadelphia, Pennsylvania, received a subpoena from the DOJ requesting certain documents from the facility. The requested documents were collected and provided to the DOJ for review and examination. Another subpoena was issued to the facility in July, 2011 requesting additional documents, which have also been delivered to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. At present, we are uncertain as to the focus, scope or extent of the investigation, liability of the facility and/or potential financial exposure, if any, in connection with this matter.

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, 2017 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, 2017.

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

In February, 2016, our Board of Directors authorized a $400 million increase to our stock repurchase program, which increased the aggregate authorization to $800 million from the previous $400 million authorization approved during the third quarter of 2014. In November, 2017, our Board of Directors authorized an additional $400 million increase in our stock repurchase program, which increased the aggregate authorization to $1.2 billion from the previous $800 million authorization as mentioned above. 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, 2018, 41,938 shares ($4.6 million in the aggregate) were repurchased pursuant to the terms of our stock repurchase program and 41,337 shares were repurchased in connection with income tax withholding obligations resulting from the exercise of stock options and the vestings of restricted stock grants.

During the period of January 1, 2018 through March 31, 2018, we repurchased the following shares:

	Additional Dollars Authorized For Repurchase (in thousands)	Total number of shares purchased	Total number of shares cancelled	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid for shares purchased as part of publicly announced program (in thousands)	Maximum number of shares that may yet be purchased under the program	Maximum number of dollars that may yet be purchased under the program (in thousands)
January, 2018	—	68,724	—	N/A	41,938	$ 109.66	$ 4,599	—	$ 359,061
February, 2018	—	271	—	N/A	—	$ -	$ -	—	$ 359,061
March, 2018	—	14,280	—	N/A	—	$ -	$ -	—	$ 359,061
Total January through March, 2018	—	83,275	—	N/A	41,938	$ 109.66	$ 4,599		

Dividends

During the quarter ended March 31, 2018, we declared and paid dividends of $.10 per share.

Item 6. Exhibits

(a) Exhibits:

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

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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 9, 2018 /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)