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

FORM 10-Q

(MARK ONE)

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

For the quarterly period ended March 31, 2024

OR

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

For the transition period from to

Commission file number 1-10765

UNIVERSAL HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

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

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

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

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

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

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

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

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

☒ Accelerated filer ☐

Large 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, 2024:

Class A	6,577,100
Class B	59,677,618
Class C	661,688
Class D	12,802

UNIVERSAL HEALTH SERVICES, INC.

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This Quarterly Report on Form 10-Q is for the quarter ended March 31, 2024. 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,	
	2024	2023
Net revenues	$ 3,843,582	$ 3,467,518
Operating charges:		
Salaries, wages and benefits	1,842,624	1,753,335
Other operating expenses	1,032,170	878,951
Supplies expense	403,573	379,989
Depreciation and amortization	141,003	141,621
Lease and rental expense	35,450	34,922
	3,454,820	3,188,818
Income from operations	388,762	278,700
Interest expense, net	52,826	50,876
Other (income) expense, net	(150)	13,723
Income before income taxes	336,086	214,101
Provision for income taxes	70,264	51,726
Net income	265,822	162,375
Less: Net income (loss) attributable to noncontrolling interests	3,988	(740)
Net income attributable to UHS	$ 261,834	$ 163,115
Basic earnings per share attributable to UHS	$ 3.90	$ 2.31
Diluted earnings per share attributable to UHS	$ 3.82	$ 2.28
Weighted average number of common shares - basic	67,204	70,535
Add: Other share equivalents	1,278	952
Weighted average number of common shares and equivalents - diluted	68,482	71,487

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,	
	2024	**2023**
Net income	$ 265,822	$ 162,375
Other comprehensive income (loss):		
Foreign currency translation adjustment	(973)	4,198
Other	17	0
Other comprehensive income (loss) before tax	(956)	4,198
Income tax expense (benefit) related to items of other comprehensive income (loss)	420	(424)
Total other comprehensive (loss) income, net of tax	(1,376)	4,622
Comprehensive income	264,446	166,997
Less: Comprehensive income (loss) attributable to noncontrolling interests	3,988	(740)
Comprehensive income attributable to UHS	$ 260,458	$ 167,737

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, 2024	December 31, 2023
Assets		
Current assets:		
Cash and cash equivalents	$ 112,093	$ 119,439
Accounts receivable, net	2,299,425	2,238,265
Supplies	216,058	216,988
Other current assets	243,352	236,658
Total current assets	2,870,928	2,811,350
Property and equipment	11,955,109	11,777,047
Less: accumulated depreciation	(5,770,371)	(5,652,518)
	6,184,738	6,124,529
Other assets:		
Goodwill	3,928,120	3,932,407
Deferred income taxes	94,853	85,626
Right of use assets-operating leases	422,268	433,962
Deferred charges	6,871	6,974
Other	538,354	572,754
Total Assets	$ 14,046,132	$ 13,967,602
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 127,477	$ 126,686
Accounts payable and other liabilities	1,830,178	1,813,015
Operating lease liabilities	71,014	71,600
Federal and state taxes	46,667	2,046
Total current liabilities	2,075,336	2,013,347
Other noncurrent liabilities	551,257	584,007
Operating lease liabilities noncurrent	374,380	382,559
Long-term debt	4,734,328	4,785,783
Redeemable noncontrolling interests	4,987	5,191
Equity:		
UHS common stockholders' equity	6,256,697	6,149,001
Noncontrolling interest	49,147	47,714
Total equity	6,305,844	6,196,715
Total Liabilities and Stockholders' Equity	$ 14,046,132	$ 13,967,602

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Three Months ended March 31, 2024
(amounts in thousands, unaudited)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2024	$ 5,191	$ 66	$ 599	$ 7	$ 0	$ (659,896)	$ 6,798,939	$ 39,289	$ 6,149,004	$ 147,714	$ 6,196
Common Stock											
Issued/(converted)	—	—	10	—	—	—	3,401	—	3,411	—	3,411
Repurchased, including excise tax	—	—	(9)	—	—	—	(162,082)	—	(162,091)	—	(162,
Restricted share-based compensation expense	—	—	—	—	—	—	5,100	—	5,100	—	5,100
Dividends paid and accrued	—	—	—	—	—	(13,546)		—	(13,546)	—	(13,5
Stock option expense	—	—	—	—	—	—	14,381	—	14,381	—	14,38
Distributions to noncontrolling interests	(649)	—	—	—	—	—	—	—	—	(3,831)	(3,83
Purchase (sale) of ownership interests by (from) minority members	—	—	—	—	—	—	—	—	—	1,721	1,721
Comprehensive income:								—			
Net income (loss) to UHS / noncontrolling interests	445	—	—	—	—	—	261,834	—	261,834	3,543	265,3
Other		—	—	—	—	—	(17)	17	—	—	—
Foreign currency translation adjustments, net of income tax	—	—	—	—	—	—	—	(1,393)	(1,393)	—	(1,39
Subtotal - comprehensive income	445	—	—	—	—	—	261,817	(1,376)	260,441	3,543	263,9
Balance, March 31, 2024	$ 4,987	$ 66	$ 600	$ 7	$ 0	$ (673,436)	$ 6,921,541	$ 37,913	$ 6,256,691	$ 149,147	$ 6,305

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Three Months ended March 31, 2023
(amounts in thousands, unaudited)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interests	Total
Balance, January 1, 2023	$ 4,695	$ 66	$ 637	$ 7	$ 0	$ (604,123)	$ 6,533,667	$ (79,668)	$ 5,920,586	$ 44,768	$ 5,965
Common Stock											
Issued/(converted)	—	—	3	—	—	—	3,092	—	3,095	—	3,095
Repurchased, including excise tax	—	—	(7)	—	—	—	(85,819)	—	(85,826)	—	(85,8
Restricted share-based compensation expense	—	—	—	—	—	—	4,494	—	4,494	—	4,494
Dividends paid and accrued	—	—	—	—	—	(14,199)	—	—	(14,199)	—	(14,1
Stock option expense	—	—	—	—	—	—	16,225	—	16,225	—	16,22
Acquisition of noncontrolling interest in majority owned business	—	—	—	—	—	—	—	—	—	—	—
Distributions to noncontrolling interests	(750)	—	—	—	—	—	—	—	—	(3,395)	(3,39
Purchase (sale) of ownership interests by (from) minority members	—	—	—	—	—	—	—	—	—	—	—
Comprehensive income:											
Net income (loss) to UHS / noncontrolling interests	324	—	—	—	—	—	163,115	—	163,115	(1,064)	162,0
Foreign currency translation adjustments, net of income tax	—	—	—	—	—	—	—	4,622	4,622	—	4,622
Subtotal - comprehensive income	324	—	—	—	—	—	163,115	4,622	167,737	(1,064)	166,6
Balance, March 31, 2023	$ 4,269	$ 66	$ 633	$ 7	$ 0	$ (618,322)	$ 6,634,734	$ (75,046)	$ 6,012,109	$ 40,309	$ 6,052

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,	
	2024	**2023**
Cash Flows from Operating Activities:		
Net income	$ 265,822	$ 162,375
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation & amortization	141,003	141,621
Gain on sale of assets and businesses	(3,725)	(295)
Stock-based compensation expense	19,630	20,964
Changes in assets & liabilities, net of effects from acquisitions and dispositions:		
Accounts receivable	(74,446)	(15,723)
Accrued interest	3,453	(662)
Accrued and deferred income taxes	72,193	46,576
Other working capital accounts	(33,291)	(119,605)
Medicare accelerated payments and deferred CARES Act and other grants	-	136
Other assets and deferred charges	(20,307)	24,727
Other	8,897	7,030
Accrued insurance expense, net of commercial premiums paid	51,112	42,545
Payments made in settlement of self-insurance claims	(33,935)	(18,936)
Net cash provided by operating activities	396,406	290,753
Cash Flows from Investing Activities:		
Property and equipment additions	(208,539)	(168,752)
Proceeds received from sales of assets and businesses	5,428	9,259
Inflows (outflows) from foreign exchange contracts that hedge our net U.K. investment	8,319	(18,818)
Decrease in capital reserves of commercial insurance subsidiary	155	-
Net cash used in investing activities	(194,637)	(178,311)
Cash Flows from Financing Activities:		
Repayments of long-term debt	(63,905)	(16,489)
Additional borrowings, net	12,038	11,300
Financing costs	-	(292)
Repurchase of common shares	(142,084)	(85,039)
Dividends paid	(13,601)	(14,214)
Issuance of common stock	3,241	2,988
Profit distributions to noncontrolling interests	(4,480)	(4,145)
Purchase of ownership interests from minority members	(156)	-
Net cash used in financing activities	(208,947)	(105,891)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(492)	1,650
(Decrease) increase in cash, cash equivalents and restricted cash	(7,670)	8,201

Cash, cash equivalents and restricted cash, beginning of period	214,470	200,837
Cash, cash equivalents and restricted cash, end of period	$ 206,800	$ 209,038
Supplemental Disclosures of Cash Flow Information:		
Interest paid	$ 48,116	$ 50,279
Income taxes paid, net of refunds	$ 2,671	$ 2,360
Noncash purchases of property and equipment	$ 60,125	$ 61,341

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, 2024. 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, 2023.

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

Relationship with Universal Health Realty Income Trust:

At March 31, 2024, we held approximately 5.7% of the outstanding shares of Universal Health Realty Income Trust (the "Trust"). We serve as Advisor to the Trust under an annually renewable advisory agreement, which is scheduled to expire on December 31st of each year, pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. The advisory agreement was renewed by the Trust for 2024 at the same rate in place for 2023, 2022 and 2021, providing for an advisory fee computation at 0.70% of the Trust's average invested real estate assets. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $1.3 million during each of the three-month periods ended March 31, 2024 and 2023.

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

Our pre-tax share of income from the Trust was approximately $300,000 during each of the three-month periods ended March 31, 2024 and 2023, and is included in other (income) expense, net, on the accompanying consolidated statements of income for each period. We received dividends from the Trust amounting to $571,000 and $563,000 during the three-month periods ended March 31, 2024 and 2023, respectively. The carrying value of our investment in the Trust was approximately $6.7 million and $7.0 million at March 31, 2024 and December 31, 2023, respectively, and is included in other assets in the accompanying condensed consolidated balance sheets. The market value of our investment in the Trust was $28.9 million at March 31, 2024 and $34.1 million at December 31, 2023, 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. The base rents are

paid monthly and the bonus rent, which as of January 1, 2022 is applicable only to McAllen Medical Center, is 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.

On December 31, 2021, we entered into an asset purchase and sale agreement with the Trust, which was amended during the first quarter of 2022, pursuant to the terms of which: (i) a wholly-owned subsidiary of ours purchased from the Trust the real estate assets of the Inland Valley Campus of Southwest Healthcare System located in Wildomar, California, at its fair market value; (ii) two wholly-owned subsidiaries of ours transferred to the Trust, at their respective fair-market values, the real estate assets of Aiken Regional Medical Center ("Aiken"), located in Aiken, South Carolina (which includes a 211-bed acute care hospital and a 62-bed behavioral health facility), and Canyon Creek Behavioral Health ("Canyon Creek"), located in Temple, Texas, and; (iii) we received approximately $4.1 million in cash from the Trust.

As a result of the purchase options within the lease agreements for Aiken and Canyon Creek, the asset purchase and sale transaction is accounted for as a failed sale leaseback in accordance with U.S. GAAP. We have accounted for the asset exchange and substitution transaction with the Trust as a financing arrangement and, since we did not derecognize the real property related to Aiken and Canyon Creek, we will continue to depreciate the assets. Our condensed consolidated balance sheets as of March 31, 2024 and December 31, 2023 reflects a financial liability of $76.6 million and $77.5 million, respectively, which is included in debt, for the fair value of real

estate assets that we exchanged as part of the transaction. Our monthly lease payments payable to the Trust will be recorded to interest expense and as a reduction to the outstanding financial liability. The amount allocated to interest expense is determined using our incremental borrowing rate and is based on the outstanding financial liability.

The aggregate rent payable to the Trust in connection with the leases on McAllen Medical Center, Wellington Regional Medical Center, Aiken Regional Medical Center and Canyon Creek Behavioral Health was approximately $5 million during each of the three months ended March 31, 2024 and 2023.

Pursuant to the Master Leases by certain subsidiaries of ours and the Trust as described in the table below, dated 1986 and 2021 (“the Master Leases”) which govern the leases of McAllen Medical Center and Wellington Regional Medical Center (each of which is governed by the Master Lease dated 1986), and Aiken Regional Medical Center and Canyon Creek Behavioral Health (each of which is governed by the Master Lease dated 2021), we have the option to renew the leases at the lease terms described above and below by providing notice to the Trust at least 90 days prior to the termination of the then current term. We also have the right to purchase the respective leased hospitals at their appraised fair market value upon any of the following: (i) at the end of the lease terms or any renewal terms; (ii) upon one month’s notice should a change of control of the Trust occur, or; (iii) within the time period as specified in the lease in the event that we provide notice to the Trust of our intent to offer a substitution property/properties in exchange for one (or more) of the hospital properties leased from the Trust should we be unable to reach an agreement with the Trust on the properties to be substituted. In addition, we have rights of first refusal to: (i) purchase the respective leased facilities during and for a specified period 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 a specified period after, the lease term at the same terms and conditions pursuant to any third-party offer.

In addition, we are the managing, majority member in a joint venture with an unrelated third-party that operates Clive Behavioral Health, a 100-bed behavioral health care facility located in Clive, Iowa. The real property of this facility, which was completed and opened in late 2020, is also leased from the Trust (annual rental of approximately $2.8 million and $2.7 million during 2024 and 2023, respectively) pursuant to the lease terms as provided in the table below. In connection with the lease on this facility, the joint venture has the right to purchase the leased facility from the Trust at its appraised fair market value upon either of the following: (i) by providing notice at least 270 days prior to the end of the lease terms or any renewal terms, or; (ii) upon 30 days' notice anytime within 12 months of a change of control of the Trust (UHS also has this right should the joint venture decline to exercise its purchase right). Additionally, the joint venture has rights of first offer to purchase the facility prior to any third-party sale.

The table below provides certain details for each of the hospitals leased from the Trust as of March 31, 2024:

Hospital Name	Annual Minimum Rent	End of Lease Term	Renewal Term (years)	
McAllen Medical Center	$5,485,000	December, 2026	5	(a)
Wellington Regional Medical Center	$6,639,000	December, 2026	5	(b)
Aiken Regional Medical Center/ Aurora Pavilion Behavioral Health Services	$4,072,000	December, 2033	35	(c)
Canyon Creek Behavioral Health	$1,841,000	December, 2033	35	(c)
Clive Behavioral Health Hospital	$2,775,000	December, 2040	50	(d)

(a) We have one 5-year renewal option at existing lease rates (through 2031).

(b) We have one 5-year renewal option at fair market value lease rates (through 2031). Upon the December 31, 2021 expiration of the lease on Wellington Regional Medical Center, a wholly-owned subsidiary of ours exercised its fair market value renewal option and renewed the lease for a 5-year term scheduled to expire on December 31, 2026. On each January 1st through 2026, the annual rent will increase by 2.5% on a cumulative and compounded basis.

(c) We have seven 5-year renewal options at fair market value lease rates (2034 through 2068). On each January 1st through 2033, the annual rent will increase by 2.25% on a cumulative and compounded basis.

(d) This facility is operated by a joint venture in which we are the managing, majority member and an unrelated third-party holds a minority ownership interest. The joint venture has three, 10-year renewal options at computed lease rates as stipulated in the lease (2041 through 2070) and two additional, 10-year renewal options at fair market value lease rates (2071 through 2090). In each January through 2040 (and potentially through 2070 if three, 10-year renewal options are exercised), the annual rental will increase by 2.75% on a cumulative and compounded basis.

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

During the third quarter of 2023, the Trust acquired the McAllen Doctor's Center, a 79,500 rentable square feet medical office building located in McAllen, Texas. A master lease was executed between a wholly-owned subsidiary of ours and the Trust, pursuant to the terms of which our subsidiary will master lease 100% of the rentable square feet of the MOB at an initial minimum rent of $624,000 annually. The master lease commenced during August, 2023 and is scheduled to expire in twelve years.

During the first quarter of 2023, the Trust substantially completed construction on a new 86,000 rentable square feet multi-tenant MOB that is located on the campus of Northern Nevada Sierra Medical Center in Reno, Nevada. Northern Nevada Sierra Medical Center, a 170-bed newly constructed acute care hospital owned and operated by a wholly-owned subsidiary of ours, was completed and opened in April, 2022. In connection with this MOB, a ground lease and a master flex lease was executed between a wholly-owned subsidiary of ours and the Trust, pursuant to the terms of which our subsidiary will master lease approximately 68% of the rentable square feet of the MOB at an initial minimum rent of $1.3 million annually plus a pro-rata share of the common area maintenance expenses. The master flex lease could be reduced during the term if certain conditions are met. The ground lease and master flex lease each commenced during the first quarter of 2023.

Other Related Party Transactions:

In December, 2010, our Board of Directors approved the Company’s entering into supplemental life insurance plans and agreements on the lives of Alan B. Miller (our Executive Chairman of the Board) and his wife. As a result of these agreements, as amended in October, 2016, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $28 million in premiums, and certain trusts owned by our Executive Chairman of the Board, would pay approximately $9 million in premiums. Based on the projected premiums mentioned above, and assuming the policies remain in effect until the death of the insureds, we will be entitled to receive death benefit proceeds of no less than approximately $37 million representing the $28 million of aggregate premiums paid by us as well as the
$9 million of aggregate premiums paid by the trusts. In connection with these policies, we will pay/we paid approximately $1.0 million, net, in premium payments during 2024 and 2023.

In August, 2015, Marc D. Miller, our President and Chief Executive Officer 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 vested ratably over a seven-year period (2014 through 2020), contingent upon our continued participation and minority ownership interest in the GPO. During the third quarter of 2020, we entered into an agreement with Premier pursuant to the terms of which, among other things, our ownership interest in Premier was converted into shares of Class A Common Stock of Premier. We have elected to retain a portion of the previously vested shares of Premier, the market value of which is included in other assets on our condensed consolidated balance sheets. Based upon the closing price of Premier’s stock on each respective date, the market value of our shares of Premier was approximately $49 million and
$50 million as of March 31, 2024 and December 31, 2023, respectively. The change in market value of our Premier shares since December 31, 2023 was recorded as an unrealized gain and included in “Other (income) expense, net” in our condensed consolidated statements of income for the three-month period ended March 31, 2024. Additionally, we received cash dividends from Premier amounting to approximately $470,000 for each of the three-month periods ended March 31, 2024 and 2023 which are

included in “Other (income) expense, net” in our condensed consolidated statements of income.

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

(3) Other Noncurrent liabilities and Redeemable/Noncontrolling Interests

Other noncurrent liabilities include the long-term portion of our professional and general liability, workers’ compensation reserves, pension and deferred compensation liabilities, 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, 2024, outside owners held noncontrolling, minority ownership interests of: (i) approximately 7% in an acute care facility located in Texas; (ii) 49%, 20%, 30%, 20%, 25%, 48% and 26% in seven behavioral health care facilities located in Arizona, Pennsylvania, Ohio, Washington, Missouri, Iowa and Michigan, respectively, and; (iii) approximately 5% in an acute care facility located in Nevada. The noncontrolling interest and redeemable noncontrolling interest balances of $49 million and $5 million, respectively, as of March 31, 2024, 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 consolidated balance sheets, 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. Accordingly, the amounts recorded as redeemable noncontrolling interests on our consolidated balance sheets reflect the estimated fair market value of these ownership interests.

(4) Treasury

Credit Facilities and Outstanding Debt Securities:

In June, 2022, we entered into a ninth amendment to our credit agreement dated as of November 15, 2010, as amended and restated as of September, 2012, August, 2014, October, 2018, August, 2021, and September, 2021, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders, and JPMorgan Chase Bank, N.A., as administrative agent, (the "Credit Agreement"). The ninth amendment provided for, among other things, the following: (i) a new incremental tranche A term loan facility in the aggregate principal amount of $700 million which is scheduled to mature on August 24, 2026, and; (ii) replaces the option to make Eurodollar borrowings (which bear interest by reference to the LIBO Rate) with Term Benchmark Loans, which will bear interest by reference to the Secured Overnight Financing Rate ("SOFR"). The net proceeds generated from the incremental tranche A term loan facility were used to repay a portion of the borrowings that were previously outstanding under our revolving credit facility.

As of March 31, 2024, our Credit Agreement provided for the following:

- a $1.2 billion aggregate amount revolving credit facility that is scheduled to mature in August, 2026 (which, as of March 31, 2024, had $733 million of aggregate available borrowing capacity net of $463 million of outstanding borrowings and $3 million of letters of credit), and;
- a tranche A term loan facility with $2.23 billion of outstanding borrowings as of March 31, 2024.

The tranche A term loan facility provides for installment payments of $30.0 million per quarter through June, 2026. The unpaid principal balance at June 30, 2026 is payable on the August 24, 2026 scheduled maturity date of the Credit Agreement.

Revolving credit and tranche A term loan 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 term SOFR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.25% to 0.625%, or (2) the one, three or six month term SOFR rate plus 0.1% (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.25% to 1.625%. As of March 31, 2024, the applicable margins were 0.50% for ABR-based loans and 1.50% for SOFR-based loans under the revolving credit and term loan A facilities. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company and our material subsidiaries (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, if sold to a receivables facility pursuant to the Credit Agreement, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

The Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement also contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens, indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage. We were in compliance with all required covenants as of March 31, 2024 and December 31, 2023.

As of March 31, 2024, we had combined aggregate principal of $2.0 billion from the following senior secured notes:

- $700 million aggregate principal amount of 1.65% senior secured notes due in September, 2026 (“2026 Notes”) which were issued on August 24, 2021.
- $800 million aggregate principal amount of 2.65% senior secured notes due in October, 2030 (“2030 Notes”) which were issued on September 21, 2020.
- $500 million of aggregate principal amount of 2.65% senior secured notes due in January, 2032 (“2032 Notes”) which were issued on August 24, 2021.

Interest on the 2026 Notes is payable on March 1st and September 1st until the maturity date of September 1, 2026. Interest on the 2030 Notes is payable on April 15th and October 15th, until the maturity date of October 15, 2030. Interest on the 2032 Notes is payable on January 15th and July 15th until the maturity date of January 15, 2032.

The 2026 Notes, 2030 Notes and 2032 Notes (collectively “The Notes”) were initially issued 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”). In December, 2022, we completed a registered exchange offer in which virtually all previously outstanding Notes were exchanged for identical Notes that were registered under the Securities Act, and thereby became freely transferable (subject to certain restrictions applicable to affiliates and broker dealers). Notes originally issued under Rule 144A or

Regulation S that were not exchanged remain outstanding and may not be offered or sold in the United States absent registration under the Securities Act or an applicable exemption from registration requirements thereunder.

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

As discussed in Note 2 to the Consolidated Financial Statements-Relationship with Universal Health Realty Income Trust and Other Related Party Transactions, on December 31, 2021, we (through wholly-owned subsidiaries of ours) entered into an asset purchase and sale agreement with Universal Health Realty Income Trust (the "Trust"). Pursuant to the terms of the agreement, which was amended during the first quarter of 2022, we, among other things, transferred to the Trust, the real estate assets of Aiken Regional Medical Center ("Aiken") and Canyon Creek Behavioral Health ("Canyon Creek"). In connection with this transaction, Aiken and Canyon Creek (as lessees), entered into a master lease and individual property leases, as amended, (with the Trust as lessor), for initial lease terms on each property of approximately twelve years, ending on December 31, 2033. As a result of our purchase option within the Aiken and Canyon Creek lease agreements, this asset purchase and sale transaction is accounted for as a failed sale leaseback in accordance with U.S. GAAP and we have accounted for the transaction as a financing arrangement. Our lease payments payable to the Trust are recorded to interest expense and as a reduction of the outstanding financial liability, and the amount allocated to interest expense is determined based upon our incremental borrowing rate and the outstanding financial liability. In connection with this transaction, our consolidated balance sheets at March 31, 2024 and December 31, 2023 reflect financial liabilities, which are included in debt, of approximately $77 million as of each date.

At March, 2024, the carrying value and fair value of our debt were approximately $4.9 billion and $4.6 billion, respectively. At December 31, 2023, the carrying value and fair value of our debt were approximately $4.9 billion and $4.6 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.

Foreign Currency Forward Exchange Contracts:

We use forward exchange contracts to hedge our net investment in foreign operations against movements in exchange rates. The effective portion of the unrealized gains or losses on these contracts is recorded in foreign currency translation adjustment within

accumulated other comprehensive income and remains there until either the sale or liquidation of the subsidiary. In connection with these forward exchange contracts, we recorded net cash inflows of $8 million during the three-month period ended March 31, 2024 and net cash outflows of $19 million during the three-month period ended March 31, 2023.

Derivatives Hedging Relationships:

The following table presents the effects of our foreign currency forward exchange contracts on our results of operations for the three-month periods ended March 31, 2024 and 2023 (in thousands):

	Gain/(Loss) recognized in AOCI	
	Three months ended	
	March 31, 2024	March 31, 2023
Net Investment Hedge relationships		
Foreign currency forward exchange contracts	$ 9,897	$ (22,144)

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

Cash, Cash Equivalents and Restricted Cash:

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

	March 31, 2024	March 31, 2023	December 31, 2023
Cash and cash equivalents	$ 112,093	$ 109,969	$ 119,439
Restricted cash (a)	94,707	99,069	95,031
Total cash, cash equivalents and restricted cash	$ 206,800	$ 209,038	$ 214,470

(a)
Restricted cash is included in other assets on the accompanying condensed consolidated balance sheets.

(5) Fair Value Measurement

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

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

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

(in thousands)	Balance at March 31, 2024	Balance Sheet Location	Basis of Fair Value Measurement Level 1	Level 2	Level 3
Assets:					
Money market mutual funds	$ 110,856	Other noncurrent assets	$110,856		
Certificates of deposit	2,201	Other noncurrent assets		2,201	
Equity securities	49,342	Other noncurrent assets	49,342		
Deferred compensation assets	46,163	Other noncurrent assets	46,163		
	$ 208,562		$206,361	$ 2,201	-
Liabilities:					
Foreign currency exchange contracts	$ 333	Accounts payable and other liabilities		$ 333	
Deferred compensation liability	46,163	Other noncurrent liabilities	46,163		
	$ 46,496		$ 46,163	$ 333	-

(in thousands)	Balance at December 31, 2023	Balance Sheet Location	Basis of Fair Value Measurement Level 1	Level 2	Level 3
Assets:					

Money market mutual funds	$ 111,129	Other noncurrent assets	$111,129		
Certificates of deposit	2,300	Other noncurrent assets		2,300	
Equity securities	49,923	Other noncurrent assets	49,923		
Deferred compensation assets	43,060	Other noncurrent assets	43,060		
	$ 206,412		$204,112	$ 2,300	-
Liabilities:					
Foreign currency exchange contracts	$ 1,911	Accounts payable and other liabilities		$ 1,911	
Deferred compensation liability	43,060	Other noncurrent liabilities	43,060		
	$ 44,971		$ 43,060	$ 1,911	-

The fair value of our money market mutual funds, certificates of deposit and equity securities with a readily determinable fair value are computed based upon quoted market prices in an active market. The fair value of deferred compensation assets and the offsetting

liability are computed based on market prices in an active market held in a rabbi trust. The fair value of our foreign currency exchange contracts is determined using quoted forward exchange rates and spot rates at the reporting date.

(6) Commitments and Contingencies

Professional and General Liability, Workers' Compensation Liability

The vast majority of our subsidiaries are self-insured for professional and general liability exposure up to: (i) $20 million for professional liability and $3 million for general liability per occurrence in 2024, 2023, 2022 and 2021; (ii) $10 million and $3 million per occurrence in 2020; (iii) $5 million and $3 million per occurrence, respectively, during 2019, 2018 and 2017, and; (iv) $10 million and $3 million per occurrence, respectively, prior to 2017.

These subsidiaries are provided with several excess policies through commercial insurance carriers which provide for coverage in excess of the applicable per occurrence and aggregate self-insured retention or underlying policy limits up to approximately $175 million in 2024; $165 million in 2023; $162 million in 2022; $155 million in 2021 and $250 million during each of 2014 through 2020. 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 £16 million of professional liability coverage, and £25 million of general liability coverage. The commercial insurance limits indicated above for each policy year may have been reduced due to payment of covered claims or suits, subject to the policy terms and conditions.

As disclosed below in Legal Proceedings, on March 28, 2024, a jury returned a verdict for compensatory damages of $60 million and punitive damages of $475 million and a related judgment was entered against The Pavilion Behavioral Health System (the "Pavilion"), an indirect subsidiary of ours. We are uncertain as to the ultimate financial exposure related to the Pavilion matter (which relates to a 2020 occurrence) and we can make no assurances regarding its outcome, or the amount of damages that may be ultimately held recoverable after post-judgment proceedings and appeal. While the Pavilion has general and professional liability insurance to cover a portion of these amounts, the resolution of the Pavilion matter may have a material adverse effect on the Company. As of March 31, 2024, without reduction for any potential amounts related to the Pavilion matter, the Company and its subsidiaries have aggregate insurance coverage of approximately $221 million remaining under commercial policies for matters applicable to the 2020 policy year (in excess of the applicable self-insured retention amounts of $10 million per occurrence for professional liability claims and $3 million per occurrence for general liability claims). In the event the resolution of the Pavilion matter exhausts all or a significant portion of the remaining commercial insurance coverage available to the Company and its subsidiaries related to other matters that occurred in 2020, or the Pavilion matter causes the posting of a large bond or other collateral during an appeal process, our future results of operations and capital resources could be materially adversely impacted.

As of March 31, 2024, the total net accrual for our professional and general liability claims was $447 million, of which $70 million was included in current liabilities. As of December 31, 2023, the total net accrual for our professional and general liability claims was $431 million, of which $70 million was included in current liabilities.

As a result of unfavorable trends experienced during the last several years, our results of operations included pre-tax increases to our reserves for self-insured professional and general liability claims amounting to $7 million during the first quarter of 2024, $25 million during 2023 ($20 million and $5 million recorded during the second and third quarters of 2023, respectively) and $16 million during 2022. Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimates of incurred but

not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Given our significant self-insured exposure for professional and general liability claims, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

As of March 31, 2024, the total accrual for our workers’ compensation liability claims was $132 million, $55 million of which was included in current liabilities. As of December 31, 2023, the total accrual for our workers’ compensation liability claims was $130 million, $55 million of which was included in current liabilities. As a result of favorable trends experienced in prior years, included in our results of operations during the full year of 2023, was a pre-tax decrease to our reserves for self-insured workers' compensation liability claims of approximately $10 million (recorded during the second quarter of 2023).

Although we are unable to predict whether or not our future financial statements will require updates to estimates for our prior year reserves for self-insured general and professional and workers’ compensation claims, given the relatively unpredictable nature of 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 the period of June 1, 2023 to June 1, 2024, providing property and business interruption coverage for losses in excess of $25 million per occurrence or per location (as applicable based upon the event) up to a $1 billion annual policy limitation for certain catastrophic events or perils. These commercial policies provide for coverage of up to $250 million of annual aggregate coverage for losses resulting from windstorm damage. 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) $100 million limitation for our facilities located in California, New Madrid Seismic Zone, Pacific Northwest Seismic Zone, Alaska and various counties in Nevada; (ii) $100 million limitation for our facilities located in fault zones within the United States; (iii) $40 million limitation for our facilities located in Puerto Rico, and; (iv) $250 million limitation for many of our facilities located in other states. Our commercially insured flood coverage has a limit of $100 million annually. There is also a $10 million sublimit for one of our facilities located in Houston, Texas, and a $1 million sublimit for our facilities located in Puerto Rico. Property insurance for our behavioral health facilities located in the U.K. are provided on an all risk basis up to a £1.5 billion policy limit, with coverage caps per location, that includes coverage for real and personal property as well as business interruption losses.

These commercial policies are subject to a deductible of: (i) $5 million per location for damage resulting from earthquake, wind, hail and flood, and; (ii) $5 million per occurrence for all other events. For per location or per occurrence losses in excess of the applicable deductible, we are self-insured, through our wholly-owned captive, for up to $20 million of annual aggregate losses. Should the $20 million self-insured annual aggregate limitation be exhausted during the policy year, we have commercial insurance coverage for the next $20 million of annual aggregate losses in excess of the applicable deductible. In the event the $20 million of commercial coverage is also exhausted, we are self-insured for all per location or per occurrence losses up to $25 million, including the $5 million deductible.

Commitment to Develop, Lease and Operate an Acute Care Hospital in Washington, D.C.

During 2020, we entered into various agreements with the District of Columbia (the "District") related to the development, leasing and operation of an acute care hospital and certain other facilities/structures on land owned by the District ("District Facilities"). The agreements contemplate that we will serve as manager for development and construction of the District Facilities on behalf of the District, with a projected aggregate cost of approximately $439 million, approximately $229 million of which was incurred as of March 31, 2024, which will be entirely funded by the District. Construction of the District Facilities is expected to be completed during 2025.

Upon completion of the District Facilities, we will lease the District Facilities for a nominal rental amount for a period of 75 years and are obligated to operate the District Facilities during the lease term. We have certain lease termination rights in connection with the District Facilities beginning on the tenth anniversary of the lease commencement date for various and decreasing amounts as provided for in the agreements. Additionally, any time after the 10^{th} anniversary of the lease term, we have a right to purchase the District Facilities for a price equal to the greater of fair market value of the District Facilities or the amount necessary to defease the bonds issued by the District to fund the construction of the District Facilities. The lease agreement also entitles the District to participation rent should certain specified earnings before interest, taxes, depreciation and amortization thresholds be achieved by the acute care hospital.

Additionally, we have committed to expend no less than $75 million (approximately $5 million of which has been incurred as of March 31, 2024), over a projected 12-year period, in healthcare infrastructure including expenditures related to the District Facilities as well as other healthcare related expenditures in certain specified areas of Washington, D.C. Pursuant to the agreements, the District is entitled to certain termination fees and other amounts as specified in the agreements in the event we, within certain specified periods of time, cease to operate the acute care hospital or there is a transfer of control of us or our subsidiary operating the hospital.

Legal Proceedings

We operate in a highly regulated and litigious industry which subjects us to various claims and lawsuits in the ordinary course of business as well as regulatory proceedings and government investigations. These claims or suits include claims for damages for personal injuries, medical malpractice, commercial/contractual disputes, wrongful restriction of, or interference with, physicians' staff privileges, and employment related claims. In addition, health care companies are subject to investigations and/or actions by various state and federal governmental agencies or those bringing claims on their behalf. Government action has increased with respect to investigations and/or allegations against healthcare providers concerning possible violations of fraud and abuse and false claims statutes as well as compliance with clinical and operational regulations. Currently, and from time to time, we and some of our facilities are subjected to inquiries in the form of subpoenas, Civil Investigative Demands, audits and other document requests from various federal and state agencies. These inquiries can lead to notices and/or actions including repayment obligations from state and federal government agencies associated with potential non-compliance with laws and regulations. Further, the federal False Claims Act allows private individuals to bring lawsuits (qui tam actions) against healthcare providers that submit claims for payments to the government.

Various states have also adopted similar statutes. When such a claim is filed, the government will investigate the matter and decide if they are going to intervene in the pending case. These qui tam lawsuits are placed under seal by the court to comply with the False Claims Act's requirements. If the government chooses not to intervene, the private individual(s) can proceed independently on behalf of the government. Health care providers that are found to violate the False Claims Act may be subject to substantial monetary fines/ penalties as well as face potential exclusion from participating in government health care programs or be required to comply with Corporate Integrity Agreements as a condition of a settlement of a False Claims Act matter. In September 2014, the Criminal Division of the Department of Justice ("DOJ") announced that all qui tam cases will be shared with their Division to determine if a parallel criminal investigation should be opened. The DOJ has also announced an intention to pursue civil and criminal actions against individuals within a company as well as the corporate entity or entities. In addition, health care facilities are subject to monitoring by state and federal surveyors to ensure compliance with program Conditions of Participation. In the event a facility is found to be out of compliance with a Condition of Participation and unable to remedy the alleged deficiency(s), the facility faces termination from the Medicare and Medicaid programs or compliance with a System Improvement Agreement to remedy deficiencies and ensure compliance.

The laws and regulations governing the healthcare industry are complex covering, among other things, government healthcare participation requirements, licensure, certification and accreditation, privacy of patient information, reimbursement for patient services as well as fraud and abuse compliance. These laws and regulations are constantly evolving and expanding. Further, the original Patient Protection and Affordable Care Act, as amended by the Health and Education Reconciliation 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:

Knight v. Miller, et. al.

In July 2021, a shareholder derivative lawsuit was filed by plaintiff, Robin Knight, in the Chancery Court in Delaware against the members of the Board of Directors of the Company as well as certain officers (C.A. No.: 2021-0581-SG). The Company was named as a nominal defendant. The lawsuit alleges that in March 2020 stock options were awarded with exercise prices that did not reflect the Company's fundamentals and business prospects, and in anticipation of future market rebound resulting in excessive gains. The lawsuit makes claims of breaches of fiduciary duties, waste of corporate assets, and unjust enrichment. The lawsuit seeks monetary damages allegedly incurred by the Company, disgorgement of the March 2020 stock awards as well as any proceeds derived therefrom and unspecified equitable relief. Defendants deny the allegations. We filed a motion to dismiss the complaint and the court granted part and denied part of our motion. During the third quarter of 2022, we reached a preliminary settlement, which would not have had a material impact on our consolidated financial statements. The settlement required court approval which the court declined to provide. Our Board of Directors authorized the formation of a Special Litigation Committee ("SLC") to review the matter and determine whether it is in the best interests of the Company to pursue this claim. The court stayed the litigation until April 15, 2024 while the SLC conducted their review. According to the SLC's status letter to the Court of Chancery, dated April 15, 2024, after a thorough examination of documentary evidence, interviews with relevant persons, and a review of the applicable law,

the SLC has determined that the claims asserted in the shareholder derivative lawsuit do not have merit and that pursuing them would not be in the interest of the Company. The SLC further advised the Court that the SLC has concluded that the claims should be dismissed. Currently, the SLC is conferring with the parties to the action about the appropriate next steps. We are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter.

Disproportionate Share Hospital Payment Matter:

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

share for FFY 2011 to 2013 until all hospital appeals are resolved but recouped the federal share. For FFY 2014 and FFY 2015, the Department initiated the recoupment of the alleged overpayments (both federal and state shares). Starting in FY 2016, the first full fiscal year after the January 1, 2015 effective date of Medicaid expansion in Pennsylvania, the Department no longer characterized managed care payments received by the hospitals as DSH payments. While the administrative appeals on the disputed DSH payments remain pending, we are in continued settlement discussions with the Department. As a part of these discussions, we have presented certain calculation errors that we believe, if corrected, could materially reduce the alleged overpayments. We can provide no assurance that we will ultimately be successful in our legal and administrative appeals related to the Department's repayment demands and are unable to assess liability or damages with certainty at this time. If our legal and administrative appeals are unsuccessful, our future consolidated results of operations and financial condition could be adversely impacted by these repayments.

Rachel Capriglione, as natural mother and Next Friend of A.T., a minor, Plaintiff, v. The Pavilion Foundation d/b/a The Pavilion Behavioral Health System

As previously reported on Form 8-K as filed on April 1, 2024, the Pavilion Behavioral Health System (the "Pavilion"), an indirect subsidiary of the Company, is a defendant in a lawsuit filed in Champaign County, Illinois, relating to the sexual assault of one minor patient by another minor patient in 2020. Plaintiff asserted claims of negligence and misrepresentation. The Pavilion denied any liability.

The case went to trial in March of 2024. On March 28, 2024, a jury returned a verdict for compensatory damages of $60 million and punitive damages of $475 million. Based on a search of verdicts in comparable cases, the magnitude of this verdict was unexpected and is unprecedented for a single-plaintiff injury case of this type in Champaign County, Illinois. The Pavilion is evaluating all legal options and intends to challenge this verdict in post-judgment trial court proceedings and on appeal.

We are uncertain as to the ultimate financial exposure related to the Pavilion matter and we can make no assurances regarding its outcome, or the amount of damages that may be held recoverable after post-judgment proceedings and appeal. While the Pavilion has general and professional liability insurance to cover a portion of these amounts, in the event the resolution of the Pavilion matter exceeds the remaining commercial insurance coverage available, or the Pavilion matter causes the posting of a large bond or other collateral during an appeal process, our future results of operations and capital resources could be materially adversely impacted.

Other Matters:

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

impact on our future results of operations, financial position, cash flows and, potentially, our reputation.

(7) Segment Reporting

Our reportable operating segments consist of acute care hospital services and behavioral health care services. The “Other” segment column below includes centralized services including, but not limited to, information technology, purchasing, reimbursement, accounting and finance, taxation, legal, advertising and design and construction. The chief operating decision making group for our acute care services and behavioral health care services is comprised of our Chief Executive Officer 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, 2023. 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, based upon each segment’s respective percentage of total operating expenses.

	Three months ended March 31, 2024			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$12,910,102	$2,754,684		$15,664,786
Gross outpatient revenues	$8,346,289	$ 278,528		$8,624,817
Total net revenues	$2,185,081	$1,656,067	$ 2,434	$3,843,582
Income/(loss) before allocation of corporate overhead and income taxes	$ 205,468	$ 319,938	$(189,320)	$ 336,086
Allocation of corporate overhead	$ (64,846)	$ (46,935)	$ 111,781	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 140,622	$ 273,003	$ (77,539)	$ 336,086
Total assets as of March 31, 2024	$6,336,429	$7,534,702	$ 175,001	$14,046,132

	Three months ended March 31, 2023			
	Acute Care Hospital Services	Behavioral Health Services (a)	Other	Total Consolidated
	(Dollar amounts in thousands)			
Gross inpatient revenues	$11,401,491	$2,627,990		$14,029,481
Gross outpatient revenues	$7,296,116	$ 272,371		$7,568,487
Total net revenues	$1,973,532	$1,490,489	$ 3,497	$3,467,518
Income/(loss) before allocation of corporate overhead and income taxes	$ 133,296	$ 266,356	$(185,551)	$ 214,101
Allocation of corporate overhead	$ (67,262)	$ (46,642)	$ 113,904	$ 0
Income/(loss) after allocation of corporate overhead and before income taxes	$ 66,034	$ 219,714	$ (71,647)	$ 214,101
Total assets as of March 31, 2023	$6,001,135	$7,343,276	$ 211,548	$13,555,959

(a) Includes net revenues generated from our behavioral health care facilities located in the U.K. amounting to approximately $208 million and $168 million for the three-month periods ended March 31, 2024 and 2023, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.336 billion and $1.265 billion as of March 31, 2024 and 2023, respectively.

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

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

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

	Three months ended March 31,	
	2024	2023
Basic and Diluted:		
Net income attributable to UHS	$ 261,834	$ 163,115
	(45)	(129)

Less: Net income attributable to unvested restricted share grants		
Net income attributable to UHS – basic and diluted	$ 261,789	$ 162,986
Weighted average number of common shares - basic	67,204	70,535
Net effect of dilutive stock options and grants based on the treasury stock method	1,278	952
Weighted average number of common shares and equivalents - diluted	68,482	71,487
Earnings per basic share attributable to UHS:	$ 3.90	$ 2.31
Earnings per diluted share attributable to UHS:	$ 3.82	$ 2.28

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 1.3 million for the three months ended March 31, 2024 and 5.1 million for the three months ended March 31, 2023.
All classes of our common stock have the same dividend rights.

Stock-Based Compensation:

During the three-month periods ended March 31, 2024 and 2023, pre-tax compensation costs of $14.4 million and
$16.2 million, respectively, was recognized related to outstanding stock options. In addition, during the three-month periods ended March 31, 2024 and 2023, pre-tax compensation cost of approximately $5.1 million and $4.5 million, respectively, was recognized related to restricted stock awards, restricted stock units and performance based restricted stock units. As of March 31, 2024 there was approximately $236.3 million of unrecognized compensation cost related to unvested options, restricted stock awards, restricted stock units and performance based restricted stock units which is expected to be recognized over the remaining weighted average vesting period of 2.9 years. There were 3,000 stock options granted during the first three months of 2024 under the 2020 Stock Incentive Plan with a weighted-average grant date fair value of $44.58 per option. There were an aggregate of
545,810 restricted units granted during the first three months of 2024 under the 2020 Stock Incentive Plan, including 63,362 performance based restricted stock units, with a weighted-average grant date fair value of $180.77 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 $19.6 million and $21.0 million during the three-month periods ended March 31, 2024 and 2023, respectively.

(9) Dispositions and acquisitions

Three-month period ended March 31 2024:

Acquisitions:

During the first three months of 2024, there were no acquisitions.

Divestitures:

During the first three months of 2024, we received $5 million from the sales of assets and businesses.

Three-month period ended March 31, 2023:

Acquisitions:

During the first three months of 2023, there were no acquisitions.

Divestitures:

During the first three months of 2023, we received $9 million from the sales of assets and businesses.

(10) Dividends

We declared and paid dividends of $13.6 million, or $.20 per share, during the first quarter of 2024 and $14.2 million, or $.20 per share, during the first quarter of 2023. Included in the amounts above were dividend equivalents applicable to unvested restricted stock units which were accrued during 2024 and 2023 and will be, or were, paid upon vesting of the restricted stock unit.

(11) Income Taxes

Our effective income tax rates were 20.9% and 24.2% during the three-month periods ended March 31, 2024, and 2023, respectively. The decrease in our effective tax rate during the three months ended March 31, 2024, compared with the same period in 2023, was primarily due to an
$8 million decrease in our provision for income taxes attributable to employee share-based payments and an increase in net income attributable to noncontrolling interests during the first quarter of 2024 as compared to the first quarter of 2023.

As of January 1, 2024, our unrecognized tax benefits were approximately $2 million. The amount, if recognized, that would favorably affect the effective tax rate is approximately $2 million. During the three months ended March 31, 2024, 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, 2024, we have less than $1 million of accrued interest and penalties. The U.S. federal statute of limitations remains open for 2020 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. We believe that adequate accruals have been provided for federal, foreign and state taxes.

(12) Revenue

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

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

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

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

The following table disaggregates our revenue by major source for the three-month periods ended March 31, 2024 and 2023 (in thousands):

	For the three months ended March 31, 2024					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$349,087	16%	$ 76,816	5%		$ 425,903	11%
Managed Medicare	373,401	17%	96,074	6%		469,475	12%
Medicaid	234,862	11%	248,363	15%		483,225	13%
Managed Medicaid	159,359	7%	423,308	26%		582,667	15%
Managed Care (HMO and PPOs)	698,785	32%	404,173	24%		1,102,958	29%
UK Revenue	0	0%	207,796	13%		207,796	5%
Other patient revenue and adjustments, net	123,333	6%	144,131	9%		267,464	7%
Other non-patient revenue	246,254	11%	55,406	3%	2,434	304,094	8%
Total Net Revenue	$2,185,081	100%	$1,656,067	100%	$ 2,434	$3,843,582	100%

	For the three months ended March 31, 2023					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$329,446	17%	$ 76,544	5%		$ 405,990	12%
Managed Medicare	344,032	17%	75,077	5%		419,109	12%
Medicaid	110,009	6%	206,473	14%		316,482	9%
Managed Medicaid	192,298	10%	398,951	27%		591,249	17%
Managed Care (HMO and PPOs)	654,795	33%	391,297	26%		1,046,092	30%

UK Revenue	0	0%	167,789	11%		167,789	5%
Other patient revenue and adjustments, net	120,957	6%	121,677	8%		242,634	7%
Other non-patient revenue	221,995	11%	52,681	4%	3,497	278,173	8%
Total Net Revenue	$1,973,532	100%	$1,490,489	100%	$ 3,497	$3,467,518	100%

(13) Lease Accounting

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

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

Five of our hospital facilities are held under operating leases with Universal Health Realty Income Trust with two leases expiring in 2026, two expiring in 2033 and one expiring in 2040 (see Note 2 for additional disclosure). We are also the lessee of the real property of certain facilities from unrelated third parties.

Supplemental cash flow information related to leases for the three-month period ended March 31, 2024 and 2023 are as follows (in thousands):

	Three months ended March 31,	
	2024	2023
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	$ 32,518	$ 32,043
Operating cash flows from finance leases	$ 932	$ 967
Financing cash flows from finance leases	$ 958	$ 882
Right-of-use assets obtained in exchange for lease obligations:		
Operating leases	$ 8,983	$ 24,256

(14) Recent Accounting Standards

In November 2023, the FASB issued ASU 2023-07, “Improvements to Reportable Segment Disclosures (Topic 280)”. ASU 2023-07 modifies reportable segment disclosure requirements, primarily through enhanced disclosures about segment expenses categorized as significant or regularly provided to the Chief Operating Decision Maker (CODM). In addition, the amendments enhance interim disclosure requirements, clarify circumstances in which an entity can disclose multiple segment measures of profit or loss, and contain other disclosure requirements. The purpose of the amendments is to enable investors to better understand an entity’s overall performance and assess potential future cash flows. This ASU is effective for annual periods beginning after December 15, 2023, and interim periods within annual periods beginning after December 15, 2024, with early adoption permitted. We are currently evaluating the impact this new standard will have on the related disclosures in the consolidated financial statements, but do not believe there will be a material impact.

In December 2023, the FASB issued ASU 2023-09, “Improvements to Income Tax Disclosures (Topic 740)”. ASU 2023-09 requires enhanced disclosures on income taxes paid, adds disaggregation of continuing operations before income taxes between foreign and domestic earnings and defines specific categories for the reconciliation of jurisdictional tax rate to effective tax rate. This ASU is effective for fiscal years beginning after December 15, 2024, and can be applied on a prospective basis. We are currently evaluating the impact this new standard will have on the related disclosures in the consolidated financial statements.

From time to time, new accounting guidance is issued by the FASB or other standard setting bodies that is adopted by the Company as of the effective date or, in some cases where early adoption is permitted, in advance of the effective date. The Company has assessed the recently issued guidance that is not yet effective and 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

As of March 31, 2024, we owned and/or operated 360 inpatient facilities and 47 outpatient and other facilities, including the following, located in 39 states, Washington, D.C., the United Kingdom and Puerto Rico:

Acute care facilities located in the U.S.:

- 27 inpatient acute care hospitals;
- 27 free-standing emergency departments, and;
- 9 outpatient centers & 1 surgical hospital.

Behavioral health care facilities (333 inpatient facilities and 10 outpatient facilities):

Located in the U.S.:

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

Located in the U.K.:

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

Located in Puerto Rico:

- 3 inpatient behavioral health care facilities.

Net revenues from our acute care hospitals, outpatient facilities and commercial health insurer accounted for 57% of our consolidated net revenues during each of the three-month periods ended March 31, 2024 and 2023. Net revenues from our behavioral health care facilities and commercial health insurer accounted for 43% of our consolidated net revenues during each of the three-month periods ended March 31, 2024 and 2023.

Our behavioral health care facilities located in the U.K. generated net revenues of approximately $208 million and $168 million during the three-month periods ended March 31, 2024 and 2023, respectively. Total assets at our U.K. behavioral health care facilities were approximately $1.336 billion as of March 31, 2024 and $1.327 billion as of December 31, 2023.

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

Forward-Looking Statements and Risk Factors

You should carefully review the information contained in this Quarterly Report and should particularly consider any risk factors that we set forth in our Annual Report on Form 10-K for the year ended December 31, 2023, this Quarterly Report and in other reports or documents that we file from time to time with the Securities and Exchange Commission (the "SEC"). In this Quarterly Report, we state our beliefs of future events and of our future financial performance. This Quarterly Report contains "forward-looking statements" that reflect our current estimates, expectations and projections about our future results, performance, prospects and opportunities. Forward-looking statements include, among other things, the information concerning our possible future results of operations, business

and growth strategies, financing plans, expectations that regulatory developments or other matters will or will not have a material adverse effect on our business or financial condition, our competitive position and the effects of competition, the projected growth of the industry in which we operate, and the benefits and synergies to be obtained from our completed and any future acquisitions, and statements of our goals and objectives, and other similar expressions concerning matters that are not historical facts. Words such as “may,” “will,” “should,” “could,” “would,” “predicts,” “potential,” “continue,” “expects,” “anticipates,” “future,” “intends,” “plans,” “believes,” “estimates,” “appears,” “projects” and similar expressions, as well as statements in future tense, identify forward-looking statements. In evaluating those statements, you should specifically consider various factors, including the risks related to healthcare industry trends and those set forth herein in Item 1A. Risk Factors and Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations-Forward Looking Statements and Risk Factors in our Annual Report on Form 10-K for the year ended December 31, 2023 and in Item 2. Management’s Discussion and Analysis of Financial Condition and Results of Operations-Forward Looking Statements and Risk Factors, as
included herein. 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 are difficult to predict and many of which are outside of our control. Many factors, including those set forth herein in Item 1A. Risk Factors in our Annual Report on Form 10-K for the year ended December 31, 2023, and other important factors disclosed in this Quarterly Report, and from time to time in our other filings with the SEC, could cause actual performance or results to differ materially from those expressed in the statements. Such factors include, among other things, the following:

- in our acute care segment, we have experienced a significant increase in hospital based physician related expenses, especially in the areas of emergency room care and anesthesiology. Although we have implemented various initiatives to mitigate the increased expense, to the degree possible, increases in these physician related expenses could continue to have an unfavorable material impact on our results of operations for the foreseeable future;

- the healthcare industry is labor intensive and salaries, wages and benefits are subject to inflationary pressures, as are supplies expense and other operating expenses. In addition, the nationwide shortage of nurses and other clinical staff and support personnel experienced by healthcare providers in the past has been a significant operating issue facing us and other healthcare providers. In the past, the staffing shortage has, at times, required us to hire expensive temporary personnel and/or enhance wages and benefits to recruit and retain nurses and other clinical staff and support personnel. At certain facilities, particularly within our behavioral health care segment, there have been occasions when we were unable to fill all vacant positions and, consequently, we were required to limit patient volumes. The staffing shortage has required us to enhance wages and benefits to recruit and retain nurses and other clinical staff and support personnel or required us to hire expensive temporary personnel. We have also experienced general inflationary cost increases related to medical supplies as well as certain of our other operating expenses. Many of these factors, which had a material unfavorable impact on our results of operations in prior years, moderated to a certain degree more recently;

- in 2021, the rate of inflation in the United States began to increase and has since risen to levels not experienced in over 40 years. We are experiencing inflationary pressures, primarily in personnel costs, and we anticipate continuing impacts on other cost areas within the next twelve months. The extent of any future impacts from inflation on our business and our results of operations will be dependent upon how long the elevated inflation levels persist and the extent to which the rate of inflation further increases, if at all, neither of which we are able to predict. If elevated levels of inflation were to persist or if the rate of inflation were to accelerate, our expenses could increase faster than anticipated and we may utilize our capital resources sooner than expected. Further, given the complexities of the reimbursement landscape in which we operate, our ability to pass on increased costs associated with providing healthcare to Medicare and Medicaid patients is limited due to various federal, state and local laws, which in certain circumstances, limit our ability to increase prices. In addition, although we have been requesting and negotiating increased rates from commercial payers to defray our increased cost of providing patient care, commercial payers may be unwilling or unable to increase reimbursement rates commensurate with the inflationary impacts on our costs;

- the rapid increase in interest rates has increased our interest expense significantly increasing our expenses and reducing our free cash flow and our ability to access the capital markets on favorable terms. As such, the effects of inflation and increased borrowing rates may adversely impact our results of operations, financial condition and cash flows;

- President Biden signed into law fiscal year 2024 appropriations to federal agencies for continuing projects and activities through September 30, 2024. We cannot predict whether or not there will be future legislation averting a federal government shutdown, however, our operating cash flows and results of operations could be materially unfavorably impacted by a federal government shutdown;

- the impact of the COVID-19 pandemic, which began in March, 2020, has had a material effect on our operations and financial results, at various times, since that time. We cannot predict if there will be future disruptions caused by COVID-19. On December 29, 2022, the Consolidated Appropriations Act, 2023, was signed into law phasing out the enhanced federal medical assistance percentage rate that states received during the COVID-19 public health emergency and fully eliminated the increase on December 31, 2023. States were also permitted to begin Medicaid eligibility redeterminations on March 31, 2023, which has resulted in a decrease in Medicaid enrollment;

- 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. For example, Congress has reduced to $0 the penalty for failing to maintain health coverage that was part of the original Patient Protection and Affordable Care Act, as amended by the Health and Education Reconciliation Act (collectively, the "Legislation") as part of the Tax Cuts and Jobs Act. President Biden has undertaken and is expected to undertake additional executive actions that will strengthen the Legislation and

reverse the policies of the prior administration. To date, the Biden administration has issued executive orders implementing a special enrollment period permitting individuals to enroll in health plans outside of the annual open enrollment period and reexamining policies that may undermine the Legislation or the Medicaid program. The Inflation Reduction Act of 2022 ("IRA") was passed on August 16, 2022, which among other things, allows for CMS to negotiate prices for certain single-source drugs reimbursed under Medicare Part B and Part D. The American Rescue Plan Act's expansion of subsidies to purchase coverage through a Legislation exchange, which the IRA continued through 2025, is anticipated to increase exchange enrollment. However, if the subsidies are not extended beyond 2025, exchange enrollment may be adversely impacted;

- there have been numerous political and legal efforts to expand, repeal, replace or modify the Legislation, since its enactment, some of which have been successful, in part, in modifying the Legislation, as well as court challenges to the constitutionality of the Legislation. The U.S. Supreme Court held in California v. Texas that the plaintiffs lacked standing to challenge the Legislation's requirement to obtain minimum essential health insurance coverage, or the individual mandate. The Court dismissed the case without specifically ruling on the constitutionality of the Legislation. As a result, the Legislation will continue to remain law, in its entirety, likely for the foreseeable future. On September 7, 2022, the Legislation faced its most recent challenge when a Texas Federal District Court judge, in the case of Braidwood Management v. Becerra, ruled that a requirement that certain health plans cover services without cost sharing violates the Appointments Clause of the U.S. Constitution and that the coverage of certain HIV prevention medication violates the Religious Freedom Restoration Act. The government has appealed the decision to the U.S. Circuit Court of Appeals for the Fifth Circuit. Any future efforts to challenge, replace or replace the Legislation or expand or substantially amend its provision is unknown. See below in Sources of Revenues and Health Care Reform for additional disclosure;

- under the Legislation, hospitals are required to make public a list of their standard charges, and effective January 1, 2019, CMS has required that this disclosure be in machine-readable format and include charges for all hospital items and services and average charges for diagnosis-related groups. On November 27, 2019, CMS published a final rule on "Price Transparency Requirements for Hospitals to Make Standard Charges Public." This rule took effect on January 1, 2021 and requires all hospitals to also make public their payer-specific negotiated rates, minimum negotiated rates, maximum negotiated rates, and discounted cash rates, for all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient. Failure to comply with these requirements may result in daily monetary penalties. On November 2, 2021, CMS released a final rule amending several hospital price transparency policies and increasing the amount of penalties for noncompliance through the use of a scaling factor based on hospital bed count. On April 26, 2023, CMS announced updated enforcement processes that requires a shortened timeline for coming into compliance when a violation has been identified and the automatic imposition of a civil monetary penalties in certain circumstances of noncompliance;

- as part of the Consolidated Appropriations Act of 2021 (the "CAA"), Congress passed legislation aimed at preventing or limiting patient balance billing in certain circumstances. The CAA addresses surprise medical bills stemming from emergency services, out-of-network ancillary providers at in-network facilities, and air ambulance carriers. The CAA prohibits surprise billing when out-of-network emergency services or out-of-network services at an in-network facility are provided, unless informed consent is received. In these circumstances providers are prohibited from billing the patient for any amounts that exceed in-network cost-sharing requirements. HHS, the Department of Labor and the Department of the Treasury have issued interim final rules, which begin to implement the legislation. The rules have limited the ability of our hospital-based physicians to receive payments for services at usually higher out-of-network rates in certain circumstances, and, as a result, have caused us to increase subsidies to these physicians or to replace their services at a higher cost level. On February 28, 2022, a district judge in the Eastern District of Texas invalidated portions of the rule governing aspects of the Independent Dispute Resolution (“IDR”) process. In light of this decision, the government issued a final rule on August 19, 2022 eliminating the rebuttable presumption in favor of the qualifying payment amount (“QPA”) by the IDR entity and providing additional factors the IDR entity should consider when choosing between two competing offers. On September 22, 2022, the Texas Medical Association filed a lawsuit challenging the IDR process provided in the updated final rule and alleging that the final rule unlawfully elevates the QPA above other factors the IDR entity must consider. On February 6, 2023, a federal judge vacated parts of the rule, including provisions related to considerations of the QPA. The government's appeal of the district court's order is pending in the U.S. Court of Appeals for the Fifth Circuit;

- possible unfavorable changes in the levels and terms of reimbursement for our charges by third party payers or government based payers, including Medicare or Medicaid in the United States, and government based payers in the United Kingdom;

- our ability to enter into managed care provider agreements on acceptable terms and the ability of our competitors to do the same;

- the outcome of known and unknown litigation, government investigations, inquiries, false claims act allegations, and liabilities and other claims asserted against us and other matters, and the effects of adverse publicity relating to such matters, including, but not limited to, the March 28, 2024, jury verdict (of compensatory damages of $60 million and punitive damages of $475 million) returned against The Pavilion Behavioral Health System (the "Pavilion"), an indirect subsidiary of the Company, as disclosed in Note 6 to the Consolidated Financial Statements - Commitments and Contingencies, Legal Proceedings. We are uncertain as to the ultimate financial exposure related to the Pavilion matter (which relates to an occurrence in 2020) and we can make no assurances regarding its outcome, or the amount of damages that may be ultimately held recoverable after post-judgment proceedings and appeal. While the Pavilion has general and professional liability insurance to cover a portion of these amounts, the resolution of this matter may have a material adverse effect on the Company. As of March 31, 2024, without reduction for any potential amounts related to the above-mentioned Pavilion matter, the Company and its subsidiaries have aggregate insurance coverage of approximately $221 million remaining under commercial policies for matters applicable to the 2020 policy year (in excess of the applicable self-insured retention amounts of $10 million per occurrence for professional liability claims and $3 million per occurrence for general liability claims). In the event the resolution of the Pavilion matter exhausts all or a significant portion of the remaining commercial insurance coverage available to the Company and its subsidiaries related to other matters that occurred in 2020, or the Pavilion matter causes the posting of a large bond or other collateral during an appeal process, our future results of operations and capital resources could be materially adversely impacted;
- 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 and related expenses resulting from a shortage of nurses, physicians and other healthcare professionals;
- demographic changes;

- there is a heightened risk of future cybersecurity threats, including ransomware attacks targeting healthcare providers. If successful, future cyberattacks could have a material adverse effect on our business. Any costs that we incur as a result of a data security incident or breach, including costs to update our security protocols to mitigate such an incident or breach could be significant. Any breach or failure in our operational security systems, or any third-party security systems that we rely on, can result in loss of data or an unauthorized disclosure of or access to sensitive or confidential member or protected personal or health information and could result in violations of applicable privacy and other laws, significant penalties or fines, litigation, loss of customers, significant damage to our reputation and business, and other liability or losses. We may also incur additional costs related to cybersecurity risk management and remediation. There can be no assurance that we or our service providers, if applicable, will not suffer losses relating to cyber-attacks or other information security breaches in the future or that our insurance coverage will be adequate to cover all the costs resulting from such events;

- the availability of suitable acquisition and divestiture opportunities and our ability to successfully integrate and improve our acquisitions since failure to achieve expected acquisition benefits from certain of our prior or future acquisitions could result in impairment charges for goodwill and purchased intangibles;

- the impact of severe weather conditions, including the effects of hurricanes and climate change;

- our business, results of operations, financial condition, or stock price may be adversely affected if we are not able to achieve our environmental, social and governance (“ESG”) goals or comply with emerging ESG regulations, or otherwise meet the expectations of our stakeholders with respect to ESG matters;

- 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 annual Medicaid revenues of approximately $100 million, or greater, from each of Texas, Nevada, California, Illinois, Pennsylvania, Kentucky, Washington, D.C., Massachusetts, Florida, Mississippi and Virginia. We also receive Medicaid disproportionate share hospital ("DSH") payments in certain states including, most significantly, Texas. 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;

- our ability to continue to obtain capital on acceptable terms, including borrowed funds, to fund the future growth of our business;

- our inpatient acute care and behavioral health care facilities may experience decreasing admission and length of stay trends;

- our financial statements reflect large amounts due from various commercial and private payers and there can be no assurance that failure of the payers to remit amounts due to us will not have a material adverse effect on our future results of operations;
- the Budget Control Act of 2011 (the "2011 Act") imposed annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Select Committee on Deficit Reduction (the "Joint Committee"), which was tasked with making recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year with a uniform percentage reduction across all Medicare programs. The Bipartisan Budget Act of 2015, enacted on November 2, 2015, continued the 2% reductions to Medicare reimbursement imposed under the 2011 Act. Recent legislation suspended payment reductions through December 31, 2021 in exchange for extended cuts through 2030. Subsequent legislation extended the payment reduction suspension through March 31, 2022, with a 1% payment reduction from then until June 30, 2022 and the full 2% payment reduction thereafter. The most recent legislation extended these reductions through 2032. 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;
- we have exposure to fluctuations in foreign currency exchange rates, primarily the pound sterling. We have international subsidiaries that operate in the United Kingdom. We routinely hedge our exposures to foreign currencies with certain financial institutions in an effort to minimize the impact of certain currency exchange rate fluctuations, but these hedges may be inadequate to protect us from currency exchange rate fluctuations. To the extent that these hedges are inadequate, our reported financial results or the way we conduct our business could be adversely affected. Furthermore, if a financial counterparty to our hedges experiences financial difficulties or is otherwise unable to honor the terms of the foreign currency hedge, we may experience material financial losses;
- the impact of a shift of care from inpatient to lower cost outpatient settings and controls designed to reduce inpatient services on our revenue, 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

There have been no significant changes to our critical accounting policies or estimates from those disclosed in our 2023 Annual Report on Form 10-K.

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

Results of Operations

Clinical Staffing, Physician Related Expenses and Effects of Inflation:

The healthcare industry is labor intensive and salaries, wages and benefits are subject to inflationary pressures, as are supplies expense and other operating expenses. In addition, the nationwide shortage of nurses and other clinical staff and support personnel experienced by healthcare providers in the past has been a significant operating issue facing us and other healthcare providers. In some areas, the labor scarcity has strained our resources and staff, which has required us to utilize higher-cost temporary labor and pay premiums above standard compensation for essential workers. In the past, the staffing shortage has, at times, required us to hire expensive temporary personnel and/or enhance wages and benefits to recruit and retain nurses and other clinical staff and support personnel. At certain facilities, particularly within our behavioral health care segment, there have been occasions when we were unable to fill all

vacant positions and, consequently, we were required to limit patient volumes. The staffing shortage has required us to enhance wages and benefits to recruit and retain nurses and other clinical staff and support personnel or required us to hire expensive temporary personnel. We have also experienced general inflationary cost increases related to medical supplies as well as certain of our other operating expenses. Many of these factors, which had a material unfavorable impact on our results of operations in prior years, moderated to a certain degree more recently.

In our acute care segment, we have experienced a significant increase in hospital-based physician related expenses, especially in the areas of emergency room care and anesthesiology. Although we have implemented various initiatives to mitigate the increased expense, to the degree possible, increases in these physician related expenses could continue to have an unfavorable material impact on our results of operations for the foreseeable future.

Although our ability to pass on increased costs associated with providing healthcare to Medicare and Medicaid patients is limited due to various federal, state and local laws which, in certain circumstances, limit our ability to increase prices, we have been requesting and negotiating increased rates from commercial insurers to defray our increased cost of providing patient care. In addition, we have implemented various productivity enhancement programs and cost reduction initiatives including, but not limited to, the following: team-based patient care initiatives designed to optimize the level of patient care services provided by our licensed nurses/clinicians; efforts to reduce utilization of, and rates paid for, premium pay labor; consolidation of medical supply vendors to increase purchasing discounts; review and reduction of clinical variation in connection with the utilization of medical supplies, and; various other efforts to increase productivity and/or reduce costs including investments in new information technology applications.

Financial results for the three-month periods ended March 31, 2024 and 2023:

The following table summarizes our results of operations and is used in the discussion below for the three-month periods ended March 31, 2024 and 2023 (dollar amounts in thousands):

	Three months ended March 31, 2024		Three months ended March 31, 2023	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 3,843,582	100.0%	$ 3,467,518	100.0%
Operating charges:				
Salaries, wages and benefits	1,842,624	47.9%	1,753,335	50.6%
Other operating expenses	1,032,170	26.9%	878,951	25.3%
Supplies expense	403,573	10.5%	379,989	11.0%
Depreciation and amortization	141,003	3.7%	141,621	4.1%
Lease and rental expense	35,450	0.9%	34,922	1.0%
Subtotal-operating expenses	3,454,820	89.9%	3,188,818	92.0%
Income from operations	388,762	10.1%	278,700	8.0%
Interest expense, net	52,826	1.4%	50,876	1.5%
Other (income) expense, net	(150)	(0.0)%	13,723	0.4%
Income before income taxes	336,086	8.7%	214,101	6.2%
Provision for income taxes	70,264	1.8%	51,726	1.5%
Net income	265,822	6.9%	162,375	4.7%
Less: Income (loss) attributable to noncontrolling interests	3,988	0.1%	(740)	(0.0)%
Net income attributable to UHS	$ 261,834	6.8%	$ 163,115	4.7%

Net revenues increased by 10.8%, or $376 million, to $3.844 billion during the three-month period ended March 31, 2024, as compared to $3.468 billion during the first quarter of

2023. The net increase was primarily attributable to: (i) a $338 million, or 10.0%, increase in net revenues generated from our acute care hospital services and behavioral health services operated during both periods (which we refer to as “Same Facility”), and; (ii) an other combined net increase of $38 million, including a $56 million increase in provider tax assessments (which increased net revenues and other operating expenses but had no impact on income before income taxes), partially offset by a $19 million decrease in net revenues generated at Desert Springs Hospital Medical Center ("Desert Springs") located in Las Vegas, Nevada, which discontinued all inpatient operations during the first quarter of 2023.

Income before income taxes (before income attributable to noncontrolling interests) increased by $122 million, or 57%, to $336 million during the three-month period ended March 31, 2024 as compared to $214 million during the first quarter of 2023. The net increase was due to:

- an increase of $72 million at our acute care facilities, as discussed below in Acute Care Hospital Services;
- an increase of $54 million at our behavioral health care facilities, as discussed below in Behavioral Health Care Services, and;
- $4 million of other combined net decreases.

Net income attributable to UHS increased by $99 million, or 61%, to $262 million during the three-month period ended March 31, 2024 as compared to $163 million during the first quarter of 2023. This increase was attributable to:

- a $122 million increase in income before income taxes, as discussed above;
- a decrease of $5 million due to an unfavorable change in income/loss attributable to noncontrolling interests, and;
- a decrease of $19 million resulting from an increase in the provision for income taxes resulting primarily from: (i) the increase in the provision for income taxes resulting from the $117 million increase in pre-tax income, partially offset by; (ii) a $9 million decrease in the provision for income taxes during the first quarter of 2024 from the impact of ASU 2016-09, Compensation-Stock Compensation: Improvements to Employee Share-Based Payment Accounting ("ASU 2016-09").

Adjustments to self-insured professional and general liability and workers' compensation liability reserves:

Professional and general liability:
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.

As a result of unfavorable trends experienced during the past several years, included in our results of operations during the first three months of 2024, was a $7 million increase to our reserves for self-insured professional and general liability claims, of which approximately $5 million is included in our same facility basis acute care hospitals services' results and approximately $2 million is included in our behavioral health services' results.

During the full year of 2023, our reserves for self-insured professional and liability claims was increased by approximately $25 million, approximately $20 million of which was recorded during the second quarter of 2023 and $5 million of which was recorded during the third quarter of 2023.

Acute Care Hospital Services

The following table sets forth certain operating statistics for our acute care hospital services for the three-month periods ended March 31, 2024 and 2023.

	Same Facility Basis		All	
	2024	2023	2024	2023
Average licensed beds	6,657	6,610	6,657	6,798
Average available beds	6,485	6,438	6,485	6,626
Patient days	415,327	397,998	415,327	404,253
Average daily census	4,564.0	4,422.2	4,564.0	4,491.7
Occupancy-licensed beds	68.6%	66.9%	68.6%	66.1%
Occupancy-available beds	70.4%	68.7%	70.4%	67.8%
Admissions	83,581	79,063	83,581	80,126
Length of stay	5.0	5.0	5.0	5.0

Acute Care Hospital Services-Same Facility Basis

We believe that providing our results on a "Same Facility" basis (which is a non-GAAP measure), which includes the operating results for facilities and businesses operated in both the current year and prior year periods, is helpful to our investors as a measure of our operating performance. Our Same Facility results also neutralize (if applicable) the effect of

items that are non-operational in nature including items such as, but not limited to, gains/losses on sales of assets and businesses, impacts of settlements, legal judgments and lawsuits, impairments of long-lived and intangible assets and other amounts that may be reflected in the current or prior year financial statements that relate to prior periods.

Our Same Facility basis results reflected on the table below also exclude from net revenues and other operating expenses, provider tax assessments incurred in each period as discussed below Sources of Revenue-Various State Medicaid Supplemental Payment Programs. However, these provider tax assessments are included in net revenues and other operating expenses as reflected in the table below under All Acute Care Hospital Services. The provider tax assessments had no impact on the income before income taxes as reflected on the tables below since the amounts offset between net revenues and other operating expenses. To obtain a complete understanding of our financial performance, the Same Facility results should be examined in connection with our net income as determined in accordance with U.S. 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, 2024 and 2023 (dollar amounts in thousands):

	Three months ended March 31, 2024		Three months ended March 31, 2023	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 2,107,434	100.0 %	$ 1,922,464	100.0 %
Operating charges:				
Salaries, wages and benefits	860,676	40.8 %	826,975	43.0 %
Other operating expenses	577,076	27.4 %	504,617	26.2 %
Supplies expense	347,095	16.5 %	325,371	16.9 %
Depreciation and amortization	90,120	4.3 %	93,007	4.8 %
Lease and rental expense	23,793	1.1 %	23,995	1.2 %
Subtotal-operating expenses	1,898,760	90.1 %	1,773,965	92.3 %
Income from operations	208,674	9.9 %	148,499	7.7 %
Interest expense, net	1,300	0.1 %	(577)	(0.0)%
Other (income) expense, net	(81)	(0.0)%	6,213	0.3 %
Income before income taxes	$ 207,455	9.8 %	$ 142,863	7.4 %

Three-month periods ended March 31, 2024 and 2023:

During the three-month period ended March 31, 2024, as compared to the comparable prior year quarter, net revenues from our acute care hospital services, on a Same Facility basis, increased by $185 million or 9.6%. Income before income taxes (and before income attributable to noncontrolling interests) increased by $65 million, or 45%, amounting to $207 million, or 9.8% of net revenues during the first quarter of 2024, as compared to $143 million, or 7.4% of net revenues during the first quarter of 2023. Included in our Same Facility basis' net revenues and income before income taxes, during the first quarter of 2024, was approximately $38 million of net reimbursements (net of related provider taxes) recorded in connection with the Nevada state directed payment program which was approved by the Centers for Medicare and Medicaid Services in December, 2023. Please see additional disclosure below in Sources of Revenue-Nevada State Directed Payment Program.

During the three-month period ended March 31, 2024, net revenue per adjusted admission increased by 4.6% while net revenue per adjusted patient day increased 5.8%, as compared to the comparable quarter of 2023. During the three-month period ended March 31, 2024, as compared to the comparable prior year quarter, inpatient admissions to our acute care hospitals increased by 5.7% while adjusted admissions (adjusted for outpatient activity) increased by 4.5%. Patient days at these facilities increased by 4.4% and adjusted patient days increased by 3.4% during the three-month period ended March 31, 2024, as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 5.0 days during each of the three-month periods ended March 31, 2024 and 2023. The occupancy rate, based on the average available beds at these facilities, was 70% and 69% during the three-month periods ended March 31, 2024 and 2023, respectively.

On a Same Facility basis during the three-month period ended March 31, 2024, as compared to the comparable quarter of 2023, salaries, wages and benefits expense increased by $34 million, or 4.1%. Although our acute care facilities experienced an increase in patient volumes during the first quarter of 2024, as compared to the comparable quarter of 2023, the related incremental staffing cost increase was offset by the following: (i) a reduction in premium pay (overtime paid to employees and external temporary resources' expense) which decreased by approximately $18 million during the first quarter of 2024, as compared to the first quarter of 2023, and; (ii) a restructuring, during the first quarter of 2024, at certain of our acute care hospitals that reduced the number of employees in positions that were not directly related to the delivery of patient care. As a percentage of net revenues, salaries, wages and benefits expense decreased to 40.8% during the first quarter of 2024 as compared to 43.0% during the first quarter of 2023.

Other operating expenses increased $72 million, or 14.4%, during the first quarter of 2024, as compared to the comparable quarter of 2023. The increase during the first quarter of 2024, as compared to the comparable quarter of 2023, was due, in part, to the following: (i)

an $18 million, or 12.7%, increase in physician-related expenses (as discussed above in Results of Operations - Clinical Staffing, Physician Related Expenses, Effects of Inflation; (ii) a $13 million, or 12.4%, increase in the operating expenses incurred by our commercial health insurer, and; (iii) the expenses related to the increase in patient volumes.

Supplies expense increased $22 million, or 6.7%, during the first quarter of 2024, as compared to the first quarter of 2023. The increase was due, in part, to the increase in patient volumes experienced during the first quarter of 2024, as compared to the comparable quarter of 2023. As a percentage of net revenues, supplies expense decreased to 16.5% during the three-month period ended March 31, 2024, as compared to 16.9% during the first quarter of 2023.

All Acute Care Hospital Services

The following table summarizes the results of operations for all our acute care operations during the three-month periods ended March 31, 2024 and 2023. These amounts include: (i) our acute care results on a Same Facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iii) certain other amounts including, if applicable, the results of recently acquired/opened facilities and businesses as well as the operating results for Desert Springs which discontinued all inpatient operations during the first quarter of 2023. Dollar amounts below are reflected in thousands.

	Three months ended March 31, 2024		Three months ended March 31, 2023	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 2,185,081	100.0 %	$ 1,973,532	100.0 %
Operating charges:				
Salaries, wages and benefits	861,547	39.4 %	843,960	42.8 %
Other operating expenses	654,983	30.0 %	544,300	27.6 %
Supplies expense	347,004	15.9 %	328,060	16.6 %
Depreciation and amortization	90,312	4.1 %	93,326	4.7 %
Lease and rental expense	23,833	1.1 %	24,154	1.2 %
Subtotal-operating expenses	1,977,679	90.5 %	1,833,800	92.9 %
Income from operations	207,402	9.5 %	139,732	7.1 %
Interest expense, net	1,300	0.1 %	(577)	(0.0)%
Other (income) expense, net	634	0.0 %	7,013	0.4 %
Income before income taxes	$ 205,468	9.4 %	$ 133,296	6.8 %

Three-month periods ended March 31, 2024 and 2023:

During the three-month period ended March 31, 2024, as compared to the comparable prior year quarter, net revenues from our acute care hospital services increased by $212 million, or 10.7%, due to: (i) the $185 million, or 9.6% increase in Same Facility revenues, as discussed above; (ii) a $47 million increase in provider tax assessments (which had no impact on income before income taxes since the amounts offset between net revenues and other operating expenses), and; (iii) $20 million of other combined net decreases consisting primarily of decreased revenues at Desert Springs.

Income before income taxes increased by $72 million, or 54%, to $205 million, or 9.4% of net revenues during the first quarter of 2024, as compared to $133 million, or 6.8% of net revenues during the first quarter of 2023. The $72 million increase in income before income taxes from our acute care hospital services resulted primarily from the $65 million Same Facility basis' increase in income before income taxes from our acute care hospital services, as discussed above, and an $8 million favorable change in the pre-tax income/loss related to Desert Springs.

During the three-month period ended March 31, 2024, as compared to the comparable quarter of 2023, salaries, wages and benefits expense increased by $18 million, or 2.1%. The increase was due primarily to the above-mentioned $34 million increase related to our acute care hospital services, on a Same Facility basis, partially offset by the decreased salaries, wages and benefits expense incurred at Desert Springs.

Other operating expenses increased $111 million, or 20.3%, during the first quarter of 2024, as compared to the comparable quarter of 2023. The increase was due primarily to the $72 million above-mentioned increase related to our acute care hospital services, on a Same Facility basis, the $47 million above-mentioned increase in provider tax assessments, partially offset by decreased operating expenses incurred at Desert Springs.

Supplies expense increased by $19 million, or 5.8%, during the first quarter of 2024, as compared to the comparable quarter of 2023. The increase was due primarily to the above-mentioned $22 million increase related to our acute care hospital services, on a Same Facility basis, partially offset by decreased supplies expense incurred at Desert Springs.

Please see above in Results of Operations - Clinical Staffing, Physician Related Expenses and Effects of Inflation for additional disclosure regarding the factors impacting our operating costs.

Charity Care and Uninsured Discounts:

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, 2024 and 2023:

Uncompensated care:

Amounts in millions	Three Months Ended			
	March 31, 2024	%	March 31, 2023	%
Charity care	$ 217	27%	$ 193	32%
Uninsured discounts	588	73%	418	68%
Total uncompensated care	$ 805	100%	$ 611	100%

Estimated cost of providing uncompensated care:

The estimated costs of providing uncompensated care as reflected below were based on a calculation which multiplied the percentage of operating expenses for our acute care hospitals to gross charges for those hospitals by the above-mentioned total uncompensated

care amounts. The percentage of cost to gross charges is calculated based on the total operating expenses for our acute care facilities divided by gross patient service revenue for those facilities.

Amounts in millions	Three Months Ended March 31, 2024	Three Months Ended March 31, 2023
Estimated cost of providing charity care	$ 19	$ 19
Estimated cost of providing uninsured discounts	52	40
Estimated cost of providing uncompensated care	$ 71	$ 59

Behavioral Health Care Services

The following table sets forth certain operating statistics for our behavioral health care services for the three-month periods ended March 31, 2024 and 2023.

	Same Facility Basis		All	
	2024	2023	2024	2023
Average licensed beds	24,124	24,106	24,378	24,232
Average available beds	24,024	24,006	24,278	24,132
Patient days	1,596,431	1,562,130	1,608,992	1,572,571
Average daily census	17,543.2	17,357.0	17,681.2	17,473.0
Occupancy-licensed beds	72.7%	72.0%	72.5%	72.1%
Occupancy-available beds	73.0%	72.3%	72.8%	72.4%
Admissions	118,897	119,615	119,930	120,560
Length of stay	13.4	13.1	13.4	13.0

Behavioral Health Care Services-Same Facility Basis

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

Our Same Facility basis results reflected on the table below also excludes from net revenues and other operating expenses, provider tax assessments incurred in each period as discussed below Sources of Revenue-Various State Medicaid Supplemental Payment Programs. However, these provider tax assessments are included in net revenues and other operating expenses as reflected in the table below under All Behavioral Health Care Services. The provider tax assessments had no impact on the income before income taxes as reflected on the tables below since the amounts offset between net revenues and other operating expenses. To obtain a complete understanding of our financial performance, the Same Facility results should be examined in connection with our net income as determined in accordance with U.S. 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, 2024 and 2023 (dollar amounts in thousands):

	Three months ended March 31, 2024		Three months ended March 31, 2023	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,616,312	100.0 %	$ 1,463,723	100.0 %
Operating charges:				
Salaries, wages and benefits	868,876	53.8 %	808,938	55.3 %
Other operating expenses	312,285	19.3 %	278,722	19.0 %
Supplies expense	56,766	3.5 %	52,485	3.6 %
Depreciation and amortization	47,108	2.9 %	45,332	3.1 %
Lease and rental expense	11,446	0.7 %	10,598	0.7 %
Subtotal-operating expenses	1,296,481	80.2 %	1,196,075	81.7 %
Income from operations	319,831	19.8 %	267,648	18.3 %
Interest expense, net	1,027	0.1 %	1,210	0.1 %
Other (income) expense, net	(676)	(0.0)%	(576)	(0.0)%
Income before income taxes	$ 319,480	19.8 %	$ 267,014	18.2 %

Three-month periods ended March 31, 2024 and 2023:

During the three-month period ended March 31, 2024, as compared to the comparable prior year quarter, net revenues from our behavioral health services, on a Same Facility basis, increased by $153 million or 10.4%. Income before income taxes increased by $52 million, or 20%, amounting to $319 million or 19.8% of net revenues during the first quarter of 2024, as compared to $267 million or 18.2% of net revenues during the first quarter of 2023.

During the three-month period ended March 31, 2024, net revenue per adjusted admission increased by 11.2% while net revenue per adjusted patient day increased by 8.2%, as compared to the comparable quarter of 2023. During the three-month period ended March 31, 2024, as compared to the comparable prior year quarter, inpatient admissions and adjusted admissions to our behavioral health care hospitals decreased by -0.6% and -0.8%, respectively. Patient days at these facilities increased by 2.2% and adjusted patient days increased by 2.0% during the three-month period ended March 31, 2024, as compared to the comparable prior year quarter. The average length of inpatient stay at these facilities was 13.4 days and 13.1 days during the three-month periods ended March 31, 2024 and 2023, respectively. The occupancy rate, based on the average available beds at these facilities, was 73% and 72% during the three-month periods ended March 31, 2024 and 2023.

On a Same Facility basis during the three-month period ended March 31, 2024, as compared to the comparable quarter of 2023, salaries, wages and benefits expense increased $60 million or 7.4%. The increase during the first quarter of 2024, as compared to the comparable quarter of 2023, was due to a 3.4% increase in salaries, wages and benefits expense per average full time equivalent employee, as well as a 3.9% increase in the average number of full-time equivalent employees. The increased staffing was due, in part, to increased patient volumes. As a percentage of net revenues during each quarter, salaries, wages and benefits expense decreased to 53.8% during the first quarter of 2024 as compared to 55.3% during the first quarter of 2023.

Other operating expenses increased $34 million, or 12.0%, during the first quarter of 2024, as compared to the comparable quarter of 2023. The increase during the first three months of 2024, as compared to the comparable period of 2023, was due, in part, to increased patient volumes as well an increase in certain expense items experienced during the first quarter of 2024. As a percentage of net revenues during each quarter, other operating expenses increased to 19.3% during the first quarter of 2024 as compared to 19.0% during the first quarter of 2023.

Supplies expense increased $4 million, or 8.2%, during the first quarter of 2024, as compared to the comparable quarter of 2023. As a percentage of net revenues during each quarter, supplies expense decreased to 3.5% during the first quarter of 2024, as compared to 3.6% during the comparable quarter of 2023.

All Behavioral Health Care Services

The following table summarizes the results of operations for all our behavioral health care services during the three-month periods ended March 31, 2024 and 2023. 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. Dollar amounts below are reflected in thousands.

	Three months ended March 31, 2024		Three months ended March 31, 2023	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues	$ 1,656,067	100.0%	$ 1,490,489	100.0%
Operating charges:				
Salaries, wages and benefits	872,196	52.7%	809,786	54.3%
Other operating expenses	347,268	21.0%	305,232	20.5%
Supplies expense	56,924	3.4%	52,488	3.5%
Depreciation and amortization	47,872	2.9%	45,619	3.1%
Lease and rental expense	11,518	0.7%	10,668	0.7%
Subtotal-operating expenses	1,335,778	80.7%	1,223,793	82.1%
Income from operations	320,289	19.3%	266,696	17.9%
Interest expense, net	1,027	0.1%	1,211	0.1%
Other (income) expense, net	(676)	(0.0)%	(871)	(0.1)%
Income before income taxes	$ 319,938	19.3%	$ 266,356	17.9%

Three-month periods ended March 31, 2024 and 2023:

During the three-month period ended March 31, 2024, as compared to the comparable prior year quarter, net revenues generated from our behavioral health services increased by $166 million, or 11.1%. The increase was primarily attributable to the above-mentioned $153 million, or 10.4%, increase in net revenues at our behavioral health facilities, on a Same Facility basis, as well as a $10 million increase in provider tax assessments (which had no impact on income before income taxes since the amounts offset between net revenues and other operating expenses).

Income before income taxes increased by $54 million, or 20%, to $320 million or 19.3% of net revenues during the first quarter of 2024, as compared to $266 million or 17.9% of net revenues during the first quarter of 2023. The increase in income before income taxes at our behavioral health facilities during the first quarter of 2024, as compared to the comparable quarter of 2023, was primarily attributable to the $52 million, or 20% increase in income before income taxes generated at our behavioral health facilities, on a Same Facility basis, as discussed above.

During the three-month period ended March 31, 2024, as compared to the comparable quarter of 2023, salaries, wages and benefits expense increased by $62 million or 7.7%. The increase was due primarily to the above-mentioned $60 million increase related to our behavioral health facilities, on a Same Facility basis.

Other operating expenses increased by $42 million, or 13.8%, during the first quarter of 2024, as compared to the comparable quarter of 2023. The increase was due primarily to the above-mentioned $34 million increase related to our behavioral health facilities, on a Same Facility basis, as well as a $10 million increase in provider tax assessments.

Supplies expense increased $4 million, or 8.5%, during the first quarter of 2024, as compared to the comparable quarter of the 2023. As a percentage of net revenues during each quarter, supplies expense decreased to 3.4% during the first quarter of 2024, as compared to 3.5% during the comparable quarter of 2023.

Please see Results of Operations - Clinical Staffing, Physician Related Expenses and Effects of Inflation above for additional disclosure regarding the factors impacting our operating costs.

Sources of Revenue

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

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

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

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

In 2010, the Patient Protection and Affordable Care Act, as amended by the Health and Education Reconciliation Act (collectively, the "Legislation") was enacted and its two primary goals were to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses. The Legislation revised 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 reductions to Medicaid DSH payments which are scheduled to begin in 2025.

A 2012 U.S. Supreme Court ruling limited the federal government's ability to expand health insurance coverage by holding unconstitutional sections of the Legislation that sought to withdraw federal funding for state noncompliance with certain Medicaid coverage requirements. Pursuant to that decision, the federal government may not penalize states that choose not to participate in the Medicaid expansion by reducing their existing Medicaid funding. Therefore, states can choose to expand or not to expand their Medicaid program without risking the loss of federal Medicaid funding. As a result, many states, including Texas, have not expanded their Medicaid programs without the threat of loss of federal funding. CMS has previously granted section 1115 demonstration waivers providing for work and community engagement requirements for certain Medicaid eligible individuals. CMS has also released guidance to states interested in receiving their Medicaid funding through a block grant mechanism. The Biden administration withdrew certain previously issued section 1115 demonstrations aligned with these policies, but Georgia has imposed work and community engagement requirements under a Medicaid demonstration program that launched July 1, 2023. If additional section 1115 demonstrations that include work and community requirements are implemented, we anticipate that they would lead to reductions in coverage and likely increases in uncompensated care in those states where these demonstration waivers are granted.

On December 14, 2018, a Texas Federal District Court deemed the Legislation to be unconstitutional in its entirety. The Court concluded that the Individual Mandate is no longer permissible under Congress's taxing power as a result of the Tax Cut and Jobs Act of 2017 ("TCJA") reducing the individual mandate's tax to $0 (i.e., it no longer produces revenue, which is an essential feature of a tax), rendering the Legislation unconstitutional. The Court also held that because the individual mandate is "essential" to the Legislation and is inseverable from the rest of the law, the entire Legislation is unconstitutional. That ruling was ultimately appealed to the United States Supreme Court, which decided in California v. Texas that the plaintiffs in the matter lacked standing to bring their constitutionality claims. The Court did not reach the plaintiffs' merits arguments, which specifically challenged the constitutionality of the Legislation's individual mandate and the

entirety of the Legislation itself. As a result, the Legislation will continue to be law, and HHS and its respective agencies will continue to enforce regulations implementing the law. However, on September 7, 2022, the Legislation faced its most recent challenge when a Texas Federal District Court judge, in the case of Braidwood Management v. Becerra, ruled that a requirement that certain health plans cover services without cost sharing violates the Appointments Clause of the U.S. Constitution and that the coverage of certain HIV prevention medication violates the Religious Freedom Restoration Act. The government has appealed the decision to the U.S. Circuit Court of Appeals for the Fifth Circuit.

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. In December, 2022, CMS proposed to change the standard for identification of an overpayment and would require the report and return of an overpayment if a provider or supplier has actual knowledge of the existence of an overpayment or acts in reckless disregard or deliberate ignorance of an overpayment. 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.

In addition to legislative changes, the Legislation can be significantly impacted by executive branch actions. President Biden has taken executive actions that will strengthen the Legislation and may reverse the policies of the prior administration. To date, the Biden administration has issued executive orders implementing a special enrollment period permitting individuals to enroll in health plans outside of the annual open enrollment period and reexamining policies that may undermine the ACA or the Medicaid program. The American Rescue Plan Act of 2021's expansion of subsidies to purchase coverage through an exchange contributed to increased exchange enrollment in 2021. The IRA's extension of the subsidies through 2025 is expected to increase exchange enrollment in future years. The recent COVID-19 pandemic and related U.S. National Emergency declaration may significantly increase the number of uninsured patients treated at our facilities extending beyond the most recent CBO published estimates due to increased unemployment and loss of group health plan health insurance coverage. It is also anticipated that these policies may create additional cost and reimbursement pressures on hospitals.

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

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

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

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

DRG and capital payment rates are adjusted annually by the predetermined geographic adjustment factor for the geographic region in which a particular hospital is located and are weighted based upon a statistically normal distribution of severity. While we generally will not receive payment from Medicare for inpatient services, other than the MS-DRG payment, a hospital may qualify for an “outlier” payment if a particular patient’s treatment costs are extraordinarily high and exceed a specified threshold. MS-DRG rates are adjusted by an update factor each federal fiscal year, which begins on October 1. The index used to adjust the MS-DRG rates, known as the “hospital market basket index,” gives consideration to the inflation experienced by hospitals in purchasing goods and services. Generally, however, the percentage increases in the MS-DRG payments have been lower than the projected increase in the cost of goods and services purchased by hospitals.

In April, 2024, CMS published its IPPS 2025 proposed payment rule which provides for a 2.6 % market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments, and adjustments mandated by the Legislation are considered, without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 1.9%. Including DSH payments, an increase to the Medicare Outlier threshold and certain other adjustments, we estimate our overall increase from the proposed IPPS 2025 rule (covering the period of October 1, 2024 through September 30, 2025) will approximate 2.3%.

In August, 2023, CMS published its IPPS 2024 final payment rule which provides for a 3.1% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates

(including a change in the Medicare Rural Floor calculation), documenting and coding adjustments, and adjustments mandated by the Legislation are considered, without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 6.6%. Including DSH payments, an increase to the Medicare Outlier threshold and certain other adjustments, we estimate our overall increase from the final IPPS 2024 rule (covering the period of October 1, 2023 through September 30, 2024) will approximate 5.4%.

In August, 2022, CMS published its IPPS 2023 final payment rule which provides for a 4.1% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments, and adjustments mandated by the Legislation are considered, without consideration for the required Medicare DSH payments changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 4.6.%. Including DSH payments, an increase to the Medicare Outlier threshold and certain other adjustments, we estimate our overall increase from the final IPPS 2023 rule (covering the period of October 1, 2022 through September 30, 2023) will approximate 4.4%. This projected impact from the IPPS 2023 final rule includes an increase of approximately 0.5% to partially restore cuts made as a result of the American Taxpayer Relief Act of 2012 (“ATRA”), as required by the 21st Century Cures Act, but excludes the impact of the sequestration reductions related to the 2011 Act, Bipartisan Budget Act of 2015, and Bipartisan Budget Act of 2018.

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

The 2011 Act included the imposition of annual spending limits for most federal agencies and programs aimed at reducing budget deficits by $917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Committee, which was responsible for developing recommendations aimed at reducing future federal budget deficits by an additional $1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year. Subsequent legislation has extended this sequestration through 2032. The CARES Act, as amended, temporarily suspended or limited the application of this sequestration from May 1, 2020 through June 30, 2022, with a return to the full 2% Medicare payment reduction thereafter.

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 March, 2024, CMS published its Psych PPS proposed rule for the federal fiscal year 2025. Under this proposed rule, payments to our behavioral health care hospitals and units from the market basket update are estimated to increase by 2.7% compared to federal fiscal year 2024. This amount includes the effect of the 3.1% net market basket update which reflects the offset of a 0.4% productivity adjustment. When all of the proposed patient level adjustments described below as well as proposed wage index values are considered, the Company projects Psych PPS payments to increase by 2.1% in FFY 2025.

In addition to the market basket update noted above, CMS is proposing to:

- Make revisions to the methodology for determining the payment rates under the IPF PPS for psychiatric hospitals and psychiatric units based on a review of the data and information collected in prior years in accordance with section 1886(s)(5)(A) of the Social Security Act, as added by the CAA of 2023. CMS is proposing revisions to the IPF patient-level adjustment factors. The patient-level adjustments include Medicare Severity Diagnosis Related Groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and the variable per diem adjustments, and;

- Implement these revisions in a budget-neutral manner (that is, estimated payments to IPFs for FFY 2025 would be the same with or without the proposed revisions).

This proposed rule also includes two requests for information on future revisions to the IPF PPS facility-level adjustment factors and development of the new standardized IPF Patient Assessment Instrument (IPF-PAI), required by the CAA of 2023, which IPFs participating in the IPF Quality Reporting (IPFQR) Program will be required to report for Rate Year 2028.

In July, 2023, CMS published its Psych PPS final rule for the federal fiscal year 2024. Under this final rule, payments to our behavioral health care hospitals and units are estimated to increase by 3.3% compared to federal fiscal year 2023. This amount includes the effect of the 3.5% net market basket update which reflects the offset of a 0.2% productivity adjustment.

In July, 2022, CMS published its Psych PPS final rule for the federal fiscal year 2023. Under this final rule, payments to our behavioral health care hospitals and units are estimated to increase by 3.8% compared to federal fiscal year 2022. This amount includes the effect of the 4.1% net market basket update which reflects the offset of a 0.3% productivity adjustment.

On November 2, 2023, in light of the Supreme Court's decision in American Hospital Association v. Becerra (142 S. Ct. 1896 (2022)) and the district court's remand to the agency, CMS issued a final rule outlining the remedy for the 340B-acquired drug payment policy for calendar years 2018-2022. CMS published the final rule to remedy the payment rates the Court held were invalid aspects of their past policy and will affect nearly all hospitals paid under the OPPS. As part of the final remedy, CMS will make an adjustment to the update factor to maintain budget neutrality as required by statute. CMS finalized the 340B policy for calendar year 2018 in 2017 in a budget neutral manner that included increasing payments for non-drug items and services; this payment increase was in effect from calendar years 2018 through 2022. CMS estimates that hospitals were paid $7.8 billion more for non-drug items and services during this time period than they would have been paid in the absence of the 340B payment policy. Because CMS is now making additional payments to affected 340B covered entity hospitals to pay them what they would have been paid had the 340B policy never been implemented, CMS will make a corresponding offset to maintain budget neutrality as if the 340B payment policy had never been in effect. To carry out this required $7.8 billion budget neutrality adjustment, CMS will reduce future non-drug item and service payments by adjusting the OPPS conversion factor by minus 0.5% starting in calendar year 2026 and continuing for 16 years. The impact of this 0.5% reduction on our 2026 results of operations is approximately $4 million.

In November, 2023, CMS issued its OPPS final rule for 2024. The hospital market basket increase is 3.3% and the productivity adjustment reduction is 0.2% for a net market basket increase of 3.1%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2024 will aggregate to a net increase of 9.7%. This percentage reflects the impact resulting from rural floor changes to the Medicare wage index adjustment factor where certain states, such as California and Nevada, will materially benefit from this change.

In November, 2022, CMS issued its OPPS final rule for 2023. The hospital market basket increase is 4.1% and the productivity adjustment reduction is -0.3% for a net market basket increase of 3.8%. The final rule provides that in light of the Supreme Court decision in American Hospital Association v. Becerra, CMS is applying the default rate, generally average sales price plus 6%, to 340B acquired drugs and biologicals for 2023. CMS stated they will address the remedy for 340B drug payments from 2018-2022 in future rulemaking prior to the CY 2024 OPPS/ASC proposed rule. During the 2018-2022 time period, we recorded an aggregate of approximately $45 million to $50 million of Medicare revenues related to the prior 340B payment policy. When other statutorily required adjustments and hospital patient service mix are considered as well as impact of the aforementioned 340B Program policy change, we estimate that our overall Medicare OPPS update for 2023 will aggregate to a net increase of 0.9% which includes a 0.3% increase to behavioral health division partial hospitalization rates.

On November 2, 2021, CMS issued its OPPS final rule for 2022. The hospital market basket increase is 2.7% and the productivity adjustment reduction is -0.7% for a net market basket increase of 2.0%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2022 will aggregate to a net increase of 2.4% which includes a 3.0% increase to behavioral health division partial hospitalization rates.

In November, 2019, CMS finalized its Hospital Price Transparency rule that implements certain requirements under the June 24, 2019 Presidential Executive Order related to Improving Price and Quality Transparency in American Healthcare to Put Patients First. Under this final rule, effective January 1, 2021, CMS will require: (1) hospitals make public their standard changes (both gross charges and payer-specific negotiated charges) for all items and services online in a machine-readable format, and; (2) hospitals to make public standard charge data for a limited set of “shoppable services” the hospital provides in a form and manner that is more consumer friendly. On November 2, 2021, CMS released a final rule increasing the monetary penalty that CMS can impose on hospitals that fail to comply with the price transparency requirements. We believe that our hospitals are in full compliance with the applicable federal regulations. In July, 2023, CMS proposed multiple provisions, effective as of January 1, 2024, focused on increasing hospital price transparency and compliance enforcement including but not limited to: (1) standard charges data would be posted online using a CMS template, instead of using the hospital’s own form/format; (2) all standard charge information would be encoded with a specified set of data elements (e.g., hospital name; license number; payer/plan name; description of service; billing codes, among others); (3) other technical changes related to increasing consumers’ automated accessibility to hospital standard charges, and; (4) certifications regarding accuracy of standard charge data and related compliance warning notices from CMS and requiring accessibility to health system leadership regarding transparency noncompliance.

In July, 2023, the Departments of Labor, Health and Human Services and the Treasury announced proposed rules that would:

- Mandate that insurers analyze the outcomes of their coverage to ensure there's equivalent access to mental health care, including provider networks, prior authorization rates and payment for out-of-network providers, and take action to get in compliance;
- Establish when health plans can't use prior authorization or other tactics to make it more difficult to access mental health and substance use treatment;
- Require additional insurers to comply with the 2008 Mental Health Parity and Addiction Equity Act.

While these proposed rules, if adopted, would likely improve patient access to inpatient and outpatient mental health services, we are unable to estimate the related potential impact on our results of operations.

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

We receive revenues from various state and county-based programs, including Medicaid in all the states in which we operate. We receive annual Medicaid revenues of approximately $100 million, or greater, from each of Texas, Nevada, California, Illinois, Pennsylvania, Kentucky, Washington, D.C., Massachusetts, Florida, Mississippi and Virginia. We also receive Medicaid disproportionate share hospital payments in certain states including, most significantly, Texas. We are therefore particularly sensitive to potential reductions in Medicaid and other state-based revenue programs as well as regulatory, economic, environmental and competitive changes in those states. We can provide no assurance that reductions to revenues earned pursuant to these programs, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations.

The Legislation substantially increases the federally and state-funded Medicaid insurance program, and authorizes states to establish federally subsidized non-Medicaid health plans for low-income residents not eligible for Medicaid starting in 2014. However, the Supreme Court has struck down portions of the Legislation requiring states to expand their Medicaid programs in exchange for increased federal funding. Accordingly, many states in which we operate have not expanded Medicaid coverage to individuals at 133% of the federal poverty level. Facilities in states not opting to expand Medicaid coverage under the Legislation may be additionally penalized by corresponding reductions to Medicaid disproportionate share hospital payments beginning in fiscal year 2024, 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.

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

demonstration and it has not been implemented in any states. Accordingly, we are unable to predict whether the HAO demonstration will impact our future results of operations.

Summary of Various State Medicaid Supplemental Payment Programs:

The following table summarizes the revenues, taxes imposed by states in the form of a licensing fee, assessment or other mandatory payment ("Provider Taxes") and net benefit related to each of the below-mentioned Medicaid supplemental programs for three-month periods ended March 31, 2024 and 2023. 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	
	Projected Full Year 2024	March 31, 2024	March 31, 2023
Texas Supplemental Payment Programs:			
Revenues	$ 296	$ 63	$ 41
Provider Taxes	(118)	(26)	(15)
Net benefit	$ 178	$ 37	$ 26
Nevada SDP:			
Revenues	$ 265	$ 66	$ 0
Provider Taxes	(107)	(27)	0
Net benefit	$ 158	$ 39	$ 0
Various Other State Programs:			
Revenues	$ 735	$ 173	$ 121
Provider Taxes	(262)	(59)	(42)
Net benefit	$ 473	$ 114	$ 79
Subtotal-Provider Tax Programs:			
Revenues	$ 1,296	$ 302	$ 162
Provider Taxes	(487)	(112)	(57)
Aggregate net benefit from Provider Tax Programs	$ 809	$ 190	$ 105
Texas, Nevada and South Carolina DSH/SPA Programs:			
Revenues	$ 51	$ 12	$ 19
Provider Taxes	0	0	0
Net benefit	$ 51	$ 12	$ 19
Total Supplemental Medicaid Programs:			
Revenues	$ 1,347	$ 314	$ 181
Provider Taxes	(487)	(112)	(57)
Aggregate net benefit from all Supplemental Programs	$ 860	$ 202	$ 124

Texas Supplemental Payment Programs:

Certain of our acute care hospitals located in various counties of Texas participate in Medicaid supplemental payment Section 1115 Waiver indigent care programs. The 1115 Waiver has been approved by CMS through September 30, 2030. 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.

CHIRP (including QIF)

On August 1, 2022, CMS approved the Comprehensive Hospital Increase Reimbursement Program ("CHIRP"), with a pool of $5.2 billion, for the rate period effective September 1, 2022 to August 31, 2023. On July 31, 2023, CMS approved the CHIRP program, with a pool of $6.5 billion, for the rate period of September 1, 2023 to August 31, 2024.

On January 26, 2024, THHSC issued a final rule that will modify the CHIRP payments beginning with the State Fiscal Year (SFY) 2025 rate period to promote the advancement of the quality goals and strategies the program is designed to advance.

The final modifications include:

- Creation of a new a pay-for-performance incentive payment through a third component in CHIRP, the Alternate Participating Hospital Reimbursement for Improving Quality Award ("APHRIQA"). For state fiscal years beginning with

SFY 2025, THHSC does not anticipate that behavioral health hospitals or rural hospitals will be included in a pay-for-performance program.

- The funds for payment of the APHRIQA component will be transitioned from the existing uniform rate increase components of the UHRIP and the Average Commercial Incentive Award and will be paid using a scorecard that directs managed care organizations to pay providers for performance achievements on quality outcome measures. Payments will be distributed under APHRIQA on a monthly, quarterly, semi-annual, or annual basis that aligns with the measurement period determined for quality metrics reporting.

We cannot determine the impact of this final rule. However, CHIRP payment levels could be reduced materially if: (1) the pool size of the new APHRIQA component is materially less than THHSC carve-out of the current CHIRP pool, or; (2) if our hospitals are not able meet the required APHRIQA pay-for-performance metrics.

Certain of our acute care hospitals located in Texas recorded an aggregate of $33 million in Quality Incentive Fund (“QIF”) revenues during 2023 with no QIF revenue recorded in the three-month period ending March 31, 2024 and 2023. The amounts recorded during 2023 were applicable to the period of September 1, 2021 to August 31, 2022. This revenue was earned pursuant to contract terms with various Medicaid managed care plans which requires the annual payout of QIF funds when a managed care service delivery area’s actual claims-based CHIRP payments are less than targeted CHIRP payments for a specific rate year. We also anticipate these hospitals may be entitled to a comparable amount of aggregate QIF revenue during the third and fourth quarters of 2024.

UC

Included in these provider pax programs are reimbursements received in connection with the Texas Uncompensated Care program ("UC"). The size and distribution of the UC pool are determined based on charity care costs reported to THHSC in accordance with Medicare cost report Worksheet S-10 principles.

HARP

On September 24, 2021, THHSC finalized New Fee-for-Service Supplemental Payment Program: Hospital Augmented Reimbursement Program (“HARP”) to be effective October 1, 2021. The HARP program continues the financial transition for providers who have historically participated in the Delivery System Reform Incentive Payment program described below. The program, which was approved by CMS on August 15, 2023, will provide additional funding to hospitals to help offset the cost hospitals incur while providing Medicaid services. Included in our results of operations during 2023 was approximately $20 million, approximately $13 million of which is applicable to the period of October 1, 2021 through September 30, 2022. Included in our financial results was approximately $7 million recorded during the three-month period ended March 31, 2024, in connection with HARP (there was no impact from HARP during the first quarter of 2023). During 2024, we expect to record net reimbursement from HARP of approximately $28 million. HARP is technically a Medicaid Upper Payment Limit as payment under this program is based on a reasonable estimate of the amount that would be paid for the services under Medicare payment principles but is referred to as HARP by THHSC.

Nevada State Directed Payment Program ("SDP"):

As previously reported, in February, 2023, the Nevada Division of Health Care Financing and Policy (“DHCFP”) outlined a new provider fee on private hospitals located in Nevada that would effectively capture new Medicaid federal share for certain categories of services eligible for the new payment program. In late December, 2023, the Centers for Medicare and Medicaid Services (“CMS”) approved the Medicaid managed care component of the

Nevada SDP program, with an effective date of January 1, 2024. Based upon financial data provided by the DHCFP for our facilities located in Nevada, we estimate that our aggregate net reimbursements pursuant to the Medicaid managed care component of the Nevada SDP program (net of related provider taxes) will approximate $140 million during the year ended December 31, 2024. Payments made pursuant to this component of the Nevada SDP program, which requires annual approval by CMS, are subject to reconciliation by DHCFP based on actual Medicaid managed care utilization during 2024. There can be no assurance that the Medicaid managed care component of the Nevada SDP will continue for any period after December 31, 2024, or that it will not be modified.

In connection with the Nevada SDP, included in our financial results was approximately $40 million recorded during the three-month period ended March 31, 2024 (there was no impact on our financial results from the Nevada SDP during the first quarter of 2023). Including the impact of the Medicaid fee for service upper payment limit component of the Nevada SDP program (estimated net reimbursements of $18 million attributable to our Nevada facilities during the year ended December 31, 2024), which was approved by CMS in November and December of 2023, we estimate that our aggregate net reimbursements pursuant to both components of the Nevada SDP program (net of related provider taxes) will approximate $158 million during the year ended December 31, 2024.

Various Other State Programs:

We receive substantial reimbursement from multiple states in connection with various supplemental Medicaid payment programs. The states include, but are not limited to, the state programs listed below from which we receive significant reimbursements.

Kentucky Hospital Rate Increase Program (“HRIP”):

In early 2021, CMS approved the Kentucky Medicaid Managed Care Hospital Rate Increase Program (“HRIP”). Included in our financial results during the three-month periods ended March 31, 2024 and 2023, was approximately $21 million and $19 million, respectively, recorded in connection with the Kentucky HRIP. Programs such as HRIP require an annual state submission and approval by CMS. In January, 2024, CMS approved the program for the period of January 1, 2024 through December 31, 2024 at rates comparable to the prior year. We estimate that our net reimbursements pursuant to HRIP will approximate $76 million during the year ended December 31, 2024.

California SPA:

In California, the state continues to operate Medicaid supplemental payment programs consisting of three components: Fee For Service Payment, Managed Care-Pass-Through Payment and Managed Care-Directed Payment. The non-federal share for these programs are financed by a statewide provider tax. The Directed Payment method will be based on actual concurrent hospital Medicaid managed care in-network patient volume whereas the other programs are based on prior year Medicaid utilization. The CMS program approval status is outlined in the table below.

California Hospital Fee Program CMS Approval Status:

Hospital Fee Program Component	**CMS Methodology Approval Status**	**CMS Rate Setting Approval Status**
Fee For Service Payment	Approved through December 31, 2024	Approved through December 31, 2024; Paid through March 31, 2023
Managed Care-Pass-Through Payment	Approved through December 31, 2024	Approved through December 31, 2022 and paid through December 31, 2022
Managed Care-Directed Payment	Approved through December 31, 2024	Approved through December 31, 2022 and paid through June 30, 2022

Included in our financial results during the three-month periods ended March 31, 2024 and 2023, was approximately $13 million and $10 million, respectively, recorded in connection with this program. We estimate that our net reimbursements pursuant to this program will approximate $51 million during the year ended December 31, 2024.

On April 25, 2024, the Office of Health Care Affordability (“OHCA”) board approved a five-year statewide health care spending growth target for 2025 through 2029 as follows 3.5%, 3.5%, 3.2%, 3.2% and 3.0%. The FY 2025 target is non-enforceable. The Company is not able to predict the financial impact from this spending target on its hospitals operating in California.

Mississippi Hospital Access Program

In September, 2023, subject to CMS approval, Mississippi announced a $689 million, two-part Medicaid payment proposal, effective retroactively to July 1, 2023, that would be funded by annual hospital assessments to the state's Medicaid program. These hospital assessments are calculated using a formula provided under state law. The first part of the proposal, known as the Mississippi Hospital Access Program (“MHAP”), would provide direct payments for hospitals that serve patients in the state's Medicaid managed care delivery system. Hospitals would be reimbursed near the average commercial rate, which is

the upper limit for Medicaid managed care reimbursements. The second part of the proposal would supplement Medicaid payment rates for hospitals providing inpatient and outpatient services up to Medicaid's regulated upper payment limit. In December, 2023, CMS approved the MHAP program component.

Included in our financial results during the three-month periods ended March 31, 2024 and 2023, was approximately $11 million and $3 million, respectively, recorded in connection with this new program and the prior program. We estimate that our net reimbursements pursuant to these supplemental payment programs will approximate $45 million during the year ended December 31, 2024.

Florida Medicaid Managed Care Directed Payment Program (“DPP”):

The Florida DPP provides for an additional payment for Medicaid managed care contracted services. In connection with this program, included in our financial results was approximately $43 million during 2023 and $36 million during 2022 (recorded during the fourth

quarter of each year). We estimate that our net reimbursements pursuant to this DPP will approximate $41 million during the year ended December 31, 2024 (to be recorded during the fourth quarter of 2024).

Illinois Medicaid Supplemental Payment Programs

The Illinois Medicaid Supplemental Payment Programs are comprised of three components: (1) Medicaid managed care directed payment program; (2) Medicaid managed care pass-through program, and; (3) Medicaid fee for service supplemental payment program. These programs require various related legislative and regulatory approvals each year.

Included in our financial results during the three-month periods ended March 31, 2024 and 2023, was approximately $10 million and $8 million, respectively, recorded in connection with these programs. We estimate that our net reimbursements pursuant to these supplemental payment programs will approximate $38 million during the year ended December 31, 2024.

Indiana Medicaid Managed Care DPP

The Indiana DPP provides for an additional payment for Medicaid managed care contracted services. Included in our financial results during the three-month periods ended March 31, 2024 and 2023, was approximately $8 million and $9 million, respectively, recorded in connection with this program. We estimate that our net reimbursements pursuant to this program will approximate $33 million during the year ended December 31, 2024.

Oklahoma (Transition to Managed Care and Implementation of a Medicaid Managed Care DPP)

The current Oklahoma Medicaid supplemental payment program in effect, prior to the planned implementation of the new DPP in 2024, is the Supplemental Hospital Offset Payment Program (“SHOPP”). The SHOPP component will remain in place for certain categories of Medicaid patients that will continue to be enrolled in the traditional Medicaid Fee for Service program.

In May, 2022, Oklahoma enacted legislation that directs the Oklahoma Health Care Authority ("OHCA") to: (i) transition its Medicaid program from a fee for service payment model to a managed care payment model by no later than October 1, 2023, and: (ii) concurrently implement a Medicaid managed care DPP using a managed care gap of 90% of average commercial rates. In December, 2022, the OHCA delayed the implementation date of the Medicaid managed care change and related DPP until April 1, 2024. In September, 2023, CMS approved the DPP program effective as of April 1, 2024.

Included in our financial results during the three-month periods ended March 31, 2024 and 2023, was approximately $3 million and $2 million, respectively, recorded in connection with this program. We estimate that our net reimbursements pursuant to these two supplemental payment programs (i.e. SHOPP and DPP) will approximate $22 million during the year ended December 31, 2024.

South Carolina Health Access, Workforce and Quality (“HAWQ”) Program

In September 2023, CMS approved the South Carolina HAWQ Program retroactive to July 1, 2023. This program is Medicaid managed care directed payment program that provides for a rate enhancement to Medicaid managed care encounters. Included in our financial results was approximately $5 million during the three-month period ended March 31, 2024, recorded in connection with this new program and the prior program (there was no impact during the three-month period ending March 31, 2023). We estimate that our net reimbursements pursuant to these supplemental payment programs will approximate $21 million during the year ended December 31, 2024.

Michigan Directed Payment Program (“DPP”)

In March 2024, CMS approved the Michigan Medicaid DPP retroactive to October 1, 2023 based on Average Commercial Rates (“ACR”). The Michigan DPP provides for an additional payment for Medicaid managed care contracted services. Included in our financial results

during the three-month periods ended March 31, 2024 and 2023, was approximately $7 million (including $3 million related to the fourth quarter of 2023) and $4 million, respectively, recorded in connection with this program and prior program. We estimate that our net reimbursements pursuant to this program will approximate $30 million during the year ended December 31, 2024.

Idaho Upper Payment Limit (“UPL”)

In April 2024, the Idaho Department of Health and Welfare (“IDHW”) released its updated Medicaid UPL calculation for SFY 2024 (July 1, 2023 to June 30, 2024) and revised its SFY 2023 (July 1, 2022 to June 30, 2023) UPL calculation. Included in our financial results during the three-month periods ended March 31, 2024 and 2023, was approximately $3 million and $11 million, respectively, recorded in connection with this program. As a result of the state agency UPL recalculation, we estimate that our net reimbursements pursuant to this program will approximate $29 million during the year ended December 31, 2024, including $17 million we expect to record during the three-month period ending June 30, 2024 (including $9 million related to prior years). Subject to CMS approval, the IDHW plans to continue this UPL program through SFY 2025 (July 1, 2024 to June 30, 2025) at payment levels comparable to SFY 2024. In SFY 2026, the IDHW intends to replace the UPL program with a Medicaid managed care state directed payment program. We are unable to predict whether payments levels under the planned new state directed payment program will be comparable to the SFY 2024 UPL payment levels.

Tennessee Directed Payment Program (“DPP”)

On April 29, 2024 the Tennessee legislature transmitted a Bill (SB1740) to the Governor that imposes on covered hospitals an annual coverage assessment for fiscal year 2024-2025, such that the total assessment on all covered hospitals in the aggregate will be equal to 6% of the federally recognized annual coverage assessment base. If signed into law by the Governor, the assessment proceeds will be used to fund an increase to the state’s SFY 2025 (July 1, 2024 to June 30, 2025) DPP payment pool to be based on average commercial rates (“ACR”). The state agency (TennCare) intends to submit the required preprint to CMS in May, 2024. If enacted into law and approved by CMS, the DPP payment increase will be retroactive to July 1, 2024. Although we are unable to predict whether the new DPP program will be signed into law by the Governor or approved by CMS, or the timing of such approval should it occur, TennCare's financial models indicate that our annual SDP reimbursements could range from $40 million to $56 million.

Texas, Nevada and South Carolina DSH/Other Programs:

Texas DSH:

Upon meeting certain conditions and serving a disproportionately high share of Texas’ low income patients, our qualifying facilities located in Texas receive additional reimbursement from the state’s DSH fund. The Texas DSH program was renewed for the state’s 2024 DSH fiscal year (covering the period of October 1, 2023 through September 30, 2024).

Included in our financial results during the three-month periods ended March 31, 2024 and 2023, was approximately $8 million and $10 million, respectively, recorded in connection with this program. We estimate that our aggregate net reimbursements earned pursuant to the Texas DSH program will approximate $34 million during 2024.

The Legislation and subsequent federal legislation provides for a significant reduction in Medicaid disproportionate share payments beginning in federal fiscal year 2024 (see above in Sources of Revenues and Health Care Reform-Medicaid for additional disclosure related to the delay of these DSH reductions). HHS is to determine the amount of Medicaid DSH payment cuts imposed on each state based on a defined methodology. As Medicaid DSH payments to states will be cut, consequently, payments to Medicaid-participating providers, including our hospitals in Texas, will be reduced in the coming years. Based on the CMS final rule published in September, 2019, beginning in fiscal year 2024 (as amended by the CARES Act and the CAA), annual Medicaid DSH payments in Texas could be reduced by approximately 41% from current DSH payment levels. A series of federal continuing resolutions ("CR") were passed by the federal government which provided for ongoing federal funding.

We continue to maintain reserves in the financial statements for cumulative Medicaid DSH and UC reimbursements related to our behavioral health hospitals located in Texas that amounted to $29 million as of March 31, 2024 and $31 million as of December 31, 2023 related to certain DSH and UC adverse federal court decisions including the Children’s Hospital Association of Texas v. Azar (“CHAT”).

Nevada State Plan Amendment ("SPA")

CMS initially approved an SPA in Nevada in August, 2014 and this SPA has been approved for additional state fiscal years, including the 2023 fiscal year covering the period of July 1, 2022 through June 30, 2023. CMS approval for the 2024 fiscal year, which is still pending, is expected to occur.

Included in our financial results during the three-month periods ended March 31, 2024 and 2023, was approximately $4 million and $7 million, respectively, recorded in connection with this program. We estimate that our net reimbursements pursuant to this program will approximate $17 million during 2024.

South Carolina DSH:

One of our facilities located in South Carolina received additional reimbursement from the state's DSH fund. However, the South Carolina HAWQ Program, as described above, ended our DSH payment eligibility in the South Carolina DSH program during 2023. There were no South Carolina DSH revenues recorded during the three-month period ending March 31, 2024. In connection with this DSH program, included in our financial results during the three-month periods ended March 2023 was approximately $2 million.

Future changes to these terms and conditions could materially reduce our net benefit derived from the programs which could have a material adverse impact on our future consolidated results of operations. In addition, Provider Taxes are governed by both federal and state laws and are subject to future legislative changes that, if reduced from current rates in several states, could have a material adverse impact on our future consolidated results of operations. As described below in 2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation, a 6.2% increase to the Medicaid Federal Matching Assistance Percentage ("FMAP") was included in the Families First Coronavirus Response Act. The CAA of 2023 provided for the transitional reduction of the 6.2% enhanced FMAP during 2023 to 5.0% during the second quarter, 2.5% during the third quarter and 1.5% during the fourth quarter of 2023. The impact of the enhanced FMAP Medicaid supplemental and DSH payments are reflected in our financial results for the three-month periods ended March 31, 2024 and 2023.

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. 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 cause our estimates to differ by material amounts which could have a material adverse effect on our future results of operations.

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

We receive Medicaid SDP payments from MCOs authorized by CMS under 42 CFR §438.6 (c). Consistent with capitated rates paid by Medicaid state agencies to MCO's for managing Medicaid beneficiary lives under a risk-based arrangement, SDP program related capitated rates must also be developed by the state in accordance with actuarial soundness standards noted at 42 CFR §438.4 and non-compliance could result in a reduction to SDP payment levels.

We incur 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 that are used by respective states to finance the non-federal share of SDP's (or other Medicaid supplemental payment programs). 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 supplemental payment programs. States are subject to CMS both concurrent and retrospective review for their compliance with the applicable Provider Tax regulations and related federal statute. If CMS determines Provider Taxes used by a state Medicaid program to finance the non-federal share of a SDP (or other Medicaid supplemental payment programs) are not in compliance with the applicable Provider Tax regulations and related federal statute, Company SDP payments (and other Medicaid supplemental payments) could be subject to recoupment by the respective state agency when non-compliance is determined by CMS to exist.

We believe that the SDP (and other state supplemental payment) programs are designed by each state to be in full compliance with the applicable federal regulations and federal statutes. However, we are unable to provide assurance CMS will determine on a retroactive basis that a state's SDP (or other Medicaid supplemental payment program) design and Medicaid financing structures is in full compliance with the applicable federal regulations and federal statute(s).

On April 22, 2024, CMS issued Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule ("Managed Care Rule"). CMS intends for the Managed Care Rule to:

- Strengthen standard for timely access to care and states' monitoring and enforcement efforts;
- Enhance quality and fiscal and program integrity standards for state directed payments ("SDPs");

- Specify the scope of in lieu of services and settings (“ILOSs”) to better address health-related social needs (HRSNs);
- Further specify medical loss ratio (“MLR”) requirements, and;
- Establish a quality rating system (“QRS”) for Medicaid and CHIP managed care plans.

The SDP provisions included in the Managed Care Rule include but are not limited to:

- Requires that provider payment levels for state directed payments for inpatient and outpatient hospital services, nursing facility services, and the professional services at an academic medical center not exceed the average commercial rate.
- Prohibits the use of post-payment reconciliation processes for state directed payments that are based on fee schedules.
- Makes explicit in regulation the existing requirement that state directed payments must comply with all federal laws concerning funding sources of the non-federal share.
- Requires that states ensure each provider receiving a state directed payment attest that it does not participate in any arrangement that holds taxpayers harmless for the cost of a tax. CMS concurrently released an informational bulletin regarding CMS’ exercise of enforcement discretion until calendar year 2028 for existing health-care related tax programs with certain hold-harmless arrangements involving the redistribution of Medicaid payments.

As disclosed herein, we receive a significant amount of Medicaid and Medicaid managed care revenue from both base payments and supplemental payments. Although we are unable to estimate the impact of the Managed Care Rule on our future results of operations,

if implemented as proposed, Managed Care Rule related changes could have a material adverse impact on our future results of operations.

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

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

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

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

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

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

Surprise Billing Interim Final Rule: On September 30, 2021, the Department of Labor, and the Department of the Treasury, along with the Office of Personnel Management ("OPM"), released an interim final rule with comment period, entitled "Requirements Related to Surprise Billing; Part II." This rule is related to Title I (the "No Surprises Act") of

Division BB of the Consolidated Appropriations Act, 2021, and establishes new protections from surprise billing and excessive cost sharing for consumers receiving health care items/services. It implements additional protections against surprise medical bills under the No Surprises Act, including provisions related to the independent dispute resolution process, good faith estimates for uninsured (or self-pay) individuals, the patient-provider dispute resolution process, and expanded rights to external review. On February 28, 2022, a district judge in the Eastern District of Texas invalidated portions of the rule governing aspects of the Independent Dispute Resolution ("IDR") process. In light of this decision, the government issued a final rule on August 19, 2022 eliminating the rebuttable presumption in favor of the qualifying payment amount ("QPA") by the IDR entity and providing additional factors the IDR entity should consider when choosing between two competing offers. CMS regulations and guidance implementing the IDR process has been subject to a significant amount of provider-initiated litigation. As a result, portions of those regulations and guidance materials have been vacated by a federal district court, causing CMS to, on several occasions, pause and resume IDR process operations, causing significant delay in the processing of claims. On October 27, 2023, HHS, the Department of Labor, the Department of the Treasury, and OPM issued a proposed rule intended to improve the functioning of the federal IDR process. Additionally, arguments made by the plaintiffs in such litigation have included allegations that CMS's regulations and guidance materials are favorable to payers. We cannot predict the impact of the proposed rule on our operations at this time.

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

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

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

Medicaid Federal DSH Allotment:

Although the implementation has been delayed several times, the Legislation (as amended by subsequent federal legislation) requires annual aggregate reductions in federal Medicaid DSH allotment from FFY 2025 through FFY 2027. Commencing in federal fiscal year 2025, and continuing through 2027, DSH payments are scheduled to be reduced by $8 billion annually. H.R. 2872, enacted into law on January 17, 2024 delayed the aforementioned Medicaid Disproportionate Share Hospital cuts through March 8, 2024. The Consolidated Appropriations Act, 2024 was enacted into law on March 9, 2024 and delayed the $8 billion ACA DSH Cuts for FFY 2024. The $8 billion DSH reduction is now scheduled to be implemented January 1, 2025 through September 30, 2025, in effect offsetting the FFY 2025 $8 billion reduction over nine months rather than twelve months if not delayed further by Congressional action.

Value-Based Purchasing:

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

The Legislation required HHS to implement a value-based purchasing program for inpatient hospital services which became effective on October 1, 2012. The Legislation requires HHS to reduce inpatient hospital payments for all discharges by 2% in FFY 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions. As part of the FFY 2022 IPPS final rule and FFY 2023 final rule, as discussed above, and as a result of the COVID-19 pandemic, CMS has implemented a budget neutral payment policy to fully offset the 2% VBP withhold during each of FFY 2022 and FFY 2023. In FFY 2024, as part of the FFY 2024 IPPS final rule, CMS removed the budget neutral policy that was in place in FFY 2022 and FFY 2023.

Hospital Acquired Conditions:

The Legislation prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat hospital acquired conditions (“HAC”). Beginning in FFY 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. As part of the FFY 2023 final rule discussed above, and as a result of the on-going COVID-19 pandemic, CMS suppressed all six measures in the HAC Reduction Program for the FY 2023 program year and eliminate the HAC reduction program’s one percent payment penalty. In FFY 2024, as part of the FFY 2024 IPPS final rule, CMS eliminated the suppression of the applicable HAC measures and as a result reinstated the HAC reduction program.

Readmission Reduction Program:

In the Legislation, Congress also mandated implementation of the hospital readmission reduction program (“HRRP”). Hospitals with excessive readmissions for conditions

designated by HHS will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. The HRRP currently assesses penalties on hospitals having excess readmission rates for heart failure, myocardial infarction, pneumonia, acute exacerbation of chronic obstructive pulmonary disease ("COPD") and elective total hip arthroplasty ("THA") and/or total knee arthroplasty ("TKA"), excluding planned readmissions, when compared to expected rates. In the fiscal year 2015 IPPS final rule, CMS added readmissions for coronary artery bypass graft ("CABG") surgical procedures beginning in fiscal year 2017. To account for excess readmissions, an applicable hospital's base operating DRG payment amount is adjusted for each discharge occurring during the fiscal year. Readmissions payment adjustment factors can be no more than a 3 percent reduction. As part of the FFY 2023 IPPS final rule discussed above, CMS will modify all of the condition-specific readmission measures to include an adjustment for patient history of COVID-19 for FFY 2024.

Accountable Care Organizations:

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

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

2019 Novel Coronavirus Disease Medicare and Medicaid Payment Related Legislation

In response to the growing threat of COVID-19, on March 13, 2020 a national emergency was declared. The declaration empowered the HHS Secretary to waive certain Medicare, Medicaid and CHIP program requirements and Medicare conditions of participation under Section 1135 of the Social Security Act. Having been granted this authority by HHS, CMS issued a broad range of blanket waivers, which eased certain requirements for impacted providers, including: (i) Waivers and Flexibilities for hospitals and other healthcare facilities including those for physical environment requirements and certain Emergency Medical Treatment & Labor Act provisions; (ii) Provider Enrollment Flexibilities; (iii) Flexibility and Relief for State Medicaid Programs including those under section 1135 Waivers, and; (iv) Suspension of Certain Enforcement Activities.

In addition to the national emergency declaration, various forms of legislation were enacted intended to support state and local authority responses to COVID-19 as well as provide fiscal support to businesses, individuals, financial markets, hospitals and other healthcare providers.

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

Medicaid FMAP Enhancement

- The FMAP was increased by 6.2% retroactive to the federal fiscal quarter beginning January 1, 2020 and each subsequent federal fiscal quarter for all states and U.S. territories during the declared public health emergency through December 31, 2022, in accordance with specified conditions. The CAA of 2023, signed into law on December 29, 2022, provided for the transitional reduction of the 6.2% enhanced FMAP during 2023 to 5.0% during the second quarter, 2.5% during the third quarter and 1.5% during the fourth quarter of 2023.

- Effective April 1, 2023, the CAA of 2023 allows states to initiate Medicaid renewals, post-enrollment verifications, and redeterminations over a 12-month period for all individuals who are enrolled in such plan (or waiver) as of April 1, 2023. This activity was previously prohibited as a condition for the receipt of the enhanced FMAP during the PHE. This Medicaid enrollment related activity is likely to reduce Medicaid beneficiary enrollment. In the states in which we operate, we cannot predict the extent to which disenrolled Medicaid beneficiaries will be able to replace their Medicaid coverage with employer-based insurance coverage or via coverage obtained through the ACA Health Insurance Exchange. We are therefore unable to estimate the impact of this Medicaid enrollment activity on our results of operations.

Public Health Emergency Declaration

- Up to its expiration on May 11, 2023, the PHE provided for certain Medicare payment provisions that were contingent on the PHE including the twenty percent (20%) Medicare add-on for inpatient hospital COVID-19 patients noted below.

Medicare add-on for inpatient hospital COVID-19 patients

- Increased the payment that would otherwise be made to a hospital for treating a Medicare patient admitted with COVID-19 by twenty percent (20%) for the duration of the COVID-19 public health emergency.

- Our financial results for the three-month period ended March 31, 2024 did not include any add-on revenue while the three-month period ended March 31, 2023 included $5 million. These payments were intended to offset the increased expenses associated with the treatment of Medicare COVID-19 patients.

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

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

Other Operating Results

Interest Expense:

As reflected on the schedule below, interest expense was $53 million and $51 million during the three-month periods ended March 31, 2024 and 2023, respectively (amounts in thousands):

	Three Months Ended March 31, 2024	Three Months Ended March 31, 2023
Revolving credit & demand notes (a.)	$ 7,246	$ 5,627
Tranche A term loan facility (a.)	39,472	36,062
$800 million, 2.65% Senior Notes due 2030 (b.)	5,356	5,356
$700 million, 1.65% Senior Notes due 2026 (c.)	2,932	2,932
$500 million, 2.65% Senior Notes due 2032 (d.)	3,345	3,345
Subtotal-revolving credit, demand notes, Senior Notes, term loan facilities and accounts receivable securitization program	58,351	53,322
Amortization of financing fees	1,256	1,258
Other combined interest expense	2,112	435
Capitalized interest on major projects	(8,578)	(4,009)
Interest income	(315)	(130)
Interest expense, net	$ 52,826	$ 50,876

(a.) As of March 31, 2024, our credit agreement dated November 15, 2010, as amended, provided for the following:

- a $1.2 billion aggregate amount revolving credit facility that is scheduled to mature in August, 2026 (which, as of March 31, 2024, had $733 million of aggregate available borrowing capacity net of $463 million of outstanding borrowings and $3 million of letters of credit), and;
- a tranche A term loan facility with $2.23 billion of outstanding borrowings as March 31, 2024 (including the $700 million increase that occurred in June, 2022).

(b.) In September, 2020, we completed the offering of $800 million aggregate principal amount of 2.65% Senior Notes due in 2030.

(c.) In August, 2021, we completed the offering of $700 million aggregate principal amount of 1.65% Senior Notes due in 2026.

(d.) In August, 2021, we completed the offering of $500 million aggregate principal amount of 2.65% Senior Notes due in 2032.

Interest expense increased approximately $2 million during the three-month period ended March 31, 2024, as compared to the three-month period ended March 31, 2023. The increase was primarily due to: (i) a net $5 million increase in aggregate interest expense on our revolving credit, demand notes, senior notes, and term loan facilities, resulting from an increase in our aggregate average cost of borrowings pursuant to these facilities (4.96% during the first quarter of 2024 as compared to 4.55% during the comparable quarter of 2023), offset by a slight decrease in the aggregate average outstanding borrowings pursuant to these facilities ($4.65 billion during the first quarter of 2024 as compared to

$4.67 billion during the first quarter of 2023), partially offset by; (ii) a net $3 million decrease in other combined interest expenses, due primarily to a $5 million increase in capitalized interest on major projects. The average effective interest rates, including amortization of deferred financing costs and original issue discount, on borrowings outstanding under our revolving credit, demand notes, senior notes and term loan A facility, which amounted to approximately $4.65 billion and $4.67 billion during the first quarters of 2024 and 2023, respectively, were 5.1% and 4.7% during the three-month periods ended March 31, 2024 and 2023, 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, 2024 and 2023 (dollar amounts in thousands):

	Three months ended	
	March 31, 2024	March 31, 2023
Provision for income taxes	$ 70,264	$ 51,726
Income before income taxes	336,086	214,101
Effective tax rate	20.9%	24.2%

The provision for income taxes increased $19 million during the first quarter of 2024, as compared to the comparable quarter of 2023, due primarily to: (i) the income tax expense recorded in connection with a $117 million increase in pre-tax income (consisting of $122 million increase in income before income taxes and a $5 million unfavorable change in the income/loss attributable to noncontrolling interests), partially offset by; (ii) a decrease of $9 million resulting from the income tax benefit recorded during the first quarter of 2024 in connection with employee share-based payments. Excluding from each period the impact of the income tax benefit/expense recorded in connection with employee share-based payments, our effective tax rates were 23.6% and 24.1% during the first quarters of 2024 and 2023, respectively.

Due to recent guidance and enacted laws surrounding the global 15% minimum tax rate that will be effective after 2024 from the Organization for Economic Co-operation and Development ("OECD") as well as jurisdictions that we operate in, we anticipate adverse effects to our provision for income taxes as well as cash taxes. We do not expect these adverse effects to be material and will continue to monitor changes in tax policies and laws issued by the OECD and jurisdictions that we operate in.

Liquidity

Net cash provided by operating activities

Net cash provided by operating activities was $396 million during the three-month period ended March 31, 2024 and $291 million during the first three months of 2023. The net increase of $106 million was attributable to the following:

- a favorable change of $98 million resulting from an increase in net income plus/minus depreciation and amortization expense, stock-based compensation expense and gains on sales on sales of assets and businesses;
- a favorable change of $86 million in other working capital accounts due primarily to the timing of disbursements for accrued liabilities;
- an unfavorable change of $59 million in accounts receivable;
- an unfavorable change of $45 million in other assets and deferred charges, and;
- $26 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 54 days and 53 days at March 31, 2024 and 2023, respectively.

Net cash used in investing activities

During the first three months of 2024, we used $195 million of net cash in investing activities as follows:

- $209 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $8 million received in connection with net cash inflows from forward exchange contracts that hedge our investment in the U.K. against movements in exchange rates, and;

- $5 million received from the sales of assets and businesses;

During the first three months of 2023, we used $178 million of net cash in investing activities as follows:

- $169 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $19 million paid in connection with net cash outflows from forward exchange contracts that hedge our investment in the U.K. against movements in exchange rates, and;
- $9 million received from the sales of assets and businesses.

Net cash used in financing activities

During the first three months of 2024, we used $209 million of net cash in financing activities as follows:

- spent $142 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our stock repurchase program ($106 million; excluding $19 million of purchases made during the first quarter that settled in April, 2024), and; (ii) income tax withholding obligations related to stock-based compensation programs ($36 million);
- spent $64 million on net repayments of debt as follows: (i) $30 million related to our tranche A term loan facility; (ii) $32 million related to our revolving credit facility, and; (ii) $2 million related to other debt facilities;
- generated $12 million of additional borrowings related to other debt facilities;
- spent $14 million to pay quarterly cash dividends of $.20 per share;
- spent $4 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $3 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

During the first three months of 2023, we used $106 million of net cash in financing activities as follows:

- spent $85 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our stock repurchase program ($79 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($6 million);
- spent $16 million on net repayments of debt as follows: (i) $15 million related to our tranche A term loan facility, and; (ii) $1 million related to other debt facilities;
- spent $14 million to pay quarterly cash dividends of $.20 per share;
- generated $11 million of additional borrowings pursuant to our revolving credit facility;
- spent $4 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $3 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

Expected capital expenditures during remainder of 2024

During the full year of 2024, we expect to spend approximately $850 million to $1 billion on capital expenditures which includes expenditures for capital equipment, construction of new facilities, and renovations and expansions at existing hospitals. During the first three months of 2024 we spent approximately $209 million on capital expenditures and expect to spend approximately $641 million to $791 million during the remainder of 2024.

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

In June, 2022, we entered into a ninth amendment to our credit agreement dated as of November 15, 2010, as amended and restated as of September, 2012, August, 2014, October, 2018, August, 2021, and September, 2021, among UHS, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders, and JPMorgan Chase Bank, N.A., as administrative agent, (the “Credit Agreement”). The ninth amendment provided for, among other things, the following: (i) a new incremental tranche A term loan facility in the aggregate principal amount of $700 million which is scheduled to mature on August 24, 2026, and; (ii) replaces the option to make Eurodollar borrowings (which bear interest by reference to the LIBO Rate) with Term Benchmark Loans, which will bear interest by reference to the Secured Overnight Financing Rate (“SOFR”). The net proceeds generated from the incremental tranche A term loan facility were used to repay a portion of the borrowings that were previously outstanding under our revolving credit facility.

As of March 31, 2024, our Credit Agreement provided for the following:

- a $1.2 billion aggregate amount revolving credit facility that is scheduled to mature in August, 2026 (which, as of March 31, 2024, had $733 million of aggregate available borrowing capacity net of $463 million of outstanding borrowings and $3 million of letters of credit), and;

- a tranche A term loan facility with $2.23 billion of outstanding borrowings as of March 31, 2024.

The tranche A term loan facility provides for installment payments of $30.0 million per quarter through June, 2026. The unpaid principal balance at June 30, 2026 is payable on the August 24, 2026 scheduled maturity date of the Credit Agreement.

Revolving credit and tranche A term loan 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 term SOFR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.25% to 0.625%, or (2) the one, three or six month term SOFR rate plus 0.1% (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.25% to 1.625%. As of March 31, 2024, the applicable margins were 0.50% for ABR-based loans and 1.50% for SOFR-based loans under the revolving credit and term loan A facilities. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Credit Agreement is secured by certain assets of the Company and our material subsidiaries (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, if sold to a receivables facility pursuant to the Credit Agreement, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

The Credit Agreement includes a material adverse change clause that must be represented at each draw. The Credit Agreement also contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens, indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage. We were in compliance with all required covenants as of March 31, 2024 and December 31, 2023.

As of March 31, 2024, we had combined aggregate principal of $2.0 billion from the following senior secured notes:

- $700 million aggregate principal amount of 1.65% senior secured notes due in September, 2026 ("2026 Notes") which were issued on August 24, 2021.
- $800 million aggregate principal amount of 2.65% senior secured notes due in October, 2030 ("2030 Notes") which were issued on September 21, 2020.
- $500 million of aggregate principal amount of 2.65% senior secured notes due in January, 2032 ("2032 Notes") which were issued on August 24, 2021.

Interest on the 2026 Notes is payable on March 1st and September 1st until the maturity date of September 1, 2026. Interest on the 2030 Notes is payable on April 15th and October 15th, until the maturity date of October 15, 2030. Interest on the 2032 Notes is payable on January 15th and July 15th until the maturity date of January 15, 2032.

The 2026 Notes, 2030 Notes and 2032 Notes (collectively "The Notes") were initially issued 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"). In December, 2022, we completed a registered exchange offer in which virtually all previously outstanding Notes were exchanged for identical Notes that were registered under the Securities Act, and thereby became freely transferable (subject to certain restrictions applicable to affiliates and broker dealers). Notes originally issued under Rule 144A or Regulation S that were not exchanged remain outstanding and may not be offered or sold in the United States absent registration under the Securities Act or an applicable exemption from registration requirements thereunder.

The Notes are guaranteed (the "Guarantees") on a senior secured basis by all of our existing and future direct and indirect subsidiaries (the "Subsidiary Guarantors") that

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

As discussed in Note 2 to the Consolidated Financial Statements-Relationship with Universal Health Realty Income Trust and Other Related Party Transactions, on December 31, 2021, we (through wholly-owned subsidiaries of ours) entered into an asset purchase

and sale agreement with Universal Health Realty Income Trust (the “Trust”). Pursuant to the terms of the agreement, which was amended during the first quarter of 2022, we, among other things, transferred to the Trust, the real estate assets of Aiken Regional Medical Center (“Aiken”) and Canyon Creek Behavioral Health (“Canyon Creek”). In connection with this transaction, Aiken and Canyon Creek (as lessees), entered into a master lease and individual property leases, as amended, (with the Trust as lessor), for initial lease terms on each property of approximately twelve years, ending on December 31, 2033. As a result of our purchase option within the Aiken and Canyon Creek lease agreements, this asset purchase and sale transaction is accounted for as a failed sale leaseback in accordance with U.S. GAAP and we have accounted for the transaction as a financing arrangement. Our lease payments payable to the Trust are recorded to interest expense and as a reduction of the outstanding financial liability, and the amount allocated to interest expense is determined based upon our incremental borrowing rate and the outstanding financial liability. In connection with this transaction, our consolidated balance sheets at March 31, 2024 and December 31, 2023 reflect financial liabilities, which are included in debt, of approximately $77 million as of each date.

At March, 2024, the carrying value and fair value of our debt were approximately $4.9 billion and $4.6 billion, respectively. At December 31, 2023, the carrying value and fair value of our debt were approximately $4.9 billion and $4.6 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 44% as of both March 31, 2024 and December 31, 2023.

We expect to finance all capital expenditures and acquisitions and pay dividends and potentially repurchase shares of our common stock utilizing internally generated and additional funds. Additional funds may be obtained through: (i) borrowings under our existing revolving credit facility, which had $733 million of available borrowing capacity as of March 31, 2024, or through refinancing the existing Credit Agreement; (ii) the issuance of other short-term and/or long-term debt, and/or; (iii) the issuance of equity. We believe that our operating cash flows, cash and cash equivalents, available commitments under existing agreements, 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.

Supplemental Guarantor Financial Information

As of March 31, 2024, we had combined aggregate principal of $2.0 billion from The Notes:

- $700 million aggregate principal amount of the 2026 Notes;
- $800 million aggregate principal amount of the 2030 Notes, and;
- $500 million of aggregate principal amount of the 2032 Notes.

The Notes are fully and unconditionally guaranteed pursuant to the Guarantees on a senior secured basis by the Subsidiary Guarantors. The Notes and the Guarantees are secured by first-priority liens, subject to permitted liens, on certain of the Company’s and the Subsidiary Guarantors’ assets now owned or acquired in the future by the Company or the Subsidiary Guarantors (other than real property, accounts receivable sold pursuant to the Company’s existing receivables facility (as defined in the Indentures pursuant to which The Notes were issued), and certain other excluded assets). The Company’s obligations with respect to The Notes, the obligations of the Subsidiary Guarantors under the Guarantees, and the performance of all of the Company’s and the Subsidiary Guarantors’ other

obligations under the Indentures, are secured equally and ratably with the Company's and the Subsidiary Guarantors' obligations under the Credit Agreement and The Notes by a perfected first-priority security interest, subject to permitted liens, in the collateral owned by the Company and its Subsidiary Guarantors, whether now owned or hereafter acquired. However, the liens on the collateral securing The Notes and the Guarantees will be released if: (i) The Notes have investment grade ratings; (ii) no default has occurred and is continuing, and; (iii) the liens on the collateral securing all first lien obligations (including the Credit Agreement and The Notes) and any junior lien obligations are released or the collateral under the Credit Agreement, any other first lien obligations and any junior lien obligations is released or no longer required to be pledged. The liens on any collateral securing The Notes and the Guarantees will also be released if the liens on that collateral securing the Credit Agreement, other first lien obligations and any junior lien obligations are released.

The Notes will be structurally subordinated to all obligations of our existing and future subsidiaries that are not and do not become Subsidiary Guarantors of The Notes. No appraisal of the value of the collateral has been made, and the value of the collateral in the event of liquidation will depend on market and economic conditions, the availability of buyers and other factors. Consequently, liquidating the collateral securing The Notes may not produce proceeds in an amount sufficient to pay any amounts due on The Notes.

We and our subsidiaries may be able to incur significant additional indebtedness in the future. Although our Credit Agreement contains restrictions on the incurrence of additional indebtedness and our Credit Agreement and The Notes contain restrictions on our ability to incur liens to secure additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the additional indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent

us from incurring obligations that do not constitute indebtedness. In addition, if we incur any additional indebtedness secured by liens that rank equally with The Notes, subject to collateral arrangements, the holders of that debt will be entitled to share ratably with you in any proceeds distributed in connection with any insolvency, liquidation, reorganization, dissolution or other winding up of our company. This may have the effect of reducing the amount of proceeds paid to holders of The Notes.

Federal and state fraudulent transfer and conveyance statutes may apply to the issuance of The Notes and the incurrence of the Guarantees. Under federal bankruptcy law and comparable provisions of state fraudulent transfer or conveyance laws, which may vary from state to state, The Notes or the Guarantees (or the grant of collateral securing any such obligations) could be voided as a fraudulent transfer or conveyance if we or any of the Subsidiary Guarantors, as applicable, (a) issued The Notes or incurred the Guarantees with the intent of hindering, delaying or defrauding creditors or (b) under certain circumstances received less than reasonably equivalent value or fair consideration in return for either issuing The Notes or incurring the Guarantees.

Basis of Presentation

The following tables include summarized financial information of Universal Health Services, Inc. and the other obligors in respect of debt issued by Universal Health Services, Inc. The summarized financial information of each obligor group is presented on a combined basis with balances and transactions within the obligor group eliminated. Investments in and the equity in earnings of non-guarantor subsidiaries, which would otherwise be consolidated in accordance with GAAP, are excluded from the below summarized financial information pursuant to SEC Regulation S-X Rule 13-01.

The summarized balance sheet information for the consolidated obligor group of debt issued by Universal Health Services, Inc. is presented in the table below:

(in thousands)	March 31, 2024	December 31, 2023
Current assets	$ 2,318,249	$ 2,292,716
Noncurrent assets (1)	8,904,696	8,876,623
Current liabilities	1,814,098	1,786,642
Noncurrent liabilities	5,627,816	5,728,371
Due to non-guarantors	926,008	913,481

(1) Includes goodwill of $3,267 million as of March 31, 2024 and December 31, 2023, respectively.

The summarized results of operations information for the consolidated obligor group of debt issued by Universal Health Services, Inc. is presented in the table below:

(in thousands)	Three Months Ended March 31, 2024	Twelve Months Ended December 31, 2023
Net revenues	$ 3,091,319	$ 11,454,260
Operating charges	2,738,512	10,416,176
Interest expense, net	52,929	277,521
Other (income) expense, net	(1,480)	24,996
Net income	$ 230,322	$ 556,423

Affiliates Whose Securities Collateralize the Senior Secured Notes

The Notes and the Guarantees are secured by, among other things, pledges of the capital stock of our subsidiaries held by us or by our secured Guarantors, in each case other than certain excluded assets and subject to permitted liens. Such collateral securities are secured equally and ratably with our and the Guarantors' obligations under our Credit

Agreement. For a list of our subsidiaries the capital stock of which has been pledged to secure The Notes, see Exhibit 22.1 to this Report.

Upon the occurrence and during the continuance of an event of default under the indentures governing The Notes, subject to the terms of the Security Agreement relating to The Notes provide for (among other available remedies) the foreclosure upon and sale of the Collateral (including the pledged stock) and the distribution of the net proceeds of any such sale to the holders of The Notes, the lenders under the Credit Agreement and the holders of any other permitted first priority secured obligations on a pro rata basis, subject to any prior liens on the collateral.

No appraisal of the value of the collateral securities has been made, and the value of the collateral securities in the event of liquidation will depend on market and economic conditions, the availability of buyers and other factors. Consequently, liquidating the collateral securities securing The Notes may not produce proceeds in an amount sufficient to pay any amounts due on The Notes.

The security agreement relating to The Notes provides that the representative of the lenders under our Credit Agreement will initially control actions with respect to that collateral and, consequently, exercise of any right, remedy or power with respect to enforcing interests in or realizing upon such collateral will initially be at the direction of the representative of the lenders.

No trading market exists for the capital stock pledged as collateral.

The assets, liabilities and results of operations of the combined affiliates whose securities are pledged as collateral are not materially different than the corresponding amounts presented in the consolidated financial information of Universal Health Services, Inc.

Off-Balance Sheet Arrangements

During the three months ended March 31, 2024 there have been no material changes in the off-balance sheet arrangements consisting of standby letters of credit and surety bonds.

As of March 31, 2024 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $193 million consisting of: (i) $174 million related to our self-insurance programs, and; (ii) $19 million of other debt and public utility guarantees.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

There have been no material changes in the quantitative and qualitative disclosures about market risk during the three months ended March 31, 2024. 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, 2023.

Item 4. Controls and Procedures

As of March 31, 2024, 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 during the first quarter of 2024 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

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

Item 1A. Risk Factors

The following is an update to the risk factors set forth in our Annual Report on Form 10-K for the fiscal year ended December 31, 2023. Other than the following update, there have been no material changes to the risk factors previously disclosed under the heading "Risk Factors" in our Annual Report on Form 10-K for the fiscal year ended December 31, 2023. You should carefully consider the risk factors contained in our Annual Report on Form 10-K, our Quarterly Reports on Form 10-Q and our other filings made with the Securities and Exchange Commission.

We are subject to pending legal actions, purported stockholder class actions, governmental investigations, inquiries and regulatory actions.

We and our subsidiaries are subject to pending legal actions, governmental investigations, inquiries and regulatory actions and judgments (see Note 6 to the Consolidated Financial Statements-Commitments and Contingencies as contained in this Quarterly Report on Form 10-Q). We may become subject to additional medical malpractice lawsuits, product liability lawsuits, class action lawsuits, investigations and other legal actions in the ordinary course of business.

Defending ourselves against the allegations in the lawsuits and governmental investigations, inquiries, or similar matters and any related publicity, could potentially entail significant costs and could require significant attention from our management and our reputation could suffer significantly. We are unable to predict the outcome of these matters or to reasonably estimate the amount or range of any such loss; however, these lawsuits and the related publicity and news articles that have been published concerning these matters could have a material adverse effect on our business, financial condition, results of operations and/or cash flows which in turn could cause a decline in our stock price. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement. Amounts we pay to settle any of these matters may be material. All professional and general liability insurance we purchase is subject to policy limitations. We believe that, based on our past experience and actuarial estimates, our insurance coverage is adequate considering the claims arising from the operations of our hospitals. While we continuously monitor our coverage, our ultimate liability for professional and general liability claims could change materially from our current estimates. If such policy limitations should be partially or fully exhausted in the future, or payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our operations.

For example, as discussed elsewhere herein, a jury recently returned a verdict for compensatory damages of $60 million and punitive damages of $475 million against the Pavilion Behavioral Health System (the "Pavilion"), one of our indirect subsidiaries. The Pavilion is evaluating all legal options and intends to challenge this verdict in post-judgment trial court proceedings and on appeal. We are uncertain as to the ultimate financial exposure related to the Pavilion matter and we can make no assurances regarding its outcome, or the amount of damages that may be held recoverable after post-judgment proceedings and appeal.

Also, in July 2022, UHS along with three other companies that own Residential Treatment Facilities ("RTFs") received a letter from U.S. Senator Patty Murray (then Chair of the Senate Health, Education, Labor and Pensions Committee) and U.S. Senator Ron Wyden (Chairman of the Senate Finance Committee) requesting information about policies and practices in providing treatment to children and youths in RTFs. We have cooperated with

the inquiry and provided certain documents and information to the Committees. Recently, we received new and supplemental requests for information and documentation. In addition, we have recently been advised that the Senate Finance Committee intends to hold a public hearing on the topic and to issue a report of their findings in the coming months.

We are and may become subject to other loss contingencies, both known and unknown, which may relate to past, present and future facts, events, circumstances and occurrences. Should an unfavorable outcome occur in some or all of our legal proceedings or other loss contingencies, or if successful claims and other actions are brought against us in the future, there could be a material adverse impact on our financial position, results of operations and liquidity.

In particular, government investigations, as well as qui tam and stockholder lawsuits, may lead to material fines, penalties, damages payments or other sanctions, including exclusion from government healthcare programs. The federal False Claims Act permits private parties to bring qui tam, or whistleblower, lawsuits on behalf of the government against companies alleging that the defendant has defrauded the federal government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of whistleblower lawsuits that have been filed against providers has increased significantly in recent years. Because qui tam lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. Settlements of lawsuits involving Medicare and Medicaid issues routinely require both monetary payments and corporate integrity agreements, each of which could have a material adverse effect on our business, financial condition, results of operations and/or cash flows.

If our financial exposure in connection with litigation relating to the Pavilion Behavioral Health System exhausts all or a significant portion of the remaining commercial insurance coverage available to our subsidiaries related to other occurrences in 2020, or it causes us to have to post a large bond or other collateral during an appeal process, our future results of operations and capital resources could be materially adversely impacted.

As previously reported on Form 8-K as filed on April 1, 2024, the Pavilion Behavioral Health System (the "Pavilion"), an indirect subsidiary of the Company, is a defendant in a lawsuit filed in Champaign County, Illinois, relating to the sexual assault of one minor patient by another minor patient in 2020. The plaintiff asserted claims of negligence and misrepresentation. The Pavilion denied any liability. The case went to trial in March of 2024. On March 28, 2024, a jury returned a verdict for compensatory damages of $60 million and punitive damages of $475 million and a related judgment was entered against the Pavilion. Based on a search of verdicts in comparable cases, the magnitude of this verdict was unexpected and is unprecedented for a single-plaintiff injury case of this type in Champaign County, Illinois. The Pavilion is evaluating all legal options and intends to challenge this verdict in post-judgment trial court proceedings and on appeal. We are uncertain as to the ultimate financial exposure related to the Pavilion matter and we can make no assurances regarding its outcome, or the amount of damages that may be held recoverable after post-judgment proceedings and appeal. While the Pavilion has professional liability insurance to cover a portion of these amounts, the resolution of this matter may have a material adverse effect on the Company. As of March 31, 2024, without reduction for any potential amounts related to the above-mentioned Pavilion matter, the Company and its subsidiaries have aggregate insurance coverage of approximately $221 million remaining under commercial policies for matters applicable to the 2020 policy year (in excess of the applicable self-insured retention amounts ($10 million per occurrence for professional liability claims and $3 million per occurrence for general liability claims)). In the event the resolution of the Pavilion matter exhausts all or a significant portion of the remaining commercial insurance coverage available to the Company and its subsidiaries for claims that occurred in 2020, or it causes us to have to post a large bond or other collateral during an appeal process, our future results of operations and capital resources could be materially adversely impacted.

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

As of December 31, 2023, we had an aggregate available repurchase authorization of $422.9 million pursuant to our stock repurchase program. Pursuant to this program, shares of our Class B Common Stock may be repurchased, from time to time as conditions allow, on the open market or in negotiated private transactions. There is no expiration date for our stock repurchase program.

As reflected below, during the three-month period ended March 31, 2024, we have repurchased 700,000 shares at an aggregate cost of approximately $125.10 million (approximately $178.71 per share) pursuant to the terms of our stock repurchase program. In addition, during the three-month period ended March 31, 2024, 205,172 shares were repurchased in connection with income tax withholding obligations resulting from stock-based compensation programs.

During the period of January 1, 2024 through March 31, 2024, 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	Aggregate purchase price paid for shares purchased as part of publicly announced program	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)

						announced program	(in thousands)		
January 2024	$ -	7,978	81	$ 0.01	—	$ -	$ -	—	$ 422,883
February, 2024	$ -	10,665	13	$ 0.01	—	$ -	$ -	—	$ 422,883
March, 2024	$ -	886,529	13	$ 0.01	700,000	$ 178.71	$ 125,096	—	$ 297,787
Total January through March, 2024	$ -	905,172	107	$ 0.01	700,000	178.71	$ 125,096		

Dividends

During the quarter ended March 31, 2024, we declared and paid dividends of $.20 per share. Dividend equivalents are accrued on unvested restricted stock units and will be paid upon vesting of the restricted stock unit.

Item 5. Other Information

None of the Company's directors or officers adopted, modified or terminated a Rule 10b5-1 trading arrangement or a non-Rule 10b5-1 trading arrangement during the Company's quarter ended March 31, 2024, as such terms are defined under Item 408(a) of Regulation S-K.

Item 6. Exhibits

22.1	List of Guarantor Subsidiaries and Issuers of Guaranteed Securities and Affiliates Whose Securities Collateralize Securities of the Registrant.
31.1	Certification of the Company's Chief Executive Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
31.2	Certification of the Company's Chief Financial Officer pursuant to Rule 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934.
32.1	Certification of the Company's Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of the Company's Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	Inline XBRL Instance Document –the instance document does not appear in the Interactive Data file because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document
104	The cover page from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2024, has been formatted in Inline XBRL.

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES

Signatures

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

Universal Health Services, Inc.
(Registrant)

Date: May 8, 2024

/s/ Marc D. Miller

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

/s/ Steve Filton

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