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Q1 2012 Universal Health Services Earnings Conference Call

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PRESENTATION

Operator

Good morning, my name is Christy and I will be your conference operator. At this time, I would like to welcome everyone to the UHS first quarter earnings conference call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. (Operator Instructions) I will now turn the conference over to Mr Steve Filton, CFO.

Steve Filton *Universal Health Services Inc - CFO*

Thank you. Good morning. Alan Miller, our CEO is also joining us this morning. Welcome to this review of Universal Health Services' results for the first quarter ended March 31, 2012. During this conference call, Alan and I will be using words such as believes, expects, anticipates, estimates and similar words that represent forecasts, projections and forward-looking statements. For anyone not familiar with the risks and uncertainties inherent in these forward-looking statements, I recommend a careful reading of the Section on risk factors and forward-looking statements and risk factors in our Form 10-K for the year ended December 31, 2011. We'd like to highlight just a couple of developments and business trends before opening the call up to questions.

As discussed in our press release last night, the Company recorded net income attributable to UHS per diluted share of $1.31 for the quarter. After adjusting for the prior year impact of several reimbursement items recorded during the quarter, our adjusted net income attributable to UHS per diluted share for the quarter ended March 31, 2012, was $1.13. On a same facility basis revenues in our behavioral health division increased 5.3% during the first quarter of 2012. We note that the PSI facilities are included in our same-store data for the entire quarter.

Adjusted admissions in patient days to our behavioral health facilities owned for more than a year increased 9.2% and 2.8% respectively during the first quarter. Revenue per adjusted patient day rose 2.4% during the first quarter of 2012 over the comparable prior-year quarter.

Operating margins for our behavioral health hospitals owned for more than a year increased to 26.8% during the quarter ended March 31, 2012. As compared to 26.5% during the comparable prior-year period. On a same facility basis in our acute care division, revenues increased 0.8% during the first quarter of 2012. The increase resulted primarily from a 1.6% increase in adjusted admissions to our hospitals owned for more than a year.

The relatively muted revenue growth reflects a difficult comparison to the prior-year quarter when our net revenues were favorably impacted by positive changes in payer mix, especially stabilization in uninsured volumes. On a same facility basis, operating margins for our acute hospitals decreased to 18.6% during the first quarter of 2012, from 20.5% during the first quarter of 2011. We also note that there are no EHR-related revenues included in our quarterly financial statements.

Our acute care hospitals provided charity care and uninsured discounts based on charges at established rates amounting to $315 million and $223 million during the three-month period ended March 31, 2012 and 2011. As a percentage of acute care net revenues, bad debts, charity, care expense and the uninsured discount in this year's first quarter were at levels higher than those experienced during the first quarter of 2011. However, due primarily to the increase in behavioral health revenues and the very low levels of bad debt and uninsured discounts in that business, our overall percentage of bad debt, charity care and uninsured discounts were lower than those experienced during the first quarter of 2011.

Our cash from operating activities was approximately $134 million during the first quarter of 2012, as compared to $183 million in the first quarter of 2011. Our Accounts Receivable days outstanding increased to 56 days during the first quarter of 2012, primarily due to a lack of Medicaid payments from the State of Illinois, and a lack of disproportionate share payments from Texas, as well as the Rural Floor settlement recorded as a receivable during the quarter. At March 31, 2012, our ratio of debt to total capitalization was 59.6%.

We spent $93 million on capital expenditures during the first quarter. Included in our capital expenditures were the construction costs related to the ongoing construction of a new acute care hospital in Temecula, California and a new bed tower at our Wellington facility in Florida. Effective in the first quarter of 2012, we have completed all of the divestitures required by the FTC as part of the PSI acquisition.

Alan and I would be pleased to answer your questions at this time.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions) Adam Feinstein, Barclays Capital.

Brian Sekino *Barclays Capital - Analyst*

This is Brian Sekino on behalf of Adam this morning. Just wanted to know if you could provide us with some details in Vegas on some of the mix shift that you saw in the acute care versus the strong Q1 of 2011. If you could provide us with some details on how the mix shifted, if that was really the bolus of the mix shift in the quarter?

Steve Filton *Universal Health Services Inc - CFO*

Sure, Brian. I think that in talking about the comparison, the anomaly was in the first quarter of last year. For those of you who recall, we talked a great deal in Q1 of 2011 about the fact that rather dramatically, unemployment rates had declined in the Vegas market from 15% at the end of 2010 to 12% in the first quarter of 2011, that we saw a benefit from that in our business almost immediately. We saw a reduction in uninsured volumes in the first quarter of 2011, that had an extremely favorable effect on our results and our revenues per admission, et cetera. As the 2011 progress, the payer mix regressed back to a normal mean, if you will, both in the Vegas market and I think in the portfolio in general.

Most of those trends continued into the first quarter of 2011 -- excuse me, to the first quarter of 2012. Those trends are, again, the same as we've talked about the last few quarters, commercial volumes are down, Medicare volumes are down, really the only volumes that are up are Medicaid, which is actually managed Medicaid and to some degree our uninsured volumes. That's particularly true in some of our more economically troubled markets like Vegas and South Texas, but it's generally true through the portfolio. And that's what made the comparison so difficult from an acute care perspective in Q1.

Brian Sekino *Barclays Capital - Analyst*

Okay. Then just a question on the behavioral side, looks like adjusted admissions were up very strong and adjusted patient days were up, but there was a gap in the growth. Is there a shift in more acute versus RTC? Or is there also some length of stay pressures from the Medicaid payers as well?

Steve Filton ***Universal Health Services Inc - CFO***

Brian, again, it's a continuing trend where we're seeing compression in our length of stay, not anything new but also not something that seems to be decelerating yet at this point. It is primarily focused in the residential business, length of stay is down on both sides of our behavioral business but primarily on the residential side. And it is mostly, I think a function of Medicaid and managed Medicaid payers intentionally, obviously trying to get their patients out of the residential facilities sooner than previously.

Operator

Tom Gallucci, Lazard Capital.

Tom Gallucci ***Lazard Capital Markets - Analyst***

Thanks for the details, Steve. Just on volumes, over and above mix on absolute utilization, did you see anything that was new or different as you look inside the details of the numbers that indicate that anything is better or worse to maybe where the trends have been in recent quarters? Or more stabilization?

Steve Filton ***Universal Health Services Inc - CFO***

The growth in volumes, that 1.6% growth in adjusted admissions, same-store admissions, we thought seemed to be much as expected, and a reasonable number. I think Tom, we're more focused on the fact that when the economy begins to improve, in a number of our markets but in particularly some of our larger markets, that we're well-positioned to benefit from that, and we're waiting patiently for that to happen. Obviously, this has been an extended recession and it's been particularly extended again in some of our most important markets. So that's really what we're keeping our eye on most importantly.

Tom Gallucci ***Lazard Capital Markets - Analyst***

Okay. So not same things worse but it does sound like you're still waiting for things to get a little bit better. On the cash flow you mentioned some of the state collections I guess in particular, was there anything else that you can talk about on collections? Are rates still pretty consistent relative to outside of the states that you mentioned?

Steve Filton ***Universal Health Services Inc - CFO***

I think from a rate perspective, there's nothing significant going on either from our government payers or our private payers. The biggest collection issue, which we discussed last quarter as well, is almost a complete lack of payments from Illinois Medicaid, although payments did resume again this past week, so we view that as an encouraging sign. And we believe the Texas Medicaid disproportionate share payments, which were not made in Q1, we're actually expecting at least a portion of those payments to be made either today or Monday. So we're hoping to get a little bit of easing of that pressure.

Tom Gallucci ***Lazard Capital Markets - Analyst***

Okay. Then as Illinois resumed, do they have a catch up or how fast do you expect to make up what you haven't been paid in the past?

Steve Filton ***Universal Health Services Inc - CFO***

I wish I could precisely answer that question, Tom. The state is not terribly helpful in letting folks know what their plan is, although they certainly have taken the position consistently that they intend to pay all the outstanding receivables. So that's our expectation and obviously that's the way we've reflected in our financials. But there is no plan that the state has issued as to when the timing of those payments will take place.

Operator

Darren Lehrich, Deutsche Bank.

Darren Lehrich ***Deutsche Bank - Analyst***

A couple things here. First, I want to start with capital deployment. It does look like you held a little back in the quarter on share repurchase. I guess I'd be curious just to know if you are preserving capital for any particular reason at the moment, and to the extent that ties into what you're seeing in the acquisition pipeline, how we should be thinking about that and how maybe that's changed over the last six months or so as you think about deploying capital?

Steve Filton ***Universal Health Services Inc - CFO***

Darren, I don't think there's anything terribly new this quarter. As I think we've probably said, pretty consistently over the course of the last few quarters, we are mostly focused on generating cash and repaying debt. As effectively as we can. We are entertaining other opportunities, both internal and external to deploy capital. If we discover or are able to take advantage of opportunities that we find really compelling, we're prepared to do so. But again, I'll make the point that in our minds, they're going to have to be pretty compelling.

Darren Lehrich ***Deutsche Bank - Analyst***

Okay. Then just with the NAP deal looking like it's off the table for now, is there anything else that looks more imminent in the pipeline? Just on the acute side, would love to get a comment or two there about what kinds of things you're evaluating.

Steve Filton ***Universal Health Services Inc - CFO***

Yes. So as we discussed last quarter, the NAP deal that we had previously announced has lapsed, largely because the seller has been unable to meet all their obligations and are involved in some litigation at the moment. So you're right, we put that off to the side. As is our practice, Darren, I don't think we're going to make any specific comments about opportunities on either side of the business. Again, just suffice it to say that we're continuing to look and we're continuing to pursue internal opportunities as well. I mentioned in my remarks that we're building new hospitals, or new acute capacity in California and Florida. And we certainly continue to explore those opportunities as well.

Darren Lehrich ***Deutsche Bank - Analyst***

Great. Okay. Then as you look at the acute business, obviously the comp was the big factor here. Is there any way to help us think about how things progressed over the course of the quarter? And can you just comment a little bit about how you see that comp impacting Q2? I know it was still pretty strong throughout the first half last year, but how should we be thinking about that?

Steve Filton ***Universal Health Services Inc - CFO***

Well, as far as the progression goes, Darren, I would say that both volumes and payer mix probably strengthened a little bit as the quarter went on although in fairness, I don't -- I'm not exactly sure how or what to read into that. You're absolutely right, our expectations that we set a couple months ago when we gave guidance for 2012 is that acute care revenue growth would be fairly modest in 2012 in the 2.5% to 3% range. Part of that thinking was that we knew that in the first half of the year, the comparisons would be difficult so even though we didn't get into specifics and won't do that today either, I think the notion was we would be somewhat lower than the 2.5% to 3% in the first half of the year and a little bit higher in the back half of the year as the comparisons got easier. And that's still our view. I should make the point that I think the first quarter played out very consistent with our internal expectations, certainly from an overall basis. But from a pricing perspective, we are I think a little disappointed with the level of acute care pricing but don't view it as all as out of line with our full-year guidance.

Operator

Ralph Giacobbe, Credit Suisse.

Ralph Giacobbe ***Credit Suisse - Analyst***

Steve, going back to what you said in terms of the pricing number down 0.8% on the acute care side, obviously impacted by the mix but I was just wondering on the pure pricing side maybe you could remind us what rates you're getting from managed care, if it's in line with what you historically gotten a little bit lower and maybe even on the Medicaid side, maybe tell us what the pure price decline was in the first quarter?

Steve Filton ***Universal Health Services Inc - CFO***

Yes. I think from a rate perspective, Ralph, we continue to get commercial rate increases in the 5% to 7% range that we've talked about for some time. Our Medicaid declines as we've been saying since July of last year are in the 3% to 4% range, and I think what's driving -- as I tried to outline before, what's driving the pressure on acute care pricing is not rates from a particular payer, but the mix of business. And that mix continues to shift from our better paying commercial and Medicare patients to our weaker paying Medicaid and frankly

non-paying patients. That trend has been in place for a while now, and that's -- the fact that, that trend was interrupted in the first quarter of 2011 last year and we're seeing it resumed in the back half of 2011 and into 2012, that's really what's driving that very difficult comparison in Q1.

Ralph Giacobbe ***Credit Suisse - Analyst***

Okay. That's fair. Maybe you can give us in terms of your managed care contracts, do you have what percentage is done for 2012 versus 2013?

Steve Filton ***Universal Health Services Inc - CFO***

I would say at this point, we've probably got somewhere between two-thirds and 0.75 of our 2012 contracts done and maybe a 0.25 to a third of our of 2013 contracts.

Ralph Giacobbe ***Credit Suisse - Analyst***

Okay. Then just going back to the behavioral side where your conversation earlier around the decline in length of stay, is this something we should think about that's going to comp out shortly, or is there just a lot more days to come out as more -- as we get more of a shift to managed Medicaid?

Steve Filton ***Universal Health Services Inc - CFO***

I'm not sure, Ralph, that we can answer that question with great confidence. This pressure on length of stay has been existing now for some time. I think it is largely a function of state Medicaid programs or their contractor, managed Medicaid providers who are attempting to address budgetary concerns and drive costs down by reducing length of stay. As we expect with Medicaid rates, we think that pressure will ease a little bit in this next budgetary cycle beginning this summer. But I suspect that we may not see length of stay compression completely stabilize at that point. It may still continue to trend downward.

Operator

AJ Rice, UBS.

AJ Rice ***UBS - Analyst***

A couple of questions, if I could ask. On the acute side, the year-to-year margin trend, down 190 basis points, I assume that you would say that's mostly due to the top line pressure, but I did want to at least ask is there anything on labor or supply that's worth calling out that you saw in the quarter? That was particularly noteworthy absent just a natural effect of the pressure on the top line?

Steve Filton ***Universal Health Services Inc - CFO***

No, AJ, I think that we would attribute the margin decline almost exclusively to the top line pressure.

AJ Rice ***UBS - Analyst***

Okay. You didn't recognize any high-tech revenue in the quarter or incentive payments in the quarter. You did collect it looks like [$17] million in cash. Do you have an updated estimate or what is your thought on how much you would likely collect in cash this year? And any thought -- updated thought on timing of recognition?

Steve Filton ***Universal Health Services Inc - CFO***

I think I would just reiterate what we talked about from a free cash flow perspective last year. Excuse me, at our 2012 -- guidance, and that is we expect to generate free cash flow in the $400 million to $500 million range. And again much like our operating income guidance, I don't think we have any changes to that.

AJ Rice ***UBS - Analyst***

Okay. Then just finally on the Medicare proposed rule, any comment or thought or reaction to that relative to what you were thinking?

Steve Filton ***Universal Health Services Inc - CFO***

I don't know what others have said, but I think we probably reacted by thinking that the update was maybe 100 to 150 basis points lower than we expected, mostly because of higher than expected coding adjustment and a higher threshold on the outliers. I'm not smart enough to predict how the final rule will look. Obviously the industry will lobby hard for some relief on both those issues.

Alan Miller ***Universal Health Services Inc - CEO***

AJ, you guys did very well in the draft. You've got a first rounder in Jim Forbes.

Operator

Gary Lieberman, Wells Fargo.

Gary Lieberman ***Wells Fargo Securities, LLC - Analyst***

Behavioral continues to be very strong. Is it possible for you to parse out how much of that is organic, how much of that is continuing to benefit from the synergies on the site solution assets?

Steve Filton ***Universal Health Services Inc - CFO***

I don't know that I can do it precisely, Gary. I will tell you that we continue to improve the margin on the PSI assets. Or the PSI portfolio. And I think our view is that there is still a benefit -- a continuing benefit to be had, so we're generally positive about behavioral performance for two reasons. One is we view the revenue growth in that business as very solid and strong. We've been growing at above 5% for 2.5 years now in the teeth obviously, of a very severe recession. So we feel real good about the underlying demand in that business. Then we still feel, as I said that there are opportunities that we've talked about in many occasions before to continue to drive slightly higher margins in the PSI portfolio.

Gary Lieberman ***Wells Fargo Securities, LLC - Analyst***

And so the total compared to when you first purchased the assets, the total expectation is higher, lower, the same in terms of the total synergies that you'll be able to get out of it?

Steve Filton ***Universal Health Services Inc - CFO***

In terms of the margin improvement, which we pegged all along at 50 to 100 basis points, cumulatively I'd say we feel fairly confident we'll come in at the high end of that number.

Operator

Gary Taylor, Citigroup.

Gary Taylor ***Citigroup - Analyst***

Just had two questions. Steve, is this the first quarter that PSI is fully in the same store or was that last quarter?

Steve Filton ***Universal Health Services Inc - CFO***

No. It's the first quarter where we have a full quarter comparison.

Gary Taylor ***Citigroup - Analyst***

Okay. That's what I thought. So you had been running on the legacy UHS north of 6% revenue growth for some time and this number is 5.3%. Did I miss any comment in terms of -- have you parsed out at all PSI versus legacy UHS? Or is the length of stay issue kind of impacting both of the assets?

Steve Filton ***Universal Health Services Inc - CFO***

I think that the length of stay issue is affecting the residential assets primarily again in both portfolios. I will say -- I don't know that you were getting to this question or getting to this point with your question, but having the PSI facilities in for a full quarter of comparison, we get a little bit of a drag from their Pines facilities in Virginia. Those were facilities that were somewhat of a problem for PSI, they were having troubled facilities at the time that PSI owned them and quite frankly remain so for us. So including that, we closed down one of

the three campuses that we operate there. That clearly drove revenue down in the quarter in an effort to right that ship and get the quality issues in line for future growth, which I think we feel well poised to do, but it was a bit of a drag in the quarter and the mechanics of having PSI in the same-store comparison contributed to that.

Gary Taylor ***Citigroup - Analyst***

Okay. Yes, that is what I was after. I presume you're not going to want to break those out separately anymore, but I'm just wondering if the slightly slower revenue growth was the impact of PSI coming into the quarter and it sounds like it was. Would you agree -- does leap year have a positive benefit for the behavioral book?

Steve Filton ***Universal Health Services Inc - CFO***

I always been a believer that leap year doesn't have much of an effect either way. It affects the cosmetic metrics a little bit, you've got an extra obviously, day of both admissions and patient days but you also have an extra day of salary expense. And so I don't think it makes a whole lot of difference.

Gary Taylor ***Citigroup - Analyst***

Okay. My last question, maybe more for Alan, I'd be interested I was reading the other day about this $1.5 billion Union Village development in Las Vegas that's supposed to have four hospitals and just wondering if you guys have a view if that's still a pipe dream at this stage or if at any point that geographically that would possibly create any threat to you if they eventually get these hospitals built, any thoughts around that?

Steve Filton ***Universal Health Services Inc - CFO***

I'll take that one, Gary. So that big development, which is in the Southeast part of Las Vegas, or in Henderson, has been on the boards for many, many years. It sounds like it's a little bit closer to reality, perhaps than it has been from a hospital perspective. I think the developers went to Catholic Healthcare West because they clearly have historically dominated that quadrant of the market. What we have heard -- and I don't mean it in any way to be definitive is that whether or not Catholic Healthcare West will build -- what they will build as part of that development is very much still uncertain at this point. So no, I think from our perspective, that is not a quadrant of the city that we have ever competed terribly robustly in. And I don't think that's changing anytime soon.

Operator

Kevin Fischbeck, Bank of America.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

It wasn't clear to me whether you answered this in response to AJ's question, but as far as the EPS guidance, that you're giving, are you reaffirming that kind of ex the Medicare boost?

Steve Filton ***Universal Health Services Inc - CFO***

Yes. Our practice I think always is if we don't say anything, we're not changing anything. But we would reconfirm our year end guidance.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

Okay. Then the Medicare boost would be on top of that -- the one-time items discussed this quarter would be on top of that?

Steve Filton ***Universal Health Services Inc - CFO***

Right. As we're excluding that from our guidance just like we excluded them during the quarter.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

Okay, all right. Perfect. I guess maybe the answer was -- in response to Gary's question, but I would have thought that the same-store behavioral revenue growth would have been a little bit stronger given the leap year. Is it really just that one facility or is there anything else -- how much was closing down that one campus to your same-store metrics?

Steve Filton ***Universal Health Services Inc - CFO***

I don't know the precise impact, but that was probably the biggest impact, Kevin. We closed the facility in Missouri, a residential facility in a process to convert it to acute care beds. That had again, a slightly negative impact in the quarter although obviously we think an ongoing more positive impact. We continue to work on some regulatory issues in Illinois that I think long-term should have a positive impact, but I don't know that any of those had real needle moving impacts.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

Okay. Then as far as Vegas goes, I guess we're kind of seeing some modest economic improvement in Vegas. How in your experience, how long is there between a change in the underlying economic metrics in a market before that starts to really flow through to the numbers? Because it sounds like it's not showing up yet, but when would you start to expect that to show up?

Steve Filton ***Universal Health Services Inc - CFO***

I think that historically, Kevin, our view is that there's usually something like a two to four quarter lag before our business, the hospital business starts to really get the impact of underlying economic metrics particularly changes in unemployment. It's why we were so surprised a year ago that we seemed to get an almost real-time immediate benefit from a decline in unemployment in that market and why we frankly at the time didn't think that was necessarily going to be sustainable. But to your point, I think that some of the news coming out of the Vegas market over the last few months has been encouraging. We're certainly encouraged by it, and we would hope that by the end of this year, we'd start to see some of that benefit in our business.

Operator

Todd Corsair, UBS.

Todd Corsair ***UBS - Analyst***

Just wondered if you guys could comment on your outlook for allocating free cash flow as someone earlier pointed out, you had only a couple million spent on share repurchase during the quarter, and I think per your 10-K, you are expecting a pretty significant amount of free cash flow. So really just interested in hearing where you stand in terms of the balance sheet at this point. Do you want to -- are you guys prioritizing moving back toward investment grade or might we expect a more balanced allocation of free cash flow perhaps with a little more towards the equity in terms of stock repurchase going forward?

Steve Filton ***Universal Health Services Inc - CFO***

Todd, I think that Darren asked a similar question before, and I just very quickly reiterate that absent compelling opportunities on the M&A front, we are largely dedicating our free cash flow to debt repayment. But are exploring these opportunities and if compelling ones arise, we will be prepared to take advantage of them.

Todd Corsair ***UBS - Analyst***

But outside of M&A, stock repurchase is a far lower priority than debt reduction?

Steve Filton ***Universal Health Services Inc - CFO***

I think all the priorities have to be considered at the same time. So I think that if there is a lack of compelling M&A opportunities, we might have a different point of view about free cash flow -- about share repurchase, but I don't think we can answer the opportunity in a vacuum. I think we are exploring all those alternatives at the same time.

Todd Corsair ***UBS - Analyst***

That's very helpful, thanks. Lastly, if could you just refresh us on what remaining capacity you have under existing authorization?

Steve Filton ***Universal Health Services Inc - CFO***

I think our existing authorization is fairly thin, but I don't think that's a determinant factor. If we think it's appropriate to move forward, we certainly, I think, can expand that authorization with without a great deal of difficulty.

Todd Corsair ***UBS - Analyst***

No obstacle there.

Operator

(Operator Instructions) Whit Mayo, Robert W Baird.

Whit Mayo ***Robert W. Baird & Company, Inc. - Analyst***

Just a couple final questions. Steve, is it still your expectation that the Medicare rule for behavioral will be a notice and will probably avoid the formal rule making session? Does that really mean anything to you one way or the other?

Steve Filton ***Universal Health Services Inc - CFO***

Well, Whit, I think that the question has been put to us quite differently over the course of the last few months. And that is where we expecting major changes to the site PPS regulations? And we said no. We expected that the action of CMS would likely either just be the regular market basket update or some minor tweaks to the system. That remains our expectation. It strikes me more about this than I do, but it strikes me that the investors and the investing public are coming around to that point of view. We've had that point of view for some months now.

Whit Mayo ***Robert W. Baird & Company, Inc. - Analyst***

I'd agree. Maybe one other question, several of your peers are feeling the pinch on salaries and other expenses from employment costs, income guarantees, whatever physician strategy they have. It's really never been central to what you guys view as core to your strategy. Just wanted to confirm that nothing has really changed one way or the other as you think about realigning interest with physicians.

Steve Filton ***Universal Health Services Inc - CFO***

Well, I think just to be clear, we certainly believe as I think most of our peers do that physician integration is a critical piece of our strategy moving forward. I think as you've described it and I think, fairly described it, we may not be as enthusiastic about the idea that the only way to address the physician integration issue is through employment and acquisition. We're pursuing a whole array of alternatives, including clinical integration, et cetera, and we'll continue to do so in large part because we recognize I think as you alluded to in your comments that the purchase of physician practices and the employment of physicians often results in negative consequences, like increased cost, et cetera that if we can we'd prefer to avoid. But we very much view physician integration as a market by market issue and as I said, we don't have a one solution fits all approach to it. But we are very conscious of the fact that providers over the years have had very negative experiences in many cases with the economics of physician employment and acquisition. So we're very cautious about it.

Whit Mayo ***Robert W. Baird & Company, Inc. - Analyst***

Yes. Maybe shifting gears just to high-tech and maybe a longer-term question, but do you have any internal thoughts as you look out to Stage Two and the requirements, I know it's a little over the horizon but I'm curious what's on the top of mind with your IT department right now.

Steve Filton ***Universal Health Services Inc - CFO***

I'm not exactly sure what you're asking, Whit. If you are asking, do you think we can comply with the Stage Two requirements, I think the answer is yes. Our EHR implementation, which is still in relatively early stages, but we've got probably a quarter of our hospitals implemented at this point, we're feeling pretty good about the way it's going. We're not yet there in terms of meeting the meaningful use requirements, but we expect to be there and are feeling generally positive about the process.

Whit Mayo ***Robert W. Baird & Company, Inc. - Analyst***

I guess I was just asking whether or not you felt that there were going to have to be more additional internal resources committed to get to Stage Two and Three and maybe a corollary to that being the cost associated with it. I guess a few of us have a great idea for what it looks into Stage Two and Three at this point.

Steve Filton ***Universal Health Services Inc - CFO***

Okay. No, I understand the question better. I think that at this point, our overall estimates of what the EHR implementation will cost us have not changed. Butt in fairness, I think your question points to a good point or makes a good point, yes, it's a changing process. Every time we do an implementation, we rethink our approach, et cetera. So it's certainly not impossible that at some point down the road we come back and revise our estimates of cost or whatever. But at the moment, I think we're comfortable with what we've put out there.

Whit Mayo ***Robert W. Baird & Company, Inc. - Analyst***

Got it. One last one, sorry to slip this in, may have missed it, but did you give any colors on surgical growth and maybe what you're seeing with the birthrate and maybe acuity in the quarter?

Steve Filton ***Universal Health Services Inc - CFO***

Acuity has not really changed for us. We've not had any significant changes in acuity. I think birthrate remains as it has been for the last few years, down a little bit. From a surgical perspective, I think our overall surgeries were probably down 1% or 2% for the quarter, with inpatient surgeries being down a little bit more and outpatient surgeries being a little bit better than that.

Operator

Adam Feinstein, Barclays.

Adam Feinstein ***Barclays Capital - Analyst***

I know we asked one previously, so I will be brief here, but I just wanted to maybe ask -- you guys have done a great job of investing CapEx over the years in some of these bigger projects. So I just thought maybe it would be helpful just to give a quick update on some of the bigger projects in recent years, maybe just talk about how those have ramped up. As you think about doing future projects, just wanted to get a quick update on some of the large ones in recent years like Texoma and Palmdale and Wellington, coming up.

Steve Filton ***Universal Health Services Inc - CFO***

Sure. So the three big acute care projects that we've completed in the last few years, Adam, are a new hospital, a replacement facility in the acquired Texoma market, which is North of Dallas. A replacement facility for our Lancaster Hospital in Palmdale, California and then a significant new tower for Summerlin in Las Vegas. Obviously -- although this wasn't contemplated when we undertook those three projects that were all, frankly, begun around the same time, they were all begun right in the -- frankly, before the recession and opened in the middle of the recession, and so I think we've said a number of times that all three of those projects have been somewhat slower to ramp up than our original expectations. On the other hand, I don't think that our fundamental view of any of those projects has fundamentally changed from when we undertook them. We think that they will all be ultimately accretive and helpful to our earnings.

Texoma's probably the one that's had the most success so far. It's a market that probably has had the least economic drag. Southern California and Las Vegas have had more of an economic drag, so the Summerlin and Palmdale projects have been a little bit slower. In terms of the new projects that we have going, the new hospital in Temecula, California, is part of our Riverside County network where we got three existing hospitals. There's data out there that shows that Temecula is the largest metropolitan area without a hospital in the US, so we think that there's a tremendous unmet demand there that we're hoping to serve. Then our Wellington Hospital on the East Coast of Florida has been a hospital that has been extremely successful for us particularly over the last five or seven years. We're just trying to take advantage of the fact that we've had some capacity constraints there, and so we'll have that tower opened by the end of this year.

Operator

Frank Morgan, RBC Capital Markets.

Frank Morgan ***RBC Capital Markets - Analyst***

I hopped on late so I apologize here if you've already answered this. But did you talk about, Steve, the uninsured admit rates as either the growth in it or the mix as a percentage of total admits that were uninsured?

Steve Filton ***Universal Health Services Inc - CFO***

Frank, I think what we've said is that basically the trend we're seeing in our acute care business is lower commercial and Medicare admits and higher managed Medicaid and self pay admits. And that's a trend that frankly has probably been present now for a good three, maybe four quarters.

Operator

There are no further questions at this time.

Steve Filton ***Universal Health Services Inc - CFO***

Okay. Well, we thank everybody. We know everybody has a busy morning and we look forward to speaking with you again next quarter.

Operator

Thank you again for participating in today's conference call. You may now disconnect.

THOMSON REUTERS

PLACEHOLDER TRANSCRIPT

Q2 2012 Universal Health Services Earnings Conference Call

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Alan Miller *Universal Health Services Inc - Chairman & CEO*

CONFERENCE CALL PARTICIPANTS

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A.J. Rice *UBS - Analyst*
Ralph Giacobbe *Credit Suisse - Analyst*
Gary Lieberman *Wells Fargo Securities, LLC - Analyst*
Darren Lehrich *Deutsche Bank - Analyst*
Kevin Campbell *Avondale Partners - Analyst*
Gary Taylor *Citigroup - Analyst*
John Ransom *Raymond James & Associates - Analyst*
Frank Morgan *RBC Capital Markets - Analyst*
Kevin Fischbeck *BofA Merrill Lynch - Analyst*

PRESENTATION

Operator

Good morning. My name is Bonita, and I will be your conference operator today.

At this time, I would like to welcome everyone to the UHS Second Quarter Earnings Conference Call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session.

(Operator Instructions)

Thank you. I would now like to turn the call over to Mr. Steven Filton, Chief Financial Officer. Sir, please begin.

Steven Filton *Universal Health Services Inc - SVP & CFO*

Thank you. Good morning. Alan Miller, our CEO, is also joining us this morning.

Welcome to this review of Universal Health Services results for the second quarter ended June 30, 2012. During the conference call, Alan and I will be using words such as believes, expects, anticipates, estimates, and similar words that represent forecasts, projections, and forward-looking statements. For anyone not familiar with the risks and uncertainties inherent in these forward-looking statements, I recommend a careful reading of the section on risk factors and forward-looking statements and risk factors in our Form 10-K for the year ended December 31, 2011, and our Form 10-Q for the quarter ended March 31, 2012.

We would like to highlight just a couple of developments and business trends before opening the call up to questions. As discussed in our press release last night, the Company reported net income attributable to UHS per diluted share of $1.10 for the quarter. After adjusting for the prior-year impact of several reimbursement items recorded during the quarter, and the revenues and expenses associated with the implementation of electronic health records applications at our acute care hospitals, our adjusted net income attributable to UHS per diluted share for the quarter ended June 30, 2012, was $1.12.

On a same-facility basis, revenues in our behavioral health division increased 4.1% during the second quarter of 2012 over the comparable prior year quarter. Adjusted admissions and patient days to our behavioral health facilities owned for more than a year increased 3.3% and 0.2% respectively during the second quarter. Revenue per adjusted patient day rose 3.5% during the second quarter of 2012 over the comparable prior-year quarter. Operating margins for our behavioral health hospitals owned for more than a year increased to 28.6% during the quarter ended June 30, 2012, as compared to 26.9% during the comparable prior-year period.

On a same-facility basis in our acute care division, revenues increased -- decreased, excuse me -- 2.2% during the second quarter of 2012. The decrease resulted primarily from a 1.3% decrease in adjusted patient admissions and a 0.9% decrease in revenue per adjusted admission to our hospitals owned for more than a year. The revenue decline reflects a difficult comparison to the prior-year quarter,

when our net revenues were favorably impacted by positive changes in payer mix, especially stabilization in uninsured volumes.

On a same-facility basis, operating margins for our acute care hospitals decreased to 16.3% during the second quarter of 2012, from 17.8% during the second quarter of 2011. Our acute care hospitals provide a charity care and uninsured discounts based on charges at established rates, amounting to $266 million and $239 million during the three-month periods ended June 30, 2012, and 2011, respectively.

As a percentage of acute care net revenues, bad debts, charity care expense, and the uninsured discount, in this year's second quarter we're at levels higher than those experienced during the second quarter of 2011. However, due primarily to the increase in behavioral health revenues and the very low levels of bad debt and uninsured discounts in that business, our overall percentage of bad debt to charity care and uninsured discounts were lower than those experienced during the second quarter of 2011.

Our cash from operating activities was approximately $246 million during the second quarter of 2012, as compared to $173 million in the second quarter of 2011. Our accounts receivable days outstanding decreased to 54 days during the second quarter of 2012 from 56 days during the first quarter of this year, as we collected a portion of outstanding Medicaid receivables from the state of Illinois. At June 30, 2012, our ratio of debt-to-total capitalization was 57.7%, and debt-to-EBITDA was 2.99 times.

We spent $90 million on capital expenditures during the second quarter. Included in our capital expend expenditures during the first half 2012 were the construction costs related to the construction of a new acute care hospital in Temecula, California; a new bed tower at our Wellington facility in Florida, and 222 beds added to facilities within our behavioral health division.

Against the backdrop of a sluggish economic recovery and based upon the operating trends and financial results experienced during the first six months of 2012, our revised estimated range of adjusted net income attributable to UHS for the year ended December 31, 2012, is $4.25 to $4.35 per diluted share. This revised guidance, which represents a 2% to 3% decrease from our original 2012 guidance, excludes the estimated favorable impact associated with the implementation of electronic health records applications at our acute care hospitals. And the impact of the other items reflected on the supplemental schedule for the six months ended June 30, 2012, as disclosed in last night's press release. As well as any incremental impact resulting from our previously announced acquisition of Ascend Health Corporation, which we expect to complete during the fourth quarter of this year.

Alan and I would be pleased to answer your questions at this time.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions)

Tom Gallucci, Lazard Capital Markets.

Tom Gallucci ***Lazard Capital Markets - Analyst***

Thanks. Good morning. Two quick questions. Steve, first on the acute care side, given the trends you've seen and the change in guidance, just wondering what you've baked into your guidance as we think about the second half of the year versus first-half trends.

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Tom, in our original guidance, if people recall, was that acute care revenues would grow in 2012 by somewhere in the neighborhood of 3%, and I think we believe, because of the comparisons to 2011, that was back-end loaded. We grow by, let's say, 2% in the first half of the year, and by 4% in the back half of the year.

I think the revised guidance is, frankly, almost exclusively a reflection of the fact that we think that 4% growth that was embedded in the back half of the year in the original guidance is now probably 1.5% or 2%, and is reflective just of the existing operating trends that we're seeing.

Tom Gallucci *Lazard Capital Markets - Analyst*

Okay. On the behavioral health side, obviously you had very good trends there for 18 months or so that were above average, is I guess the way we looked at them. We sort of came back down to earth a little bit this quarter. Can you point to anything in particular that may have changed, and I guess what is your long-term growth outlook for that business at this stage?

Steven Filton *Universal Health Services Inc - SVP & CFO*

Yes, I think Tom, that we've said a number of times that we think that going forward a reasonable revenue growth rate in the behavioral division is probably in the 5%, 5.5% range, and we've been pretty consistently meeting those targets. We were a little lower than that in Q2.

As we looked at the detail of it, I think we identified a number of facilities where, because of ongoing either new construction projects, or ongoing construction projects to convert residential to acute beds, we had to close down some capacity. We think that cost us maybe 50 or 60 or 70 basis points of revenue growth in the second quarter. I think when adjusted for that, I think we feel like, again, that 5%, 5.5% growth rate is reasonable. The other piece is that beginning in July of 2012, the severe Medicaid reductions that we saw at this time last year of 3% to 4% moderate to something like flat to down 1%, and so that's a helpful comparison, as well.

Tom Gallucci *Lazard Capital Markets - Analyst*

Okay. Thank you very much.

Operator

AJ Rice, UBS.

A.J. Rice *UBS - Analyst*

Hi, everybody. Maybe I'll ask two questions, as well. Following up on the Behavioral business, can you point to -- is the moderation, and albeit slight and you had great margins -- is it basically a capital constraint issue in the second quarter that somehow gets a little better in the back half of the year? How much of it was that, or how much of it's just the natural ebb and flow from Q1 to Q2?

Steven Filton *Universal Health Services Inc - SVP & CFO*

AJ, just following on what I was saying to Tom, I think that the 50, 60, 70 basis points that I alluded to is exactly what you're talking about. We had beds that we had to have out of service for these construction projects, and I think our sense is two-fold. Once we are able to get those beds back in service, and once the new beds that we're building, or the converted beds that we're building go back on line, that we're very comfortable that the demand is actually there to support this sort of 5%, 5.5% growth rate.

A.J. Rice *UBS - Analyst*

Right, okay. On the -- back on the acute side, and I guess I'm sitting here, again, cost-control-wise, you guys have done a good job. I can't remember the last time I've seen someone post negative same-store revenue growth in acute business, but, obviously, you had a very tough comp a year ago. One of the things we're seeing from some of the other guys is they report soft in-patient volumes. It seems like they're getting a little help from revenue per adjusted admission being somewhat stronger.

The argument that at least is being made is that the soft volumes tend to be in cases that have lower revenues associated with them, and, therefore, it's not impacting the overall revenue growth. They're still posting 3%, 4%, 5% revenue growth on a same-store basis. It doesn't seem like that dynamic is at play here in your case. I just wondered if you had any thoughts about it in terms of where you're seeing the softness in the volume and the revenue per adjusted admission being a little -- sort of flattish, or only slightly up?

Steven Filton *Universal Health Services Inc - SVP & CFO*

Yes, so I think if you look at the difference between our admissions, our unadjusted admissions, and our adjusted admissions, there is a measurable difference, which obviously implies that our outpatient revenues are growing faster than our inpatient. We are certainly

experiencing some of that same shift that you're alluding to, AJ, that I think the other companies are referencing.

What it does also highlight, however, is that the unadjusted admissions, that is really the straight inpatient admissions, are rather weak and remain rather weak, and we think that's largely a function of these sort of very difficult economic conditions in certain of our markets, most notably Vegas and South Texas. I think that's the major explanation. I think other than that, we feel like, as we look at what the other companies are reporting, that in general and directionally, we're experiencing much of the same trends.

A.J. Rice ***UBS - Analyst***

I guess the point I was making is, Steve had pointed to upper respiratory, ob-gyn cases, which sometimes can be lower revenue cases, and then obviously your surgery and so forth, and suggests that maybe they're not losing as many as the inpatient hiring cases, is that -- when you look at where the softness is on the inpatient volume, is that sort of across the board, or does it tend to be in those types of cases?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Well, I think that's a valid observation, and I think the way we would or I would sort of proof that, if you will, is by saying that our acuity has changed very little, and that our acuity has remained consistently high, which suggests that we continue to get the most tertiary and the most severe and acute cases, and that the business that we're losing tends to be the less intense business that is shifting either to outpatient or just shifting to a non-admitted status.

A.J. Rice ***UBS - Analyst***

Okay. All right, thanks a lot.

Operator

Ralph Giacobbe, Credit Suisse

Ralph Giacobbe ***Credit Suisse - Analyst***

Steve, do you have the payer mix in the quarter, if possible, the percentages by payer, maybe, this quarter versus a year ago?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Ralph, I don't have the specific metrics in front of me, but I will tell you that the trend that we saw in the quarter was, again, very similar to what we have been seeing, which is taking whatever metric you like, if you take the 1.3% decline in adjusted admissions, that commercial and Medicare admissions declined more than that, and Medicaid and uninsured admissions increased more than that. That unfavorable shift is one that's been under way for some time, and continues. Quite frankly, until we believe the economies improve in our local markets, et cetera, that it's going to be difficult to reverse those trends.

Ralph Giacobbe ***Credit Suisse - Analyst***

Okay. Can you remind me of the drag on Medicaid from the cuts that started last July, and then the head wind or, I think, tail wind that you see for fiscal 2013?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Yes. In July of 2012 -- excuse me, in July of 2011, we said that Medicaid rates, on average, were decreasing 3% to 4%. Our guidance for 2012 presume that in July of 2012, Medicaid rates would be flat to down 1%, and given all the states that we've been able to get results from, et cetera, and have their rates in place, we believe we're in that range.

Ralph Giacobbe ***Credit Suisse - Analyst***

Okay. All right, that's helpful. Just the last one. I think there's been questions in the past on sort of the margin and EBITDA growth in behavioral and revenue trends have been higher. Revenue was obviously a little bit lower this quarter, but you had better margins and growth. Is that related to PSI synergies incrementally coming on board, or is it just more broad-based and maybe sustainability of that going forward?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

I think the answer is sort of two-fold. One, again, as you alluded to Ralph, I certainly think that we continue to improve the PSI legacy margins, if you will. In short order, we're going to stop using that term. I also believe, and we've made the case, that if we're able to grow revenues by 4% or 5%, in what amounts to a fixed, a largely fixed and semi-fixed cost business, we should be able to continue to expand margins. Again, I think you saw in that Q2.

It's not always absolutely linear, so there's some quarters in which we -- revenue grew by a little bit more, and margins didn't increase quite as much, and in Q2 of this year, revenue was a little more moderated, but cost controls were better. In general, I think if we can have that 5% revenue growth that I have mentioned a few times on the call, we should continue to generate expanded margins in the Behavioral business.

Ralph Giacobbe ***Credit Suisse - Analyst***

Okay. Thank you.

Operator

Gary Lieberman, Wells Fargo.

Gary Lieberman ***Wells Fargo Securities, LLC - Analyst***

Good morning. Thanks for taking the call. Alan, I would be interested to get your perspective on Washington heading into the elections and with the fiscal cliff coming up, the potential that Congress addresses sequestration, either in a lame duck or in a new Congress?

Alan Miller ***Universal Health Services Inc - Chairman & CEO***

Yes, I thought you were going to ask about anything that is new. Nothing happens before the election, and lame ducks are difficult. We don't really have any indication, except that Vice President Cheney came out of sort of seclusion and went up on the Hill and talked about the defense. So, I think they're going to have to try and address something, but we have -- we don't have any indication as to where and how, except that the other thing I'll say is that we are in good shape with the administration, the hospitals are. I think we've got them on the defensive a little bit because of the state's reaction to Medicaid. I think that -- I know for a fact that the administration is going to try and be helpful to hospitals.

Gary Lieberman ***Wells Fargo Securities, LLC - Analyst***

Since you brought it up is there anything new?

Alan Miller ***Universal Health Services Inc - Chairman & CEO***

In what regard?

Gary Lieberman ***Wells Fargo Securities, LLC - Analyst***

Just in general.

Alan Miller ***Universal Health Services Inc - Chairman & CEO***

You mean legislatively?

Gary Lieberman ***Wells Fargo Securities, LLC - Analyst***

Yes, anything that you're aware of or anything that's come across your radar screen that you find particularly interesting.

Alan Miller ***Universal Health Services Inc - Chairman & CEO***

No, nothing. I think that it is the law, but a lot of people don't like it, and a lot is happening at the state level, as you're well aware with regard to the Medicaid, and it is going to be a very brutal, challenging situation legislatively in Washington, regardless of who wins. I think it's unlikely that Republicans can have a sweep of all three, house, Senate, White House. But it's going to be a really very interesting year next year.

As I said, I think we're in good shape. We're in as good a shape as we can be, because of, I, think, very smart moves on the part of some of our representatives. I don't mean legislatively, representing the different organizations. I think the administration is very strongly on our side, for whatever good that is.

Gary Lieberman ***Wells Fargo Securities, LLC - Analyst***

Okay, great. Thanks for your thoughts.

Operator

Darren Lehrich, Deutsche Bank.

Darren Lehrich ***Deutsche Bank - Analyst***

A few things here. As it relates to the M&A activity, Steve, we saw the deal termination and the cash flow statement. I just want to confirm that you have exited that South Texas situation. Is that what that was?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Yes. As we've, I think, disclosed at the end of last year, we had a tentative agreement to buy Knapp Medical Center in the South Texas market. Subsequent to reaching a definitive agreement, the seller discovered some limitations they had in being able to sell the facility, and as a result of that, they were unable to resolve those, and the agreement was terminated.

Darren Lehrich ***Deutsche Bank - Analyst***

Right, and I guess just a refund of your money. Auburn, we're still on track for a September close there. I just wanted to also ask about Ascend timing. Is there anything different that we should be thinking about there?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

No. As you suggest, we -- our intent is to close Auburn late in the third quarter, and our intent, which is a little less precise and specific because it involves FTC approvals, is that we close, or be able to close Ascend sometime during the fourth quarter.

Darren Lehrich ***Deutsche Bank - Analyst***

If I could, Alan, would love to just get your thoughts on the acquisition outlook for the Company. Obviously, Ascend is a really unique situation for you in behavioral. How are you thinking now about acute and the outlook in that pipeline, the opportunity for more behavioral like Ascend? Just would love to get your updated thoughts there.

Alan Miller ***Universal Health Services Inc - Chairman & CEO***

I think Ascend is very unusual in that the quality of it, nine facilities, every one of them is really good. There's new beds coming on. They've been very well managed, but there's a lot of growth in it. We think Ascend was unusually good quality-wise. We're very happy with that, very happy with it. We think we can see a lot of growth coming from it. I don't think there are networks that we know of that are similar to Ascend. I think ascend was -- we think Ascend was just a great acquisition.

With regard to other acquisitions, we're seeing a lot. I think in this environment, it's a question of what you want to direct yourself towards, but there's a lot of opportunities. We're going to close Ascend and move on to look at other opportunities, both acute and behavioral. I just want to stress, I think the Ascend deal was really an excellent deal for us, unusually excellent.

Darren Lehrich ***Deutsche Bank - Analyst***

Thanks for that. The last thing here, we have heard your commentary a lot about just the comps, and obviously, knew going into this year that that was going to be a challenge, particularly in Vegas, given the success first half in Summerlin. I guess the thing I'd like to ask, is there anything new or different beyond the macro you're seeing in Vegas competitively, the way physicians are being organized, anything that we ought to also consider?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

I don't think so, Darren. I would make the comment that, obviously, when a market is contracting the way that Vegas or South Texas has been, that, you know, it's natural to see competition ramp up. People are competing for a smaller base of patients, and it becomes sort of

more intense and more severe, and I think we've seen in that both markets. But I think our market position remains largely the same. There are small shifts in market share, et cetera, but I think that the overarching issue, again, in both of those markets has been market softness that quite frankly, we've been struggling with for a long time now.

Darren Lehrich ***Deutsche Bank - Analyst***

Okay. Thanks a lot.

Operator

Kevin Campbell, Avondale Partners.

Kevin Campbell ***Avondale Partners - Analyst***

Good morning. Thanks for taking my questions, a couple quick ones on guidance. Can you give us an estimate of the impact that moving Auburn Regional Medical Center out of continuing ops had on the earnings guidance?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Just to be clear, because of its relative immateriality, we did not show or report Auburn as a discontinued op, we just removed the detailed revenues and expenses and recorded the EBITDA loss of Auburn, which was a couple of million dollars in the quarter in the other operating expense line. Because we expect to dispose of Auburn in the third quarter, we've included in our guidance a comparable amount for Q3, and then assume that it's no longer owned by us.

Kevin Campbell ***Avondale Partners - Analyst***

Okay, that's helpful. As you look at your volumes, particularly in the fourth quarter and the new re-admission rules coming into play, are you anticipating any unusually -- unusual difference in volumes fourth quarter this year versus prior years because of the new re-admission rules, or do you feel like you already have a pretty good handle on re-admissions, and therefore it's not going to be a material impact on your volumes in the fourth quarter?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

No, I think Kevin, as you sort of suggest, that the attention to the re-admission rules has now been present for a while. The government regulations and rules about the incentive penalties in that regard have been well-known now for a while. I don't sense that we're likely to see any significant or impactful change as we move forward.

Kevin Campbell ***Avondale Partners - Analyst***

Okay. Last question on the non-controlling interest. How should we think about that from a modeling perspective going forward, just on a pure dollars basis?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

As everybody, I think, knows, the most significant item on that non-controlling interest line is the minority interest in the Vegas market. As Darren, I think, and others have asked about, that's a market that's been soft. I think that part of our reason for revising guidance is an expectation that at least in the short run it remains so. To me, the current run rate in that market, and therefore the impact on that line is probably as good a guide to at least the next couple of quarters as anything else.

Kevin Campbell ***Avondale Partners - Analyst***

Okay, great, thank you very much.

Operator

Gary Taylor, Citigroup.

Gary Taylor ***Citigroup - Analyst***

Good morning. Just a couple of housekeeping things, Steve. On the high tech payment that you receive and that you break out in the supplemental tables, I think it's actually called revenue. I just wanted to make sure, that's being netted in the other operating expense line, it's not in the revenue line, correct?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

No, it is on the revenue line, Gary.

Gary Taylor ***Citigroup - Analyst***

Okay. On the minority interest share attributable to some of those high tech expenses, I assume that's down in the minority interest line as part of that line, as well, right, not rolled up in other ops?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Yes. No, that's correct. It is on the minority interest line.

Gary Taylor ***Citigroup - Analyst***

I guess my last question is, can you talk a little bit about the length of stay pressure in RTC and any expectations of when that might abate, or is there a significant state where some policy changes might anniversary, or when we should expect, or if we can expect reasonably that some of that length-of-stay pressure is going to ease?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Again, this is another dynamic that certainly has been present now for, I would say going on a couple of years, where we've seen, really since I think the recession began, we've seen Medicaid programs throughout the country tighten up on both the rate of payment, which lots of companies discuss; but for us, in the behavioral division, also on utilization, which really I think is most notably reflected in length of stay contraction.

Actually, I thought one of the encouraging, albeit mildly encouraging, dynamics in Q2 was that I thought the length-of-stay reduction decelerated a little bit. To your point, Gary, and may sense is that just as we talked about rates, Medicaid rate reductions decelerating in July of 2012, my sense is that length-of-stay contractions should respond the same way, because it quite frankly is emblematic of the same sorts of budgetary issues. I think it remains to be seen. I don't think we've bottomed out yet, but I think the hope is that we'll at least start to see some deceleration or stabilization in that contraction.

Gary Taylor ***Citigroup - Analyst***

Are there, I guess in RTC, are there some hard stops or policy changes, or this is just more active utilization management, I guess, for lack of a better word in terms of number of days a state is allowing?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Yes, I think much less than hard stops is just kind of a series of initiatives that different states take on in different ways, trying to move these kids out sooner, move them into less-intensive settings like group homes and stuff like that. Those are the kinds of things you see, as opposed to again, as you describe, a hard stop where they just say absolutely not after 25 days, or whatever the issue is. It's just a variety of initiatives.

Interestingly, the admission growth level has not really changed, which sort of implies, and to some degree I think it's remained pretty strong, which sort of implies that clinically, the effort to get these kids out sooner in the end is not really meeting the overall objectives, in that they may just be returning to facilities because they're not completing an effective course of treatment.

Gary Taylor ***Citigroup - Analyst***

Okay, thank you.

Operator

John Ransom, Raymond James.

John Ransom ***Raymond James & Associates - Analyst***

Hi, good morning. Just based on our estimate, it looks like your profit contribution between behavioral and acute, if you factor in Ascend is close to 70% behavioral and 30% acute, if we do some estimate allocation. As you look at your mix of M&A and you think about your

portfolio, do you think that number is a good number? Is that going to hold, or are we at the high-water mark, in terms of the relative behavioral mix in the business?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

John, I think we've said many times over the years that we've never set target percentages in the way that you've framed your question. As you know, obviously that allocation used to be dramatically different with the acute contribution being higher.

I think our view always is we're looking for the next dollar of invested capital to go into whatever investment that is, whether it's an external M&A investment in acute or behavioral, or an internal CapEx investment in one of those segments, or in buying back our own shares. We are always looking for it to go in the place where we think it's going to earn the greatest return, and I think that remains our approach and our point of view.

John Ransom ***Raymond James & Associates - Analyst***

Do you -- are you seeing any large acute care deals that you're even close to pulling the trigger on? I know you guys are very picky, and you should be commended at being so. Conversely, do you think it's possible you might explore any more acute divestitures?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

I think as Alan suggested, we are seeing a large number of deals available out in the market place, and I think that's reflective of what our peers say, as well. As you suggest, John, we're quite proud of the fact that we're very judicious in how we evaluate those deals and what we choose to pursue. Our general sense, on the acute side especially, is that those deals are going to be available. Not those specific deals, but deals of that kind will be available now for the foreseeable future.

I think the landscape of healthcare is changing in the country, and this pipeline that is robust at the moment, I think, will remain so. And so, we'll continue to look at those kinds of deals. Just as we're looking at organic expansion, I alluded to a couple of new project in my remarks that were under way, and new beds in behavioral. Again, all those items are on the table as we think about our Business going forward.

John Ransom ***Raymond James & Associates - Analyst***

I've heard -- I mean there's plenty of second-tier and rural deals. I guess I was curious if there were kind of whole-market acquisitions and larger urban market type deals, or if it's still kind of more one-off a hospital in this market or that market or maybe a market that's not growing. Are you seeing the upper -- like the opportunity to go and do a large market and take 30% share or something? Are you seeing any of those kind of deals?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

It strikes me that there is starting to be an evolution, as you suggest of the deals available. I think for the last couple of years it's been heavily skewed towards the single, stand-alone, more rural providers, and I think that we're starting to see a shift to bigger systems, multiple facility systems, et cetera. Again, my sense is that's going to continue, that we're nowhere near the top of the curve on that yet.

Alan Miller ***Universal Health Services Inc - Chairman & CEO***

John, you're particularly astute, and I can tell you, and I'm sure you have seen this, or you -- the industry is going through a real transition. These things take time. It's going to be slow, but it's going to be a real transition. I think the companies that are experienced and have been successful over a long period of time, and know how to evaluate opportunities, and are not impatient are going to do really well.

John Ransom ***Raymond James & Associates - Analyst***

I guess that's what I think. I would think there's a pretty high probability we're going to wake up in the next two years and you guys are going to go into a new market in a pretty big way. You've husbanded your resources accordingly, and I know you're not going to jump at something just because it's there. Anyway that will be interesting.

My other question is, I guess there was a little bit of chatter about the revenue multiple that you paid for Ascend. I know they have very

high margins, and it's been a very well run company, but this seemed a little bit like a stretch multiple, for you guys in particular. What are we missing? Is it the growth? Is it the ability to add capacity on the back end of this? Is that what we might be missing here?

Alan Miller ***Universal Health Services Inc - Chairman & CEO***

I'll just say one thing. Really good opportunities are not bargain priced, so I wouldn't say that this was a bargain price. Cole Hamels just went for $144 million. There aren't a lot of really great left-handers around, so we think Ascend was worth what we paid in the long run.

John Ransom ***Raymond James & Associates - Analyst***

Okay, thank you.

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Next question.

Operator

Frank Morgan, RBC Capital Markets.

Frank Morgan ***RBC Capital Markets - Analyst***

Good morning, thanks. Steve, I was hoping you could go back on the volume side, obviously weak by geographies. But in terms of service lines, can you comment and give some kind of characterization of the volume between, say, what looked better or worse between, say ortho or cardio, or any of those specific business lines. On the topic of the weak volume, I know Gary asked about tighter utilization management in behavioral care. Are you seeing anything different in your acute markets? Would that be a contributor, as well as just a weak economy?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Sure. Again, I think the trends, Frank, overall, remain much the same. That is -- and again, I think AJ was asking a similar question, kind of from a different angle. We continue to see relatively steady volumes in our most tertiary, most severe procedures. As you would expect, because quite frankly, there sort of is no alternative to in-patient treatment for those kinds of procedures.

Within those kinds of procedures, we've seen a shift, as I think most of our peers have, away from cardiac into orthopedics and certain other specialties over the last few years. We've seen the same decline in births that many of our peers have seen. Again, I don't necessarily feel like any of the trends that we've seen, other than sort of as indicated by the specific conditions in our market, are terribly different than what our peers say and experience, as well.

As far as the utilization management goes, in effect, I'd give the same answer. I think we face the same increased pressure on rigorous review of the appropriateness of admissions as every hospital in the country, and as a consequence, we're feeling that same shift from inpatient to outpatient that again, I think every hospital feels, but I don't necessarily have any reason to believe that in our markets or in our hospitals we're sort of experiencing it in any sort of unique way or any differently than the average hospital in the country is experiencing it.

Frank Morgan ***RBC Capital Markets - Analyst***

Okay. One more follow-up. You mentioned in your earlier comments on -- you had a theory about re-admission, potential re-admissions, on the behavioral side of the RTC. Do you actually have a number, like what percentage of RTC patients actually end up being re-admitted in any given year? Have you ever seen that number, or do you look at that number?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

I'm not aware of that. It may well be that we have that data. Really, all I was suggesting is that as Medicaid programs try and reduce utilization, one might expect to see a reduction in both admission rates and length of stay, and for the most part what we have seen over the last few years is really no decline in admissions, in fact, pretty strong admissions on both the residential and acute side, but a contraction in length of stay.

Again, my sort of conclusion that I draw from that is that it may be a somewhat self-defeating strategy, in that you're getting some

patients out sooner, but you're not really helping drive down the overall utilization if they're not effectively completing a course of treatment.

Frank Morgan ***RBC Capital Markets - Analyst***

Thank you.

Operator

(Operator Instructions)

Kevin Fischbeck, Bank of America Merrill Lynch.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

You talked a little bit about it, but could you just talk a little bit more about what was going on in Las Vegas this quarter? I know that we had commentary last quarter was that some of the economic data points were starting to firm, and that you kind of hoped that things might start to turn by the end of the year. We've seen some data points get a little bit weaker in Vegas. What are your thoughts there?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Kevin, I think you've summarized it fairly accurately. I think there were some macro indications last quarter that there was going to be overall improvement in the market. Some of those indicators have moved sideways or slipped a little bit. The one thing we've consistently said, and I think we would repeat this quarter is that we're not seeing the recovery in the hospital business yet, and that's still the case. Again, I think part of the decision to take guidance down a little bit is tied to that idea that our expectation now, at least in the short term, is that there's not likely to be significant recovery in that market.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

Okay. You did mention earlier you have some CapEx projects coming, you're starting. But obviously, you took down guidance in part because of concern about the economy impact on things. How do you balance those two things -- the desire to invest for growth down the line, versus kind of what you're seeing right now as a weaker demand profile? What's your thought process there?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

My general sense, Kevin, is that CapEx decisions tend to have a longer-term perspective to them than operating decisions. We, I thought, had very good cost control, as an example, in both of our business segments this quarter as we reacted to a more modest revenue growth environment, and we react very much in real time to those kinds of changes.

As we think about CapEx, and particularly as you think about bigger CapEx, building a new hospital in Temecula, building a new tower at Wellington, or adding beds in behavioral, those I think are much longer-term decisions. We have to think beyond just the current economic recovery and just the market position and what we view as the long-term projections in the market, and that's how we do it. I think that's why you see sort of more immediate changes in our operating cost structure, and less immediate changes in our capital planning.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

Okay. I don't know, maybe I missed it, but you guys are booking high-tech revenue differently than your peers. I guess it's in the revenue number for you. Where does that show up in your same-store metrics? Is that excluded from same store? Does it show up in other revenue on your supplementals?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

It's excluded from same-store, which, and you guys know this better than I do, but I think may be a reason why sometimes our revenue data compares unfavorably to our peers, because I think they do include it in their same-store numbers.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

Now most companies are booking it on a net basis as a contrary expense line. Okay, so does that number then show up in other revenue for you?

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Yes, it's in non-same store acute, is where it will show up in the Q.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

All right. Great, thanks.

Operator

(Operator Instructions)

Mr. Filton, there are no further questions.

Alan Miller ***Universal Health Services Inc - Chairman & CEO***

I have an announcement before everybody gets off. Hello? I have been asked by the Republican Party to host the vice presidential nomination very, very directly after he is named. I say he, most likely a he. It's going to be at my home in Philadelphia sometime between August 12 and 23.

The convention starts the 24th and, of course, the 27th, I believe that's a Monday night, is when all the confirmations are done, et cetera. If you would like to come to Philadelphia and have a really first-hand opportunity to meet the vice presidential prospect, let Steve know. Of course, there's a contribution involved. I will look forward to seeing some of you. It should be really a fun event.

Steven Filton ***Universal Health Services Inc - SVP & CFO***

Okay. Thanks everybody for your time, and we will talk with everybody next quarter.

Operator

And this concludes today's conference call. You may now disconnect.

THOMSON REUTERS

PLACEHOLDER TRANSCRIPT

Q3 2012 Universal Health Services Earnings Conference Call

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Kevin Campbell *Avondale Partners - Analyst*
John Ransom *Raymond James & Associates - Analyst*
A.J. Rice *UBS - Analyst*
Frank Morgan *RBC Capital Markets - Analyst*

PRESENTATION

Operator

Good morning. My names is Felicia, and I'll be your conference operator today. At this time, I would like to welcome everyone to the UHS Third Quarter Earnings Conference Call. All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question-and-answer session.

(Operator Instructions)

Thank you. At this time I will now turn the conference over to Mr. Steve Filton, Chief Financial Officer. Mr. Filton, you may begin your conference.

Steve Filton *Universal Health Services Inc - CFO*

Thank you, and good morning. Alan Miller our CEO is also joining us this morning. Welcome to this review of Universal Health Services results for the third quarter ended September 30, 2012. During this call, Alan and I will be using words such as believes, expects, anticipates, estimates, and similar words that represent forecast projections and forward-looking statements. For anyone not familiar with the risks and uncertainties inherent in these forward-looking statements, I recommend a careful reading of the section on risk factors and forward-looking statements and risk factors in our form 10-K for the year ended December 31, 2011, and our form 10-Q for the quarter ended June 30, 2012.

We would like to highlight just a couple of developments and business trends before opening the call up to questions. As discussed in our press release last night, the Company reported net income attributable to UHS per diluted share of $0.73 for the quarter. After adjusting for the after tax costs of debt extinguishment recorded during the quarter and the incentive income and expenses associated with the implementation of electronic health records applications at our acute care hospitals, our adjusted net income attributable to UHS per diluted share for the quarter ended September 30, 2012 was $0.91 compared to $0.86 per diluted share recorded in the third quarter of 2011 as calculated on the supplemental schedules included with last night's press release. On a same facility basis, revenues in our behavioral health division increased 3.4% during the third quarter of 2012 over the comparable prior year quarter. Adjusted admissions and patient days to our behavioral health facilities owned for more than a year increased 2.6% and 0.7% respectively during the third quarter.

Revenue per adjusted patient day rose 2.6% during the third quarter of 2012 over the comparable prior year quarter. Operating margins for our behavioral health hospitals owned for more than a year increased to 27.8% during the quarter ended September 30, 2012, as compared to 26.5% during the comparable prior year period. On a same facility basis in our acute care division, revenues decreased 0.4% during the third quarter of 2012. The decrease resulted primarily from a 1.7% decrease in adjusted admissions, partially offset by a 1.3% increase in revenue per adjusted admission to our hospitals owned for more than a year. The rate of organic revenue growth was weaker than expected, contributing to a decline in operating margins. On a same facility basis, operating margins for our acute care hospitals decreased to 13.4% during the third-quarter of 2012 from 14.8% during the third quarter of 2011.

Our acute care hospitals provided charity care and uninsured discounts based on charges at established rates amounting to $259 million and $246 million during the three-month periods ended September 30, 2012 and 2011 respectively. As a percentage of acute care net

revenues, bad debts, charity care expense, and the uninsured discount in this year's third quarter were at levels higher than those experienced during the third quarter of 2011. However, due primarily to the increase in behavioral health revenues and the very low levels of bad debt and uninsured discounts in that business, our overall percentage of bad debts, charity care, and uninsured discounts were lower than those experienced during the third quarter of 2011. Our cash provided by operating activities was approximately $162 million during the third quarter of 2012, as compared to $207 million in the third quarter of 2011. Our accounts receivable days outstanding increased to 57 days during the third quarter of 2012, from 51 days during the third quarter of last year as we continue to have a substantial outstanding Medicaid receivable from the State of Illinois.

At September 30, 2012, our ratio of debt to total capitalization was 56.9%, and debt to EBITDA was 2.96 times. We spent $100 million on capital expenditures during the third quarter. Included in our capital expenditures during the first nine months of 2012 were the construction costs related to the ongoing construction of a new hospital in Temecula, California. We opened a new bed tower at our Wellington Hospital in West Palm Beach early in October, and expect to open a new behavioral facility in Chicago later in the quarter. The operating trends and financial results experienced by our behavioral health facilities met our executions during the first nine months of 2012. However, again to the backdrop of a continued sluggish economic recovery, the operating trends and financial results experienced by our acute hospitals were below our expectations for the third quarter of 2012, and those trends are expected to continue during the fourth quarter of this year.

Based upon our consolidated financial results experienced during the first nine months of 2012 and most notably the results experienced by our acute care hospitals during the third quarter of 2012, our revised estimated range of adjusted net income attributable to UHS for the year ended December 31, 2012 is $4 to $4.10 per diluted share. This revised guidance, which includes the EHR impact and the impact of the other items reflected on the supplemental schedule for the nine months ended September 30, 2012, represents a decrease of approximately 6% from the previously provided range of $4.25 to $4.35 per diluted share. The operating pressures that we continue to experience in many of our acute care markets has increased the volatility of the financial results of our acute care hospitals, making estimation of future results more challenging. However, we continue to actively and aggressively respond to these challenges through strategic initiatives and operational enhancements such as physician recruitment and integration, and implementation of expense controls and other operating efficiencies. Alan and I would be pleased to answer your questions at this time.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions)

Tom Gallucci of Lazard Capital Markets.

Tom Gallucci *Lazard Capital Markets - Analyst*

Hello, good morning. This is Colleen Lang on for Tom. Steve, just on the guidance, I was just wondering if you could walk us through what changed in Q3 versus what you were thinking at the time of Q2. Were the admissions worse, or did the mix not improve as you would have hoped?

Steve Filton *Universal Health Services Inc - CFO*

Sure Colleen. So I think in our original guidance for the full year, we were anticipating acute care revenue growth of 3% for the full year. And that was broken down into slightly a lower amount, let's say 2% in the first half of the year, and a slightly higher of like 4% in the back half of the year, which was reflective of the fact that we were aware that our comparisons were going to be more difficult in the first half of the year. At the end of the second quarter, when we revised our guidance down slightly, it was really an acknowledgement on our part that acute-care revenue growth would likely not even meet that 4% level in the back half of the year, so we revised it down to about 2% growth. And as you can see in Q3, we didn't meet the 2%. Our acute care same store revenue growth was actually slightly negative. And really, the revised guidance for the fourth quarter is really just reflective of that trend and the expectation that trend is likely to continue into Q4.

Tom Gallucci ***Lazard Capital Markets - Analyst***

Okay. Great. And then just quickly on the behavioral side. I think last quarter you talked about how you took some beds off line for construction projects in converting some beds from RTC to acute. Did you see that impact again this quarter?

Steve Filton ***Universal Health Services Inc - CFO***

We did. The 3.4% revenue same store revenue growth that we saw in acute in Q3, I would remind people different than the acute dynamic is compared to a pretty robust number in Q3 of 2011, close to 7% same store revenue growth. So the 3.4% was against a difficult comparison. But it does reflect the metric that we talked about last quarter, which is that probably the single greatest pressure we feel on the behavioral side is continued pressure on our Medicaid link per say in the residential business that has been driving our same store revenue growth down.

And we are, as we discussed last quarter, doing any number of things to try and counter that including adding more acute care beds. Obviously, the Ascend transaction will add a significant number of acute care beds. Converting residential beds to acute. And all of those initiatives continue. And so yes, I think that a little bit of a dampening impact on our revenue growth in the quarter. And we think as the initiatives gain traction, that number will start to climb back to a level that we saw just a few quarters ago.

Tom Gallucci ***Lazard Capital Markets - Analyst***

Great. Thank you.

Operator

Kevin Fischbeck of Bank of America.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

Thanks. Was wondering about this guidance reduction in 2012, and how to think about it for 2013. I know that you're not providing 2013 guidance at this point, but if you took down EPS guidance by 6% the second half of the year, is there a reason not to kind of say well let's annualize that and take down the number by 12% for the year and use that as our basis for how we think about growing into 2013? I guess you mentioned the cost study initiatives that should help offset this next year. But why isn't, taking the impact, analyzing annualizing it, and then growing off of that the right way to think about 2013?

Steve Filton ***Universal Health Services Inc - CFO***

Well Kevin, I want to reinforce what you said, which is that we're not giving 2013 guidance. And we're not prepared to do that. But I'll talk a little bit. I think some of the dynamics that have weighed heavily on acute-care revenue growth in 2012 are the economic weakness in our local markets. And when we do give our 2013 guidance at the end of February, we'll talk I think more about what our outlook is for those metrics in 2013. But obviously, there is a hope that we will start to see some recovery in some of those markets, albeit we tend to believe it will be a relatively gradual incremental recovery.

The other issue is a number of other companies have talked about, I think that there's been this continued shift from inpatient to outpatient, which has muted revenues. Some in the acute space. Some of that I think is a real shift where the delivery of services has truly changed from one setting to another. And then some of it is this reimbursement dynamic of just more days being billed and reimbursed as observation days rather than as inpatient. And I think at some point we will begin to anniversary that impact. I think some of the companies may have already started to see that anniversary's impact. So those would be, at least in my mind Kevin, the two reasons why I would think that you wouldn't necessarily just want to take the third and projected fourth quarter performance and assume that's to be extrapolated to 2013.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

Okay. that's helpful. And I guess as we think about the economic weakness that you mentioned, could you just talk a little bit about on the acute-care business some of the major markets and where most of that weakness was? Or was it more broad based? And the, if it's broad based, just give an update on Vegas.

Steve Filton ***Universal Health Services Inc - CFO***

Yes. I think the weakness was generally broad based. Vegas was down in the third quarter compared to last year. But so we're quite frankly a number of other markets including South Texas, which we certainly have talked about before as well as a handful of others. So I don't think the weakness is isolated to a particular market. As far as Vegas goes, and quite frankly as far as the number of other markets go, the over arching metrics as we've mentioned before seem to be getting better. Unemployment is improving in a number of these markets, et cetera. I would think it's fair to say that in most of these markets that sort of macro growth or macro recovery isn't yet filtering down to the hospital business, but we expect that in the near and intermediate future that it should.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

Okay, great. And then just one last quick question. The behavioral facility in Chicago. Is that a new facility or is that a replacement facility?

Steve Filton ***Universal Health Services Inc - CFO***

It's effectively a new facility. So we had a facility called Hartgrove that we closed a few years ago, and built a replacement facility. We have now subsequently renovated the Hartgrove physical plant and are reopening it. But it is effectively a net new facility for us in the Chicago market.

Kevin Fischbeck ***BofA Merrill Lynch - Analyst***

Okay. Great. Thanks.

Operator

Kevin Campbell of Avondale Partners.

Kevin Campbell ***Avondale Partners - Analyst***

Good morning. thanks for taking my questions. I just wanted to start with maybe some color you could give us on the EHR incentive income and maybe what you expect to receive there in the fourth quarter. And I know you break it out in your guidance or exclude it, but just in general maybe what we should expect from that line in the fourth quarter and beyond. If possible.

Steve Filton ***Universal Health Services Inc - CFO***

Yes. I will sort of just recap. I think what we've said about our EHR experience in total, and that is we've projected to spend something in the neighborhood of $190 million to $200 million to implement this EHR over the course of four or five years beginning at the very end of 2009 and into 2010. We expect to get Medicaid and Medicare reimbursement related to those expenditures in the $140 million to $150 million range. And therefore, our net expenditure will be $50 million to $60 million Kevin. We will, as we have in the press release, as we will in our 2013 guidance, will give our best guesses as to what we think those numbers, both from an income and expense line, will be in 2013. I don't think we're prepared to do that today.

Kevin Campbell ***Avondale Partners - Analyst***

Okay. And as we think about that in general, the costs that you associate there, and you break out in the adjusted net income, are those theoretically one time costs as well? Or are those ongoing costs associated with that once those incentive payments go away, you'll still have those higher costs?

Steve Filton ***Universal Health Services Inc - CFO***

No. The reason that we choose to exclude them, because we think that it gives a better picture of what ongoing operating results are is because we believe that both the income and the expenses are one time. I will just remind people that we had in an EHR system before implementing the current one, and we had operating costs associated with that. We believe that the operating costs associated with the new implementation are fairly comparable. And so we have a universe of operating EHR costs that have been embedded in our results for years, and will continue to be our operating results and will not be excluded.

Kevin Campbell ***Avondale Partners - Analyst***

Okay. And just a couple of sort of housekeeping items. The D&A went up sequentially. It looks like a lot of that was related to the EHR costs. What sort of should we assume that same sort of run rate that you had in the quarter? What was it $77 million, $78 million?

Steve Filton ***Universal Health Services Inc - CFO***

As we continue to bring facilities live on this current version of the EHR, obviously the D&A expense will go up. I haven't really thought this through all the way, but we may consider trying to break that out when we give our 2013 guidance. Obviously, we break it out in total, but we may want to break it out by functional line item.

Kevin Campbell ***Avondale Partners - Analyst***

Yes, okay. And on the other operating expenses, that ticked up sequentially. But when you look back versus maybe the first quarter it was not materially different. Can you -- was it just unusually low in the second quarter? It was around $347 million versus $363 million here in the third. And maybe what sort of a more normalized run rate we should use there.

Steve Filton ***Universal Health Services Inc - CFO***

Yes. As I think about it, Kevin, there's only a couple of sort of unusual items I think that are in the third quarter, none of which are terribly material. There's probably $2 million of Ascend transaction costs. There's probably $5 million of costs related to our small construction management business. And those costs are offset by a very like amount of revenues. I think other than those two items, I would say that other operating expenses in Q3 reflect a pretty reasonable run rate going forward.

Kevin Campbell ***Avondale Partners - Analyst***

Okay. And what were the Ascend costs in the quarter? I don't think you broke those out, did you, and I just --

Steve Filton ***Universal Health Services Inc - CFO***

Yes, I don't have it in front of me, but it's only $2 million.

Kevin Campbell ***Avondale Partners - Analyst***

Okay. Great. Thank you very much.

Operator

John Ransom of Raymond James.

John Ransom ***Raymond James & Associates - Analyst***

Hello. I just wanted to drill down into the behavioral business a little bit more. The same-store revenue missed out model by about 160 bips. And I know you mentioned the length of stay issue in Medicaid. How is the adult side and the commercial side doing relative to your expectations?

Steve Filton ***Universal Health Services Inc - CFO***

John, I think that -- and I called out the Medicaid length of stay issue as really the one metric that has been sort of pressuring the business. I would say that generally trends on the acute side of the behavioral business are strong both from an admission or volume perspective, length of stay remains fairly constant, because it is almost exclusively non Medicaid pricing on the acute side. Pricing remains strong, et cetera. So the pressures really have been almost exclusively on the residential side of the acute business, and almost exclusively on the Medicaid part of that which is the biggest piece of it.

Kevin Campbell ***Avondale Partners - Analyst***

And just two follow-ups on that, thanks. One is, remind me how much -- if we were to look at your overall plan over the next two or three years, what's your plan to expand your bed count on a percentage basis and your behavioral? And then secondly, I guess it's not entirely clear if Medicaid is imposing shorter length of stay, what you can do to specifically counteract that. I'm not sure -- I'm not familiar with the tactics you might use push against that. Thanks.

Steve Filton ***Universal Health Services Inc - CFO***

Yes, so I think, obviously, we're always -- and I think this has always been the case. We're always fighting for the appropriate length of stay, and justifying medically necessary length of stay, et cetera. That's something we always do. But quite frankly, the main technique and tactic that we've talked about in the last few quarters is we're trying to lessen our reliance on the residential business. We've talked before about one of the significant attractions and compelling arguments for Ascend, was that it's a business that is very highly weighted to acute beds rather than residential beds. We've been adding, in response to your question John, something in the neighborhood of 300, 350 new beds a year in the behavioral segment. And those beds have been largely a acute beds.

And then finally, we've talked in the last quarter or so about conversion of residential beds to acute beds. And we're probably on pace in 2012 to convert a couple of hundred residential beds to acute beds. And my guess would be we probably have a like amount in the queue for next year as well.

Kevin Campbell ***Avondale Partners - Analyst***

And what's your mix now between adult and RTC -- or I'm sorry, RTC, non RTC.

Steve Filton ***Universal Health Services Inc - CFO***

So before the Ascend transaction our historical revenue mix I think revenue mix was like 75% acute, 25% residential.

Kevin Campbell ***Avondale Partners - Analyst***

And you can you move -- how much can you move that a year with your conversions and your bed adds?

Steve Filton ***Universal Health Services Inc - CFO***

Well again, if you think about basically a base of roughly 20,000 beds. And if you're adding 300 to 350 acute and converting another couple hundred, it's sort of 500 beds on a basis of 20,000, gives you some sense of what we're able to do.

Kevin Campbell ***Avondale Partners - Analyst***

So a couple percent?

Steve Filton ***Universal Health Services Inc - CFO***

Exactly.

Kevin Campbell ***Avondale Partners - Analyst***

I know ourselves and others have tried to allocate your G&A. And we come up with an EBITDA mix if you allocate your G&A of something in the range of 67% to 70% of EBITDA now comes from behavioral, and the remainder comes from acute. Would you agree with that math, or would you allocate the overhead differently? Is there something that we need to adjust in our thinking?

Steve Filton ***Universal Health Services Inc - CFO***

No, I think we've said publicly that post the Ascend transaction, our run rate will reflect an EBITDA contribution from the behavioral segment of about 70% of the total.

Kevin Campbell ***Avondale Partners - Analyst***

Okay. Thank you.

Operator

A.J. Rice of UBS.

A.J. Rice ***UBS - Analyst***

Thanks. Hello everybody. A couple questions, if I might. First of all, maybe I missed this. But does is Ascend results in your fourth quarter guidance?

Steve Filton ***Universal Health Services Inc - CFO***

No A.J., I was just referring to the fact that we had some transaction costs related to Ascend -- I'm sorry, in the third quarter. In the fourth quarter yes, I'm sorry, we do assume we will get $0.02 benefit from having Ascend in the fourth quarter.

A.J. Rice ***UBS - Analyst***

Okay. When I look at the margin trend, I know you commented on the other operating. Obviously, the behavioral is moving in a positive direction, and the acute is in a negative direction. I think you'd probably say that both of those are largely driven by top line performance. But could you comment on the individual expense items in the two divisions? What was under pressure on the acute side and where was the positive leverage on the psych side?

Steve Filton ***Universal Health Services Inc - CFO***

Look, A.J., I think you got to the crux of the point or the crux of the matter. Because both of these businesses are largely fixed and semi-fixed cost businesses, they really require some amount of revenue growth to create operating leverage. Not a significant amount. And I think our behavior performance in Q3 is reflective of that. So we had 3.5% revenue growth in behavioral in Q3, 8% or 9% EBITDA expansion. Very positive, strong, robust result in our minds. And something that we think we can and will continue to replicate.

On the acute side, it's really sort of just the opposite. I think we've been, quite frankly for many years now, for a good three or four years now, focused on really creating leaner, more efficient, operating structures in the acute division. And I think we've been largely successful in doing it. The fact of the matter, however, is that unless we can sort of drive 2% or 3% revenue growth, it's pretty hard to avoid margin contraction, which is what you saw in Q3. I think that's largely true across the board again in both divisions, but where the real leverage tends to come, again, is in the more fixed and semi-fixed costs. You just can't cut your utilities and your taxes and your insurance, et cetera, as your revenue shrinks in the same way that you can adjust headcount and things like that, which I think we've done a good job of doing.

A.J. Rice ***UBS - Analyst***

Okay. And maybe just lastly, any update on your thinking around provider tax, UPL and dish payments either as they reflected in the third quarter or going forward from here?

Steve Filton ***Universal Health Services Inc - CFO***

Again, I think we'll certainly I think provide more color when we give our 2013 guidance. But I think for now, our expectation is that -- I'll sort of call those special items, UPL, Dispro provider taxes, will likely continue at or around the same levels that they're at now.

A.J. Rice ***UBS - Analyst***

Okay. And there wasn't anything unusual in the quarter around any of those?

Steve Filton ***Universal Health Services Inc - CFO***

No.

A.J. Rice ***UBS - Analyst***

Okay. All right. Thanks a lot.

Operator

(Operator Instructions)

Anton Hie of RBC Capital Markets.

Frank Morgan ***RBC Capital Markets - Analyst***

Hello, Frank Morgan here. Steve, my question is on hopefully getting an update on the state reimbursement outlook for the new fiscal year, particularly on the behavioral side. Are you seeing any improvement at all, or is it basically about the same?

Steve Filton ***Universal Health Services Inc - CFO***

No, I think beginning in the sort of July of 2011 timeframe Frank, we talked about the outlook for the next 12 months, which is basically the Medicaid fiscal year as being Medicaid cuts of sort of flat to down 1%. I think we've probably trended to the, however you want to think about it, the lower end meaning the 1% cuts rather than flattish. And again, that contributes to a little bit of that same Medicaid pressure that I was alluding to before. Mostly as a length of stay pressure, but also a little bit of rate pressure. I think it's too early to say what that will look like come July of 2012 -- excuse me, 2013. And obviously, what I meant was July of 2012 for the flat to down 1%. Obviously, when we give our guidance for 2013, we will embed in that an estimate for the back half of the year for Medicaid pricing. And hopefully, we'll have a better sense of it at that point in time.

Frank Morgan ***RBC Capital Markets - Analyst***

Okay. Thanks. In terms of -- could you talk a little bit more about the cost reduction efforts? You touched on this with A.J. a little bit, but the cost reduction efforts going on through the process of the third quarter relative to the slowdown in volumes. And I'm just curious, could the fourth quarter be a quarter where you get the full benefit of the cost reductions you were making across the course of the third quarter, and then with any pickup in volume that maybe the effect here reverses the other way. And then maybe could you just talk a little bit about what you're seeing in volume so far in the fourth? Thanks.

Steve Filton ***Universal Health Services Inc - CFO***

Well I think it's worth noting, and I know a number of the other companies that have previously reported this quarter mentioned that September for them was clearly the weakest month of the quarter. That was certainly true for us as well. And so as I think normally occurs with that sort of thing, both are volumes and payer mix weakened in September. It's difficult to respond in real-time to that almost immediately, but we do and we have responded, and so we will get some continuing benefit from that in Q4.

Now, part of our revised guidance assumptions in Q4, quite frankly, is that the negative trends that we experienced in September will largely continue in to Q4. Certainly we hope that they improve. And I would say the very first glimpses we've had of Q4, which are basically October volumes, look a little bit better. Although, I wouldn't draw too many definitive conclusions from that on its own. So I think the question you're asking Frank is the third quarter deteriorated, we began making some more aggressive cost cuts towards the end of the third quarter. If the revenue trajectory improves a little bit in Q4 from where it was in September, we should certainly benefit from that and get a pick up and that would make our revised guidance look a little more conservative, but I think it's way too early to make that judgment.

Frank Morgan ***RBC Capital Markets - Analyst***

Okay. Thank you.

Operator

(Operator Instructions)

And there are no further questions at this time.

Steve Filton ***Universal Health Services Inc - CFO***

Okay. Well, we'd like to thank everybody. We hope that everybody stays safe and continues to recover from the hurricane. And look forward to talking with you at the end of the year. Thank you.

Operator

And this does conclude today's conference. You may now disconnect at this time.

THOMSON REUTERS

PLACEHOLDER TRANSCRIPT

Q4 2012 Universal Health Services Earnings Conference Call

EVENT DATE/TIME: MARCH 01, 2013 / 2:00PM GMT

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CONFERENCE CALL PARTICIPANTS

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Josh Raskin *Barclays Capital - Analyst*
Tom Gallucci *Lazard Capital Markets - Analyst*
Frank Morgan *RBC Capital Markets - Analyst*
Joanna Gajuk *BofA Merrill Lynch - Analyst*
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PRESENTATION

Operator

Good morning, my name is Ginger and I will be your conference operator today. At this time, I would like to welcome everyone to the Universal Health Services Q4 earnings conference call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. (Operator Instructions).

Thank you. Mr. Steve Filton, you may begin your conference.

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Thank you. Good morning. I am Steve Filton. Alan Miller, our CEO, is also joining us this morning. Welcome to this review of Universal Health Services results for the full year and fourth quarter ended December 31, 2012.

During this conference call Alan and I will be using words such as believes, expects, anticipates, estimates and similar words that represent forecasts, projections and forward-looking statements. For anyone not familiar with the risks and uncertainties inherent in these forward-looking statements, I recommend a careful reading of the section on risk factors, and forward-looking statements and risk factors in our Form 10-K for the year ended December 31, 2012.

We'd like to highlight just a couple of developments and business trends before opening the call up to questions. As discussed in our press release last night, the Company recorded net income attributable to UHS per diluted share of $4.53 for the year and $1.39 for the quarter. After adjusting for a reduction in malpractice reserves relating primarily to prior years, the gain on the sale of our Auburn facility, and the incentive income and expenses associated with the implementation of electronic health record applications at our acute care hospitals, our adjusted net income attributable to UHS per diluted share for the quarter ended December 31, 2012, was $1.00.

Included in the quarter is an increase to our effective tax rate due to nondeductible transaction costs related to the Ascend acquisition. On a same facility basis, revenues in our Behavioral Health division increased 4.5% during the fourth quarter of 2012. Adjusted admissions and patient days to our Behavioral Health facilities owned for more than a year increased 5% and 0.5%, respectively, during the fourth quarter.

Revenue per adjusted patient day rose 4% during the fourth quarter of 2012 over the comparable prior year quarter. We define operating margins as operating income or net revenue less salaries, wages and benefits, other operating expenses, supplies expense, and doubtful accounts, divided by net revenue. Operating margins for our Behavioral Health hospitals owned for more than a year increased to 27.6% during the quarter ended December 31, 2012, as compared to 25.3% during the comparable prior year period.

As discussed in the Form 10-K we filed last night, the OIG has served a subpoena requesting various documents concerning UHS and

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

On a same facility basis in our Acute division, revenues increased 3.1% during the fourth quarter of 2012. The increase resulted primarily from a 1.7% increase in adjusted admissions and a 1.4% increase in revenues per adjusted admission. On a same facility basis, operating margins for our acute hospitals and decreased to 14.4% during the fourth quarter of 2012 from 15.5% during the fourth quarter of 2011.

Our acute care hospitals provided charity care and uninsured discounts based on charges at established rates amounting to $206 million and $248 million during the three-month periods ended December 31, 2012 and 2011, respectively. As a percentage of acute care net revenues, bad debts, charity care expense, and the uninsured discount in this year's fourth quarter were at levels higher than those experienced during the fourth quarter of 2011. However, due primarily to the increase in Behavioral Health revenues and the very low levels of bad debt and uninsured discounts in that business, our overall percentage of bad debts, charity care and uninsured discounts were lower than those experienced during the fourth quarter of 2011.

Our cash from operating activities was approximately $280 million during the fourth quarter of 2012 as compared to $156 million in the fourth quarter of 2011. Our accounts receivable days outstanding increased to 56 days during the fourth quarter of 2012, as we continue to have a substantial Medicaid receivable from the state of Illinois.

At December 31, 2012, our ratio of debt to total capitalization was 58%.

We spent $81 million on capital expenditures during the fourth quarter. Included in our capital expenditures were the ongoing construction costs related to a new acute care hospital in Temecula, California. We opened a new bed tower at our Wellington hospital in West Palm Beach, Florida early in October. We opened a total of 270 new behavioral health beds at some of our busiest facilities in 2012.

During 2013, we expect to spend approximately $360 million to $385 million on capital expenditures, which includes expenditures for capital equipment, renovations, new projects at existing hospitals, and construction of new facilities.

Excluding the favorable $0.13 per diluted share EHR impact described in our press release, our estimated range of earnings per diluted share attributable to UHS for the year ended December 31, 2013, is $4.35 to $4.50 on projected net revenues of $7.4 billion. We are pleased to answer questions at this time.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions) A.J. Rice, UBS.

A.J. Rice *UBS - Analyst*

Thanks. Hi, everybody. A couple questions, if I could ask. First of all, it's good to see obviously a return to the positive on the inpatient acute care volumes. Can you give us a little more flavor? Was that -- I mean, do you have a sense of how much, if any, the flu impacted that? Or maybe in terms of geographies, was that a Vegas driven turn, or was that more broad-based? Any color would be helpful.

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Sure, A.J. I think that, like everybody, we experienced a busier flu season this past winter than we have had in several years. Although, again, I think as most hospital providers have reported, for us it was probably more of an ER dynamic and more ER visits than actual inpatient admissions. I think we believe we had a bit of a pickup in inpatient admissions, but don't believe it to be a material number, or certainly a material impact from a financial statement perspective for the quarter.

As far as the improved, I think, both volumes and payer mix in the Acute division for the quarter, I think that strength was relatively pervasive throughout the division. It was not focused in one or two markets, but more of a trend that we tended to see throughout the facilities and throughout the portfolio.

A.J. Rice *UBS - Analyst*

Okay. And then if you -- on your 2013 guidance, I know you gave us the numbers for the high-tech incentives and so forth. How about just operating assumptions? Are you assuming any kind of turn, either in the acute business or steady state in the psych? Can you give us a little more flavor for some of the key underlying assumptions there?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Yes, I think that the guidance for next year is generally premised on stabilizing trends underlying the business. On the Acute side, I think that it is reflective of the sort of revenue growth that we saw in the third quarter. That is kind of in the 2.5%, 3% range, split sort of evenly between pricing and volumes.

Obviously, we have factored into our guidance, as have our peers, the effect of sequestration beginning in April and the effect of both the disproportionate share in coding cuts that will become effective in October as part of the Affordable Care Act.

On the Behavioral side, I think just generally more of the same -- 4% or 5% revenue growth and mid-single-digit EBITDA growth. And then obviously we have got a full year of the Ascend facilities in our guidance for next year.

A.J. Rice *UBS - Analyst*

Okay. And then just the last question maybe, I don't know how much you can say on the OIG subpoena, but clearly a lot of the regulatory and questions that have been related to the psych business over really the last decade have been more clinical type of questions as opposed to billing questions. Is there any way to look at the wording of the thing and make any assessment as to whether it's -- which of those two directions it seems to be going?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

No. I think, A.J., as you suggest, the trend in behavioral care has been to have these investigations focus on clinical practices. And I would say that the content of the subpoenas would suggest that's largely the focus here.

I will say that I believe the government often pursues a technique in which they try and tie together what they perceive to be clinical issues and quality deficiencies then with an argument that a false claim has been filed because there is not adequate care, et cetera. We have no idea if that's where the government is going in this case and certainly couldn't predict that.

A.J. Rice *UBS - Analyst*

Okay. All right. Thanks a lot.

Operator

Josh Raskin, Barclays Capital.

Josh Raskin *Barclays Capital - Analyst*

Hi. Thanks. Good morning. Just a first question on the Behavioral, Steve, following up. I think you said sort of 4% to 5% on the revenue growth. I think historically you guys have targeted something sort of north of 5%, 5.5%.

So was there some of the bed conversion impact still going on? Or, I'm just curious. Is 4% to 5% now a better sort of long-term Behavioral Health growth rate?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Josh, I think that the key variable that has sort of tempered a little bit of our expectations from something a little bit higher than 5%, let's say, is the length of stay issue. As you saw in the press release and I reiterated in my prepared remarks, admissions grew a very solid 5%, or adjusted admissions grew 5%, but adjusted patient days only grew 0.05%. And obviously the dynamic there is we continue to see

length of stay compression. And because the vast majority of our reimbursement is on a per diem basis, that length of stay compression, which is very much focused in the residential component of our Behavioral business, continues to temper our revenue growth.

Now, we speculate, and we believe, and I think from a clinical perspective we particularly believe that there is a natural floor to that length of stay compression and reduction, that at some point, and I think our clinical people would argue we've probably passed that point, the continued early discharge of these patients is really not a clinically effective treatment protocol.

So we'll see. But I think our expectation that we grow at the current rates is that we continue to see those length of stay pressures.

Josh Raskin *Barclays Capital - Analyst*

Okay. So you are actually assuming another reduction in length of stay in the Behavioral Health side (multiple speakers).

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

I think we are assuming the trajectory continues as it is now.

Josh Raskin *Barclays Capital - Analyst*

Okay. Got you. And then, just a second question, you mentioned the coding and DSH cuts that are effective October. Can you size those, maybe what your DSH payments were on both Medicare and Medicaid and sort of give us a sense as to what the actual dollar impact do you think could be in the fourth quarter?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Yes. So I think the issue vis-a-vis the fourth quarter cuts from the ACA really are surrounding Medicare disproportionate share. Our annual Medicare disproportionate share reimbursement is in the neighborhood of a little over $100 million. We are assuming that about half of that goes away.

I know there have been some discussions on some of our peers' calls about some of the mechanics that go into that calculation and we, by no means, can be terribly precise about it, but we are assuming about half of that goes away. So something like $50 million of DSH begins to be cut in the fourth quarter. Obviously, a quarter of that is something in the neighborhood of $13 million or $14 million impact in the fourth quarter of 2013.

Josh Raskin *Barclays Capital - Analyst*

Okay. And that's just a fourth-quarter impact.

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Correct.

Josh Raskin *Barclays Capital - Analyst*

Okay. Got you. And then the coding adjustment?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

And then the coding adjustment, which also is just the fourth quarter, is another $4 million or $5 million.

Josh Raskin *Barclays Capital - Analyst*

$4 million or $5 million for the quarter.

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Correct.

Josh Raskin *Barclays Capital - Analyst*

Okay, perfect. Okay. Thanks.

Operator

Tom Gallucci, Lazard Capital Markets.

Tom Gallucci *Lazard Capital Markets - Analyst*

Good morning, guys. Thank you. I guess just, Steve, the margins in the quarter in the Acute Care side were still under a little bit of pressure. Revenues rebounded. I'm wondering if you had any thoughts there, and sort of what your expectations are in that regard as you think about 2013.

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Yes, Tom, I mean, you probably have heard me say and others say that I think generally our view is that when we get to about 3% same-store revenue growth on the Acute side, that we feel that is a sufficient level of growth to have at a minimum sort of flattish EBITDA, maybe even slightly improved, and we were down a little bit in the fourth quarter.

I think that the single biggest driver of that was probably $4 million or $5 million of incremental expense associated with physician employment and physician practice acquisition. Those who follow us know we probably have not pursued those physician strategies, at least in terms of the significant dollars of investment, as aggressively as some of our peers. But we are certainly doing it in some of our markets and, clearly, you saw that impact a little bit in the fourth quarter of 2012.

As far as 2013 goes, I think, generally, we sort of view it as sort of a push in our guidance, meaning that we don't think our physician expenses grow much. I think we feel like whatever new investment we make in 2013 will be offset by some of the efficiencies we are able to achieve in the existing practices that we have.

Tom Gallucci *Lazard Capital Markets - Analyst*

Does that suggest that you sort of anticipate more stable margins as we think about the coming year?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Yes, I mean, I think what it suggests, Tom, in my mind is that we believe that if we can get to that level of growth that we had in Q4, that is 3% growth, that we ought to be able to have margins that are relatively flat or slightly improving. Obviously, the real challenge in the budget next year is to get to that level of revenue growth with all of the reimbursement cuts that we've highlighted so far.

Tom Gallucci *Lazard Capital Markets - Analyst*

Right, right. Okay. And then just wondering on the balance sheet and sort of the acquisition side of things, obviously you did Ascend. Wondering sort of where your thinking is on delevering and what the pipeline might look like, particularly on the Acute Care side, and your appetite there. Thanks a lot.

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Yes, I mean, I don't think our view has changed really at all there, Tom. You've heard us say before, we tend to be opportunistic. And we are always looking at opportunities to either strengthen our existing Acute Care franchises and Behavioral as well, or to penetrate new markets or enter new markets that look particularly compelling.

I think one of the hurdles to that for a number of years now has been the still what we view as fairly rich valuations for a lot of these acquisitions which make it very hard to earn a reasonable return. I think UHS has a history of being very judicious about where we invest and what we invest in, and I see that continuing.

On the other hand, as you've heard Alan and I talk about, I think, on these calls before, there is obviously a great deal of change going on in this industry and I think it's causing not-for-profit hospitals in particular to rethink their future plans. And we may see an uptick in activity in the M&A landscape, and we will certainly be paying attention to that and evaluate those opportunities as they arise.

Tom Gallucci *Lazard Capital Markets - Analyst*

Okay. Thank you.

Operator

Frank Morgan, RBC Capital Markets.

Frank Morgan *RBC Capital Markets - Analyst*

Good morning. Just one quick one here to start with. On the guidance, what is the implied cash flow from ops number you would see on the year based on your EPS guidance?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

So I think when you factor in, Frank, the CapEx projections that we detailed, I think you're talking about free cash flow in the $450 million range.

Frank Morgan *RBC Capital Markets - Analyst*

Okay. Secondly, just on reform, it looks like expectations are shifting. You see a lot more benefit from Medicaid expansion early on in the reform process.

I'm just curious, as it relates to your Behavioral Healthcare business, do you think there is a big enough impact there to really affect your bad debt expenses early on, particularly with that adult male population that you may have been treating in the past that may now be covered under reform? So any thoughts that you could see some kind of material improvement in bad debts on the Behavioral side in 2014 when reform cranks up?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

So obviously, as you can tell, Frank, and others, I mean, our bad debt percentage in Behavioral runs fairly low already. It's in that 2.5% to 3% range. And so I think our view from the outset, of thinking about reform, has been that the opportunity on the Behavioral side, while there is some opportunity to reduce our uncompensated load, the big opportunity in that regard is on the Acute side.

The larger, I think, opportunity on the Behavioral side is to have an expanded universe of patients that have coverage, either through Medicaid, as you suggest, or through the exchanges, who might be eligible for admission to our hospitals who were not previously eligible. I think we've articulated in prior presentations, et cetera, that it's difficult to quantify that opportunity in any precise way, but we think that it may be a significant portion of the population that will now have insured mental health benefits, that don't have them today.

Frank Morgan *RBC Capital Markets - Analyst*

Okay. And then one final on length of stay; are there any particular states where you're seeing more focus on the issue of length of stay management? And then I will hop off. Thank you.

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

I think for the most part, as I was saying before to Josh, that the length of stay issue, I think, is generally focused in our residential business, which is the smaller component of our Behavioral business. It's very much a Medicaid and Medicaid managed care issue, but I don't know that is particularly focused on a state or a particularly aggressive payer. I just think in general we are seeing most Medicaid payers, whether they are the traditional state payers or the managed payers, being more rigorous about their utilization review, et cetera.

I mean, obviously, we see it a little bit more aggressive in certain states than others. But it's pretty much an across-the-board phenomenon.

Frank Morgan *RBC Capital Markets - Analyst*

Thanks.

Operator

Kevin Fischbeck, Bank of America Merrill Lynch.

Joanna Gajuk ***BofA Merrill Lynch - Analyst***

Good morning. Actually, this is Joanna Gajuk in today for Kevin. Thanks for taking my question.

Just on the topic of the reform, you mentioned -- you talked about the psych business, but I guess what relates to both businesses, can you talk about what are your expectations or what you are seeing out there in terms of rates on the new exchanges? Some of your peers commented they were able to secure some contracts already. So any color you could provide, where you see those rates falling.

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Joanna, I can certainly comment on expectations. I think we've said from the beginning that our expectations are the commercial exchange rates would fall into our range of commercial pricing. But I think we've also said that, as recently as literally just weeks ago, that we've really not negotiated any firm rates on exchanges, et cetera.

I know that's a little bit different than some of our peers who, in this earnings season, have been able to point to some actual contract negotiations. We are unable to do that. I mean, again, I think our expectations are very similar to our peers, but I don't know that we can point with any sort of certainty to actual negotiations that have been concluded as did some of our peers.

Joanna Gajuk ***BofA Merrill Lynch - Analyst***

That makes sense. And then on a different topic in terms of your outlook for next year, can you give us maybe a little bit more color on what you expect on the Medicaid rates?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

I think our expectation about Medicaid rates is that they remain similar to this year, so that in the sort of July of 2013 Medicaid pricing cycle, I think we've presumed in our guidance that Medicaid rates remain sort of flat or maybe down 1%, very similar to what they did in the July of 2012 cycle.

Joanna Gajuk ***BofA Merrill Lynch - Analyst***

Okay. Thank you. And the last one, can you just talk a little bit more about the Vegas performance and your expectations there for this year?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

As I said previously, I think that the overarching trends that were present in the Acute business in the fourth quarter, which were slightly improved volumes and slightly improved payer mix, were generally present throughout the portfolio and that there were not necessarily any markets that were really extremely positive performing or negative. I think, again, we saw the general improvement throughout the portfolio. I think our basic view of 2013 are generally stable trends, again, as it comes to volumes and payer mix.

I think it's a little too early to read into the fourth quarter performance that we are on a kind of a steadily increasing trajectory at this point. As I noted to a previous question, I think some of the benefit, although not a huge number, but some of the impact in Q4 may have been the flu. I think some of that carries over into at least January or so of the first quarter.

So we'll see. I think we'd like to see another quarter or two of that sort of strong performance to presume we've really had a turn here. But otherwise, I think generally our 2013 outlook is for stabilizing trends in the Acute division.

Joanna Gajuk ***BofA Merrill Lynch - Analyst***

Great. Thank you so much. That's all for me.

Operator

Justine (sic) Lake, JPMorgan.

Justin Lake *JPMorgan - Analyst*

Thanks. Good morning. Steve, if we could start off on the psych side with the OIG, is there anything that you can tell us in terms of billing of psych that has historically been controversial, that maybe they could be looking at here?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

I mean, again, I think it's very difficult, Justine (laughter), for us to really predict with any sort of level of accuracy what the government is angling for. As I think I suggested in an earlier comment to a question, the bulk of the request, I think, is on patient records or is for patient records, et cetera, which would sort of lead you to believe it's -- the focus is probably more on clinical matters. Although, again, I think there's a history of the government trying to convert that, if you will, into a billing issue. But, no, it's not like we've had a pattern of billing issues or irregularities in the Behavioral business, by any means.

Justin Lake *JPMorgan - Analyst*

Got it. And, Steve, my recollection is the OIG had been looking into one of the facilities previously -- not one of this batch, but you've had the OIG looking at or asking for information on one of the other facilities, right?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Well, I mean, there's a little bit of history here. I mean, PSI had a facility that had a Department of Justice subpoena that I think goes back all the way to 2008. We've disclosed an investigation of our Peachford facility for at least several quarters, so it's not the first time a behavioral facility has been investigated, if that's the question.

Justin Lake *JPMorgan - Analyst*

Well, I'm just curious that if there's anything you can look at in terms of how those investigations went and what they were looking at that you might be able to share with us here.

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

No. I mean, the PSI investigation, which began, frankly, well before our ownership, I think, again, the subpoena goes back to 2008. Nothing has ever really come of that investigation. And as far as the Peachford investigation goes, we've had no indication from the government other than our response to the subpoena, no feedback from them about what they're looking for.

And, Justin, just let me say, I have no reason to believe that either of those previous investigations are connected to this current subpoena.

Justin Lake *JPMorgan - Analyst*

Got it. Okay. So -- and then if we kind of jump away from that, free cash flow for 2014, Steve, can you give us a number? I assume there is nothing in guidance for deployment there, so can you kind of walk us through what your thoughts are for 2013 for capital deployment?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Yes. Just from a guidance perspective, I think our convention always has been to assume that all of our free cash flow goes towards the repayment of debt, unless at the time of giving guidance we have a specific transaction that is very far along, which is not the case this year. So we've assumed, as I indicated in the previous -- to the previous questioner, about $450 million of free cash flow, and all that goes to repayment of debt.

Justin Lake *JPMorgan - Analyst*

Okay. That's it for me. Thanks a lot.

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Thanks.

Operator

Ralph Giacobbe, Credit Suisse.

Ralph Giacobbe ***Credit Suisse - Analyst***

Thanks. Good morning. Steve, are you aware of maybe others in the industry also getting a similar request from OIG? Or do you not know?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Unaware. I mean, Ralph, I think the only way we would be aware is if folks have disclosed that, and I don't know that we would have any other way of knowing that.

Ralph Giacobbe ***Credit Suisse - Analyst***

Okay. And then just switching gears here, on the Behavioral side, I guess as you think about next year, do you think you have the capacity to deal with the potential bump in volume into 2014?

And then, I think in the past you have mentioned there are uninsured today that I guess you have the potential opportunity, or may not accept to some degree in your facilities. Is there any way for you to give a sense or to measure the magnitude of that number?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

So let me answer the latter question first. No, I think it's difficult to do. It is sort of trying to capture a patient population who effectively either get care elsewhere today or, frankly, doesn't get care at all. And so that's just not a number that we have easy access to.

We do know, just from sort of ongoing operations, et cetera, that there is a significant universe of people -- and, again, this is not particularly unique to us, but we know there is a fairly significant universe of people who don't have insurance and therefore don't have access to the current system, and who, if they get insurance, will have access to the system.

As far as our ability to absorb that increased demand, I would suggest to you that if you go back and look at our occupancy rates for the last 10 years in the Behavioral division, you'll see that as recently as 2005 or so, we were running 85% occupancy in our Behavioral division. We currently run in the mid-to-upper 70%'s. So we certainly could move higher.

Now, when we were running in the mid-80%'s is when we began a program of fairly aggressive capacity expansion, because I think we believe that that's a fairly inefficient level of occupancy and we are turning away insured patients at that level of occupancy. But I think the answer is, in the short term, if demand were to increase as we expected it might, to some degree, we can certainly accommodate that in the short run and then begin plans to add new beds relatively quickly and aggressively, much as the way we have been doing so for the last seven or eight years.

Ralph Giacobbe ***Credit Suisse - Analyst***

Okay. All right. That's helpful. And then just my last one, is there anything we need to consider in terms of the guidance of incremental cost in 2013 that may roll off in 2014, just in general or maybe to prepare for reform?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

I don't know that to prepare for reform is really specific. I will say though one probably UHS-specific item in guidance that's probably a little different, and people have not anticipated, is opening in the back half of 2013 our hospital in Temecula, California. We've certainly discussed that construction before, but it opens in the sort of September-October time frame. And there's probably a good $16 million, $17 million, $18 million in our guidance in our budget of startup losses and costs associated with that opening, which, obviously, is somewhat of a drag on our back half of 2013.

Ralph Giacobbe ***Credit Suisse - Analyst***

Back half meaning sort of 4Q as sort of a way to think about an offset from some of the pressures that you talked about earlier from the DSH cuts and coding? Is that the way to think about it?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Well, it's not an offset, it's a further headwind and it's in (multiple speakers).

Ralph Giacobbe ***Credit Suisse - Analyst***

Right. Right.

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

It's sort of startup costs in Q3 and then operating losses in Q4.

Ralph Giacobbe ***Credit Suisse - Analyst***

Right. But point being that those don't repeat next year.

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

No. The presumption would be that as the facility operates, there's probably -- the startup losses continue into the first half of 2014, but by the back half of 2014 we would start to turn that around.

Ralph Giacobbe ***Credit Suisse - Analyst***

Okay. Great. All right. Thank you.

Operator

Chris, your line is open.

Chris Rigg ***Susquehanna Financial Group - Analyst***

Chris Rigg? Okay. Sorry. I couldn't hear you. Thanks for taking my questions, Steve. Just to follow up a little bit on the last question, can you just remind us the total investment expansion -- investment money running through the P&L in 2012, whether that's Wellington or Behavioral bed development, versus what you are inspecting in 2013, Temecula and additional beds on the Behavioral side?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Yes, Chris, I think it's about the same. I mean, I'll just round the numbers and say that we are going to spend $375 million in -- well, we spent $375 million in CapEx in 2012. We will spend a like amount in 2013.

Probably $100 million of that is maintenance capital that's mostly focused in the Acute division. That's capital that basically is just there to upgrade the equipment and keep the facilities running, et cetera. No real return being associated with that.

And then another $100 million to $150 million of Behavioral expansion and another $100 million to $150 million of Acute expansion.

Chris Rigg ***Susquehanna Financial Group - Analyst***

But in terms of what's running through the income statement, is that also about -- are you saying that's also about the same?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

I don't really -- I apologize, because I don't -- when you say capital --

Chris Rigg ***Susquehanna Financial Group - Analyst***

I guess what -- yes, maybe it was unclear. I got caught a little off-guard there when the queue opened.

But with regard to -- you know, you said you're going to spend $16 million, $17 million, $18 million on Temecula, I'm sure you had something similar for Wellington and then also in terms of is there anything on Behavioral startup costs. I'm just trying to figure out apples-to-apples what the investment headwinds running through the income statement would be.

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Okay. No, I got that. I think that that Temecula startup losses and startup costs are unique in the sense that at Wellington we opened a bed tower in an existing facility, and there is not anywhere remotely close to the same level of startup costs, et cetera. We are talking about a brand-new, greenfield hospital in Temecula. It's a much different dynamic.

Most of the Behavioral expansion is like the Wellington tower. It is additional beds at existing facilities. So, again, there is nothing comparable this year to that Temecula number next year.

Chris Rigg ***Susquehanna Financial Group - Analyst***

Okay. And then on the OIG subpoena -- and I'm not sure what you can say here, but can you give us a sense for the revenue exposure with regard to the facilities that are cited in the subpoena?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Yes, I had a few analysts say to me last night that they simply went to AHD data or whatever for the facilities identified and got 6% or 7% of our consolidated revenues. And I think that's a fairly accurate number of the 10 or 11 facilities that have been identified.

Chris Rigg ***Susquehanna Financial Group - Analyst***

Okay. Thank you.

Operator

Kevin Campbell, Avondale Partners.

Kevin Campbell ***Avondale Partners - Analyst***

Good morning. Thanks for taking my questions. Just a couple of modeling questions at this point. The sale of the Acute Care hospital, where exactly does that impact the income statement in the fourth quarter if we wanted to back that out in our own models? And really same question for the favorable reserve impact; which line item and which segment does that affect?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

So they are both on the other operating expense line, and obviously Auburn is an acute facility. The malpractice reserve affects both divisions, although it's probably skewed to the Acute division.

Kevin Campbell ***Avondale Partners - Analyst***

Okay. And then from the Temecula hospital, what sort of quarterly D&A jump should we see from Q3 to Q4 from that opening?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

You know, it's a $150 million investment to be amortized or depreciated over 25 years.

Kevin Campbell ***Avondale Partners - Analyst***

Okay. Great. That's all I have. Thank you very much.

Operator

Gary Lieberman, Wells Fargo.

Gary Lieberman ***Wells Fargo Securities - Analyst***

Good morning. Thanks for taking the question. You've talked in the past about transitioning some of the RTC beds into Acute. Can you give us a sense of where you are, I guess either as a percentage of revenue or percentage of volumes at the end of 2012, and where you might hope to be at the end of 2013?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Yes. Hi, Gary. So I think roughly the Behavioral revenue split is about 75% acute behavioral, 25% residential behavioral. I think our view is that as we convert beds, maybe we are affecting that split by 50 or 75 basis points a year, is kind of the general sense of what we can accomplish.

Gary Lieberman ***Wells Fargo Securities - Analyst***

Okay. And then I guess just in terms of either anticipating the impact from healthcare reform, or as you see more volumes from the reform, can you speed that up? Or would you be satisfying the additional demand mainly from new additional beds on the Acute side?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Yes, I think the general sense is that adding beds in the Behavioral space can be -- the process can be accelerated some if the demand is there. We have probably said before that the biggest challenge or hurdle to adding beds on the Behavioral side tends to be kind of the regulatory local zoning sorts of issues, so sometimes that's not within our control.

But, yes, generally, I think our view is that if reform results in a measured increase in demand, that we will accelerate the expansion program that we've already been -- had underway for seven or eight years. And so we are quite familiar with how to do it and what needs to be done, and that we can make that happen somewhat faster.

Gary Lieberman ***Wells Fargo Securities - Analyst***

Okay. And then can you just remind us what type of average commercial rate increases are incorporated into the guidance for 2013?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Yes, I mean, I think all of our commercial rate increases on the Acute side have been averaging 5% to 7%, and I believe we still feel are in that range. On the Behavioral side, that number is historically a couple hundred basis points lower, and I think remains so in our guidance. So those numbers, honestly, have not changed very much in the past few years.

Gary Lieberman ***Wells Fargo Securities - Analyst***

Okay. And no material changes in contract terms or contract types?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Not yet.

Gary Lieberman ***Wells Fargo Securities - Analyst***

Okay. Great. Thanks a lot.

Operator

John Ransom, Raymond James.

John Ransom ***Raymond James - Analyst***

We've noticed with you and some others that the charity and bad debt blipped up a little bit in the fourth quarter, which seems a little odd kind of where we are in the employment recovery. Do you have any thoughts about that?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

John, I mean, I think what we saw was a shift from charity and uninsured discount to bad debts. As you've heard me comment any number of times over the years, we view the uncompensated expense sort of all as one large pool, so we never spend a lot of time trying to analyze or explain shifts between the categories.

I think in general, our view was that payer mix improved a little bit in Q4. And these are really Acute Care observations that, even though we continue to see decelerating commercial and Medicare volumes, and accelerating Medicaid and uninsured volumes, both the rates of deceleration and acceleration were somewhat muted or more mitigated in Q4. So I think we had a view that actually payer mix got a little better in the quarter.

John Ransom ***Raymond James - Analyst***

Okay. Yes. If nothing happened with mix, and all that flowed through was your pricing, how much would bad debt go up for you every year?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Yes, I mean, so I think in general our gross pricing continues to go up between 6% and 8% a year, so you can sort of do that math. I mean, that in and of itself drives a lot of the increase in bad debt and charity care expense. I don't have a calculation in front of me, but I think you can kind of do that back of the envelope.

John Ransom ***Raymond James - Analyst***

Right. Is there any -- I know a while back you guys were a little more optimistic about deploying some capital on the Acute Care side. Has your enthusiasm waxed or waned on your pipeline since that time?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Yes, I wouldn't describe it as either, John. I mean, I think we have a very kind of opportunity-specific view of the world, and that is we evaluate every opportunity on its own. If an individual opportunity makes sense, we will pursue it.

So I don't know that I think I would make any kind of macro characterizations of our view at the moment. And, obviously, the proof is in the pudding. We haven't made a ton of external acute investments in the last four or five years because we have not found them compelling.

Now, in fairness, as we've mentioned about Temecula and the Wellington bed tower and Summerlin Tower, et cetera, and Palmdale, we've made a lot of internal capital investments in Acute Care because we felt like they were the more likely -- or the more economically prudent investments to earn above-average returns.

John Ransom ***Raymond James - Analyst***

How many, would you say, UHS quality assets come on the market in a given year now? And is it more or fewer than it was a few years ago?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Again, I think there are more assets that come to the market today. I think that there are lots of -- a reasonable number of quality assets that come on the market. Again, we are not the only party out there bidding for those assets, et cetera. So I think, more than anything, it becomes a price valuation issue in terms of whether you can acquire the asset at a valuation that allows you to earn a reasonable return.

John Ransom ***Raymond James - Analyst***

Okay. So it's more the pricing than it is the supply.

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

I believe so.

John Ransom ***Raymond James - Analyst***

Okay. Thanks.

Operator

Whit Mayo, Robert Baird.

Whit Mayo ***Robert W. Baird - Analyst***

Hey. Thanks. Steve, I think you have called out med-mal as a favorable one-time benefit I think every year almost for five years now. At what point does that become recurring? I mean, your peers all take credit for it, so I'm just wondering what the thinking was on that.

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

It's a fair comment, Whit. Obviously, I think for the most part, the reason that we exclude it from current operating earnings is that almost by definition it is focused on prior year amounts and prior year reserves. But to your point, UHS has had a long history of taking a very conservative position on its malpractice expense and reserves.

I think our main focus is just trying our best to get the current expense -- the current year malpractice provision correct and accurate. And we believe we are getting closer to that, but I appreciate your pointing out that we have penalized ourselves to some degree by always tossing these numbers out.

Whit Mayo ***Robert W. Baird - Analyst***

Sure. And maybe just any comments on Ascend and the integration, and how that is progressing.

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Yes, I mean, obviously, it's a much smaller deal and therefore integration than the PSI deal was, as we're talking nine facilities. We have commented sort of from the beginning when we announced the deal that we anticipated getting about $200 million in revenues and about $60 million in EBITDA from Ascend. And I think we feel like we are very much on track to do that.

Those are really the numbers that are embedded in our 2013 guidance. And we are very pleased. Even though it's early on in the process, we are pleased with the way that integration is going.

Whit Mayo ***Robert W. Baird - Analyst***

Great. And maybe just last, final one. Any thoughts on the sequence of earnings this year? Historically, you've always had a lot sort of weighted in the first half of the year for Acute, and then maybe a year ago or so you felt that imbalance would balance out, if you will. And the calendar looks a little tough in Q1. So just wondering if you had any updated thoughts for how we should see the sequence of earnings progress throughout the year.

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

No. I mean, other than a few of the things that we have discussed, I mean, I think there will be a little bit of a benefit from the flu in the first quarter. And then obviously these reimbursement cuts, as well as the Temecula opening that we talked about, are skewed towards the latter half of the year.

Sequestration is effective beginning in April and then you've got all those cuts over the balance of the year. And then you've got the disproportionate share coding cuts in the fourth quarter, and then the Temecula drag in the third and fourth quarter.

Whit Mayo ***Robert W. Baird - Analyst***

Okay. That's helpful. Thanks a lot.

Operator

(Operator Instructions) Glen Losev, WallachBeth.

Glen Losev ***WallachBeth Capital - Analyst***

Yes. Hi. Steve, can you comment on surgical volumes in 4Q relative to the first nine months of the year and what your expectations are for, let's say, 2013?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Yes, surgical volumes, Glen, picked up a little bit in Q4. Inpatient volumes were sort of flattish, which is frankly the best they've been in a number of quarters. And outpatient was down a little bit, but that was also the best we've seen probably at least since the first quarter of the year. So, much like the other metrics that I talked about in terms of overall volumes and payer mix, surgical volumes showed a bit of an improvement in Q4 as well.

Glen Losev ***WallachBeth Capital - Analyst***

And was the acuity of the surgeries, was it higher than you've seen recently or it was a lower acuity surgeries?

Steve Filton ***Universal Health Services, Inc. - SVP & CFO***

Well, definitely our Medicare CMI was higher in Q4.

Glen Losev *WallachBeth Capital - Analyst*

And one last question. Can you give us any color on what you guys see in your Las Vegas and Texas markets?

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Did you say in Las Vegas and Texas or--?

Glen Losev *WallachBeth Capital - Analyst*

Yes.

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Yes. No, again, as I mentioned to a few different people, in general, the trends that I've articulated a few times -- slightly better volumes, slightly better surgical volumes, a little bit better payer mix in the Acute division in Q4 -- were generally present throughout the portfolio, not necessarily terribly better or worse in any markets, including Las Vegas and South Texas.

Glen Losev *WallachBeth Capital - Analyst*

All right. Thank you.

Operator

There are no further questions at this time.

Steve Filton *Universal Health Services, Inc. - SVP & CFO*

Okay. Well, we thank everybody and look forward to speaking to everybody in a couple months after the first quarter. Thank you.

Operator

Ladies and gentlemen, this does conclude today's conference call. Thank you for participating. At this time, you may now disconnect.