Willamette Valley Behavioral Health

Certificate of Need Application to Build a New, 100-Bed Psychiatric Hospital in Washington County

July 2019

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(OAR 333-580-0080)

STATE OF OREGON

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DATE RECEIVED	
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Facility Name: NEWCO Oregon, Inc.

Street Address: 9470 SW Day Road City/Zip: Wilsonville OR

Applicant/ Licensee: NEWCO Oregon, Inc., a Delaware Corporation

Licensee Address (if different):

Facility Administrator: To be determined Phone:

Medicare Provider No.: Medicaid Provider No.:

PERSON AUTHORIZED TO ANSWER QUESTIONS, ACT AND RECEIVE SERVICE ON BEHALF OF THE APPLICANT (if other than the facility administrator)

Name: Mr. Ron Escarda and Frank Fox, PhD. Phone: Mr. Escarda-(425) 821-2000; Dr. Fox (206) 366-1550

Title: Mr. Escarda-UHS Group Director of the Pacific Northwest; DR. Fox-Consultant

Firm: UHS of Delaware, Inc.

Address: 367 South Gulph Road City/Zip: King of Prussia PA 19406-0958

Have you previously submitted an application for this or a similar project? YES ☒ NO ☐

If yes, date submitted: January 5, 2016 Application ID No. CN #675

CERTIFICATION BY APPLICANT

I hereby attest that I reviewed the application and have knowledge of the content of information contained in this application. I therefore declare under penalty of perjury, that the project described and each statement, amount and supporting documents included are true and correct to the best of my knowledge and belief.

Name: Ron Escarda Title: UHS Group Director, Pacific Northwest

Signature: Ron Escarda Date: 7/2/19

CERTIFICATE OF NEED APPLICATION FORM

Signature: _____ Date: _____

Organization of Certificate of Need Application

This application requests approval for a 100-bed adolescent, adult, and older adult inpatient psychiatric hospital. Organization of this Application follows the organization of the OARs.

OAR 580 Section A:
OAR 333-580-0020

OAR 580 Section B:
OAR 333-580-0030

OAR 333-580-0040

OAR 333-580-0050

OAR 333-580-0060

OAR 333-580-0070

OAR 580 Section C:

OAR 333-580-0080

OAR 333-580-0090

OAR 333-580-0100

OAR 590:

OAR 333-590-0050

OAR 333-590-0060

OAR 615:

OAR 333-615-0020

OAR 333-615-0030

OAR 333-615-0040

OAR 333-615-0050

Division 580 Certificate of Need Application

OAR 333-580-0020

Section A: Introduction
The applicant shall provide a short introductory narrative of the proposal outlining the major aspects of the proposal.

NEWCO Oregon, Inc., DBA Willamette Valley Behavioral Health ("WVBH"), proposes to develop a freestanding 100-bed psychiatric hospital for adolescents, adults, and older adult (geropsychiatric) voluntary and involuntary patients in Washington County of the State of Oregon. We have identified a substantial, unmet need for adult inpatient psychiatric beds within the proposed Service Area of Clackamas and Washington counties, as well as for adolescent and older adult inpatient psychiatric beds within the Clackamas, Multnomah, and Washington counties.[1]

Based on careful review of inpatient psychiatric utilization statistics for service area residents and preparation of a reasonable inpatient psychiatric bed need forecast model for adolescent, adult, and older adult inpatients, we estimate a current (2019) shortage of 130 inpatient psychiatric beds, increasing to forecasted shortages of 146 beds in 2022 (three year projection) and 185 in 2029 (ten year projection).

There is significant demand for inpatient psychiatric care by both the most seriously ill individuals who are often involuntarily detained or committed, as well as for adolescents, adults, and older adults with less severe diagnoses but nonetheless requiring inpatient psychiatric care. Our application to develop and operate a 100-bed psychiatric hospital recognizes the pressing demand for inpatient psychiatric services and will also provide access to a comprehensive suite of outpatient services.

WVBH is a wholly owned subsidiary of Universal Health Services ("UHS"). UHS is also the owner of Cedar Hills Hospital, a 94-bed adult, inpatient psychiatric hospital, located in Portland Oregon. Willamette Valley Behavioral Health will benefit from the local clinical expertise and market knowledge from Cedar Hills as well as the broad experience and expertise of UHS in developing and operating psychiatric hospitals.

<u>Background and History</u>

UHS is one of the largest and most respected hospital management companies in the nation with a mission to provide superior quality healthcare services. Since its founding in 1979, UHS has built an impressive record of continuous achievement and performance. As of February 27, 2019, UHS subsidiaries owned and/or operated 26 acute care hospitals, 324 inpatient behavioral health

[1] As identified in OAR 333-580-0040, the selected Service Area for adult inpatient psychiatric beds is Clackamas and Washington counties, whereas the subspecialty adolescent and older adult inpatient psychiatric beds also include Multnomah County.

facilities, and 37 outpatient centers in 37 states, Washington, D.C., the United Kingdom, and Puerto Rico. It has extensive experience with siting and building facilities similar to the proposed WVBH.[2] As of 2018, UHS operated 23,509 licensed behavioral health beds, providing 6,418,334 behavioral patient days.[3] Please see Appendix 1 for a complete list of UHS facilities.

Behavioral Health Division

UHS is the largest facility-based behavioral health provider in the country. In 1983, UHS began providing behavioral health care through the acquisition of four behavioral health facilities, establishing a philosophy of caring for patients who need mental health services with kindness, dignity, and respect, while providing a supportive environment and treatment to help them heal.

Our programs and services provide care for more than 400,000 lives each year through a comprehensive range of behavioral health services for adolescents, adults, and older adults. Among the services we offer are acute inpatient behavioral healthcare, partial hospitalization, outpatient and residential treatment programs dedicated to addiction and chemical dependency, bipolar disorders, depression, older adult needs, post-traumatic stress disorder and psychotic diagnoses.

We take our leadership position in the behavioral health service industry very seriously, acting as advocates for mental health issues at the national, state and local levels, including suicide prevention. We are particularly proud of our Patriot Support Program, a national network of behavioral treatment centers, support staff, and medical professionals dedicated to treating active duty service members of the military, veterans, and their families.

UHS has six facilities in the Pacific Northwest: Cedar Hills Hospital in Washington County, Oregon; Fairfax Behavioral Health, a 157-bed adolescent and adult psychiatric hospital in Kirkland, Washington; Inland Northwest Behavioral Health, a 100-bed psychiatric hospital joint-venture with Providence Health & Services in Spokane, WA; Fairfax Behavioral Health Everett, a 30-bed adult psychiatric hospital in Everett Washington; Fairfax Behavioral Health Monroe, a 34-bed hospital adult psychiatric hospital in Monroe, Washington; and Schick Shadel Hospital, an alcohol and drug rehabilitation hospital in Seattle, Washington. UHS also has an 85-bed psychiatric hospital joint venture with Providence Health & Services being developed in Olympia, Washington. For the purposes of this application, we focus on our facility in Oregon State, Cedar Hills Hospital.

Cedar Hills Hospital

UHS completed its acquisition of Ascend Health Corporation in 2012, adding nine freestanding inpatient psychiatric facilities to its industry-leading behavioral health portfolio. This acquisition included Cedar Hills Hospital in Portland, Oregon. Since this acquisition, UHS has successfully operated this facility in Washington County.

[2] Universal Health Services, Inc. 2018 Annual Report. p. 1
[3] Ibid, Form 10 K Report, pages 3-4.

As of June 2019, Cedar Hills Hospital is licensed to operate 94 inpatient psychiatric beds. Even with an expansion of fifteen additional beds since 2013, Cedar Hills has operated at near maximum capacity, deflecting on average approximately 180 referrals per month in 2018, an average which has increased to 337 deflections per month in year-to-date (January to May) 2019. At 2018 year-end, its occupancy was at 85%. UHS' commitment to providing quality behavioral health services necessitated examination of the region in which Cedar Hills Hospital is located to determine if there is need for an additional freestanding inpatient psychiatric hospital.

Proposed Project

The proposed project is a 100-bed behavioral health facility, licensed as a psychiatric hospital, with adult inpatient crisis stabilization services and mental health programs, an older adult program, inpatient adolescent services, autism programs, women-focused programs, substance abuse treatment, behavioral pain management, and general outpatient services. In addition, through our Patriot Support Program, the facility will serve military service members and their families, along with veterans with behavioral and mental health needs otherwise unable to obtain timely and efficient services. The proposed facility will serve and benefit Oregon residents with behavioral health services, where there is a documented unmet need.

The project will offer both inpatient and complementary outpatient care services, tailored to age cohorts including adolescent, adult, and older adults. Where appropriate, it will collaborate with Cedar Hills Hospital, located 13 miles north of our proposed new facility, in clinical delivery, staffing and ancillary/support services.

Inpatient programs at Willamette Valley Behavioral Health will include:

- Psychiatric
- Chemical Dependency
- Crisis stabilization
- Freedom Care Military Program: a 28-day intensive therapy program for active-duty soldiers
- Women's Program: a group therapy program for women whose psychological issues are best served in a women's-only milieu
- Pain Management Program: a group therapy program for individuals seeking treatment for chronic pain and related addictions issues

Outpatient programs at Willamette Valley Behavioral Health will include:

- Partial hospitalization
- Intensive outpatient
- Outpatient
- Chemical Dependency
- Co-Occurring Disorders Program
- Medication-assisted treatment
- Mood disorder programs
- Women's Program
- Chronic Pain Program

The proposed facility will be a two-story structure with 62,660 gross square feet for inpatient housing, administration, registration, inpatient care, outreach services, dietary services and recreation. Site improvements include parking for 140 vehicles, landscaping, and outdoor

recreation areas. Total project costs are estimated at $47.0 million. Once fully operational, our proposed facility will have approximately 200 full-time employees. The proposed start-up date is September 1, 2021.

Need for Inpatient Psychiatric Beds in the Service Area

UHS has assessed the availability of and demand for inpatient psychiatric beds and determined there is need for additional inpatient psychiatric services. In addition to observing firsthand the trends at UHS' Cedar Hills facility, we have reviewed historic utilization statistics for other inpatient psychiatric providers and prepared a bed need forecast model, consistent with the OARs (discussed in detail below). All three of these methods confirm a pronounced inpatient psychiatric bed shortage for adolescent, adult, and older adult voluntary and involuntary patients in the Clackamas, Multnomah, and Washington counties.

In Clackamas and Washington counties, which in 2019 had a population of 1.03 million residents, there are currently two hospitals with adult inpatient psychiatric beds. As of 2017, these two facilities had an average occupancy of 81%. Further, Cedar Hills' occupancy increased to 84.8% in 2018, even after adding six additional beds. Thus, both Cedar Hills and the Unity Center for Behavioral Health ("Unity Center") are effectively at capacity. For adolescents, there are only two hospitals in the Clackamas-Multnomah-Washington county area, Providence Willamette Falls Medical Center and Unity, which provide inpatient adolescent psychiatric beds (16 and 22 beds, respectively). These also represent the only two adolescent care facilities within Oregon State. Older adults face similar shortages, with two hospitals within the Clackamas, Multnomah, or Washington counties, and three hospitals within Oregon overall. By any standard, there is a shortage of inpatient psychiatric beds given capacity constraints with the current supply of beds.

In 2008, the Department approved 36 beds for Cedar Hills Hospital, finding that "[t]he applicant has demonstrated…a finding of need for further psychiatric inpatient beds in the proposed Service Area…to ensure the continued availability of psychiatric beds on demand in the tri-county area…the applicant is proposing to serve a presently unmet need that is likely to continue into the future."[4] What was true then remains true today, perhaps more so. Population growth has continued, while the supply of inpatient psychiatric beds has not kept pace. Recent changes to laws will further increase this demand for psychiatric care, some of which, due to the high acuity of some patients, must be in inpatient settings. Since 2008, Cedar Hills has expanded considerably from 36 beds to 78 beds in 2010 to 89 beds in 2014, and now it operates 94 beds. This substantial bed increase over the past decade is due to an overwhelming demand for inpatient psychiatric services, which has kept Cedar Hills consistently operating at maximum capacity.

Unusual Circumstances

In 2017, the Oregon Health Authority (OHA) denied UHS' original application to develop and operate a 100-bed psychiatric hospital.

> "The applicant has not demonstrated that the proposed facility is needed or the most effective and least costly alternative considering all appropriate and adequate way of

[4] Oregon Department of Human Services, Public Health Division, Review of Ascend Health Corporation CN #654, May 5, 2008. Page 16.

> meeting the population's need for services. For the reasons previously discussed, the proposed facility would add unneeded inpatient hospital beds to the service area. Hospital care is the most expensive level of care in the-mental health system. Less costly and more effective alternatives to the building of more resource intensive inpatient psychiatric beds are preferable. Consequently, the impact of this proposal on the cost of health care is not acceptable."[5]

As part of its denial, OHA heavily subscribed to the viewpoint that inpatient care was unneeded due to supposed availability of alternatives and other community investments in outpatient care.[6] Unfortunately, even after implementation of several of the alternatives referenced in OHA's denial, Oregon has continued to be in a state of crisis with respect to mental health and substance abuse, due in large part to the continued lack of access to a sufficient supply of inpatient psychiatric beds.

Subsequent to the 2017 denial, OHA approved Lifeways, Inc. in 2018 to develop and operate a new 16-bed psychiatric unit in Hermiston. Despite not finding need for general acute care beds, OHA approved the project due to its demonstration of 'Unusual Circumstances' of non-availability, access, and less costly alternatives.[7]

UHS submits that unusual circumstances, including the Oregon Mental Health Crisis, ongoing high levels of ED boarding, the Unity Center impact on patient demand at other inpatient psychiatric providers, and the persistent problem of insufficient inpatient psychiatric bed supply despite constant excess capacity at acute care providers, warrant approval of the proposed WVBH project despite the absence of need for general acute care beds under the OAR 333-590-0050 acute care need methodology. Please see Section 333-615-0030(4) of this application for a detailed discussion of the unusual circumstances warranting approval of the proposed WVBH project, of which we summarize here briefly.

For acute care inpatient beds, we estimate a current year surplus of about 357 beds. This surplus results from acute care providers maintaining excess inpatient bed capacity, which they have been unwilling or unable to convert into inpatient psychiatric beds. This has resulted in a severe shortage of inpatient psychiatric care in the Clackamas, Multnomah, and Washington counties, and contributed to the declaration that Oregon faces a mental health crisis with high rates of ED boarding and incarceration of mentally ill individuals in jails rather than hospitals.

ED boarding has long plagued the Oregon mental health sector, documented in a 2016 report by Oregon State University's College of Public Health and Human Sciences. The report finds that an insufficient supply of inpatient psychiatric beds, combined with limited community alternatives and mental health workforce shortages has led to significant rates of ED boarding in Oregon hospitals. News articles from 2019 have highlighted the fact that the problems identified in 2016 continue to

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[5] High, Jere ND. Re: NEWCO Oregon, Inc., Final Decision on CN Application #675. Oregon Health Authority (OHA) - Public Health Division - Certificate of Need Program. July 6, 2017. p. 8

[6] In its denial, OHA asserted there would be a negative financial impact on other community providers because it believed the proposed facility (NEWCO) would not take on its share of non-commercial patients. However, January to March 2019 data demonstrates that UHS' existing facility, Cedar Hills Hospital, provided 81% of its patient days to non-commercial patient; principally TRICARE / VA, Medicare, Managed Medicare, and Managed Medicaid.

[7] Selover, Dana MD, MPH. DEFAULT FINAL ORDER APPROVING CERTIFICATE OF NEED APPLICATION (CN#677). OHA. May 25, 2018. p. 4.

today. Moreover, analysis of data from the National Mental Health Services Survey demonstrates that there was a decrease between 2014 and 2017 in the number of Oregon mental health facilities reporting offering 24-hour inpatient, 24-hour residential, partial hospitalization / day treatment, and outpatient services. The services proposed under WVBH, which includes inpatient and a comprehensive set of outpatient services, will counter this trend and provide community access to all points of care along the behavioral health continuum.

The Unity Center for Behavioral Health, which opened in early 2017, was supposed to alleviate the problems of ED boarding in Oregon through reducing demand for inpatient psychiatric care. Unfortunately the Unity Center has failed, both at reducing demand for inpatient psychiatric care, as well as in providing a safe and stable place for patients needing that level of care. Instead of representing a solution, the Unity Center has instead exacerbated the mental health crisis facing Oregon residents. Dr. George Brown, the President and CEO of Legacy Health during the development and implementation of the Unity Center, commented in 2018, well past a year since the Unity Center opened:

> "The Unity Center for Behavioral Health, which opened in early 2017, is approaching 10,000 patients a year and operating at a loss, he said.
>
> Portland needs 'at least two or three additional facilities to manage the challenge we have in Portland,' Brown said"[8]

In a market that functions well, unmet need and excess demand would be met by increases in provider supply. However, this has not happened in Clackamas, Multnomah, or Washington counties, or in Oregon overall. Since 2015, the population of Clackamas, Multnomah, and Washington counties has increased by over 50,000 persons between the ages of 18 and 64, and by over 100,000 persons across all age groups. However, the number of beds available to serve this growing population has been stagnant. A lack of investment and unwillingness to expand inpatient psychiatric bed capacity among Clackamas, Multnomah, and Washington county providers has aggravated the mental health crisis there, and in Oregon overall. Oregon's status in delivering adequate mental health treatment to its residents has thus degenerated to the point where it now ranks among the bottom of all U.S. states. Dr. Donald Rosen, a well-respected psychiatrist and academic who was on staff many years at Oregon Health & Science University, submitted in 2017, a letter of support for UHS' prior application stating:

> "Regarding inpatient services, the community will benefit from enhanced programmatic development across the spectrum of services, including inpatient services. Moreover, there is no evidence that alternatives to inpatient treatment will provide the health outcomes of hospitalization for our most needful citizens in a manner that is quicker, safer, better, or cheaper. In addition to supporting the development of ever increasingly sophisticated care options in less restrictive environments, the influx of residents coupled with an increase in the numbers of insured citizens, as well as the current and ever increasing demand for such services, supports the reality that an increase in inpatient beds is necessary. Any strategy to improve access to treatment must include an increase in inpatient beds. The Unity Center does not increase the number of beds available, as it's

[8] Hayes, Elizabeth. Legacy's Dr. Brown on the high cost of medical school and what else ails the health system. Portland Business Journal. May 24, 2018

opening represents a consolidation of inpatient beds from Legacy, Kaiser, Tuality, OHSU, and Adventist. The opening of Unity has not alleviated the need for transfers to other facilities. Psychiatric hospitals are frequently at or near capacity, and ED Boarding has increased over the past several years, particularly in the case of adolescents."[9]

Summary

As clearly indicated by population and patient data, there is a substantial, historical and projected need for inpatient psychiatric beds in the Service Area. Immediate action to increase inpatient psychiatric capacity is critically needed. As a current provider in the Service Area, UHS is ideally situated to provide additional capacity for patient care. Due to our experience and existing relationships with other healthcare providers in the region, UHS is confident that we are capable of meeting patient needs in a timely, efficient, and cost-effective manner, and most importantly, delivering accessible, high quality care.

[9] Rosen, Donald M.D. Re: UHS - Analysis Supporting the NEWCO Proposed Decision dated 02.24.2017. May 5, 2017. p. 1.

OAR 333-580-0030

(1) The Applicant must demonstrate in narrative form that its proposal satisfies the criteria specified in OAR 333-580-0040 to 333-580-0060 and the applicable service-specific need methodologies and standards in Divisions 585 through 645. The application must have written narrative sections corresponding to each section of OAR 333-580-0040 to 333-580-0060 (those statements labeled "(1)," "(2)," etc). In each section, the criterion to be addressed is shown in italics. An explanation of the way in which the criterion is to be addressed and specific issues to be discussed is then provided. The narrative should address each of these issues.

Section B: Review Criteria (Narrative Discussion Only-No Response Required)

OAR 333-580-0040
Section B: Need

Applicants must provide a narrative discussion of each of the following:

(1) Criterion: Does the Service Area population need the project?

- ***a. Applicant must identify the Service Area's need for the proposal in the past, present and future;***
- ***b. In establishing the magnitude of present and future need for each service element, the applicant will:***
  - ***i. Use appropriate indicators of a population's need (i.e. population-based use-rates, population-based "medical necessity" rates, or established productivity standards);***
  - ***ii. Use the standards and need methodologies specified in division 585 through 645 of OAR chapter 333 application to proposed services or facilities.***
  - ***iii. Consider industry standards and historical experience as appropriate comparisons where plans are silent.***

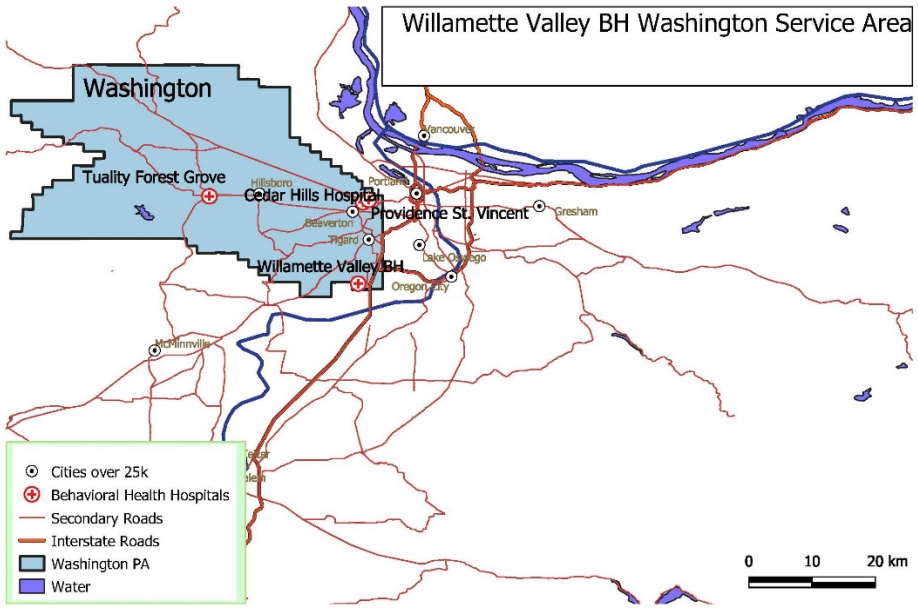
Service Area Definition

Acute Care Inpatient Beds: Washington County

The acute care inpatient bed service area for proposed new hospitals is defined in OAR 333-590-0050(1) to be "those zip codes from which either ten percent or more of the hospital's discharges are reasonably expected to originate, or in which the hospital would have at least a 20 percent market share" (OAR 333-590-0050(1)). Furthermore, "Minor adjustments to the boundaries of the service area may be made to create a contiguous service area or to conform more closely to the boundaries of demographic units for which census data are reported (county, county census division, enumeration district, or zip codes if conversion has been done)" (OAR 333-590-0050(1)).

Please see Appendix 11 for summary data tables and implementation of the acute care bed need methodology defined in OAR 333-590-0050, including determination of the appropriate acute care service area. As demonstrated in Appendix 11, there is no single zip code area that constitutes a region with ten percent or more of patient discharges or that garners 20 percent market share for general acute services. Further, to conform to the boundaries of available demographic data, service area definitions must be made at the county level. Therefore, Washington County, the county where WVBH will be located, is selected as the relevant service area for acute inpatient care (see Figure 1 below).

Figure 1 – Washington County Service Area Map



Adult Inpatient Psychiatric Beds: Clackamas and Washington Counties

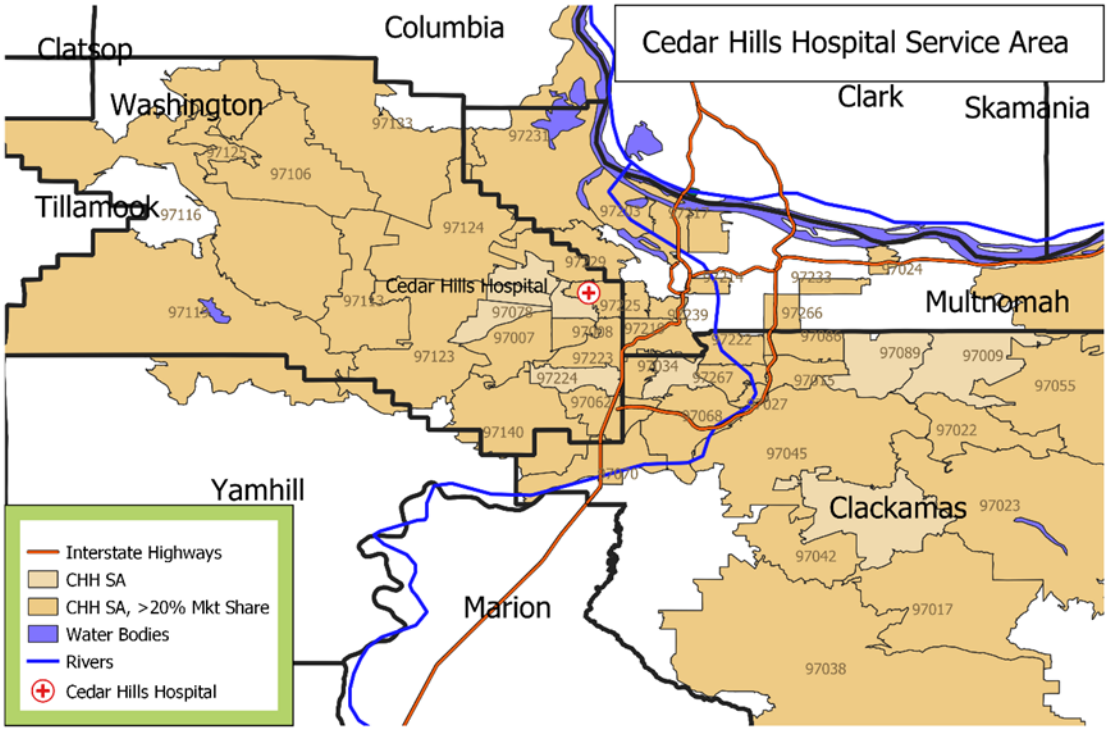
For adult inpatient psychiatric care, OAR 333-615-0030(1) specifies three different Health Service Areas based on the 14 Oregon State administrative districts.[10] OAR guidelines state that service areas for adult inpatient psychiatric care will "in general consist of single state administrative districts, or combinations of such areas", however OHA-determinations on appropriate service area definitions may constitute a subset of one of these administrative districts (OAR 333-615-0030(1)(b)).

As a free-standing inpatient psychiatric hospital, the closest analog to the proposed facility is Cedar Hills Hospital, located in the Washington County zip code 97225. Across the past five years of Cedar Hills Hospital discharge data, no zip code has constituted more than about five percent of the hospital's discharges. However, Cedar Hills Hospital has had market shares above 20% for proximate zip codes.[11] From the most recent discharge data available (2017), Cedar Hills Hospital has had a market share above 20% for 38 zip codes across the Clackamas, Multnomah, and Washington counties. These include 22 of 27 zip codes in Clackamas County, 24 of 45 zip codes in Multnomah County, and 21 of 27 zip codes in Washington County. A map of those zip codes in which Cedar Hills Hospital has more than a 20 percent market share is given in Figure 2, along with a proposed Cedar Hills service area of those zip codes plus contiguous zip codes .

[10] These 14 administrative districts include the county groupings of: Clatsop-Columbia-Tillamook; Multnomah-Washington-Clackamas; Marion-Polk-Yamhill; Benton-Linn-Lincoln; Lane; Douglas; Coos-Curry; Jackson-Josephine; Hood River-Sherman-Wasco; Crook-Deschutes-Jefferson; Klamath-Lake; Gilliam-Grant-Morrow-Umatilla-Wheeler; Baker-Union-Wallowa; Harney-Malheur.

[11] Market share is defined as the proportion of patient days from the population services by Cedar Hills Hospital, namely adults seeking inpatient psychiatric care.

Figure 2 – Cedar Hills Hospital Market Share Zip Codes

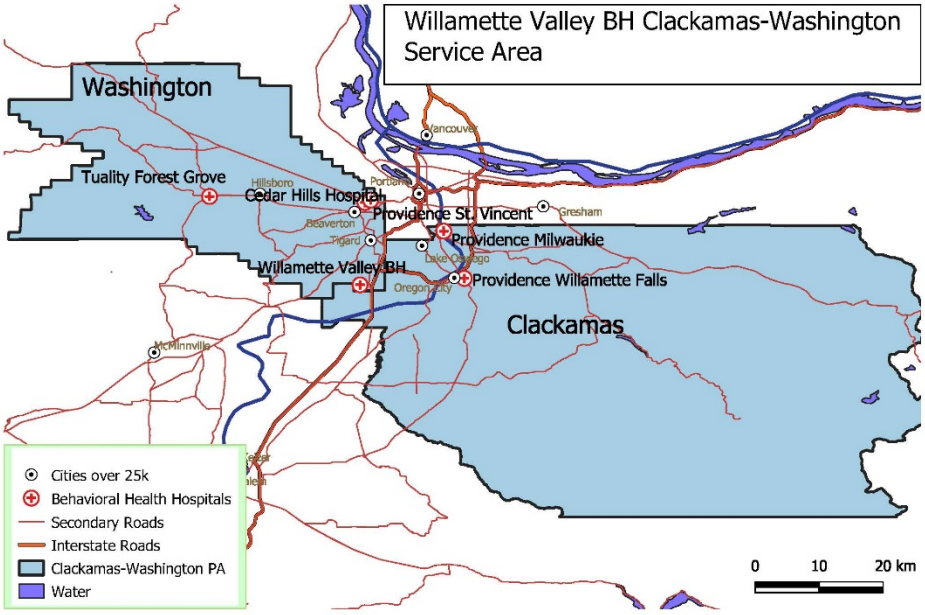


The proposed hospital will be sited in the Washington County portion of zip code 97070. Zip code 97070 straddles Washington and Clackamas counties, with about 94 percent of its geographic area and 90 percent of its population located in Clackamas. As with Cedar Hills Hospital, while it is not expected that any single zip code will comprise more than ten percent of discharges, it is expected the proposed hospital will have a market share above 20 percent in zip codes sufficiently proximate to its location and sufficiently distant from other providers. Given its location, the relative concentration of inpatient psychiatric facilities in Multnomah County, and the general lack of adult inpatient psychiatric facilities in in Washington and Clackamas counties, it is expected that:

1. Zip codes in which the proposed hospital will have meaningful market shares will be limited to Clackamas and Washington counties.
2. The proposed hospital will have market shares above 20 percent in its sited zip code, 97070, as well as in all immediate neighboring zip codes, which include the zip codes 97002, 97013, 97062, 97068, 97132, and 97140.
3. Just as Cedar Hills Hospital has market shares over 20 percent for nearly all Clackamas and Washington County zip codes distant from the Portland metropolitan region, so will the proposed hospital.
4. The proposed hospital will thus provide service to at least 20 percent of the market within the majority of zip codes in both Washington and Clackamas counties.

Based on WVBH's location, the relative concentration of inpatient psychiatric facilities in Multnomah County, and the general lack of adult inpatient psychiatric facilities in Washington and Clackamas counties, it is expected the proposed hospital will provide service to at least 20 percent of the market within the majority of zip codes in both Washington and Clackamas counties. For this reason, and to maintain consistency with the OAR Health Service Areas, our proposed service area for adult inpatient psychiatric beds is the Clackamas and Washington County geographic area (see Figure 3 below).

Figure 3 – Clackamas and Washington County Service Area Map



Adolescent and Older Adult Inpatient Psychiatric Beds: Clackamas, Multnomah, and Washington Counties

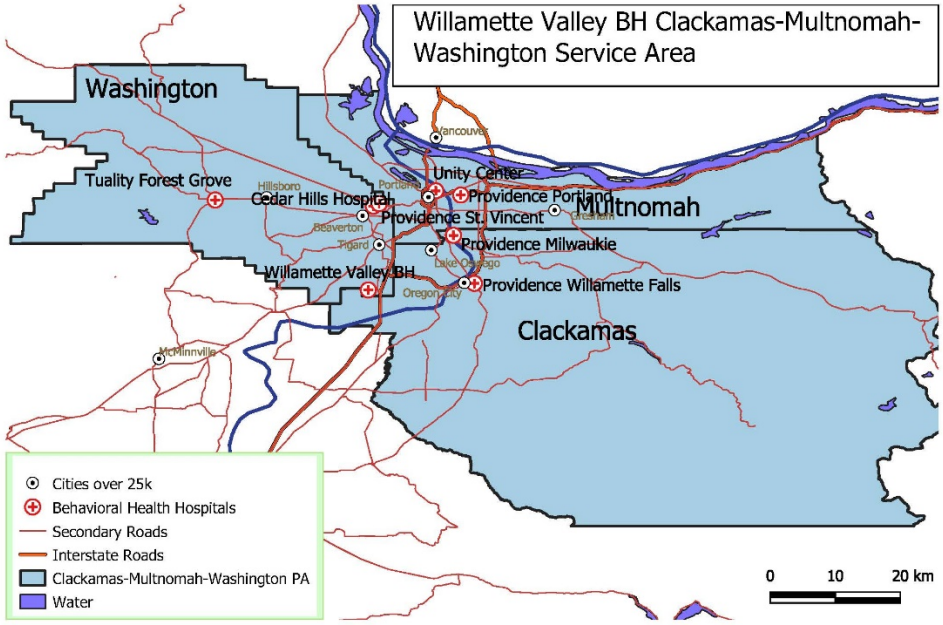
Adolescent and older adult inpatient psychiatric care is classified within the OARs as subspecialty care (OAR 333-615-0010(2)) with a service area of the state as a whole (OAR 333-615-0030(1)(d). For the purposes of this application, we have selected Clackamas-Multnomah-Washington counties service area for adolescent and older adult beds for the following reasons:

(1) Approximately 43% of Oregon adolescent residents live in one of these three counties, and about 33% of persons over the age of 65 (PRC 2017).
(2) The majority of inpatient care is delivered by providers in this service area;
(3) It is our understanding there are no dedicated adolescent psychiatric providers outside this Service Area;

(4) Since the only adolescent inpatient psychiatric providers exist within the Clackamas-Multnomah-Washington counties, along with two out of the three older adult inpatient psychiatric providers, a state-level definition of an adolescent or older adult service area will not change our conclusions of bed shortages, just increase them.

Please see Figure 4 below for a map of the Clackamas-Multnomah-Washington Service Area.

Figure 4 – Clackamas-Multnomah-Washington Service Area Map



In the analysis that follows, we will draw distinctions between adult, adolescent, and older adult populations and need analysis, as appropriate.

Service Area Population

Acute Care Service Area-Washington County

We present population counts for Washington County and Oregon State overall in Table 1. Population data is sourced from the Portland State University ("PSU") Population Research Center ("PRC") annual Oregon population reports in accordance with OAR 333-590-0050(2). 2017 represents the most recent data available, and Table 1 presents this along with the past 10 years.

Table 1: Washington County and Oregon State Historical Population

Geographic Area	2007	2012	2017	Avg. ann %Δ, 2007-2017
Washington County	509,886	542,845	595,860	1.69%
Oregon State	3,739,359	3,883,735	4,141,100	1.07%

Sources:
Population counts are aggregated from age cohort population data published by Portland State University Population Research Center (PRC) in their annual population report tables for the years 2000-2009, 2011, 2012, 2013, 2014, 2015, 2016, and 2017.

As indicated in Table 1, in 2017 the total population for Washington County was about 595,000, and for Oregon State about 4.1 million. Washington County has grown faster than the state as a whole, and in fact has grown faster than all other Oregon counties over this period, with the exception of Deschutes County which had an average annual growth rate of about 2.2%. This has led to growth in the proportion of the Oregon population concentrated in Washington County, such that in 2017 about 14.4% of Oregon's population resided there.

Table 2 presents population forecasts for Washington County and Oregon State.

Table 2: Washington County and Oregon State Forecast Population

Geographic Area	2019	2024	2029	Avg. ann %Δ, 2019-2029
Washington County	611,308	659,127	708,467	1.59%
Oregon State	4,231,029	4,470,588	4,710,556	1.13%

Sources:
Population counts are aggregated from age cohort population forecasts published by Portland State University Population Research Center (PRC) for individual counties. Statewide population estimates are determined through aggregation of individual county level PRC population forecasts. Forecasts are published in 5 year increments, and estimated for single years through linear interpolation.

Projections from Tables 2 indicates that growth in Washington county is expected to be about 1.6% per year, which will continue to outpace that of Oregon State as a whole. These projections reflect expectations that Washington county will grow marginally slower than it has over the last 10 years, while Oregon state will grow slightly faster. Washington County is projected to have among the highest rates of population growth across all of Oregon over the next decade, so from a growth perspective is an excellent location for a new inpatient psychiatric facility. The selected site is close to populated cities in Clackamas County, and is easily accessible from population centers to the north and south of the proposed site.

Adult Psychiatric Care Service Area-Clackamas and Washington Counties

Table 3 presents historical population counts for the Adult Psychiatric Care Service Area of Clackamas and Washington Counties.

Table 3: Clackamas and Washington County Historical Population

Geographic Area	2007	2012	2017	Avg. ann %Δ, 2007-2017
Washington County	509,886	542,845	595,860	1.69%
Clackamas County	368,214	381,680	413,000	1.22%
Wash. & Clack.	**878,100**	**924,525**	**1,008,860**	**1.49%**
Oregon State	3,739,359	3,883,735	4,141,100	1.07%

Sources:
Population counts are aggregated from age cohort population data published by Portland State University Population Research Center (PRC) in their annual population report tables for the years 2000-2009, 2011, 2012, 2013, 2014, 2015, 2016, and 2017.

From Table 3, in 2017 the total population of the Clackamas-Washington area was about 1 million. Washington County has had the fastest population growth over the last 10 years, although Clackamas County (about 1.2% average annual growth) has also outpaced the population growth in Oregon State. In 2017, about a fourth of Oregon residents lived in either Washington or Clackamas counties.

Table 4 presents forecast population counts for the Clackamas-Washington Service Area.

Table 4: Clackamas and Washington County Forecast Population

Geographic Area	2019	2024	2029	Avg. ann %Δ, 2019-2029
Washington County	611,308	659,127	708,467	1.59%
Clackamas County	423,425	454,009	483,972	1.43%
Wash. & Clack.	**1,034,733**	**1,113,136**	**1,192,439**	**1.52%**
Oregon State	4,231,029	4,470,588	4,710,556	1.13%

Sources:
Population counts are aggregated from age cohort population forecasts published by Portland State University Population Research Center (PRC) for individual counties. Statewide population estimates are determined through aggregation of individual county level PRC population forecasts. Forecasts are published in 5 year increments and estimated for single years through linear interpolation.

Projections from Table 4 indicate the Clackamas and Washington county populations should grow consistent with recent historical trends. Expectations are that population growth will average about 1.52% per year for the Adult Psychiatric Inpatient Care Service Area, about a ½ a percent faster than Oregon State overall. Forecast population estimates suggest a rising need for inpatient

psychiatric healthcare services over the next decade. Based on population growth alone, demand for inpatient psychiatric services will increase substantially.

Adolescent and Older Adult Psychiatric Care Service Area-Clackamas, Multnomah, and Washington Counties

In addition to adults aged 18 to 64, our proposed facility in Wilsonville will offer inpatient psychiatric healthcare for adolescents and older adults. Older adults are defined as those persons age 65 and over, which corresponds with the definition by CMS. Adolescents we define as persons aged 12 to 17 years. Table 5 presents historical population counts for the Adolescent and Older Adult Inpatient Psychiatric Care Service Area of Clackamas, Multnomah, and Washington Counties.

Table 5 – Clackamas, Multnomah, and Washington County Historical Population by Age Group

Geographic Area	2007	2012	2017	Avg. ann %Δ, 2007-2017
Adolescents (12-17)				
Clackamas, Multnomah, and Washington County	121,098	123,890	126,306	0.43%
Oregon State	294,947	293,023	294,437	-0.02%
Elderly (65+)				
Clackamas, Multnomah, and Washington County	160,435	197,886	252,541	5.74%
Oregon State	480,230	575,357	714,196	4.87%

Sources:
Population counts are aggregated from 5-year age cohort population data published by Portland State University Population Research Center (PRC) in their annual population report tables for the years 2000-2009, 2011, 2012, 2013, 2014, 2015, 2016, and 2017. Statewide population estimates are determined through aggregation of individual county-level PRC population estimates. The adolescent age group is constructed from the 5-year age groups available through the PRC using single-year age shares from the 2010 U.S. Census Table PCT12: Single Years of Age and Sex: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.

From Table 5, in 2017 there were 294,437 adolescents residing in Oregon State, a number that has remained nearly constant over the past 10 years. About 126,000 adolescents lived within either Clackamas, Multnomah, or Washington County, a proportion which has grown. The number of older adults has increased significantly since 2007, with almost a 6% per year growth in the Clackamas-Multnomah-Washington area, and about 5% growth in Oregon state overall.

Table 6 presents forecast population counts for the adolescent and older adult populations in the Clackamas-Multnomah-Washington service area.

Table 6 – Clackamas, Multnomah, and Washington County Forecast Population by Age Group

Geographic Area	2019	2024	2029	Avg. ann %Δ, 2019-2029
Adolescents (12-17)				
Clackamas, Multnomah, and Washington Counties	128,250	132,863	137,550	0.73%
Oregon State	298,965	310,150	322,146	0.78%
Elderly (65+)				
Clackamas, Multnomah, and Washington Counties	272,161	325,595	367,827	3.52%
Oregon State	768,994	904,203	1,006,342	3.09%

Sources:
Population counts are aggregated from age cohort population forecasts published by Portland State University Population Research Center (PRC) for individual counties. Statewide population estimates are determined through aggregation of individual county-level PRC population estimates. The "adolescent" age group is constructed from the 5-year age groups available through the PRC using single-year age shares from the 2010 U.S. Census Table PCT12: Single Years of Age and Sex: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.

Based on population forecasts, the adolescent demographic is expected to grow on average about 0.73% per year between 2019 and 2029 within the Clackamas-Multnomah-Washington area. As we will discuss further below, there are only two facilities within Oregon state which offer dedicated inpatient psychiatric care for adolescents.[12]

The growth of the older adult population is expected to slow but remain strongly positive. The number of persons over the age of 64 is expected to grow about 3.5% per year in the Clackamas-Multnomah-Washington service area, and about 3.1% per year in Oregon overall. As is the case with adolescents, there are few facilities which offer dedicated inpatient care for older adults. Only two exist within the proposed service area, and another elsewhere within Oregon state.[13]

Summary of Bed Need Forecasts

Acute Care

General Acute Care Bed Need Forecasts

[12] Letter from Robin Henderson, Chief Executive, Behavioral Health, Providence Medical Group, dated December 11, 2017, in NEWCO – Affected Status.
[13] Ibid.

The OARs require applicants to submit a forecast of net need for general acute care beds when applying for specialty beds such as inpatient psychiatric services. A 10 year[14] forecast of net need for general acute care beds is provided below in Table 7. The forecasts are based on the numeric need methodology contained in OAR 333-590-0050. Please see Appendix 11 for summary data tables and a description of the step-by-step process implemented to construct the acute care bed need forecast.

Table 7 - General Acute Care Bed Need Forecast, 10-Year Projection

	2019	2024	2029
	Application Submission	Year 5	Year 10
Service Area Peak ADC	747	850	946
Total Service Area Bed Supply	1,104	1,104	1,104
Net Bed Need (Surplus) - Before Project	**-357**	**-254**	**-158**

Psychiatric Bed Need Forecasts

Forecast Period

We forecast inpatient psychiatric bed need over a 10-year period, which is consistent with OARs 333-615-0030(4)(a) and 333-590-0050(6). However, in the Department's decision on the 2008 Ascend application, the Department stated that a 15-year or longer period would be appropriate for new construction:

> …while the department has previously stated that the longer forecast period is appropriate for new hospital construction, the context for use of 15 year or longer forecast need was with regard to new construction of medical centers that were intended to serve a substantial portion of a region's need, which due to their size and complexity of medical and surgical services, could not easily be started in a short period. [15]

Our proposal for a new hospital could thus reasonably argue for a 15-year forecast period. However, there is current need for our requested 100-bed hospital. Within the 10-year forecast period, provided in detail below, inpatient psychiatric need grows over time. Thus, based on the immediate and significant need for inpatient psychiatric care in the Clackamas-Washington County Service Area, a 10-year forecast period is appropriate and sufficient to provide evidence for current and future service area need.

Methodology

Inpatient psychiatric need is determined within the OARs through use of a population-based need analysis. Inpatient psychiatric need is considered to exist if, in the third year of operation, the number of beds added through the proposed facility results in a bed-to-population no more than

[14] Per OAR-333-590-0050(10), a ten year projection from the calendar year of submission of the application is used for the purposes of the acute care bed need forecast.
[15] Please see letter from Oregon Department of Human Services and Public Health Division to Mr. Stoloff, May 5, 2008, approving Ascend Corporation's (CN #654) establishment of Cedar Hills Hospital.

the ratio of 0.40 beds for 1,000 persons (OAR 333-615-0020(5) and OAR 333-615-0030(2)). Our methodology outlined in steps is as follows:

STEP 1: Obtain population estimates and projections for adults in the Clackamas-Washington Service Area, and adolescents and older adults in the Clackamas-Multnomah-Washington Service Area, for the base year (2019) and every year through the 10-year forecast (through 2029). Psychiatric bed ratios are calculated for each year for each age group.

STEP 2: Multiply the relevant bed-to-population ratio of beds per 100,000 persons by the service area population estimates and projections in Step 1. Repeat for each year of the forecast to provide a gross estimate of need.

Note: the target bed ratio applied is 32.5 beds per 100,000 residents. This is based on actual bed count averages from other states in the region, including Oregon, Alaska, Idaho, Washington, and Montana.[16] Please see section 333-615-0030 below for a description of the target bed ratio selection process.

STEP 3: Compile a list of all current inpatient psychiatric providers at the adult, adolescent, and older adult age level for the relevant service area. Count and total the number of psychiatric beds operated in each hospital for the relevant age group. Table 8 shows the supply of adult inpatient psychiatric beds is 127 in the Clackamas-Washington Service Area, while the supply of adolescent and older adult beds in the Clackamas-Multnomah-Washington Service Area is 38 and 42, respectively.

STEP 4: Subtract the total service area bed supply from Step 3 from "gross demand" estimates calculated in Step 2. The resulting value represents the estimates of net need for psychiatric beds, by year, for the adult, adolescent, and older adult age groups.

The results of the above methodology generate an estimate of future inpatient psychiatric bed need, provided below in Table 8.

Table 8 – Adult, Adolescent, and Older Adult Inpatient Psychiatric Bed Need

[16] N-MHSS 2016, https://wwwdasis.samhsa.gov/dasis2/nmhss.htm accessed 20 May 2019.

Inpatient Bed Need Summary by Age Group	Base Year	Year 1	Year 3	Year 5	Year 10
	2019	2020	2022	2024	2029
Adolescent, Adult, and Geriatric Net Bed Need	**129.9**	**134.4**	**146.1**	**158.7**	**185.0**
Adolescents (age 12 to 17)					
Clackamas-Multnomah-Washington Service Area Resident Population	128,250	129,197	131,009	132,863	137,550
Clackamas-Multnomah-Washington Available Psychiatric Beds	38.0	38.0	38.0	38.0	38.0
Target Bed Ratio	32.5	32.5	32.5	32.5	32.5
Gross Bed Need	41.7	42.0	42.6	43.2	44.7
Net Bed Need	**3.7**	**4.0**	**4.6**	**5.2**	**6.7**
Adults (age 18 to 64)					
Clackamas-Washington Service Area Resident Population	636,078	640,038	653,252	666,899	700,664
Clackamas-Washington Available Psychiatric Beds	127.0	127.0	127.0	127.0	127.0
Target Bed Ratio	32.5	32.5	32.5	32.5	32.5
Gross Bed Need	206.7	208.0	212.3	216.7	227.7
Net Bed Need	**79.7**	**81.0**	**85.3**	**89.7**	**100.7**
Geriatrics (age 65+)					
Clackamas-Multnomah-Washington Service Area Resident Population	272,161	281,219	302,312	325,595	367,827
Clackamas-Multnomah-Washington Available Psychiatric Beds	42.0	42.0	42.0	42.0	42.0
Target Bed Ratio	32.5	32.5	32.5	32.5	32.5
Gross Bed Need	88.5	91.4	98.3	105.8	119.5
Net Bed Need	**46.5**	**49.4**	**56.3**	**63.8**	**77.5**

In 2019, the forecast methodology demonstrates unmet need for 130 beds, increasing to 146 beds in Year 3 and 185 beds in Year 10. We note that using the OHA recommended ratio of 40 beds per 100,000 persons suggests current unment neet of 208 beds.

Given this forecast does not account for in- or out-migration, and in-migration to both the Clackamas-Washington and Clackamas-Multnomah-Washington service areas is much greater than out-migration, it represents a conservative forecast estimate. As shown in Table 37, in-migration at Cedar Hills tended to account for over half of patient day counts. Furthermore, as shown in Table 36, there is also significant in-migration to hospitals providing inpatient psychiatric care, but little out-migration of residents to other providers. Thus, the psychiatric patient need forecast provided in Table 8 is conservative, since it does not adjust for the current and significant net in-migration at Clackamas, Multnomah, or Washington hospitals, particularly Cedar Hills.

The forecast model in Table 8 already demonstrates need now, for more beds than we are requesting. The forecast also shows demand increases to 146 beds in Year 3 and 185 beds by 2029. If net in-migration was included in the forecast model, this would further increase the forecasted need. Although conservative, the Table 8 forecast more than demonstrates current and future need in the Service Area well in excess of our requested project.

(2) Criterion: If project involves remodeling or replacement of an existing health facility structure, are there significant functional inefficiencies, obsolescence or structural problems which the facility has which seriously compromise the effective delivery of health care to patients, and which would be substantially corrected by the proposed project?

This criterion would not be applicable. The requested project would be a new, 100-bed, freestanding hospital.

(3) Criterion: Will the proposed project result in an improvement in patients' reasonable access to services? The applicant will identify any potential problems of accessibility including traffic patterns; restrictive admissions policies; access to care for public-paid patients; and restrictive staff privileges or denial of privileges.

The proposed project will dramatically improve patient access for adult residents in Clackamas-Washington county area, and adolescent and older adult patients in the Clackamas-Multnomah-Washington county area. For adults aged 18 to 64, all psychiatric hospitals currently operating in the Clackamas-Washington service area are at or above capacity. Based on historical trends and current capacity constraints, there is a significant and immediate unmet need for additional inpatient psychiatric beds. Without the project, there simply will be no incremental access for inpatient psychiatric care for service area residents, or anyone else. This despite the existence of current excess acute care bed capacity. There are thus unusual and extenuating circumstances justifying the construction of the proposed hospital, which we have briefly described above and discuss in detail in Section 333-615-0030(4). Additionally, WVBH will not only provide inpatient care, but a comprehensive suite of outpatient services, including partial hospitalization, intensive outpatient, and several specialty programs such as co-occurring disorder, medication-assisted, and mood disorder programs, among others.

In addition to addressing the current bed crisis for psychiatric beds, our proposed facility will improve general access to inpatient and outpatient care psychiatric care for patients in the Clackamas, Multnomah, and Washington counties. In this region, the majority of inpatient psychiatric services are located in or near Portland in Multnomah County. The identified facility location is less than five (5) minutes driving distance from I-5, the major arterial in the area. It is also located on a State Highway (SW Boones Ferry Road). The location is served by bus route 96 and is a no-cost, twenty (20) minute bus ride from the Smart Transit Center in Wilsonville, making the site easily accessible for patients needing public transportation.

Our proposed site location provides easy access to much needed services outside of the congested traffic in Portland, improving accessibility for adult, adolescent, and older adult patients in the Clackamas, Multnomah, and Washington counties. Building a new inpatient facility in Wilsonville, located in Washington County, will improve patient access by providing services to

individuals living in highly populated neighboring cities, the Clackamas, Multnomah, and Washington county area as a whole, and for residents to the south of the three area counties.

OAR 333-580-0050

Section B continued: Availability of Resources and Alternative Uses of Those Resources

333-580-0050
Availability of Resources and Alternative Uses of Those Resources

Please note that responses to Criteria (1)-(2) recognize and address the principles established under 333-615-0040 (Demonstration of Need for Psychiatric Inpatient Beds - Availability of Alternative Uses for Resource)

(1) Criterion: Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs?

(a) The applicant must demonstrate that the best price for the proposal has been sought and selected;

UHS, the parent company, is one of the nation's largest and most respected healthcare management companies with vast experience in developing and operating behavioral health facilities. As of February 27, 2019, UHS subsidiaries owned and/or operated 26 acute care hospitals, 324 inpatient behavioral health facilities, and 37 outpatient centers in 37 states, Washington, D.C., the United Kingdom, and Puerto Rico. It has very extensive experience with siting and building facilities similar to the proposed Willamette Valley Behavioral Health.

UHS has and will continue to practice due diligence in its development of WVBH. A discussion of internal alternatives evaluated is presented below in (b)(A). As described therein, development of a new inpatient psychiatric hospital was determined to be the most effective and efficient allocation of resources.

(b) The applicant must demonstrate that proposed solutions to identified needs represent the best solution from among reasonable alternatives:

(A) Internal alternatives:

> **(i) The applicant must list the major internal operational adjustments considered which could lower the cost and improve the efficiencies of offering the beds, equipment or service;**

In our opinion, internal alternatives involve (1) expansion of existing facilities and/or (2) care redesign to redirect care to other, non-inpatient modalities. These will be discussed in turn.

- Expansion of existing facilities.
    - Above, we have provided data that shows Cedar Hills has internally expanded its licensed bed counts from 37 beds to 94 beds, a significant increase since it opened

nearly a decade ago, and its 2018 and YTD 2019 occupancy levels indicate it is virtually full.

- In the case of Cedar Hills, further expansion is not an option as we have achieved full occupancy of the building envelope. UHS has undertaken due diligence to evaluate whether to build additional space at Cedar Hills or build new space elsewhere. Several key factors drove the decision to request approval for 100 beds at Willamette Valley Behavioral Health and not further expand Cedar Hills, an internal alternative. These include:

  (1) It would cost roughly the same for either build-out option on a per unit basis, since Cedar Hills' expansion would require an additional building. Furthermore, there is no available land in the current site that would accommodate any additional expansion.

  (2) There is pressing need for adult inpatient beds, as well as adolescent beds for both voluntary and involuntary inpatients and suite of outpatient services.

  (3) The Clackamas-Washington Service Area covers a large geographic area that includes Cedar Hills Hospital roughly 13 miles to the north of the planned site for Willamette Valley Behavioral Health. However, Cedar Hills is not on the I-5 corridor, thus not as accessible to residents in counties to the south, including Clackamas and much of Multnomah County as would be the proposed site for Willamette Valley Behavioral Health. The proposed location is on the border of Washington and Clackamas counties and adjacent to I-5, the state's north-south transport corridor. Expansion at the Cedar Hills site would not provide these same geographic and transport corridor benefits.

- In summary, Cedar Hills has increased its capacity, but now faces physical plant and site restrictions, thus, cannot add any additional capacity. Further, there are preferred access benefits to a site further south, and adjacent to I-5. In our opinion, internal alternatives have not and likely will not meet current and forecast unmet need.

- Care redesign and/or use of increased outpatient services.

  - Theoretically, if all needed psychiatric care could be delivered on an outpatient basis, we would expect to see providers moving that direction, given its much lower delivery cost. As discussed elsewhere, Adventist Health, Kaiser Permanente, Legacy Health and Oregon Health & Science University consolidated most of their former inpatient psychiatric beds to the Unity Center for Behavioral Health—an inpatient and emergency psychiatric facility for individuals experiencing a mental or behavioral health crises. However on net, this consolidation essentially held the regional bed

supply constant,[17] and has not eliminated the need for additional inpatient psychiatric beds as originally argued. This is because some psychiatric care must be delivered in an inpatient environment, and some patients are sufficiently ill to warrant involuntary inpatient care under NMI rules.

- UHS has significant experience in behavioral health with knowledge of the optimum balance between inpatient and outpatient care. Clinical care delivery quality is its primary goal, followed by access, balanced by efficient, low cost delivery systems. This has been its operating model in Cedar Hills, its hospitals in Washington State and across the broader U.S. Finally, UHS delivers both inpatient and outpatient care, given the two elements are necessary complements to its integrated behavioral health programmatic strategy.

- To summarize, care redesign and shifting care to outpatient settings is an important element of care delivery, but it must be balanced with robust inpatient resources. As summarized above, these inpatient resources are simply not sufficiently available in the Service Area. Further, WVBH will not only provide inpatient, but outpatient services in an integrated behavioral health model very similar to Cedar Hills Hospital.

(ii) The applicant must demonstrate that the alternative considered represents the best solution for the patients, and discuss why other alternatives were rejected;

Please see discussion above in (A)(i).

(iii) If the proposal is for an inpatient service, whether new or expanded, applicant must demonstrate this method of delivery is less costly than if done on an outpatient basis;

Please see discussion above in (A)(i).

(iv) The applicant must demonstrate that the selected architectural solution represents the most cost effective and efficient alternative to solving the identified needs.

Please see discussion above describing internal alternatives assessed. Moreover, the site was selected so that it would require only a minimal effect on the existing footprint, thereby making it cost-effective and efficient relative to other alternatives identified in (A)(i).

One of the advantages is that we are not retrofitting an existing building, but building a brand new state-of-the art facility design that is specifically designed to the highest anti-ligature and patient safety standards based on our extensive operating experience throughout the United States as the largest behavioral health operator in the country.

(B) External alternatives:

[17] Technically, the Unity Center represents one additional (+1) bed compared to prior psychiatric unit bed supply counts.

(i) If the proposed beds, equipment or services are currently being offered in the service area, applicant must demonstrate:

(I) Why approval of the application will not constitute unnecessary duplication of services;

Please see findings from the psychiatric bed need model and a description of unusual circumstances summarized and presented in section 333-615-0030. As described in the October 2016 ED Boarding Report, and further substantiated in the 2019 public comments to S.B. 140, there is a severe shortage of inpatient bed capacity within the service area and across the state. This has resulted in an ongoing mental health crisis with ED boarding as one of its chief symptoms. Moreover, recent actions taken under existing licensure, as represented by the Unity Center, has not led to a material increase in available beds (net increase of one bed compared to prior psychiatric unit bed supply). As Katy King from the Oregon Chapter of ACEP stated in her January 2019 comments to S.B. 140:

> "The problem is growing more urgent; while the number of mental health-related visits to emergency departments has increased steadily, the number of inpatient psychiatric beds has decreased. Substantial declines in mental health resources have additionally burdened emergency departments with increasing numbers of patients with mental health issues."[18]

Cedar Hills operates near or at maximum capacity, deflecting on average approximately 180 referrals per month in 2018 alone, an average which has increased to 337 deflections per month in year-to-date (January to May) 2019. At the current Cedar Hills average length of stay of 10.81, this represents nearly 120 beds worth of patients deflected per day.[19] This trend has continued to increase over recent years despite the implementation of the Unity Center.[20] In fact, Cedar Hills has received persistent transfer requests and transfers from the Unity Center.

Thus, the proposed Willamette Valley Behavioral Health facility does not represent unnecessary duplication of services, as it will not replace existing services provided by other providers, but rather address the severe shortage and net need currently present and projected to continue increasing as the population grows. Further, there will be a wide variety of inpatient and outpatient specialty services, including adolescent and older adult inpatient, and dual diagnosis centered therapies, among others which are currently in insufficient supply.

(II) Why the proposal is an efficient solution to identified needs;

David Stone of Mid-Columbia Medical Center mentioned the following in his January 2019 testimony regarding S.B. 140 on the current state of caring for patients with severe mental illnesses in hospital EDs:

> "The additional resources that these patients need stretches staff thin. It also poses the potential to negatively impact overall patient safety and satisfaction." [21]

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[18] King, Katy. Testimony for the record for the Senate Health Care Committee. Oregon Chapter, American College of Emergency Physicians (O.C.E.P). January 28, 2019. p. 2.
[19] 337 x 10.81 = 3,643 patient days per month, for an ADC of about 120.
[20] See Figure 7 presented in section OAR 333-615-0030 of this application.
[21] Stone, David. Re: Senate Bill 140 – Emergency Department Boarding Prevention Pilot Funding and Task

As Mr. Stone identifies above, ED boarding is not only a tragic process from a patient-experience perspective, but it also includes patient safety concerns and is inefficient from an organizational and greater health system perspective. Willamette Valley Behavioral Health, through its proposed comprehensive set of inpatient and outpatient services, will increase inpatient psychiatric care capacity and add to and improve community-based outpatient psychiatric services, both of which are recommendations from the October 2016 ED Boarding Report to curtail ED boarding. [22]

Alleviating ED boarding is just one of the merits of Willamette Valley Behavioral Health from an efficiency standpoint. Willamette Valley Behavioral Health will also bring the experience of its parent company UHS in developing efficient and effective inpatient and outpatient behavioral health services.

(III) Why the proposal represents the most effective method of providing the proposal; and

Willamette Valley Behavioral Health will offer a comprehensive set of specialty inpatient and outpatient services, including subspecialty services such as adolescent and older adult inpatient, and dual diagnosis centered therapies, among others. By increasing the supply of both inpatient and outpatient services in the community, this will effectively address the current shortage of inpatient beds as well as develop and integrate the community's access to outpatient services.

The only two dedicated psychiatric hospitals in the region, Cedar Hills and the Unity Center, are at capacity. Other general acute hospitals that have psychiatric units often lack the robust set of outpatient services proposed by Willamette Valley Behavioral Health. Further, Willamette Valley Behavioral Health will be developed in accordance to UHS' wealth of experience developing and operating behavioral health facilities, as it operates 324 behavioral inpatient facilities as of February 27, 2019. [23]

(IV) That the applicant can provide this proposal at the same or lower cost to the patient than is currently available.

Given that Willamette Valley Behavioral Health's parent company, UHS, already operates a freestanding psychiatric hospital in the Service Area, the proposed facility would be expected to provide care at a same cost as currently available. Please also see the discussion of the existing inefficiency in the health system due to a lack of inpatient beds in the Service Area.

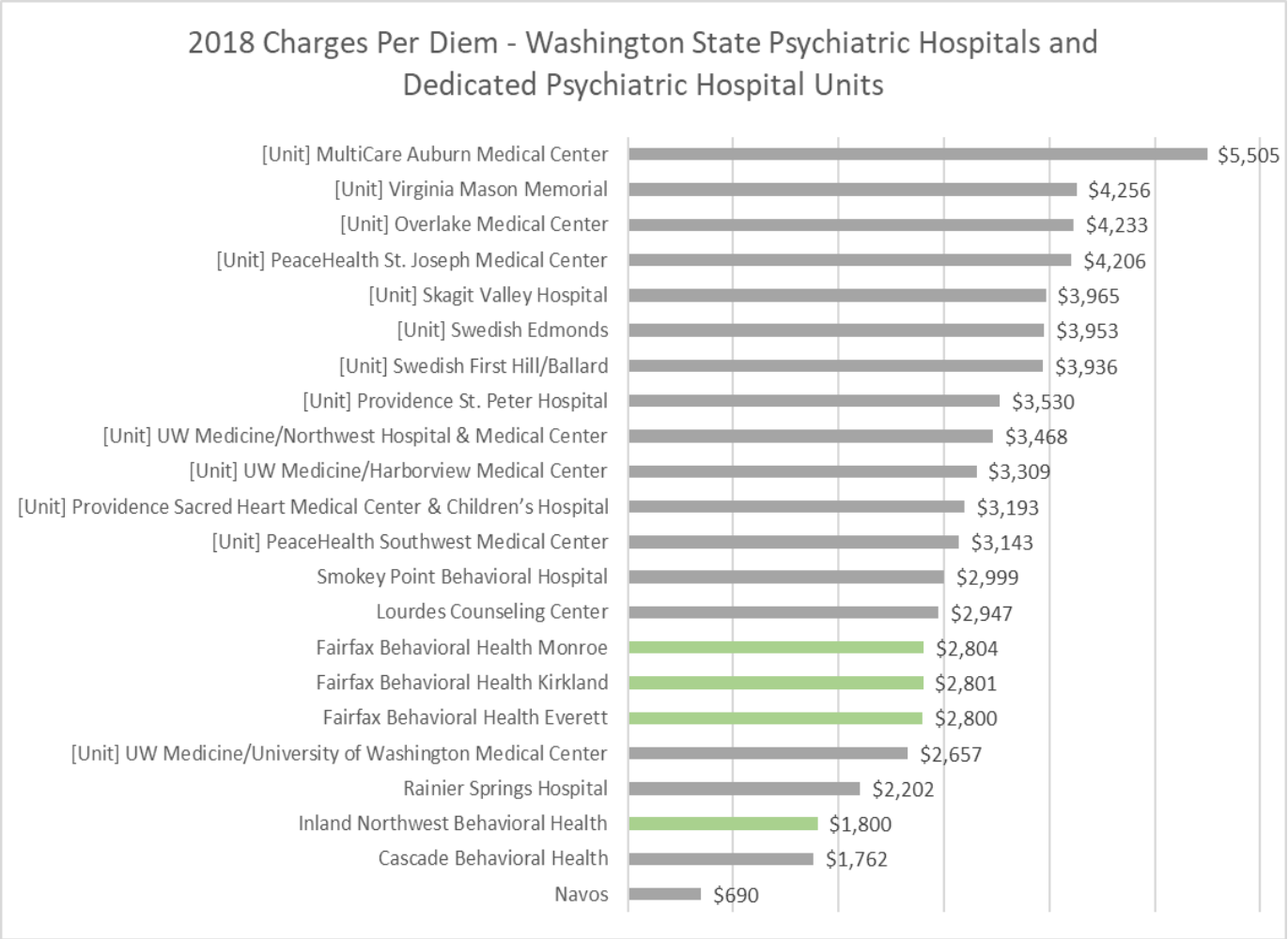
Please see Figure 5 below for comparative charge information on a per patient day basis from Washington State inpatient statistics reported for the CY2018 period. Figure 5 demonstrates that UHS facilities' in Washington State, highlighted in green, had significantly lower average charges per patient day than hospital-based psychiatric units' psychiatric services and commensurate charges per diem as other psychiatric hospitals.

Force. Mid-Columbia Medical Center. January 28, 2019.

[22] Yoon et al. "ED Boarding of Psychiatric Patients in Oregon". October 28, 2016. p. 15, 22

[23] Universal Health Services, Inc. 2018 Annual Report. p. 1.

Figure 5. 2018 Average Charges Per Diem – Washington State Inpatient Psychiatric Providers



*UHS facilities highlighted in green. Inland Northwest Behavioral Health is the joint venture with Providence Health & Services in Spokane, WA.
Source: CHARS (Washington State's Inpatient Database), 2018

(ii) If paragraphs (A)(i) to (A)(iv) of this subsection cannot be demonstrated, the applicant must show that without the proposal, the health of the service area population will be seriously compromised.

Please see discussion above, paragraphs (A)(i) to (A)(iv) can be demonstrated. Further, please see the discussion on ED boarding for a description of how the population can be seriously compromised without an adequate supply of inpatient psychiatric beds.

(C) Less costly alternatives of adequate quality:

(i) If a less costly and adequately effective alternative for the proposal is currently available in the area, the applicant must demonstrate why its proposal is:

(I) Not an unnecessary duplication; or

(II) A more efficient solution to the identified needs.

Alternative services along the care continuum such as psychiatric emergency services, residential treatment facilities, outpatient-only mental health services, medication assistance programs, and integrated mental-physical care represent compliments, not substitutes, to inpatient psychiatric care. Furthermore, the fact these alternatives don't exist in adequate numbers in the first place has contributed to the mental health crisis and growth of ED boarding in the market. Moreover, Willamette Valley Behavioral Health will offer a comprehensive scope of outpatient services such as intensive outpatient programs, partial hospitalization, and medication-assistance, among others. Dr. Donald Rosen, a well-respected psychiatrist and academic who was on staff many years at Oregon Health & Science University, submitted in 2017 a letter of support for UHS' prior application stating:

> Regarding inpatient services, the community will benefit from enhanced programmatic development across the spectrum of services, including inpatient services. Moreover, there is no evidence that alternatives to inpatient treatment will provide the health outcomes of hospitalization for our most needful citizens in a manner that is quicker, safer, better, or cheaper. In addition to supporting the development of ever increasingly sophisticated care options in less restrictive environments, the influx of residents coupled with an increase in the numbers of insured citizens, as well as the current and ever increasing demand for such services, supports the reality that an increase in inpatient beds is necessary. Any strategy to improve access to treatment must include an increase in inpatient beds. The Unity Center does not increase the number of beds available, as it's opening represents a consolidation of inpatient beds from Legacy, Kaiser, OHSU, and Adventist. The opening of Unity has not alleviated the need for transfers to other facilities. Psychiatric hospitals are frequently at or near capacity, and ED Boarding has increased over the past several years, particularly in the case of adolescents.[24]

The ED boarding crisis serves as one example that there are not suitable alternatives to care. The presence of ED boarding exists despite every incentive by the patient, providers, and others to find any possible appropriate alternative. This further validates the position that acute inpatient psychiatric care is a specialized set of services that is complemented, but not substituted, by other services comprising the behavioral health continuum.

> **(ii) Applicants must demonstrate that the identified needs of the population to be served cannot be reasonably served under current conditions, or by alternative types of service or equipment or equal quality to the proposal. "Alternatives of adequate quality" does not imply that they need be exactly like those being proposed, but only that they meet identified needs at state approved levels.**

Please see the discussion provided in (i) that includes an analysis of alternatives and current conditions.

(D) If there are competing applications for the proposal, each applicant must demonstrate why theirs is the best solution, and why a certificate of need should be granted them.

There are no competing applications. Therefore, paragraph (D) is not applicable.

[24] Rosen, Donald M.D. Re: UHS - Analysis Supporting the NEWCO Proposed Decision dated 02.24.2017. May 5, 2017. p. 1.

(2) Criterion: Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project? The applicant must demonstrate that there are, or will be sufficient physicians in the area to support the proposal; sufficient nurses available to support the proposal; sufficient technicians available to support the proposal; adequate land available to develop the proposal and accommodate future expansion; and the source(s) and availability of funds for the project.

UHS operates Cedar Hills, a facility that is virtually the same in terms of staffing as that planned for Willamette Valley Behavioral Health, with the exception that Willamette Valley Behavioral Health will also provide care for adolescent patients. UHS already participates in the Service Area labor market and has relationships with area schools and training institutes. As such UHS can leverage that experience to successfully recruit, train and employ staff for its Willamette Valley Behavioral Health operations. Further, given the two hospitals would be about 13 miles apart, there will be opportunities to jointly recruit, train and continually educate staff.

We anticipate the same approach with medical staff. Our proposed hospital will use a mixed employment model where it is expected physicians will be either contracted or employed, depending on physician preference. Other credentialed specialists in the Service Area could provide medical care to Willamette Valley Behavioral Health patients as required.[25]

This criterion requests numbers of staff, including physicians, nurses, technicians and other necessary staff to operate Willamette Valley Behavioral Health and deliver high quality care. We are not aware of any agreed-upon models that forecast demand and supply of such staff, however these numbers are modeled as part of the WVBH financial model. For a list of estimated FTE staff by occupation, please see Table 13.

Adequate Land

UHS has already identified and purchased a site in the City of Wilsonville. Please see Appendix 7 for the property tax statement for WVBH's proposed site, billed to UHS for the period July 1, 2018-June 30, 2019. The proposed site location is currently an 8.7 acre vacant lot, allowing sufficient space for the hospital and necessary parking, as required by zoning regulations.[26] The site is located at the intersection of SW Day Road and Boones Ferry Road. The building area will be 62,660 gross square feet ("GSF"), allowing for 626.5 GSF/bed (100 beds).

[25] For example, Internal Medicine physicians who could provide medical care for comorbid psychiatric patients.

[26] Universal Health Services has applied to the City of Wilsonville for applicable land use approvals. Upon annexation of the proposed site, the property will be located within the Planned Development Industrial - Regionally Significant Industrial Area (PDI-RSIA) zone. Pursuant to Wilsonville Development Code ("WDC") Section 4.135.5(.03)(N), UHS has requested the Planning Director's determination that a behavioral health facility is allowed outright as a similar use in the PDI-RSIA zone.

Description of Financing

The total estimated capital expenditures are $47.0M (Form CN-3). UHS has sufficient cash reserves to fund the requested project and provide working capital, as required. As such, there are no associated financing costs. Provided in Appendix 8 is a letter from UHS' Chief Financial Officer committing funds to the project. Provided in Appendix 9 is UHS' audited financial statement for calendar year 2018, included as part of its 10-K filing with the Security and Exchange Commission.

(3) Criterion: Will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers?

Cedar Hills, as an organization, and its staff, as caregivers in the community, are actively involved in many health care and other community/region events/actions. These include:

- Cedar Hills sponsors the NAMI (National Alliance on Mental Illness) Walk every May. It also sponsors the NAMI annual fund-raising dinner each October. These are both important, annual fund-raising events for NAMI.
- Sponsorship of the 2019 National NAMI Conference
- Active participant in Women Veterans Mental Health Awareness advocacy initiative to increase awareness around the treatment needs of women veterans.
- Lines for Life ("L4L"). Cedar Hills has created a partnership with L4L to serve as a resource center for L4L crisis lines. This organization provides follow-up programs for the first 30 days after patient discharge for all patients who enroll in the program. L4L also presents monthly to patients.
- MACAC/ED managers' meetings.
- Western Psychological and Counseling is a partner of Cedar Hills Hospital and Outpatient Services because they share a joint location at Cedar Hills Outpatient Services where patients are offered a full continuum of outpatient services.
- Central City Concern (CCC) encompasses numerous facilities, services and programs that Cedar Hills utilizes for patient care post-discharge.
- ASHA International touches the lives of more than 50,000 people nationally and internationally by empowering people on their road to recovery and wellbeing. Cedar Hills has sponsored and partnered with ASHA International over the past 6 years. Cedar Hills will continue sponsoring in the future including their upcoming Grit and Grace Women's conference.
- Multnomah County: Cedar Hills Hospital's team of Community Liaisons has participated in their Older Adult Community Group.
- Northwest Catholic Counseling: Cedar Hills has sponsored their semiannual fundraising events.
- Sponsored NW Law and Mental Health a program of the Mental Health Association of Portland.
- Oregon Housing Conference.

- AMSUS: Sponsored AMSUS (Association of Military Surgeons of the United States).
- Hold Monthly meetings with JBLM (Joint Base Lewis McChord) Care Connect Management.
- Active partnerships with more than 20 military installations.
- Cedar Hills Hospital sponsors many behavioral health organizations including Oregon Housing Conference, MHAO Peerpocalypse (Mental Health Association of Oregon) Conference, COVO (Central Oregon Veterans Outreach), and upcoming CCO of Oregon Conference.
- Community Outreach team is highly engaged in community consortiums and partnerships to include HADIN (Homeless Alcohol Drug Intervention Network), Multnomah County A&D, PING (Portland Integrated Networking Group), WITTI (Women In The Treatment Industry), and the Recovery Networking Breakfast.
- Partnership with Dual Diagnosis Anonymous by hosting weekly on-site meeting open to the public.
- Host Open House events at Cedar Hills Hospital to invite community partners for engagement.
- Partner with local law firms to provide education on Cedar Hills Hospital DUI services.
- Partnership with various residential treatment services to ensure continuity of care and timely access to services.

In summary, Cedar Hills, as a responsible steward of improved access to quality mental health care, is committed to community/regional involvement in numerous mental health organizations. Willamette Valley Behavioral Health would undertake the same actions and level of commitment to its community.

(a) The applicant must identify the extent to which the proposal and its alternatives are currently being offered to the identified service area population, or, in the case of acute inpatient beds, could be offered on the basis of an analysis under division 590 of this chapter;

Table 9 below presents a count of Oregon State providers, by facility type, based on data from the 2014 and 2017 National Mental Health Services Survey (N-MHSS), an annual survey of facilities providing mental health treatment conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). As Table 9 demonstrates, there has been an aggregate decrease in the statewide-counts of all service settings from 2014 to 2017.

Table 9 - Oregon State Mental Health Facility Count, 2014 and 2017

Service Setting	2014	2017	Aggregate % Decrease
24-hour hospital inpatient	18	14	-22.2%
24-hour residential	73	56	-23.3%
Partial Hospitalization/day treatment	22	20	-9.1%
Outpatient	120	105	-12.5%

Source: 2014 and 2017 National Mental Health Services Survey (N-MHSS)

As previously identified in the psychiatric bed need forecasts (Table 8), there is a current shortage of 130 psychiatric beds (2019), which if unmitigated, will increase to 185 beds in ten years (2029) We have also shown that virtually all existing providers within the Service Area are operating at, or near, maximum capacity (Tables 30-32 and 38). Further, only Cedar Hills Hospital and the Unity Center are dedicated psychiatric facilities most similar to our proposed hospital. As indicated above, Cedar Hills has been consistently at or above capacity, and in YTD 2019, after increasing its licensed bed total to 94 beds, it is again at 86.6% occupancy (Table 38). *By definition, the requested 100-bed project would not be an unnecessary duplication of existing services, given the demonstrated bed shortages as identified in Tables* 8*, thus meeting that portion of Criterion 3, above*. In fact, even with the addition of Willamette Valley Behavioral Health, a significant bed shortage will remain (Table 8).

In summary, current psychiatric facilities are significantly overburdened and as such, cannot reasonably be expected to provide sufficient, essential services to current and new patients in a timely manner. UHS knows this from its own experience at Cedar Hills. Hospitals in the Service Area are boarding psychiatric patients in Emergency Departments; a practice which has been recently declared unconstitutional by the Washington State Supreme Court[27]. Although the issue is multi-faceted, there is a clear way to address the current lack of inpatient capacity: add more beds to the Clackamas, Multnomah, and Washington county area.

To adequately meet the psychiatric health needs of the Service Area population, UHS proposes to build a new 100-bed psychiatric facility. This facility will work closely with Cedar Hills Hospital to best meet patient care needs of Service Area residents and in-migrants, efficiently and cost-effectively. Willamette Valley Behavioral Health will also continue the Cedar Hills practice of working closely with other Service Area providers to best meet psychiatric patient needs.

(b) The applicant will discuss to the best of his or her knowledge, any negative impact the proposal will have on those presently offering or reimbursing for similar or alternative services. Areas to be discussed are utilization, quality of care, and cost of care;

Please see our psychiatric bed need results and description of unusual circumstances. The proposed facility will not duplicate or replace existing provider services but rather address the current and projected shortage of inpatient beds in the Service Area. All data and testimonies by community stakeholders present a clear picture that existing services are at full capacity. Thus, without increase in supply, as represented by the proposed project, a continued shortfall will result in unmet need and continued waitlists associated with ED boarding.

We note that the proposed facility will not capture a disproportionate share of commercially insured patients from existing providers. Nor will the proposed facility skirt its responsibility to treat under-insured patients. Data from CHH's current payer mix demonstrates that most of the patient days are from non-commercial patients. Most notably, in YTD 2019 (Jan to Mar) the largest payer with respect to percent of patient days is Tricare/VA, at 37.6%. Further, Medicare, including managed Medicare plans, comprise 33.8% of patient days. In fact, Cedar Hills' non-

[27] Glatter, Robert. "'Boarding' of Psychiatric Patients in Emergency Departments Unconstitutional in Washington State." Forbes. Aug. 16, 2014.

commercial/HMO subtotal equaled 81% (please see Table 10 below). Further, CHH has an active Medicaid contract, including a fully established contract with the Yamhill CCO as of last year.

Table 10 - Cedar Hills Hospital Jan to Mar 2019 Inpatient Payer Mix (by Patient Days)

Payer	% of Patient Days
Tricare/VA	37.6%
Medicare and Managed Medicare	33.8%
Commercial/HMO	19.0%
Medicaid and Managed Medicaid	8.7%
Other	0.9%
Total	**100.0%**
Subtotal (non-commercial/HMO)	*81.0%*

Source: internal CHH data

(c) The applicant must demonstrate that jointly operated or shared services between the applicant and other providers have been considered and the extent to which they are feasible or not;

Collaboration and sharing of resources with Cedar Hills Hospital is ensured. UHS has met with and will continue to pursue relationships with the other providers in the Service Area to improve the quality of psychiatric healthcare for patients. We are confident that collaborative relationships will be established, as has occurred with Cedar Hills, to ensure that all support and ancillary services are obtained. Our relationship to Cedar Hills' and its resources will facilitate a seamless start-up and operation through leveraging its relationships with support and ancillary services. Just as have Cedar Hills' executives and staff have done, Willamette Valley Behavioral Health will be an active participant in community and regional mental health activities.

(d) The applicant must demonstrate that all necessary support services and ancillary services for the proposal are available at acceptable levels to insure that patients will have the necessary continuity in their health care.

Through operation of our Cedar Hills facility, UHS has established relationships with other healthcare providers in the Service Area, including hospitals, non-acute care providers (e.g. residential treatment facilities), ambulance services and other ancillary support services. We expect to utilize those same relationships and develop new ones as necessary.

Cedar Hills has agreements with Providence St. Vincent Medical Center (transfer agreement, see Appendix 12), Metro West (ambulance transport agreement); Diagnostic Laboratories (x-ray, ultrasound and EKG imaging); Pathology Associates Medical Laboratories, LLC (clinical lab specimens); and Northwest Secure transport (secure transport of patients). Willamette Valley Behavioral Health would develop the same type of agreements with the same or similar providers.

(4) Criterion: Does the proposed project conform to relevant state physical plant standards, and will it represent any improvement in regard to conformity to such standards, compared to other similar services in the area?

(a) The proposed project must comply with state licensing, architectural and fire code standards;

UHS has a long, successful history of building and operating freestanding psychiatric facilities throughout the country. UHS is familiar with state licensing, architectural standards, and fire code standards based on its extensive experience in the healthcare industry. To ensure compliance with all necessary state building standards, UHS has engaged state-certified architects and engineers.

(b) If the proposal is already being offered in the defined service area, the applicant must describe, to the best of his or her knowledge, to what degree the existing service complies with state licensing, architectural and fire code standards.

This is not applicable to the proposed project. We are requesting approval to establish a new, 100-bed inpatient psychiatric hospital.

OAR 333-580-0060
Section B continued: Economic Evaluation

Applicants must provide a narrative discussion of each of the items below. The entity actually proposing to implement a certificate of need must submit the required financial data. Additional financial data may be required to be presented by the applicant or a related entity to isolate the financial activities of the proposal:

(1) Criterion: Is the financial status of the applicant adequate to support the proposed project, and will it continue to be adequate following implementation of the project?

All funds required for the proposed project will be provided by UHS cash reserves. We have provided a letter from our Chief Operating Officer committing UHS funds to this project in Appendix 8. Additionally, we have provided the most recent audited financial statements included in UHS' 2018 Form 10-K report[28] for calendar year 2018 in Appendix 9. Appendix 9 shows UHS had $105,220,000 in cash and $1,509,909,000 net accounts receivable (the equivalent of cash) as of December 31, 2018.[29] UHS has more than sufficient cash reserves to completely fund the requested project. UHS has historically never used debt-financing for project development.

(a) Any financial forecasts which deviate significantly from the financial statements of the five-year historical period presented in the application must be fully explained and justified;

This is not applicable to the proposed project.

(b) An applicant must describe how it will cover expenses incurred by the proposal in the event the proposal fails to meet budgeted revenues in any forecasted year;

Please see above for a discussion of UHS' financial strength. Please also see Appendix 9 for UHS' audited financial statements and Appendix 8 for its letter of financial commitment to the project.

As stated above, Cedar Hills' experience has been one where available beds are filled immediately. Further, we have demonstrated there is a very large psychiatric inpatient bed shortage in the Service Area. The WVBH pro forma financial forecasts have been driven off Cedar Hills' actuals. In addition, we have deliberately assumed a relatively modest growth rate for WVBH.

Finally, as of December 31, 2018, UHS subsidiaries owned and/or operated 29 acute care hospitals, three freestanding emergency centers, six outpatient centers, 324 inpatient psychiatric hospitals, 21 outpatient psychiatric centers and one surgical hospital in 37 states, Washington, D.C., the United Kingdom and Puerto Rico.[30] It has significant experience developing/operating

[28] https://ir.uhsinc.com/static-files/c921b88d-f35c-46f5-a27b-5e52ecbcd523
[29] Please see p. 93, Universal Health Services. Inc and Subsidiaries Consolidated Balance Sheets, 2018.
[30] Ibid, p. 30.

these types of hospitals. We fully expect to meet forecasted financial performance. In fact, our patient volume forecasts are conservative. However, if our proposed facility does not reach expected patient volumes and generates operating losses in any year of operations, UHS will provide all necessary working capital to ensure the facility can continue to provide quality psychiatric healthcare to its patients.

(c) Applicants must discuss the results of ratio analysis required by Form CN-9 and OAR 333-580-0100(4), explaining strengths and weaknesses. The discussion should refer to each ratio as detailed in Table 1 of OAR 333-580-0100(4). Specifically:

(A) Applicants must describe their debt capability in terms of the required ratio analysis;

(B) The discussion of liquidity should include comments on the adequacy of cash, the collection period for patient accounts receivable, and the payment period for accounts payable;

(C) The profitability ratios required by OAR 333-580-0100(4) and Form CN-9 must be discussed.

Form CN-5 includes the WVBH Income Statement for the forecast period, beginning September 1, 2021 and continuing through full-year four of operations, 2025. It must be noted WVBH is a subsidiary of UHS and as such, WVBH will not be stand-alone from a financial perspective. An Income Statement has been provided, but a balance sheet and cash flow statement have not been included, since WVBH will operate as a subsidiary, and all assets and liabilities are held at the corporate level. As a consequence, some of the financial analysis called out in the OAR 333-580-0010 is not relevant. To the extent feasible, financials have been included in this application. We have completed, and included with our application, the following:

1. Form CN-1-Application;
2. Form CN-2-Architectural Section;
3. Form CN-3-Capital Expenditure Estimate;
4. Form CN-4-Project Cost Estimate, where we indicate there is no financing cost;
5. Form CN-5-Income Statement;
6. Form CN-8-Debt Service Coverage, where we include income and depreciation forecasts and the calculation for debt service coverage, but without debt, the rest of the form was left blank;
7. Form CN-9-Ratio Analysis, where we include calculations for the relevant percentages and ratios, understanding that most such ratios in this Form are driven off balance sheet estimates. Without a balance sheet for WVBH, these ratios were left blank;
8. Form CN-10-Volume Adjusted Expenses and Revenues; and
9. Form CN-12-Sources and Uses of Funds for the Proposed Project.

We did not complete:

10. Form CN-6 Balance Sheet.
11. Form CN-7-Statement of Changes in Financial Position; and

12. Form CN-11-Financial Analysis for Individual Service, as it is not relevant to our project.

Ratio Analysis

As stated above, WVBH will not have debt, given UHS will fund the project from cash reserves. Further, as stated above, WVBH will not have a balance sheet, since all assets, liabilities and equity are held on the UHS corporate balance sheet. Please note operating expenses exclude depreciation and allocated costs, and net income, listed as "excess revenue over expenses" in Form CN-5, is pre-tax, but does include both operating and fixed expenses, including cost allocations and depreciation (Form CN-5). These ratios are discussed below.

1. Operating Margin.
   Operating margin compares contribution margin, or as listed in Form CN-9, "operating income," (net revenue minus operating expense) to net revenue. The higher the percentage the greater the contribution margin is to net revenue. From an operations perspective, WVBH is projected to incur operating losses over partial year 2021, but become profitable thereafter, as volumes are realized and resources are more efficiently utilized, i.e., fixed expenses per unit of service decline. From full year one and thereafter, operating margin is forecast to rise above 30% and stabilize at that level.

2. Operating Ratio.
   Operating ratio compares operating expenses to net operating revenues. A ratio of less than one indicates positive performance and represents a positive operating margin figure. Form CN-9 demonstrates over the period September 1, 2021-December 31, 2021, WVBH would incur operating losses, as indicated by a ratio of 8.7. Thereafter, the ratio becomes less than one, indicating positive contribution margin. WVBH's operating ratio stabilizes, beginning in full year one, 2022, at 0.7.

3. Deductibles Ratio.
   This ratio compares deductions from revenue to gross patient revenue. WVBH deductibles ratio is 0.9 over the period September 1, 2021-December 31, 2021, then stabilizes at 0.54 in year three and thereafter. By itself, this ratio does not provide information regarding financial performance, since it only evaluates the revenue side of the equation. The higher the deductibles ratio, all other things equal, the lower the likelihood of financial viability.

4. Bottom Line Ratio.
   This ratio compares net income (pre-tax) to net revenue. The higher the bottom line ratio, the more profitable the firm. WVBH's ratio is -8.1 over the period September 1, 2021-December 31, 2021, then becomes positive in year one and thereafter.

(d) Board designated assets: The intended uses of this fund are to be discussed in general terms. Alternative uses or contingent availability of these funds, such as to meet a cash requirement, also need to be addressed. Additionally, the proportion (percent) of depreciation that was or is to be funded is to be identified for each financial period presented;

This is not applicable to the proposed project. UHS will use existing cash reserves to fund the project.

(e) The applicant must discuss the availability of other sources of funding, including, but not limited to, donor restricted assets, assets of parent or subsidiary corporations, or a related foundation which may be acquiring assets and/or producing income that is for the purpose of, or could be used for the purpose of, capital expenditure by the applicant;

This is not applicable to the proposed project. UHS has sufficient reserves to finance the project.

(f) Money market conditions must be discussed in terms of their impact on project financing, including interim financing, if applicable. Include the month and year in which financing is to be secured in this narrative:

> ***(A) The estimated rate of interest must be justified by the applicant. If debt financing is secured before or during the review process, the actual rate of interest obtained should be reported within 30 days of securing financing;***
>
> ***(B) When a bond rating report is issued before or during the review period in conjunction with a proposed bond issue to fund a certificate of need proposal, the applicant must submit a copy of the report to the division within 30 days of its issuance;***
>
> ***(C) The financing term selected must be supported with evidence showing the benefits of its selection.***

This is not applicable to the proposed project as there is no associated financing.

(g) Patient days, admissions and other units of service used in forecasting projected expenses and revenues, both for the facility as a whole and for services affected by the proposed project, must be consistent with projections used to determine area need. All assumptions must be discussed;

Table 11 below provides WVBH forecasted patient days, admissions, outpatient visits, and other units of service, which in turn, have been used to forecast WVBH utilization, occupancy, and projected expenses and revenues. The utilization forecast methodology will be further explained below.

Table 11 - WVBH Oregon, Inc. Utilization Projections, Full Year 1 - Year 5.

Statistic	Partial Year	Year 1	Year 2	Year 3	Year 4	Year 5
	September 1, 2021- December 31, 2021	2022	2023	2024	2025	2026
Admissions	98	976	2,196	2,525	2,786	2,833
Adjusted Admissions	137	1,147	2,581	2,968	3,273	3,330
Adjusted Admissions (Table 1)	129	1,077	2,433	2,786	3,072	3,126
Total Patient Days	1,038	10,316	23,211	26,693	29,442	29,949
Equivalent Outpatient Days	320.7	1,065.3	2,396.9	2,756.4	3,032.1	3,092.7
Adjusted Patient Days	1,447	12,124	27,279	31,371	34,594	35,198
Adjusted Patient Days (Table 1)	1,359	11,381	25,608	29,449	32,474	33,073
Equivalent Outpatient Days	1,367	11,397	25,702	29,481	34,417	33,073
Average Daily Census (ADC)	8.5	28.3	63.6	73.1	80.4	82.1
Adjusted ADC	11.9	33.2	74.7	85.9	94.5	96.4
Average Length of Stay	10.6	10.6	10.6	10.6	10.6	10.6
Outpatient Visits	43	4,398	9,895	11,380	12,518	12,768
Outpatient ADC	3.6	12.0	27.1	31.2	34.3	35.0
Occupancy (ADC/Beds)	8.5%	28.3%	63.6%	73.1%	80.4%	82.1%
Available Beds	100	100	100	100	100	100
Calculations from Table 1, OAR 333-580-0100 (4)						

Note: Adjusted admissions and adjusted patient days, underlined and in italics in the table, are calculated by multiplying admissions or days by the ratio of total gross revenues divided by inpatient revenues. Table 1, OAR 333-580-0100(4) defines these adjusted figures differently; Table 11 includes these adjusted figures pursuant to OAR 333-580-0100(4). As noted, adjusted admissions figures are the same calculated either way, and adjusted patient days are virtually identical. For purposes of this application, adjustments made multiplying admits or days by the ratio of total gross revenues divided by inpatient revues will be used, since it is the standard measure.

Source: Applicant.

Regarding questions from OAR 333-580-006 (g), the following information is provided:

1. Admissions were driven off Cedar Hills' operating experience. For purposes of conservatism, it is assumed the "ramp rate" will be much slower than actual admissions growth experienced at Cedar Hills, where Cedar Hills had 1,511 admissions in year one (2010), increasing to 2,290 in year two (2011).

2. Length of stay ("LOS") is assumed constant at 10.6 days, consistent with Cedar Hills' 10.6 ALOS at Fiscal Year to Date 2019.

3. Patient days are the product of admissions multiplied by LOS.

4. The adjusted admissions and adjusted patient days are calculations, as are average daily census and occupancy figures.

5. Outpatient visits are also a calculation: 44% of patient days. This is based on Cedar Hills' actuals.

6. Table 12 responds to the portion of OAR 333-580-006 (g) that requests discussion of conformance of WVBH patient days and volumes with Service Area projections. First, Service Area patient day and admissions projections must be prepared and discussed. These projections were developed as follows:

    (a) The upper portion of Table 12 repeats Table 8 bed need projections for the Service Area.
    (b) In Step 1, the bed need figures are multiplied by 365, the theoretical number of days a bed could be occupied per year. This provides projections of net patient days associated with net bed need. In this regard, it must be noted the net bed need figures in Table 12 already account for current Service Area supply, including Cedar Hills Hospital.
    (c) Step 2 uses Cedar Hills Hospital's YTD 2019 LOS of 10.6 days, for psychiatric inpatients.
    (d) Step 3 calculates admissions, which is total patient days divided by LOS. These steps estimate projected inpatient psychiatric bed need, translated into patient days and admissions.

Table 12 - Service Area Net Bed Need In Terms of Patient Days and Admissions.

Service Area Net Psychiatric Bed Need Forecast, Estimated WVBH Patient Days and Admissions as a Percent of Service Area Net Need								
	2019	2020	2021	2022	2023	2024	2025	2026
Service Area								
Adolescents and Older Adult (Clackamus, Multnomah, Washington counties) Adult Service Area (Washington and Clackamus counties)								
Net Bed Need								
Adolescents	3.7	4.0	4.3	4.6	4.9	5.2	5.5	5.8
Adult	79.7	81.0	83.1	85.3	87.5	89.7	91.7	93.9
Older Adult (geriatric)	46.5	49.4	52.7	56.3	59.9	63.8	66.1	68.8
Total Net Need	129.9	134.4	140.2	146.1	152.3	158.7	163.2	168.4
Step 1: Patient Days	47,399	49,055	51,160	53,340	55,599	57,941	59,579	61,474
Step 2: Service Area Length-of-Stay (Cedar Hills Hospital LOS, YTD 2019	10.57	10.57	10.57	10.57	10.57	10.57	10.57	10.57
Step 3: Service Area Admissions	4,484	4,641	4,840	5,046	5,260	5,482	5,637	5,816
WVBH Patient Days			1,038	10,316	23,211	26,693	29,442	29,949
WVBH Patient Days as a Percent of Net Need In Terms of Patient Days (Step 1)			2.0%	19.3%	41.7%	46.1%	49.4%	48.7%
WVBH Admissions			98	976	2,196	2,525	2,786	2,833
WVBH Admissions as a Percent of Net Need In Terms of Admissions (Step 3)			2.0%	19.3%	41.7%	46.1%	49.4%	48.7%

7. The lower portion of Table 12 includes WVBH days and admissions (Table 11), then calculates its "market share" figures as a percentage of the future unmet need in terms of patient days and admissions, as discussed above.

8. The final percentages in Table 12 are a measure of WVBH's share of otherwise unmet, net demand for inpatient psychiatric care in the Service Area. Table 12 demonstrates WVBH's patient days, as a percent of this unmet patient day demand would grow to 49.4% in 2025, then decline slightly in 2026 as WVBH patient days growth is constrained by capacity constraints. The same is true of WVBH admissions (Table 12). These percentages are not market share figures in the traditional sense; WVBH's market share of total provider days would be much less. WVBH's patient days and admissions forecasts are very reasonable when compared to Service Area incremental, unmet demand, measured either in patient days or admissions.

(h) An applicant must identify and explain all inflation assumptions and rates used in projecting future expenses and in completing the forms described in OAR 333-580-0100. It is important that the assumptions used by the applicant in preparing financial forecasts be carefully considered. All relevant factors pertaining to historical experience of the applicant, together with upcoming changes affecting the future, should be considered in forecasting the financial condition of the entity. Specifically:

(A) Projected changes in wages and salaries should be based on historical increases or known contractual obligations and planned future personnel increases.

Considerations should include expected full-time equivalent staffing levels, including increases resulting from the proposal;

(B) Projected deductions from revenues should be explained and justified;

(C) Expected changes in the intensity and/or complexity of services provided must be considered in addition to the rate of inflation in arriving at an overall rate of increase in revenues or expenses;

(D) Projected gross revenue must reflect:

(i) Patient day increases/decreases;

(ii) Outpatient activity increase/decrease;

(iii) All debt service coverage requirements; and

(iv) Other significant impacts the proposal will make on revenue projections.

The following discussion addresses OAR 333-580-0060 (1) (h), regarding the methodology and assumptions used to prepare WVBH's pro forma financial forecast.

Overview

1. Most importantly, Cedar Hills Hospital most recent actuals from YTD 2019 were used wherever possible, as further explained for revenue and expense elements. Thus, WVBH projections are driven off actual utilization and financial data from a Service Area provider of services very similar to those proposed by WVBH.
2. There is no inflation of either revenues or expenses. UHS uses a conservative financial model, where revenues and costs are driven off actuals, generally on a per patient day basis, then projects revenues and expenses forward based on projected volume growth multiplied by the actual per patient day. This approach eliminates the uncertainty of reimbursement or other revenue changes and expense increases, not driven by volume.
3. All financial models are based on accrual accounting.

Utilization

4. Patient day and admission forecasts have been explained above.

Capital Expenditures

5. Project cost is $47.0 million.
6. Movable equipment is depreciated using straight-line depreciation with a 7-year amortization period.
7. Fixed equipment and the physical plant is also depreciated using straight line depreciation with a 20-year amortization period.

Gross and Net Revenues

8. Inpatient gross revenue is calculated off YTD 2019 Cedar Hills' actuals per patient day.
9. Outpatient gross revenue is calculated off YTD 2019 Cedar Hills' actuals per visit.
10. Professional fees for physician employees have been "rolled up" into gross revenue calculations, consistent with Cedar Hills.
11. Reimbursement is based on YTD 2019 Cedar Hills' actuals per patient day basis for inpatients and per visit basis for outpatients. There is no UPL/DSH reimbursement.
12. Bad debt is assumed 0.8% of gross revenue per year.
13. Charity care is also assumed 2.0% of gross revenues per year.
14. Other deductions (denials) are assumed 0.3% of gross revenues per year.
15. There is no reimbursement for the first five (5) months of operations given the assumption of a required Medicare Survey/Joint Commission accreditation. This is modeled as "Medicare Impact" in the Income Statement (Form CN-5).
16. Payer mix is projected as follows:

Payer Category	**% of Gross Revenues**
Medicare	24.8%
Managed Medicare	8.1%
Medicaid	0.0%
Managed Medicaid	12.8%
Blue Cross/Blue Shield	6.0%
Other Managed Care	46.8%
Self-Pay	1.5%
Total	100.0%

Operating and Non-Operating Expenses

17. Full time equivalent ("FTE") employees, by class, are provided below, in Table 13. These FTEs are based on YTD 2019 Cedar Hills' actuals, adjusted for the assumed patient mix and ramp rates of patient days and outpatient visits. As seen in the table, direct patient care FTEs, given minimum staffing requirements, flex with volumes, i.e., nursing and therapy staff FTEs increase over the forecast period.

Table 13 - WVBH, Projected Number of Full-Time Equivalent Employees, Year 1 Through Year 5. Revise

		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
	September-December 31, 2021	***2022***	***2023***	***2024***	***2025***	***2026***
Schedule of FTE's (Full Time Equivalent) Employees						
Hours/FTE/Period	2,080	2,080	2,080	2,088	2,088	2,080
Orientation	4.4	3.8	4.0	6.0	7.0	8.0
Nursing Admin	8.6	8.6	9.6	9.6	10.0	10.0

Adult	14.7	30.7	69.3	79.7	87.8	89.4
Adult/Adolescent -- IOP/PHP	1.1	1.8	5.4	6.2	6.9	7.0
Recreation Therapy	1.1	1.1	3.2	3.7	4.0	4.1
Group Therapy	1.1	3.7	8.5	9.8	10.7	10.9
Social Services Admin	0.5	0.5	1.0	1.0	1.0	1.0
Pharmacy	1.4	1.4	1.4	2.2	2.4	2.5
Dietary	6.0	6.0	6.0	7.0	7.0	7.0
Plant Operations	2.0	2.0	2.0	3.0	3.0	3.0
Housekeeping	2.0	2.8	4.4	5.1	5.6	5.7
Patient Transport	-	-	1.5	2.5	3.0	3.5
Intake	9.6	9.6	10.6	11.5	12.5	12.5
Mobile Intake	2.0	2.0	2.0	3.0	3.0	3.0
Financial Counseling	1.0	1.0	1.5	2.0	2.0	2.0
Quality Assurance	1.0	1.0	2.0	2.0	2.0	2.0
Utilization Review	1.1	2.0	4.5	5.2	5.8	5.9
Medical Records	1.5	1.5	1.5	2.8	3.1	3.2
Communications	2.8	2.8	3.0	3.0	3.5	4.0
Patient Accounts	2.0	2.8	3.0	3.0	3.5	4.0
Fiscal Accounting-CFO & AP/Payroll	2.0	2.0	2.0	2.0	2.0	2.0
Purchasing	-	-	-	-	-	-
Data Processing	1.0	1.0	1.0	1.0	1.0	1.0
Administration-CEO & Admin Assist	2.0	2.0	2.0	2.0	2.0	2.0
Marketing	3.0	3.0	3.0	4.0	4.0	4.0
Personnel	1.0	1.0	1.5	2.0	2.5	2.5
Total	***72.9***	***94.2***	***153.8***	***179.1***	***194.5***	***199.0***

1. Wages and salaries have been calculated from hourly rates, by FTE class, based on YTD 2019 Cedar Hills' actuals. As noted above, there is no wage or salary inflation.
2. Benefits are modeled at 18.5% of wages and salaries, based on YTD 2019 Cedar Hills' actuals.
3. Professional fees include Medical Director stipends, medical staff compensation (salaries) and compensation for physicians' call coverage, performance of H&Ps (history and physicals for patients), patient follow-ups, consults and compensation for uncompensated care. These are based on YTD 2019 Cedar Hills' actuals.

4. Supply operating expense includes pharmacy; food; nursing units; dietary-non-food; plant operations; housekeeping and "all other." Each of these cost elements were estimated on a per patient day basis from Cedar Hills' actuals from YTD 2019. WVBH figures were the product of the per statistic figure multiplied by patient day projections.
5. Travel/education is assumed constant over time, based on YTD 2019 Cedar Hills' actuals.
6. Maintenance is calculated at 1% of net revenue, based on YTD 2019 Cedar Hills' actuals.
7. Purchased services include: clinical; laboratory; ambulance/taxi; radiology; linen; medical records; patient accounts; plant operations; grounds; and personnel. These costs are based on Cedar Hills' actuals per patient day from YTD 2019, multiplied by WVBH forecast patient days.
8. Other expenses include utilities and plant maintenance, all based on square footage of WVBH. These are based on YTD 2019 Cedar Hills' actuals.
9. Insurance, malpractice and general is based on YTD 2019 Cedar Hills' actuals, based on adjusted patient days.
10. Non-allocated expenses include estimated legal/consulting and property taxes, based on YTD 2019 Cedar Hills' actuals.
11. Depreciation has been explained above.
12. Allocated costs have been estimated at 3% of net revenues.

(i) Each applicant must submit within 30 days, a copy of the financial feasibility report if the applicant arranges for such a report and it becomes available before or during the review period.

This is not applicable to the proposed project. There has not been a financial feasibility report.

(2) Criterion: Will the impact of the proposal on the cost of health care be acceptable?

(a) The applicant must discuss the impact of the proposal both on overall patient charges at the institution and on charges for services affected by the project:

(A) An applicant must show what the proposal's impact will be on the gross revenues and expenses per inpatient day and per adjusted patient day;

In response to Criterion 2, please see Table 14 below. It demonstrates that gross revenue per patient day and per adjusted patient day would remain relatively constant, as would net revenue. This is to be expected given the model's construction, the lack of any assumed price inflation and the definition of "adjusted" patient days. Operating expenses per patient day and per adjusted patient day would fall due to economies of scale, i.e., increased efficiency per unit of service as volume increases and fixed expenses remain constant.

As explained above, this financial model is driven off YTD 2019 Cedar Hills' actuals. There is no public data available in Oregon that we are aware of that allows comparison to other providers' charges and expenses on a per statistic basis.

Table 14 - WVBH, Selected Financial Statistics. Revise

Statistic		Year 1	Year 2	Year 3	Year 4	Year 5
	September 1-December 31, 2021	2022	2023	2024	2025	2026
Gross Revenue per Patient Day	$ 3,006.59	$ 2,522.85	$ 2,521.69	$ 2,522.06	$ 2,521.16	$2,521.77
Net Revenue Per Patient Day	$ 379.49	$ 1,608.14	$ 1,154.44	$ 1,154.81	$ 1,154.30	$1,154.51
Operating Expense per Patient Day	$ 2,640.20	$ 1,106.27	$ 814.00	$ 807.73	$ 795.34	$796.65
Gross Revenue per Adjusted Patient Day	$ 2,156.10	$ 2,145.63	$ 2,145.64	$ 2,145.96	$ 2,145.74	$2,145.71
Net Revenue Per Adjusted Patient Day	$ 272.15	$ 1,368.33	$ 982.28	$ 982.60	$ 982.42	$982.35
Operating Expense per Adjusted Patient Day	$ 1,893.48	$ 941.30	$ 692.62	$ 687.28	$ 676.91	677.85
Gross Revenue per Admission	$ 31,776.91	$ 26,666.00	$ 26,653.70	$ 26,657.62	$ 26,648.15	$26,654.52
Net Revenue Per Admission	$ 4,011.00	$ 16,997.72	$ 12,202.14	$ 12,206.06	$ 12,200.72	$12,202.96
Operating Expense per Admission	$ 27,906.38	$ 11,693.03	$ 8,603.85	$ 8,537.58	$ 8,406.55	$8,240.40
Gross Revenue per Adjusted Admission (AA)	$ 22,789.49	$ 22,689.42	$ 22,678.96	$ 22,682.30	$ 22,680.04	$22,679.66
Net Revenue Per AA	$ 2,876.57	$ 14,462.93	$ 10,382.50	$ 10,385.83	$ 10,383.94	$10,383.19
Operating Expense per AA	$ 20,013.66	$ 9,949.30	$ 7,320.80	$ 7,264.41	$ 7,154.75	$7,164.71

(B) When a health service is affected by the proposal, an applicant must demonstrate what impact the proposal will have on related patient charges and operating expenses. Expenses and patient charges for individual health services will be compared to historical and forecasted rates of increase for the facility as a whole.

Please see the above discussion on WVBH charges and expenses per statistic (Table 14). There is no history for WVBH, and as stated above, we have not included any charge or expense inflation factors. Furthermore, and more importantly, the key issue, as we have identified above, is severe underbedding in the State of Oregon in general and in the Service Area in particular. Given lack of available capacity, there are a number of costs Planning Area residents currently bear, including lack of appropriate, accessible care, which consequently leads to ED boarding or travel to other providers for care, if such providers can be found. These costs are unknown, but likely are very significant, given psychiatric bed shortages.

In addition, there is significant inefficiency with the care delivery system as providers attempt to deal with behavioral health patients without proper facilities. The most notable of current practices is ED boarding, where patients are essentially held either until a psychiatric bed becomes available, which can literally be days, or until they are discharged without needed care. This is an inefficient, high-cost approach to provide patient care, and it is not the appropriate care psychiatric patients require. Here, too, these inefficiency costs are not known, but must be considered.

Based on extensive research, review of published statistics and news articles regarding the severe mental health access shortages in the state, extensive analysis of inpatient utilization statistics from Oregon and extensive review/analysis of Cedar Hills' utilization data, UHS has identified a substantial need for new inpatient psychiatric beds. We have identified and detailed these *Unusual Circumstances*, below. Our proposal for a new 100-bed psychiatric facility will alleviate the burden on existing facilities and provide necessary access to psychiatric services. This will result in a lower cost of healthcare delivery.

(b) The applicant must discuss both the proposed or actual charges for the proposed service and the profitability of the proposed service, compared to other similar services in the state (if any);

Our proposed charges for services offered at the Wilsonville facility are based on actual charges at our Cedar Hills facility. Projected net revenues are based on known reimbursement rates for inpatient and outpatient services, also driven off Cedar Hills' actuals. The same is true for operating expenses. Please see the above discussion regarding the WVBH financial model methodology and assumptions.

Given limited availability of Oregon State inpatient statistics, please see Figure 5 presented in section 333-580-0050(1)(B)(IV) above. Figure 5 demonstrates UHS' facilities in Washington State had significantly lower average charges per diem than hospital-based psychiatric units and commensurate charges as other dedicated psychiatric hospitals.

(c) The applicant must discuss the projected expenses for the proposed service, and demonstrate the reasonableness of these expense forecasts;

Please see the discussion above.

(d) If the proposed service is currently not being provided in the area, the applicant should identify potential travel cost savings by:

(A) Establishing what the existing travel costs are to patients;

(B) Establishing what the travel costs will be to patients after implementation of the proposal; and

(C) Showing what the difference is between the figures in paragraphs (A) and (B) of this subjection.

The key issue, as we have identified above, is severe underbedding in Oregon State and in the Service Area, in particular. There are providers, as we have identified, but there is still very significant net demand for inpatient psychiatric beds. Given lack of available capacity, there are a number of costs Planning Area residents bear, including lack of appropriate, accessible care. As noted above, this is well documented and includes ED boarding, or travel to other providers for care, if such providers can be found. These costs are unknown but very likely significant, given the substantial psychiatric bed shortages. Travel costs are an important element of this cost, but the key issue remains lack of access, which available statistics clearly demonstrate.

(e) The applicant must discuss the architectural costs of the proposal:

(A) An applicant must demonstrate that the existing structure will last long enough to derive full benefits from any new construction or remodeling;

(B) General construction costs must be within reasonable limits (within high/low range as described in the most current issue of the Dodge Research Report adjusted for location).

Architectural, engineering and related costs, as identified on Form CN-3, represent six percent of total capital expenditures of $47.0 million. As stated above, UHS has extensive experience designing and building psychiatric hospitals. We have used that experience in this project, and have undertaken necessary due diligence to prepare reasonable, well-defined cost estimates. Please see Form CN-3 for the signed cost estimate by a licensed architect with an architectural firm based in Portland, OR.

We have used a 20-year amortization period for fixed plant and equipment to calculate depreciation, and a 7-year amortization period for movable equipment. Please above discussion regarding financial model assumptions. It is our understanding the Dodge Report is no longer applicable.

OAR 333-580-0070
Section B continued: Special Requirements for Special Projects

This section is not applicable.

OAR 333-580-0080
Section C – Completion of Forms

Applicants must complete Forms CN-1 through CN-12 and include these forms with the application, except that forms which are not relevant to the proposal need not be completed. Applicants should contact the Public Health Division to determine which forms are relevant to their proposal. Additional tables and graphs may be provided, and should appear as appendices in Section D and be referenced to the applicable discussion and criteria in Section B. Form CN-1 should be included as the first page of the application (after any cover pages and table of contents).

The Letter of Intent, Form LOI-1, has been previously submitted to the Division. Form CN-1 is included at the beginning of this application. Please see Appendix 10 for all other relevant Forms.

OAR 333-580-0090
Section C continued: Completion of Architectural Forms

In completing Form CN-3, "Capital Expenditure Estimate", all costs identified on this form, which will be incurred at a future date, must reflect the effects of inflation.

Please see Appendix 10 for all relevant Forms

OAR 333-580-0100
Section C continued: Completion of Financial Forms

The applicant must submit financial information regarding the proposed service and the facility or organization as a whole on Forms CN-4 through CN-12. Projects with costs of under $1,000,000 need only forecast three years financial information. Other projects should forecast five years. If there is more than one entity with a financial interest in a proposal, the entity actually proposing to implement the project must submit the required financial data. Additional financial data may be required to be presented regarding other entities with an involvement in the project. All forms should be filled out using the accrual basis of accounting, unless the division has specifically approved another method:

Form CN-1, Letter of Intent, has been previously submitted to the Division. It is also included at the beginning of this application. Please see Appendix 10 for all other relevant Forms.

Division 590

Demonstration of Need for Acute Inpatient Beds and Facilities

OAR 333-590-0050 - OAR 333-590-0060

Please see Appendix 11 for analysis consistent with the methodology and steps described in OAR 333-590-0050 and OAR 333-590-0060.

Division 615

Demonstration of Need for Psychiatric Inpatient Beds

OAR 333-615-0020
Principles

[No narrative required]

(1) Service Areas for general psychiatric beds will use state administrative districts.

(2) Service Areas for psychiatric specialty beds shall be delineated to assure availability of quality services at reasonable cost.

(3) Service Areas for holding rooms. (Not applicable).

(4) The development of psychiatric units in general hospitals shall be emphasized.

(5) Demonstration of need for general psychiatric beds will be population based, rather than facility based. According to the Office for Oregon Health Policy and Research studies of actual utilization in Oregon, taken together with legislative reduction of the number of inpatient days mandated for coverage under group health insurance policies in Oregon, the "range of need" criteria based on the then available literature and consultant advice, together with existing provisions in this chapter, provide adequate safeguards against overbedding, but the legislative policy requires more stringent standards for demonstration that any proposed beds are the appropriate response to need for psychiatric care.

Therefore, there shall be a moderate standard of evidence of need if a project would result in up to .40 beds per 1,000 population in a Service Area in the third year after the date of the letter of intent; and a high standard, if the result would exceed .40. The bed-to-population ratio shall not be taken, by itself, as evidence justifying a certain number of beds in a Service Area. In determining need, the division shall take into account and the applicant shall supply, for each factor in subsections (a) to (f) of this section, a numerical, descriptive and analytic response sufficient for the division to take each factor into account:

(a) The historical utilization of psychiatric inpatient beds by persons in the Service Area involved;
(b) The historical utilization in other Oregon Service Areas of comparable size, population and characteristics; and
(c) Based on the level of placement criteria developed by the Office for Oregon Health Policy and Research or developed by insurers under ORS 743.556(16)(b), findings that, with limited exceptions based on clinical judgment in individual cases, inpatient beds are needed for immediate, short-range control of symptoms and protection of the patient when less intensive or supportive placement will not suffice; or for immediate, short-range protection of the community;

(d) The major portion of nonstate, nonfederal inpatient stays are expected to be 12 to 15 days. Approximately 10 percent of stays, at most, are expected to be longer term: Seriously disturbed, usually younger, patients for whom the benefits of 30 to 40 days of hospitalization exceed those of brief hospitalization followed by systematic, long-term residential or outpatient care; and a limited number of chronically mentally ill persons who cannot be maintained safely in the community;
(e) Inpatient beds are not considered the major resource for continued treatment of the typical schizophrenic patient, which, according to the literature, is usually most effective and economical when provided in other ways;
(f) Alternatives, as defined in OAR 333-615-0010(1), do not replace necessary inpatient utilization as described in subsections (c), (d) and (e) of this section, but are usually more effective and economical for meeting other needs for mental health treatment and care.

OAR 333-615-0030.
Estimates of Need.

The following methods are applicable to the interpretation of OAR 333-580-0040(1):

(1) Based on OAR 333-615-0030(1), Service Areas for general psychiatric beds shall be identified as follows:

(a) Geographic Service Areas for general acute, nonsubspecialty psychiatric beds, other than those directly operated by the AMHD or the federal VA, may be less than an entire health Service Area in order to maximize access provided there is sufficient projected population in the third year after the date of the letter of intent to make possible an economically feasible inpatient unit of acceptable quality, low capital cost and low operating costs. Thus, for example in health Service Area I, Clatsop-Columbia-Tillamook could be considered separately from Multnomah-Washington-Clackamas. Within a given health Service Area, all Service Areas shall be defined at one time, rather than proceeding application by application;

(b) The Service Areas described in subsection (a) of this section shall in general consist of single state administrative districts, or combinations of such areas. Available patient origin data may be interpreted by the division and taken into account in adding or deleting minor portions of such areas, or in combining districts. The division shall consider whether a lesser area, or a combination of areas, will better serve the policies and principles of this division; whether there are, or will be, enough clinicians in practice to staff the program; and whether there will be sufficient diversity of staff to meet the needs of the Service Area. The geographical units on which general psychiatric inpatient Service Areas shall be based will be the 14 state administrative districts, which are as follows:

(A) In health Service Area I: Clatsop-Columbia-Tillamook; Multnomah-Washington-Clackamas;
(B) In health Service Area II: Marion-Polk-Yamhill; Benton-Linn-Lincoln; Lane; Douglas; Coos-Curry; Jackson-Josephine;
(C) In health Service Area III: Hood River-Sherman-Wasco; Crook-Deschutes-Jefferson; Klamath-Lake; Gilliam-Grant-Morrow-Umatilla-Wheeler; Baker-Union-Wallowa; Harney-Malheur.

(c) The Service Areas identified in subsection (b) of this section shall be used for population-based review, as required by state and federal law. The methods of this division are intended to assure

that population needs are met by the service or services within the Service Area. Different facilities within a given Service Area share the responsibility for meeting the needs of the population of that area;

(d) Based on OAR 333-615-0020(2), the geographic Service Areas for subspecialty psychiatric beds, other than those directly operated by the state Addictions and Mental Health Division or the federal Veterans' Administration, as defined in OAR 333-615-0010(2), other than holding rooms, shall be the state as a whole;

(e) The geographic Service Areas for holding rooms shall be determined by the division on a case-by-case basis;

(f) Clinicians in each part of the state are encouraged to work with prospective applicants to develop proposals which meet the general psychiatric inpatient needs of individual Service Areas and/or subspecialty Service Areas.

As discussed above, the service area for adult inpatient psychiatric care is Clackamas and Washington counties, and the service area for adolescent and older adult inpatient psychiatric care is set as the Clackamas-Multnomah-Washington county area.

(2) Need for beds per 1,000 population in the Service Area shall be evaluated in relation to availability of alternatives according to the following criteria. A complete description of all alternatives under subsection (a) or (b) of this section means more than a list; it means at least, for each type of alternative listed in OAR 333-615-0010(1), an inventory with provider names, addresses, bed or slot capacity, and occupancy or utilization averages for each of the past several years:

(a) If a proposed project would result in up to .40 beds, other than those directly operated by the state AMHD or the federal VA, per 1,000 population in the third year following the date of the letter of intent, a complete description of all alternatives, as defined in OAR 333-615-0010, available in the Service Area shall be required; there shall be substantial evidence that appropriate existing alternatives in the Service Area will be fully utilized; there shall be substantial evidence that further development of alternatives by the applicant is not feasible; and there shall be substantial evidence that further development of less costly or more effective alternatives by any other prospective provider is not feasible. In addition, with respect to the proposed project itself, there shall be substantial evidence that project design and program alternatives have been considered and evaluated comparatively, with the least costly one selected that will meet identified need without substantial adverse impact on the quality of patient care;

(b) If the consequence of approval of a project would be in excess of .40 beds per 1,000 population in the third year following the date of the letter of intent, evidence submitted by the applicant shall:

(A) Demonstrate an average occupancy of applicant's existing capacity, if any, in excess of the appropriate criterion in Table 1, based on the method in section (3) of this rule, for the year ending September 30 prior to the formal application; and

(B) Be comprehensive with respect to the availability and feasibility of appropriate alternatives by meeting the requirements of subsection (a) of this section.

(c) The division may take into account evidence with respect to problems of quality or cost in other units serving the area in evaluations under subsection (b) of this section;

(d) In future years, by amendment of this rule, the division may raise the population-based limit at the same time as programmed decreases in utilization of state and federal beds serving the Service Area take place. This, however, may not be necessary if alternatives become more available and the scope of reimbursement is expanded. Because of the factors cited in OAR 333-615-0020(5), it may be appropriate, in future years, to reduce the population-based limit.

This has been addressed above.

(3) When expansion of an existing unit is under consideration, an allowance for peak-to-average utilization ratios may be made:

This criterion is not applicable as UHS is proposing a new freestanding facility.

(4) General considerations applicable to review of need for psychiatric inpatient beds include the following:

(a) As with hospital inpatient beds in general and in other specialties, new psychiatric beds, whether general or subspecialty, except under unusual circumstances with respect to nonavailability, access and less costly alternatives, shall not be approved if the net effect of the project would be additional licensed short-term acute inpatient capacity (other than AMHD operated or federal hospital beds) in the psychiatric Service Area, unless additional acute hospital beds are justified in that area by the criteria for acute inpatient beds in division 590 of this Chapter. The principles and methods in division 590 shall apply in reviewing applications for psychiatric beds to the extent that the issues involved are not addressed in this division;

(b) Unusual circumstances shall be determined in relation to an evaluation of the feasibility of meeting Service Area needs by the higher priority methods indicated in OAR 333-615-0040;

(c) Review of subspecialty beds other than chemical dependency inpatient beds, holding rooms, and freestanding mental health emergency centers shall take into account historical Service Area utilization and substantiated projections, rather than according to the population-based criteria for general psychiatric beds in this rule. The Service Areas for subspecialty beds are defined in subsections (1)(d) and (e) of this rule. Need for subspecialty units shall be evaluated with respect to population-based need; availability of existing capacity in the Service Area; effect on viability of existing quality providers; and proposed size of the unit in relation to economies of scale;

(d) Chemical dependency inpatient beds shall be reviewed according to the principles and methods of division 600 of this Chapter;

(e) Need for holding rooms and freestanding mental health emergency centers shall be evaluated in relation to local considerations of access, demand and feasibility.

Unusual Circumstances

The OHA holds the position that inpatient psychiatric bed need can be met by conversion of existing acute care inpatient bed capacity and evaluates Certificate of Need applications for inpatient psychiatric facilities against this assumption. As stated in the OHA Final Decision Approving Certificate of Need Application #677, the OHA writes that "…the method of meeting inpatient psychiatric bed need in order of preference is (1) Conversion of existing licensed space;

(2) Smallest feasible net increase in licensed capacity; and (3) a new psychiatric facility."[31] In other words the conversion of existing acute care capacity has a high priority while creation of a new psychiatric facility has a low priority. Experiences of recent years have exposed the falsity of this assumption, and its employment has contributed to the current mental health crisis which Oregon State now faces. Under this standard, because all acute care providers maintain excess acute care bed capacity, no new inpatient psychiatric facilities qualify for Certificate of Need approval without showing the "unusual circumstance" of provider inability or unwillingness to convert existing acute care beds to inpatient psychiatric beds. The approval or disapproval of all certificates of need for inpatient psychiatric beds within the last ten years has rested on the applicant's ability to demonstrate these unusual circumstances.

In their 2018 application for a 16-bed psychiatric hospital, Lifeways successfully argued unusual circumstances to the OHA through a letter sent from Dennis Burke, the CEO of Good Shepard Health Care System (GSHCS). In his letter, Mr. Burke stated:

> …It is not architecturally and economically feasible for GSHCS to convert its beds to sufficient psychiatric inpatient hospital beds to meet calculated psychiatric inpatient hospital bed need, as provided in OAR 333-590-0040(14).[32]

Mr. Burke acknowledged excess inpatient bed capacity, but wrote:

> GSCHS maintains this 'surge' capacity, because sometimes the obstetrical beds will be empty or nearly empty, but the medical/surgical inpatient beds will be filled with 25 patients. We can't put obstetrical patients in medical/surgical beds, so that when an obstetrical patient arrives at GSCHS, we must have an obstetrical bed available. We also can't put ICU patients in medical/surgical beds, so we must have that extra licensed capacity for ICU beds when there are a number of ICU patients at GSCHS.[33]

Mr. Burke further wrote:

> If GSCHS converted 'other beds' (as that term is used in OAR 333-590-0050(14) to provide a 10 bed psychiatric DPU, such conversion would eliminate approximately 20 out of the 24 licensed beds at GSCHS set aside to be readily available for surge capacity and set aside for emergency preparedness purposes. Accordingly, such a conversion would eliminate GSCHS's ability to provide for a sufficient number of obstetrical beds, observation beds, surgical recovery beds, ICU beds, and space for chemotherapy and infusion services, along with the need to GSCHS to provide for medical/surgical beds.[34]

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[31] Oregon Health Authority, "In the Matter of the Application by Lifeways, Inc., for a new 16-beb Psychiatric Hospital (CN #677); Proposed Decision Approving Certificate of Need Application," March14, 2018, p. 4.
[32] Letter from Dennis Burke to Jana Fussell on December 6, 2017.
[33] Ibid.
[34] Ibid.

Good Shepard Health System is a rural, critical access hospital, however the unusual circumstances documented by Mr. Burke are equally applicable to acute care inpatient providers in Clackamas, Washington, and Multnomah counties.

Dr. George Brown, the President and CEO of Legacy Health during the development and implementation of the Unity Center, commented in 2018, well past a year since the Unity Center opened:

> "The Unity Center for Behavioral Health, which opened in early 2017, is approaching 10,000 patients a year and operating at a loss, he said.
>
> Portland needs "at least two or three additional facilities to manage the challenge we have in Portland," Brown said"[35]

This at least partially informs the failure of inpatient psychiatric bed supply to respond to present and increasing excess inpatient psychiatric bed demand, which we document below. We argue that despite the current acute care bed capacity, which in principle could be converted to inpatient psychiatric bed supply, there exist unusual and extenuating circumstances preventing that from happening. Our discussion below evidences an over-burdened mental health system in Clackamas, Multnomah, and Washington counties, unable to respond to current or increasing demand for inpatient mental health care.

The current situation has resulted in Governor Brown declaring a "mental health crisis" for Oregon in general, and the Clackamas, Multnomah, and Washington counties, in particular. Part of this crisis is related to the persistence of "ED Boarding", and the inability for mental health patients to receive necessary inpatient care, a factor which has led to the incarceration of mental health patients in jails when they should have been treated in hospitals. Before its opening, the Unity Center for Behavioral Health was advertised as a solution to the mental health problems facing Oregon residents, and as a way to both increase access to inpatient mental health care and through community-oriented solutions reduce its necessity. *In practice, the Unity Center has done neither and has instead exacerbated the current mental health crisis.* During all this, the only organization to add adult inpatient psychiatric beds within the Clackamas, Washington, and Multnomah county area is Cedar Hills Hospital.[36] Each of these points is discussed in further detail below.

Oregon State Behavioral Health Crisis

Oregon Governor Brown declared addiction and substance abuse as a public health crisis in Oregon in March 2018, and signed bills to improve addiction prevention, treatment and recovery

[35] Hayes, Elizabeth. Legacy's Dr. Brown on the high cost of medical school and what else ails the health system. Portland Business Journal. May 24, 2018.
[36] The Unity Center for Behavioral Health added five beds in 2018, but still represents a net reduction in adult inpatient psychiatric capacity from the Legacy hospital system.

systems.[37] Governor Brown also signed two bills, HB 4143, which focuses on measures to combat the opioid epidemic[38] and HB 4137, which requires the Alcohol and Drug Policy Commission (APDC) to develop a preliminary framework of the plan that includes addiction prevention, treatment and recovery support.

As part of her declaration, Gov. Brown stated:

> "If we can make meaningful change in addiction prevention, treatment and recovery, we can create better lives for our families and lift the burden off our law enforcement and foster care systems…We will do that by lowering barriers people face to comprehensive behavioral health, by getting rid of fail first policies, and implementing creative programs like those outlined in this legislation and executive order." [39]

Furthermore and related to Governor Brown's declaration of a public health crisis, in December 2018 Oregon's Secretary of State, Dennis Richardson, released an audit of Oregon's response to the opioid crisis through the Oregon Health Authority's (OHA) Prescription Drug Monitoring Program (PDMP). The audit found that Oregon lags behind other states in implementing many best practices.[40] It also found that when it comes to providing access to treatment and recovery support for those with substance use disorders, Oregon ranks last for adults and second-to-last for adolescents. This report found Oregon has made some progress in dispensing fewer opioid prescriptions over recent years, but still prescribes opioids at a rate of 13% more than the national average, which itself is higher than other comparable countries.[41]

Oregon performs poorly across other metrics as well. Oregon has the highest rate in the nation of seniors hospitalized for opioid-related issues such as overdose, abuse, and dependence. From 2015 to 2017, 314 more children entered foster care due to a parent's drug abuse. The state also has the sixth-highest percentage of teenage drug users. Many people who are severely addicted also find themselves incarcerated at some point. Secretary Richardson stated in this December 2018 report: "Many opioid deaths are preventable, but OHA is trying to fight this crisis with one hand tied behind its back. Oregon should learn from the experiences of other states and follow the best practices being successfully implemented across the nation. This audit identifies solutions to save lives and money."[42]

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[37] https://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=2647

[38] In 2017, there were 344 overdose deaths involving opioids in Oregon—an age-adjusted rate of 8.1 deaths per 100,000 persons, compared to the national rate of 14.6 deaths per 100,000 persons. See https://www.drugabuse.gov/opioid-summaries-by-state/oregon-opioid-summary

[39] Ibid.

[40] The full findings of this audit are outlined in the Secretary of State's report entitled: "Constraints on Oregon's Prescription Drug Monitoring Program Limit the State's Ability to Help Address Opioid Misuse and Abuse."

[41] https://oregonsos.com/blog/2018/12/11/secretary-of-state-dennis-richardson-releases-audit-of-tools-to-combat-the-opioid-crisis

[42] Ibid.

In summary, Oregon faces significant access problems related to mental illness and substance abuse, which often occur together. To treat either, access to inpatient psychiatric beds and outpatient psychiatric programs is critical, however is severely lacking for Oregon residents.

Willamette Valley Behavioral Health will have dual-diagnosis inpatient and outpatient prgorams, where patients with mental health and simultaneous substance abuse issues can receive necessary care. These programs will include:

- Inpatient programs, including general medical psychiatric; chemical dependency; crisis stabilization; and pain management Program: a group therapy program for individuals seeking treatment for chronic pain and related addictions issues.

- Outpatient programs, including: partial hospitalization; intensive outpatient; and co-occurring disorders program

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ED Boarding in Clackamas, Multnomah, and Washington Counties

ED Boarding Background

The medical health care system includes a range of care modalities to cover the full spectrum of patient care need, access, and availability. Highly acute patients require immediate stabilization and inpatient care found in tertiary care settings, while less acute patients require less intensive, outpatient care facilities administered by primary or secondary care providers. The mental health care system provides a similar range of care modalities to cover the full spectrum of patient mental health care need, access, and availability: highly acute patients require immediate stabilization and inpatient care found in hospital-based settings, while less acute mentally ill patients are able to receive care in outpatient facilities.

In both the medical and mental health care systems, the highly acute patient population is considerably smaller than the general patient population. However, immediate access to high-quality care is a matter of life and death for highly acute patients. These patients need intensive and, in some cases, inpatient psychiatric care to ensure a full and healthy recovery, as well as follow-up care to manage any long-term symptoms and prevent recidivism. It is crucial that adequate numbers of emergent and intensive care options are available for these patients.

Factors such as deinstitutionalization and population growth have resulted in a lack of inpatient psychiatric services across the United States. When existing services are overcrowded, other areas of the health care system or public services are forced to compensate. In the case of the mental health care system, many persons with severe mental illness end up homeless, in prisons and jails, or boarded in hospital-based Emergency Departments.

ED boarding is a serious problem that needs proper attention and action. The Joint Commission published a report summarizing the severe problems resulting from ED boarding that included the following:

- Increases psychological stress on patients who may already be in depressed or psychotic states;
- Delays mental health treatment that could mitigate the need for a mental health inpatient stay;
- Consumes scarce ED resources;
- Worsens ED crowding;
- Delays treatment for other ED patients – some of whom may have life-threatening conditions; and
- Has a significant financial impact on ED reimbursement.[43]

ED Boarding in Oregon and Service Area

ED boarding of mentally ill patients is a persistent problem nationwide, in the State of Oregon generally, and in the counties of Clackamas, Multnomah, and Washington. In this region, highly acute mental health patients are boarded in hospital-based EDs because there are insufficient beds at existing inpatient care facilities.[44]

The shortage of inpatient psychiatric beds and consequent ED boarding is a longstanding crisis which has been documented by numerous Oregon State newspapers.

For example, a 2014 article detailed the practice of ED boarding in Oregon EDs:

> "The increasing number of individuals coming to Oregon EDs for psychiatric illness, along with a general lack of inpatient beds, has led to this all-too-common situation known as psychiatric patient 'boarding.' People coming to the ED with a psychiatric emergency are typically brought in by ambulance, police, or a concerned family member… In reality, inpatient beds are rarely available, so individuals board in the ED, often for days, awaiting transfer to a psychiatric inpatient bed somewhere in the state… the practice of psychiatric boarding is barbaric.'"[45]

More recently, an April 2019 article demonstrates that the crisis remain a pressing issue facing Oregon EDs:

> "A national mental health crisis is playing out in emergency rooms in Oregon and across the country. Patients who need immediate mental help are staying in emergency departments for weeks at a time, doctors and mental health advocates told The Lund Report.
>
> Patients, providers and the health care system all suffer the consequences. Psychiatric patients get worse without effective treatment. Emergency room doctors and nurses, who

[43] "Quick Safety: Alleviating ED boarding of psychiatric patients." Joint Commission, Issue No. 19, Dec. 2015, pg. 1. Please see: https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_19_Dec_20151.PDF
[44] Yoon et al. "ED Boarding of Psychiatric Patients in Oregon". October 28, 2016. p. 15.
[45] Meieran, Sharon. "Rethink our system of 'boarding' psychiatric patients." The Oregonian. Feb. 26, 2014.

are not trained to treat mental illness, struggle with their limited ability to help. Emergency rooms lose their capacity to treat other patients, who get sent to other hospitals."[46]

The article also highlights that one of the root causes of the need to ED board is a lack of available inpatient bed capacity:

> "Emergency rooms must admit patients considered dangerous to themselves or others even though they lack services to care for them, doctors at four Oregon emergency departments told The Lund Report.
>
> In many cases, they don't even have a spare bed for them.
>
> 'The bottom line is there aren't nearly enough appropriate beds in the city to accommodate the need,' said Dr. Chris Strear, an emergency room doctor at Legacy Emanuel Medical Center in North Portland."[47]

2016 OSU ED Boarding Report

In keeping with its commitment to address requirements established in the United States Department of Justice (USDOJ) Performance Plan, OHA commissioned Oregon State University's College of Public Health and Human Sciences to conduct a study concerning the ED boarding crisis which was completed in October 2016 ("ED Boarding Report").[48] A summary matrix of identified root causes and recommended solutions to ED boarding from the ED Boarding Report is provided below in Table 15.[49]

Table 15 - ED Boarding Report – System-Level Determinants and Recommended Solutions

System-Level Determinants	□Limited supply of inpatient psychiatric beds; □Limited availability and underfunding of community (outpatient) mental health programs; □Limited community alternatives to EDs; □Lack of care coordination for psychiatric patients; □Mental health workforce shortage; and □Insufficient training of ED staff. □Less generous mental and behavioral health benefits.
Recommendations	□ Increase inpatient psychiatric care capacity □ Quantify and monitor the extent of boarding

[46] Jessica Floum. "Boarded in the ER: Oregon's mental health crisis" The Lund Report | Salem Reporter. Apr. 21, 2019.
[47] Ibid.
[48] Ames, Linda. " Emergency Department Boarding of Psychiatric Patients Report." Oregon Health Authority. https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/122180
[49] Yoon et al. "ED Boarding of Psychiatric Patients in Oregon". October 28, 2016. pp. 15,22.

	□ Invest in comprehensive community-based psychiatric emergency services such as 24 hour help line, mobile crisis outreach team, emergency walk-in clinic, and crisis stabilization unit □ Increase community mental health services □ Enhance continuity of care in community □ Promote collaboration between EDs and community programs □ Improve care of psychiatric ED patients □ Work with law enforcement □ Increase access to insurance

Emphasis added

Current State of ED Boarding

Subsequent to the release of the 2016 ED Boarding Report, the Unity Center for Behavioral Health opened, and included inpatient and psychiatric emergency services, and state resources have been invested in developing community based mental health resources. Unfortunately, as the April 2019 news article referenced above reported, Oregon is still facing an ED boarding crisis due to a lack of inpatient capacity. This was echoed across a wide array of testimony from a diverse set of stakeholders offering public comment concerning Senate Bill 140 which would establish an Emergency Department Boarding Pilot Project in OHA.[50]

Table 16 - Selected Quotes from S.B. 140 A Testimonies[51]

Name	Organization	Selected Quotes
Katy King	Oregon Chapter, American College of Emergency Physicians (ACEP)	"Psychiatric boarding — the practice of detaining patients with mental health problems for 24-hours or more **because of limited psychiatric beds** — happens for 3.5 percent of psychiatric ED visits….Some patients, including children, board for many hours, days or even weeks at a time with no ongoing therapy. The problem is growing more urgent; **while the number of mental health-related visits to emergency departments has increased steadily, the number of inpatient psychiatric beds has decreased**. Substantial declines in mental health resources have additionally burdened emergency departments with increasing numbers of patients with mental health issues. **The severe shortage of psychiatric beds in almost all hospitals and intensive outpatient resources is leaving these patients stranded for hours and even days**."

[50] Oregon State Legislature – 2019 Regular Session – SB 140 A - Meeting Materials/Exhibits.
[51] Ibid.

Craig Zarling, MD Maya Lopez, MD	Oregon Psychiatric Physicians Association	"The task force is a good start but we recognize a systems approach is needed. We all recognize that other challenges should be addressed: … 2) There is a **shortage of community inpatient psychiatric beds** closer to patients' homes and their communities; 3) There is a **shortage of acute treatment beds for older adults**"
Scott Kelly	Asante	"It is important to recognize that the root cause of this problem relates not to the emergency department**, but rather to hospital and community capacity to provide safe and appropriate care for the population**."
David Stone	Mid-Columbia Medical Center	"The additional resources that these patients need stretches staff thin. It also poses the potential to negatively impact overall patient safety and satisfaction."
Kevin Campbell	Oregon Association Chiefs of Police	"With **inadequate mental health treatment resources and services/facilities** necessary to address the **growing number of Oregonians** who are experiencing behavioral health crisis, our hospitals and jails are left to address the gap with options that don't serve the best interests these individuals."
George Aiken, RN	Salem Health	"**One of the root causes of this problem is a lack of resources or appropriate placements for these individuals.** Some people remain in the emergency department for multiple days and in some extreme cases weeks as they wait for any type of relief from systems in the community."

Emphasis added

As clearly communicated among several stakeholders' public comments to S.B. 140 and other news articles, ED boarding is driven by a lack of existing capacity. Boarding then causes a backlog of patients who have no other options other than to be put on a waitlist until they can receive care in an appropriate setting. It is important to recognize that there continues to be an insufficient supply of inpatient services to meet demand even after several years since the opening of Unity's inpatient and psychiatric emergency services and Oregon State's investment in community-based mental health resources. Without increases in inpatient psychiatric capacity, ED boarding will continue to plague the community, a scenario that is:

- **Ineffective**: as illustrated above, general hospitals do not have the staff or training to provide the necessary care required by persons with severe mental health illnesses.
- **Inefficient**: resources are spread thin and there is lower effective capacity for non-behavioral health emergencies in the ED.

Moreover, the content presented above not only speaks to the lack of inpatient beds, but also to the lack of suitable alternatives to care [or capacity of said alternatives]. This is especially true of the tragic experience that constitutes ED boarding, which includes circumstances where there is every incentive by the patient, providers, and others to find any possible alternative that would be appropriate. This further validates the position that acute inpatient psychiatric care is a specialized set of services which compliments rather than substitutes other services comprising the behavioral health continuum.

Willamette Valley Behavioral Health will help address the very significant shortage of acute and subacute psychiatric care options in the Service Area and care for patients across the region and the Oregon State. The proposed facility will also provide crucial follow-up care for psychiatric patients, including inpatient services and outpatient care, as needed. Willamette Valley Behavioral Health, with its comprehensive service offerings, is a needed resource to alleviate ED boarding and provide quality, compassionate, and individualized care to all patients in need.

The Unity Center for Behavioral Health

In April of 2015, Legacy Emmanuel Medical Center submitted a Letter of Intent (LOI) to the Oregon Health Authority (OHA) of its proposed expansion and relocation of their existing behavioral health acute inpatient beds to what would become the Unity Center for Behavioral Health in Portland, OR. The OHA determined that, because the opening of the Unity Center would coincide with the closing of inpatient psychiatric beds at Legacy Emmanuel Medical Center, Legacy Good Samaritan Medical Center, Oregon Health Sciences University, and Portland Adventist Medical Center, this project did not constitute a "new hospital," so the Unity Center could be built without Certificate of Need review and approval.

Since its opening, the Unity Center has operated as an outlet for emergency departments in Multnomah and surrounding counties to send their patients, and so has likely helped reduced wait times and ED boarding at those hospitals. However, transferred patients face further wait times in the Unity Center "living room" which, from statements of Unity Center administrators, have tended to exceed those in the ER. However, unlike other persons waiting in the ER, the Unity Center bills persons awaiting inpatient psychiatric care to monetize the wait time those patients face.[52] The consolidation of all mental health patients awaiting care into a single room led to the exposure of patients and Unity Center staff to dangerous situations. Since it opened in 2017, the Unity Center has experienced multiple, preventable injuries to patients and staff, and multiple, preventable patient suicide attempts, one of which was unfortunately successful. The Unity Center has failed to provide a safe and stable facility for mental health patients in need of such.

[52] For bills paid by Oregon State, this rate was $125 per hour. Farentinos, Chris. (2017b) Redirecting crisis cases to dedicated services outside the ED" https://olis.leg.state.or.us/liz/2017I1/Downloads/CommitteeMeetingDocument/138229

With the opening of the Unity Center, Legacy Emmanuel Medical Center, Legacy Good Samaritan Medical Center, Oregon Health Sciences University, and Portland Adventist Medical Center closed their inpatient psychiatric facilities. On net, the Unity Center opening represented an increase in the number of available adolescent inpatient psychiatric beds from 16 to 22, and a decrease in the number of available adult inpatient psychiatric beds from 90 to 80 (later increased to 85). Its opening thus constituted a decline in inpatient psychiatric bed capacity, despite continuing increases in inpatient psychiatric need.

The Unity Center design consists of a large "living room" where patients wait for evaluation in 40 reclining chairs, along with 8 calming rooms for patients needing seclusion and the adult and adolescent inpatient beds. Although advertised as reducing patient wait times, available statements from Unity Center leaders and Unity Center patients suggests it has not. A September 2017 presentation by Chris Farentinos to the Oregon State Senate Interim Committee on Health Care stated that "On average, patients who need to move to inpatient beds at Unity are in the Psychiatric Emergency Service 15-20 hours before being admitted.[53] For comparison, a patient in a traditional emergency room can stay in the ER up to 60 hours before a hospital bed is available for behavioral health patients."[54] In her statement, Farentinos incorrectly compares an average (15- 20 hours) to a maximum to (60 hours) as evidence that the Unity Center has reduced average wait times. Although average ED wait times for Oregon are unknown, 15-20 hours exceeds the 2012 California published average of 10.05 hours. Furthermore, while unclear what the maximum wait time for Unity Center patients was, a 2017 Yelp Reviewer indicated a wait time of over 72 hours before admission to an inpatient bed from the Psychiatric Emergency Service (PES).[55]

Furthermore, the Unity Center has failed to consistently provide a safe and stable environment. While there are inherent risks associated with treating its target patient population, Unity Center's failure has occurred across multiple dimensions, eventually culminating in an investigation by the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid (CMS). The second report from the investigation, delivered on July 30, 2018, documents a facility with poor leadership, poor training, and unsafe conditions for staff and patients. In its review, it states that the "…governing body failed to ensure the provision of safe and appropriate care to patients in the hospital…", and goes on to describe the failure of the Unity Center to protect patient rights, properly administer drugs, appropriately supply nursing services, or provide a safe physical environment.[56] The HHS July 30 report attributes the failures of the Unity Center to the specific institution, and not necessarily a result of the overall design of the Unity Center's Psychiatric Emergency Service. However, patient reviews (Yelp 2019) and media interviews with former staff

[53] King, Katy. (2017) "September 2017 Legislative Update." https://oregonacep.org/wp-content/uploads/2017/09/september-legislative-days-2017.pd

[54] Farentinos, Chris. (2017a) "Unity Center Celebrates Six Months of Progress." https://olis.leg.state.or.us/liz/2017I1/Downloads/CommitteeMeetingDocument/138228

[55] Yelp. (2019). Recommended Reviews for Unity Center for Behavioral Health. https://www.yelp.com/biz/unity-center-for-behavioral-health-portland. Accessed 17 January, 2019.

[56] HHS. (2018). OMB NO. 0938-0391, Survey Completed July 30, 2018.

identify Unity Center's "living room" PES model as responsible for many of the institutional failures.[57]

The failure of the Unity Center to provide a safe and stable environment nearly led to it losing its CMS certification in 2018. After a series of reforms, the OHA recommended it keep its certification, and CMS agreed. The Unity Center thus continues to operate, although its founding director Chris Farentinos resigned in January 2019 and problems for the center and individuals associated with it continue. In April 2019, a county mental health inspector sued Multnomah County, Legacy Health, and the Unity Center for having been pressured to retire early after raising concerns of abuse at the Unity Center.[58] More recently, in May 2019, a lawsuit is pending from a former Unity Center nurse alleging the Unity Center forced him to quit due to safety concerns and fears of retaliatory actions,[59] and Unity Center nurses are in the process of unionizing due to safety and management failures at the center.[60]

Lack of Inpatient Psychiatric Beds

Every year, the advocacy group Mental Health in America publishes a report titled "The State of Mental Health in America. This report uses responses from the National Survey on Drug Use and Health to rank states according to the prevalence of mental illness, access to mental health care, adults reporting unmet mental health needs, and other indicators of the state of mental health treatment across the United States. In the 2015 overall rankings, Oregon ranked 40 out of 51 states (Washington D.C. is considered a state for survey purposes). In the four years since, Oregon has dropped 9 places, to 49 out of 51. This ranking reflects a combination of mental illness prevalence with the proportion of persons unable to access any variety of treatment. In 2017, a fourth of Oregon adults with mental illness diagnoses were unable to receive needed treatment.

In a market that functions well, unmet need and excess demand would be met by increases in provider supply. This has not happened in Clackamas, Multnomah, or Washington counties, or in Oregon overall. Since 2015, the population of Clackamas, Multnomah, and Washington counties has increased by over 50,000 persons between the ages of 18 and 64, and by over 100,000 persons across all age groups. However, the number of beds available to serve this growing population has been stagnant. Despite a 5% increase in the adult population, there has been no

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[57] Budnick, Nick. (2018) "New Complaint Highlights Legal Woes at Legacy's Unity Center." The Portland Tribune. https://pamplinmedia.com/pt/9-news/414283-314687-new-complaint-highlights-legal-woes-at-legacys-unity-center. Accessed 25 January 2019.
Floum, Jessica. (2018) "Violence at Unity Center for Behavioral Health Draws Financial Questions." The Lund Report. https://www.thelundreport.org/content/violence-unity-center-behavioral-health-draws-financial-questions. Accessed 17 January 2019.
[58] AP News. "Unity Whistleblower Sues County, Unity for $1.1M." AP News, April 3, 2019. Floum, Jessica. "Whistleblower Sues Multnomah County, Unity Center for Retaliation." The Lund Report, April 2, 2019.
[59] Hayes, Elizabeth. "Legacy Health hit with a lawsuit by former Unity Center nurse." Portland Business Journal, May 16, 2019.
[60] Harbarger, Molly. "Nurses at embattled Portland psychiatric center intend to unionize." The Oregonian, May 15, 2019.

increase in the number of adult inpatient psychiatric beds. The elderly population, which in Clackamas, Multnomah, and Washington counties has grown by almost 20% since 2015, has seen an increase in the number of available older adult inpatient psychiatric beds of under 5% (1 bed increase). The only age group "better serviced" in 2019 than in 2015 is that of adolescents. The number of adolescents in Clackamas, Multnomah, and Washington counties has remained relatively constant, while the number of adolescent inpatient psychiatric beds has grown by about 20%. This is driven by the 22 adolescent beds operated by the Unity Center, which replaced the 16 previously operated by Legacy Emmanuel Medical Center.

Since 2015, the population within Clackamas, Multnomah, and Washington counties has grown significantly across all age groups, and is expected to continue to do so. However, lack of investment and unwillingness to expand inpatient psychiatric bed capacity has aggravated the mental health crisis there. Oregon's status in delivering adequate mental health treatment to its residents has thus degenerated to the point where it now ranks among the bottom of all U.S. states.

Methodology

The Oregon State OARs specify that applications for new inpatient psychiatric beds must first show need for acute inpatient bed capacity. Failing that, applicants must show unusual circumstances which prevent the conversion of inpatient acute care beds to inpatient psychiatric beds. Our discussion above documents the unusual and extenuating circumstances preventing conversion of existing acute care bed capacity.

Given inpatient acute care need or unusual circumstances preventing conversion of such, the OARs indicate multiple methodologies for projecting inpatient need for psychiatric beds and specify applicants to use bed-to-population ratios for inpatient psychiatric bed need forecasts.[61] Our primary methodology using population-based bed ratios is detailed in the following steps:

STEP 1: Obtain population estimates and projections for adults in the Clackamas-Washington service area and adolescents and older adults for the Clackamas-Washington and Clackamas-Multnomah-Washington service areas. Present population estimates for the base year (2019) and every year through the 10-year forecast (through 2029). Population projections for the Clackamas-Washington and Clackamas-Multnomah-Washington service areas are provided below in Table 17. Psychiatric bed ratios are provided for each year for each age group in Step 3.

Table 17. Forecast population by age group and geographic area, 2019-2029

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Clackamas-Washington Service Area											
Adults (18-64)	636,078	640,038	646,592	653,252	660,021	666,899	672,809	679,615	686,525	693,541	700,664
Clackamas-Multnomah-Washington Service Area											
Adolescents (12-17)	128,250	129,197	130,098	131,009	131,931	132,863	133,702	134,641	135,595	136,564	137,550
Geriatrics (65+)	272,161	281,219	291,507	302,312	313,664	325,595	332,658	340,886	349,478	358,452	367,827

[61] See OAR 333-615-0020 (5).

STEP 2: Multiply the relevant bed-to-population ratio of beds per 100,000 persons by the service area population estimates and projections in Step 1. Repeat for each year of the forecast to provide a gross estimate of need.

Psychiatric Bed to Population Ratios

Adults

For adult inpatient psychiatric care, there is discussion in OAR 333-615-0020(5) regarding a figure of 40 beds per 100,000 persons, with there being "a moderate standard of evidence of need if a project would result in up to 0.40 beds per 1,000 population in a service area in the third year after the date of the letter of intent; and a high standard, if the result would exceed 0.40." [62] However, it is simultaneously indicated that this is not a standard for forecasting number of beds. There has been only one recent Oregon State Certificate of Need application, undertaken by Lifeways Inc. for their Aspen Springs hospital in Umatilla County. In their application, which was ultimately successful, no single bed-to-population ratio standard was used, with bed need projections determined through comparison with similar communities with inpatient psychiatric services (Lifeways 2018, p. 27).

To the best of our knowledge, there exist only two sources of data on inpatient psychiatric bed supply for all states in the U.S. The first is the American Hospital Association (AHA) Annual Survey, which collects information on about 2,600 AHA member hospitals[63] along with about another 3,800 hospitals using data from state and local associations, Medicare and Medicaid centers, national organizations and governmental bodies.[64] AHA survey data and details on its methodology and response rate are not publicly available, however data from the 2011 AHA survey on psychiatric inpatient bed supply was published in the 2014 American College of Emergency Physician's report titled "America's Emergency Care Environment, A State-by-State Report Card – 2014.[65] The second source is the National Mental Health Services Survey (N-MHSS), conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services. The N-MHSS is an annual survey designed to collect information on all known mental health treatment facilities in the United States, and represents the only source of national- and state-level data on publicly and privately operated specialty mental health treatment facilities.[66] Every second year, the N-MHSS surveys mental health providers on the number of inpatient psychiatric beds available at their facilities. For 2016, the most recent year available with inpatient bed counts, the N-MHSS identified 13,983 mental health treatment facilities in the United States which provided mental health care to non-incarcerated persons, and received responses from 91.1% of facilities.[67] With its attempt to collect

[62] See OAR 333-615-0020 (5).
[63] https://ahasurvey.org/taker/asindex.do, accessed 9 May 2019
[64] https://www.ahadataviewer.com/about/data/, accessed 9 May 2019
[65] https://protectpatientsnow.org/wp-content/uploads/2016/02/ACEP-EMReportCard2014.pdf, accessed 9 May 2019
[66] https://www.samhsa.gov/data/data-we-collect/nmhss-national-mental-health-services-survey, accessed 9 May 2019
[67] https://wwwdasis.samhsa.gov/dasis2/nmhss/2016_nmhss_puf_codebook.pdf, accessed 9 May 2019

statistics from all psychiatric inpatient treatment facilities,[68] the N-MHSS represents a more comprehensive, transparent, and reliable overview of the psychiatric inpatient care landscape than does the AHA survey. We thus recommend using the 2016 N-MHSS in establishing benchmarks against which to compare inpatient psychiatric capacity.

Oregon has been and remains underbedded. From the 2016 N-MHSS, the national average was about 37 beds per 100,000 residents, while the rate for Oregon overall was 26.4.[69] In comparison with other states in the Northwest, the average across the states of Alaska, Idaho, Washington, and Montana was about 34 beds per 100,000 residents for the same year. Including Oregon, the 2016 average was about 32.5 beds per 100,000 residents. As specified in OAR 333-615-0020(5), these ratios are not "standards" of appropriate numbers of beds of which comparison to alone provides justification of need, but indicate where Oregon falls among other states in supplying inpatient psychiatric capacity. A 2012 report by the Treatment Advocacy Center recommends a *minimum target ratio of 50 psych beds per 100,000 persons*.[70] However, this target ratio is based on expert opinion and reflects a supply of inpatient psychiatric capacity which as of 2016 only eight states in the U.S. had met.[71]

Adolescents and older adults

Inpatient psychiatric bed ratios are often given for the population overall, however based on Oregon inpatient statistics, adolescent residents use psychiatric services about 60% more than adult residents, who use psychiatric services about 10% more than older adult residents. It is therefore reasonable to consider a target bed ratio which would be highest for the adolescent age group, slightly lower for the adult age group, and further reduced for the older adult age group. In the interest of clarity and conservatism, we use a single ratio for adult, adolescent, and older adult residents, drawn from the nationally representative N-MHSS.

Recommended target bed ratio

It is our recommendation that the Northwest average, inclusive of Oregon, of 32.5 beds per 100,000 be used as the adult inpatient psychiatric bed ratio target, as it reflects the most recent and most reliable available data on Northwest inpatient psychiatric bed supply. Further, it falls below the OAR bed-to-population ratio of 40 beds per 100,000 population referenced in OAR 333-615-0020(5), thereby allowing for an adjustment of the urban setting of the proposed site and service areas.

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[68] An Inpatient Treatment Facility is defined by the N-MHSS as "a structured service setting or program that provides overnight care delivered within a psychiatric hospital or in a designated and staffed separate psychiatric service or unit of a general hospital/medical center, specifically for the treatment of mental health clients." https://info.nmhss.org/Definitions/index.asp, accessed 9 May 2019.
[69] N-MHSS 2016, https://wwwdasis.samhsa.gov/dasis2/nmhss.htm accessed 20 May 2019
[70] Target ratio originally was provided in E. Fuller Torrey et al., *The Shortage of Public Hospital Beds for Mentally Ill Persons* (Arlington, VA: Treatment Advocacy Center, 2008). The ratio continued to be used by the Treatment Advocacy Center in its 2012 report "Trends and Consequences of Closing Public Psychiatric Hospitals"
[71] N-MHSS 2016, https://wwwdasis.samhsa.gov/dasis2/nmhss.htm accessed 20 May 2019

Inpatient bed ratios to target bed ratios

Table 18 provides inpatient bed figures and population data for the Clackamas-Washington and Clackamas-Multnomah-Washington service areas for the adult, adolescent, and older adult age groups. Bed supply counts were not available through the OHA, so we calculate existing adult, adolescent, and older adult inpatient psychiatric bed supply using 2015 bed counts presented in the NEWCO 2016 CN Application, and adjusted for subsequent increases or decreases.[72] The bed counts in Table 18 thus reflect the 22 adolescent beds added through the Unity Center, as well as the accompanying elimination of 16 adolescent inpatient psychiatric beds by Legacy Emmanuel Medical Center.[73] Providence St. Vincent lists their 2016 inpatient psychiatric bed supply as standing at 33, which represents a decline of 1 bed since 2015.[74] Cedar Hills Hospital lists their current inpatient psychiatric bed capacity at 94, which is an increase of five beds since 2015.[75] We know of no other changes to the inpatient psychiatric bed supply within the Clackamas-Washington or Clackamas-Multnomah-Washington service areas since 2015.

Using the updated bed counts, we calculate inpatient psychiatric bed ratios per 100,000 persons of about 20 for adults in the Clackamas-Washington service area, and of about 29.6 and 15.4 for adolescents and older adults respectively in the Clackamas-Multnomah-Washington service area.

Table 18 - Population and inpatient psychiatric bed ratios by age group and geographic area, 2019

	Population	IP Psychiatric Beds	Per 100,000 residents	Comparison Bed Ratio	Net Bed Need
Clackamas-Washington Service Area					
Adults (18 to 64)	636,078	127	19.97	32.50	79.73
Clackamas-Multnomah-Washington Service					
Adolescents (12 to 17)	128,250	38	29.63	32.50	3.68
Geriatrics (65+)	272,161	42	15.43	32.50	46.45

Sources:
The number of inpatient beds is drawn from the 2015 data presented in NEWCO 2015 CN Application, and adjusted for new CN approved beds (CN Archive, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHCAREPROVIDERSFACILITIES/CERTIFICATENEED/Pages/CertificateofNeedUpdates.aspx) and post-2015 published statements

[72] Email from Matt Gilman, Facilities Planning and Safety Program Manager, 4 March 2019
[73] OHA Oregon Performance Plan Data Specification Worksheet, 1/8/2017; https://www.adventisthealth.org/portland/services/emotional-wellness-center/ accessed 7 May 2019
[74] Community health needs executive summary, https://communitybenefit.providence.org/~/media/Files/CBR/Oregon/2016CommunityHealthNeedsAssessmentProvidenceStVincentMedicalCenterPortland.pdf, accessed 7 May 2019
[75] https://cedarhillshospital.com/about-us/, accessed May 7, 2019

regarding bed capacity (Community Health Needs Executive Summary, 2016, https://communitybenefit.providence.org/~/media/Files/CBR/Oregon/2016CommunityHealthNeedsAssessmentProvidenceStVincentMedicalCenterPortland.pdf; OHA Oregon Performance Plan Data Specification Worksheet January 2017; Cedar Hills Hospital About Us, https://cedarhillshospital.com/about-us/)

All inpatient psychiatric bed ratios for adults, adolescents, and older adults fall well below the national average of 37 beds per 100,000 persons, as well as the Northwest average of 32.5 beds per 100,000 persons. The adult and older adult cohorts fall even below the Oregon state average of 26.4 beds per 100,000 persons. Based on the recommended ratio of 32.5 inpatient psychiatric beds per 100,000 population, we estimate the number of beds needed within each of the three service areas.

Use Rates

Limitations of relying only on Oregon inpatient figures detailed below for determining total psychiatric demand by Service Area residents include:

(1) Oregon inpatient files do not provide any statistics on inpatient psychiatric services provided in state psychiatric hospitals or hospitals such as Cedar Hills, and, therefore, underreport actual inpatient psychiatric utilization.

(2) Oregon inpatient files do not account for suppressed demand that is the result of a lack of health facilities and capacity within the Service Area to properly provide psychiatric services, leading residents to forgo desperately needed care because they cannot access it. This is reflected, in part, in the ED boarding situation, discussed above, which is the result of too few inpatient psychiatric beds.

The lack of sufficient capacity at Clackamas, Multnomah, and Washington county providers pushes residents to out-migrate for inpatient care to out-of-area hospitals, accept to be "boarded" in emergency departments, and report significant rates of unmet need. As to this last effect, some patients receive no care, as some are unable to navigate the transportation and the medical system to get appropriate care. All of these phenomena reflect "suppressed" demand.

Underbedding in the Clackamas, Multnomah, and Washington counties adds to the barriers faced by patients and limits access to needed psychiatric services. A 2019 report titled "The State of Mental Health in America" by the advocacy group Mental Health America ranks states according to responses from the National Survey on Drug Use and Health, and reports that almost a fourth of Oregon adults diagnosed with a mental illness were unable to receive needed treatment. This placed Oregon 49th out of the 51 states (including Washington D.C.).[76] While this reflects both patients who do not seek care as well as those who are unable to get care, the high proportion as well as Oregon's poor ranking suggest significant unmet need within the state.

[76] Table on "Adults with AMI Reporting Unmet Need," http://www.mentalhealthamerica.net/issues/mental-health-america-access-care-data, accessed 20 May, 2019.

Service Area Resident Use of Inpatient Psychiatric Beds

The following discussion focuses on inpatient psychiatric discharges and total patient days for adult residents in the Clackamas-Washington Service Area, and adolescent and older adult residents in the Clackamas-Multnomah-Washington Service Area. These statistics are detailed in Table 19 and Table 20. However, it should be again noted that statistics do not include specialty hospital inpatient utilization, including Cedar Hills Hospital, which in 2017 had over 3,000 psychiatric discharges associated with over 29,000 patient days, and between 2012 and 2019 has experienced about 5% average annual growth in inpatient psychiatric discharges and about 1% average annual growth in patient days. Furthermore, inpatient statistics also do not include "suppressed" demand, i.e., unmet need not reflected in the inpatient discharges by residents in the different service areas.

The inpatient data collected by the OHA and presented in Table 19 and Table 20 shows, for the Washington-Clackamas Service Area, declines in inpatient psychiatric discharges for adults and adolescents, and increases for older adult inpatient psychiatric discharges between 2008 and 2017. Over the same time period, inpatient psychiatric patient days have declines for adults, but grown slightly for adolescents and increased significantly for older adults. From the data presented, it appears that inpatient psychiatric utilization for adults has declined over the past ten years. However, this misses significant growth occurring in hospitals such as Cedar Hills, which, when included, shows adult inpatient psychiatric discharges growing by over 1% per year. We further note that the relatively slow growth in adult patient days likely highlights capacity constraints facing hospitals for inpatient psychiatric beds.

Table 19 - Service Area Resident Psychiatric Discharges, 2008 – 2017.

Psychiatric discharges by age group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Avg Annual % Δ, 2008-201
Washington-Clackamas Counties											
Adults, age 18-64	2,049	2,348	2,220	2,074	2,118	2,125	2,075	1,801	1,777	1,791	-1.26%
Clackamas, Multnomah, & Washington Counties											
Adolescents, age 12-17	660	684	719	684	723	704	676	663	497	466	-2.94%
Geriatrics, age 65+	823	803	766	719	737	768	754	749	798	955	1.60%

Source:
Oregon Inpatient Data, 2008-2017.

Notes:
Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements.

Table 20 - Service Area Resident Psychiatric Patient Days, 2008 – 2017.

Psychiatric patient days by age group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Avg Annual Δ, 2008-201
Washington-Clackamas Counties											
Adults, age 18-64	16,209	16,368	17,073	15,967	15,992	16,714	16,948	14,275	14,578	15,169	-0.64%
Clackamas, Multnomah, & Washington Counties											
Adolescents, age 12-17	4,949	5,079	5,930	6,019	5,588	5,600	5,578	5,876	4,699	5,374	0.86%
Geriatrics, age 65+	8,115	6,981	7,391	6,821	7,168	7,890	8,258	8,686	9,305	12,906	5.90%

Source:
Oregon Inpatient Data, 2008-2017.

Notes:
Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements.

Table 21 below presents utilization rates for adults in the Clackamas-Washington service area and adolescents and older adults in the Clackamas-Multnomah-Washington Service Area. Inpatient use rates for both discharges and patient days have declined for adults over the last ten years by about 1.5-2% per year. For adolescents and older adults in the Clackamas-Multnomah-Washington Service Area, discharge use rates have fallen by about 2-3% per year, while patient day use rates have increased by about 0.6% per year. We emphasize again that Oregon inpatient data excludes Cedar Hills Hospital inpatient data and excludes significant "suppressed" demand. The declining trend in adult utilization rates is likely the result of hospitals' capacity constraints, not reduced demand for inpatient psychiatric care. All available data clearly shows that demand for inpatient psychiatric care is increasing across all age groups.

Table 21 - Service Area Resident Psychiatric Use Rates, 2008 – 2017

Psychiatric use-rates by age group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Avg Annual % Δ, 2008-2017
Washington-Clackamas Counties											
Adults, age 18-64											
Discharges	3.59	4.09	3.85	3.57	3.62	3.61	3.48	2.98	2.89	2.85	-2.06%
Patient days	28.43	28.51	29.58	27.49	27.36	28.37	28.45	23.63	23.67	24.16	-1.50%
Clackamas, Multnomah, & Washington Counties											
Adolescents, age 12-17											
Discharges	5.37	5.54	5.80	5.53	5.84	5.67	5.43	5.30	3.95	3.69	-3.13%
Patient days	40.27	41.15	47.83	48.64	45.10	45.12	44.78	46.95	37.31	42.55	0.57%
Geriatrics, age 65+											
Discharges	4.83	4.52	4.18	3.81	3.72	3.68	3.43	3.26	3.31	3.78	-2.17%
Patient days	47.63	39.31	40.33	36.11	36.22	37.78	37.53	37.78	38.60	51.10	0.73%

Source:
Oregon Inpatient Data, 2008-2017. Population counts are aggregated from age cohort population counts published by Portland State University Population Research Center (PRC) for individual counties. Statewide population estimates are determined through aggregation of individual county-level PRC population estimates. The "adolescent" age group is constructed from the 5-year age groups available through the PRC using single-year age shares from the 2010 U.S. Census Table PCT12: Single Years of Age and Sex.

Notes:
Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements.

STEP 3: Compile a list of all current inpatient psychiatric providers at the adult, adolescent, and older adult age level in the relevant service area. Count and total the number of psychiatric beds operated in each hospital for the relevant age group.

Service Area Inpatient Psychiatric Care Providers:

Inpatient Psychiatric Utilization

As required by OAR 333-615-0030(2), statistics for provider organizations are provided in the following section. Table 22 below identifies inpatient psychiatric care providers and associated bed counts in the Service Area.[77]

[77] As discussed above, the provider bed counts reflect the 85 adult beds added through the Unity Center, as well as the accompanying elimination of inpatient psychiatric beds by Adventist Medical Center, Legacy Emmanuel Medical Center, Legacy Good Samaritan Medical Center, and OHSU Hospital. Providence St. Vincent states their 2016 inpatient psychiatric bed supply as standing at 33 in 2016, which represents a decline of 1 bed since 2015. Cedar Hills Hospital states its current inpatient psychiatric bed capacity is 94, which is an increase of five beds since 2015. We know of no other changes to the inpatient psychiatric bed supply within Service Area 1 or Service Area 2 since 2015. In addition, this list of acute care hospitals excludes Vibra Specialty Hospital, in Portland. It is a 73-bed long-term acute care hospital, providing care to patients with medically complex conditions that require longer inpatient stays, including cardiac diagnoses, rehabilitation, respiratory care, wound care and pain management. There are no psychiatric services provided. Please see http://www.vshportland.com/services/inpatient_services.aspx

Table 22 - Service Area Inpatient Psychiatric Bed Count, 2019.

Hospital name	County	Adult	Adolescent	Child	Geropsychiatric
Clackamas-Washington Service Area	**Total**	**127**	**16**	**6**	**42**
Providence Milwaukie Hospital	Clackamas	0	0	0	20
Providence Willamette Falls Medical Ctr.	Clackamas	0	16	6	0
Cedar Hills Hospital	Washington	94	0	0	0
Providence St. Vincent Medical Ctr.	Washington	33	0	0	0
Tuality Healthcare	Washington	0	0	0	22
Adult IP Psych. Beds:	**127**				
Clackamas-Multnomah-Washington Service Area	**Total**	**245**	**38**	**6**	**42**
Providence Willamette Falls Medical Ctr.	Clackamas	0	16	6	0
Providence Milwaukie Hospital	Clackamas	0	0	0	20
Providence Portland Medical Ctr.	Multnomah	33	0	0	0
Unity Center	Multnomah	85	22	0	0
Providence St. Vincent Medical Ctr.	Washington	33	0	0	0
Cedar Hills Hospital	Washington	94	0	0	0
Tuality Healthcare	Washington	0	0	0	22
Adolescent IP Psych. Beds:	**38**				
Geriatric IP Psych. Beds	**42**				

Sources:
The number of inpatient beds is drawn from the 2015 data presented in NEWCO 2015 CN Application, and adjusted for new CN approved beds (CN Archive, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHCAREPROVIDERSFACILITIES/CERTIFICATENEED/Pages/CertificateofNeedUpdates.aspx) and post-2015 published statements regarding bed capacity (Community Health Needs Executive Summary, 2016, https://communitybenefit.providence.org/~/media/Files/CBR/Oregon/2016CommunityHealthNeedsAssessmentProvidenceStVincentMedicalCenterPortland.pdf; OHA Oregon Performance Plan Data Specification Worksheet January 2017; Cedar Hills Hospital About Us, https://cedarhillshospital.com/about-us/)

In 2019, we count a total of 127 adult inpatient psychiatric beds in Washington and Clackamas counties, along with 38 adolescent and 42 older adult inpatient psychiatric beds in Clackamas, Multnomah, and Washington counties.

Table 23 presents inpatient psychiatric care discharges and patient days by provider for adults aged 18 to 64 in the Clackamas and Washington Service Area. OHA censors data if the number of discharges are less than 10, and hospitals with censored discharge data are indicated with a superscript “i” by their name. These censored discharges and their associated patient days are thus not included in the column totals in the relevant tables below. From data presented in Table 23, discharges fell by about 1.5% per year, and patient days grew by 1.1% per year.

Table 23 - Adult Psychiatric Patient Day and Discharge Utilization for Clackamas-Washington Service Area Inpatient Psychiatric Providers, 2008 – 2017.

Clackamas-Washington Psychiatric Discharges	Average annual % Δ	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Adults age 18-64	**1.46%**	**1,197**	**1,495**	**1,425**	**1,256**	**1,369**	**1,365**	**1,443**	**1,333**	**1,222**	**1,372**
Kaiser Sunnyside	1.7%	30	40	64	29	23	25	25	18	22	35
Providence Milwaukie[i]		-	-	-	-	-	-	-	-	-	38
Providence Willamette Falls[i]		-	-	10	-	11	-	-	-	-	-
Kaiser Westside[i]		-	-	-	-	-	-	-	-	-	-
Legacy Meridian Park[i]	-2.0%	15	10	-	-	-	-	-	11	19	12
Providence St Vincent	1.0%	1,117	1,424	1,325	1,184	1,308	1,314	1,378	1,274	1,146	1,231
Tuality	6.0%	35	21	26	43	27	26	40	30	35	56

Clackamas-Washington Psychiatric Patient Days	Average annual % Δ	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Adults age 18-64	**-1.07%**	**10,552**	**11,080**	**11,442**	**11,296**	**10,997**	**10,690**	**10,885**	**10,202**	**8,414**	**9,418**
Kaiser Sunnyside	3.3%	76	148	185	169	193	105	74	79	68	101
Providence Milwaukie[i]		-	-	-	-	-	-	-	-	-	524
Providence Willamette Falls[i]		-	-	24	-	16	-	-	-	-	-
Kaiser Westside[i]		-	-	-	-	-	-	-	-	-	-
Legacy Meridian Park[i]	-4.9%	70	48	-	-	-	-	-	32	55	36
Providence St Vincent	-2.1%	9,991	10,637	10,904	10,604	10,431	10,287	10,449	9,799	7,803	7,938
Tuality	9.7%	415	247	329	523	357	298	362	292	488	819

Source:
Oregon Inpatient Discharge Data, 2008-2017

Notes:
Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements. 22 bed Providence Willamette Falls Medical Center opened an inpatient child and adolescent (C&A) unit in 2013 and closed its 16 bed unit in Portland. Medical centers with the superscript i indicate hospitals with censored discharge and patient day data not shown and not included in the service area total. These hospitals include Kaiser Westside and Legacy Meridian Park. Average annual growth rates are only calculated for those hospitals and years with positive discharge counts.

Table 24 presents adolescent inpatient psychiatric care discharges and patient days by provider for the Clackamas-Multnomah-Washington Service Area. Between 2008 and 2017, adolescent discharges across providers fell by about 1.75% per year while patient days increased by about 2.5%.

Table 24 - Adolescent Psychiatric Patient Day and Discharge Utilization for Clackamas-Multnomah-Washington Service Area Inpatient Psychiatric Providers, 2008 – 2017.

Clackamas-Multnomah-Washington Psychiatric Discharges	Average annual % Δ	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Adolescents age 12 to 17	**-1.75%**	**1,074**	**1,096**	**1,085**	**1,044**	**1,101**	**1,058**	**1,038**	**1,076**	**914**	**886**
Kaiser Sunnyside		-	-	-	-	-	-	-	-	-	-
Providence Milwaukie[i]		-	-	-	-	-	-	-	-	-	-
Providence Willamette Falls[i]	32.3%	-	-	-	-	-	106	348	394	343	277
Adventist Health Portland		-	-	-	-	-	-	-	-	-	-
Legacy Emanuel	-8.4%	596	567	581	600	652	639	612	612	501	97
Legacy Good Samaritan		-	-	-	-	-	-	-	-	-	-
Legacy Mount Hood		-	-	-	-	-	-	-	-	-	-
Legacy Unity Behavioral Health		-	-	-	-	-	-	-	-	-	439
OHSU	21.7%	23	37	41	39	57	64	64	50	50	73
Providence Portland	-7.5%	455	492	463	405	392	249	-	-	-	-
Shriners Hospital for Children		-	-	-	-	-	-	-	-	-	-
Kaiser Westside[i]		-	-	-	-	-	-	-	-	-	-
Legacy Meridian Park[i]		-	-	-	-	-	-	-	-	-	-
Providence St Vincent		-	-	-	-	-	-	14	20	20	-
Tuality		-	-	-	-	-	-	-	-	-	-

Clackamas-Multnomah-Washington Psychiatric Patient Days	Average annual % Δ	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Adolescents age 12 to 17	**2.45%**	**8,314**	**8,514**	**9,362**	**9,126**	**8,633**	**8,562**	**8,638**	**9,734**	**9,084**	**10,347**
Kaiser Sunnyside		-	-	-	-	-	-	-	-	-	-
Providence Milwaukie[i]		-	-	-	-	-	-	-	-	-	-
Providence Willamette Falls[i]	61.6%	-	-	-	-	-	907	3,323	4,067	3,860	3,702
Adventist Health Portland		-	-	-	-	-	-	-	-	-	-
Legacy Emanuel	-7.4%	4,456	4,451	4,877	4,645	4,762	4,969	4,819	5,122	4,801	1,157
Legacy Good Samaritan		-	-	-	-	-	-	-	-	-	-
Legacy Mount Hood		-	-	-	-	-	-	-	-	-	-
Legacy Unity Behavioral Health		-	-	-	-	-	-	-	-	-	5,092
OHSU	16.2%	151	188	198	264	353	390	341	389	314	396
Providence Portland	-6.3%	3,707	3,875	4,287	4,217	3,518	2,296	-	-	-	-
Shriners Hospital for Children		-	-	-	-	-	-	-	-	-	-
Kaiser Westside[i]		-	-	-	-	-	-	-	-	-	-
Legacy Meridian Park[i]		-	-	-	-	-	-	-	-	-	-
Providence St Vincent		-	-	-	-	-	-	155	156	109	-
Tuality		-	-	-	-	-	-	-	-	-	-

Source:
Oregon Inpatient Discharge Data, 2008-2017

Notes:
Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements. 22 bed Providence Willamette Falls Medical Center opened an inpatient child and adolescent (C&A) unit in 2013 and closed its 16 bed unit in Portland. Cells with "1-9 discharges" indicate data which has been censored by the Oregon Health Authority since there were fewer than 10 discharges. Medical centers with the superscript i indicate hospitals with censored discharge and patient day data not shown and not included in the service area total. These hospitals include Providence Milwaukie, Providence Willamette Falls, Legacy Mount Hood, Kaiser Westside and Legacy Meridian Park. Average annual growth rates are only calculated for those hospitals and years with positive discharge counts.

Table 25 presents inpatient psychiatric care discharges and patient days by provider for older adult residents aged 65+ in the Clackamas-Multnomah-Washington Service Area. For the three

counties, older adult inpatient discharges have grown by about 2.5% per year between 2008 and 2017, while patient days have grown by about 6.8% during that same period.

Table 25 - Older Adult Psychiatric Patient Day and Discharge Utilization at Service Area 2 Inpatient Psychiatric Providers, 2008 – 2017.

Clackamas-Multnomah-Washington Psychiatric Discharges	Average annual % Δ	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Geriatrics age 65+	**2.47%**	**980**	**999**	**922**	**934**	**912**	**886**	**846**	**821**	**1,059**	**1,222**
Kaiser Sunnyside	10.3%	35	80	73	46	33	37	42	54	75	71
Providence Milwaukie[i]	182.7%	11	-	12	-	10	-	-	15	-	212
Providence Willamette Falls[i]		-	11	10	13	10	12	-	12	11	-
Adventist Health Portland	-8.0%	109	76	90	86	81	100	87	66	87	22
Legacy Emanuel	0.4%	24	19	20	29	37	24	29	27	19	25
Legacy Good Samaritan	39.3%	54	55	44	45	46	48	51	86	255	266
Legacy Mount Hood[i]	-4.5%	20	18	-	-	-	16	15	26	11	11
Legacy Unity Behavioral Health		-	-	-	-	-	-	-	-	-	51
OHSU	-2.4%	58	61	52	75	60	92	67	65	60	44
Providence Portland	0.0%	35	35	35	35	35	35	35	35	35	35
Shriners Hospital for Children		-	-	-	-	-	-	-	-	-	-
Kaiser Westside[i]		-	-	-	-	-	-	18	29	20	24
Legacy Meridian Park	-1.9%	43	54	19	24	27	23	27	41	40	35
Providence St Vincent	-1.2%	138	169	140	144	163	138	143	156	124	122
Tuality	-3.3%	453	421	427	437	410	361	332	209	322	304

Clackamas-Multnomah-Washington Psychiatric Patient Days	Average annual % Δ	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Geriatrics age 65+	**6.84%**	**9,585**	**9,469**	**9,273**	**9,505**	**9,647**	**9,440**	**9,537**	**10,159**	**13,237**	**16,143**
Kaiser Sunnyside	4.5%	242	439	329	186	147	131	212	376	355	352
Providence Milwaukie[i]	1047.1%	38	-	21	-	37	-	-	77	-	4,017
Providence Willamette Falls[i]		-	39	24	94	34	40	-	49	50	-
Adventist Health Portland	-7.8%	904	575	822	928	843	953	800	743	995	201
Legacy Emanuel	2.5%	221	178	220	209	511	308	327	381	239	277
Legacy Good Samaritan	66.3%	455	321	337	264	402	376	408	886	3,793	3,472
Legacy Mount Hood[i]	6.8%	103	62	-	-	-	75	78	270	70	173
Legacy Unity Behavioral Health		-	-	-	-	-	-	-	-	-	914
OHSU	-4.9%	611	656	552	847	439	757	611	701	608	313
Providence Portland	0.0%	35	35	35	35	35	35	35	35	35	35
Shriners Hospital for Children		-	-	-	-	-	-	-	-	-	-
Kaiser Westside[i]		-	-	-	-	-	-	82	172	105	100
Legacy Meridian Park	3.0%	172	192	85	96	107	80	117	209	221	223
Providence St Vincent	-0.1%	1,247	1,317	1,105	1,059	1,301	1,165	1,325	1,519	1,113	1,232
Tuality	-1.3%	5,557	5,655	5,743	5,787	5,791	5,520	5,542	4,741	5,653	4,834

Source:
Oregon Inpatient Discharge Data, 2008-2017

Notes:
Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements. 22 bed Providence Willamette Falls Medical Center opened an inpatient child and adolescent (C&A) unit in 2013 and closed its 16 bed unit in Portland. Cells with "1-9 discharges" indicate data which has been censored by the Oregon Health Authority since there were fewer than 10 discharges. Medical centers with the superscript i indicate hospitals with censored discharge and patient day data not shown and not included in the service area total. These hospitals include Adventist Health Portland, Legacy Good Samaritan, and Legacy Meridian Park. Average annual growth rates are only calculated for those hospitals and years with positive discharge counts.

Service Area Hospitals

As required in OAR 333-615-0030 (2), provided in Table 26 below are the names and addresses for hospitals with dedicated adult, adolescent, or older adult inpatient psychiatric beds in Clackamas, Multnomah, or Washington counties.

Table 26 - Name and Addresses for Hospitals with Dedicated Inpatient Psychiatric Beds in Service Area 1 and Service Area 2.

Hospital Name	Inpatient Psychiatric Beds, 2019			County	Address	City	Zip
	Adult	Adolescent	Geriatric				
Providence Milwaukie Hospital	0	0	20	Clackamas	10330 SE 32nd Ave	Milwaukie	97222
Providence Willamette Falls Medical Center	0	16	0	Clackamas	1500 Division St.	Oregon City	97045
Providence Portland Medical Center	33	0	0	Multnomah	4805 NE Glisan St.	Portland	97213
Unity Center	85	22	0	Multnomah	1225 NE 2nd Ave	Portland	97232
Cedar Hills Hospital	94	0	0	Washington	10300 SW Eastridge St.	Portland	97225
Providence St. Vincent Medical Center	33	0	0	Washington	9205 SW Barnes Rd.	Portland	97225
Tuality Healthcare	0	0	22	Washington	1809 Maple St.	Forest Grove	97116

Sources:
The number of inpatient beds is drawn from the 2015 data presented in NEWCO 2015 CN Application, and adjusted for new CN approved beds (CN Archive, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHCAREPROVIDERSFACILITIES/CERTIFICATENEED/Pages/CertificateofNeedUpdates.aspx) and post-2015 published statements regarding bed capacity (Community Health Needs Executive Summary, 2016, https://communitybenefit.providence.org/~/media/Files/CBR/Oregon/2016CommunityHealthNeedsAssessmentProvidenceStVincentMedicalCenterPortland.pdf; OHA Oregon Performance Plan Data Specification Worksheet January 2017; Cedar Hills Hospital About Us, https://cedarhillshospital.com/about-us/)

Service Area providers' average daily census ("ADC") figures for adult, adolescent, and older adult psychiatric inpatients in the Clackamas-Washington and Clackamas-Multnomah-Washington service areas are provided below in Table 27 (adults), Table 28 (adolescents), and Table 29 (older adults). Data in these tables is used to calculate occupancy statistics for each inpatient psychiatric provider.

Table 27 - Average Daily Census at Adult Psychiatric Inpatient Providers, Clackamas and Washington Counties, 2013 – 2017.

Clackamas-Washington ADC	Average annual % Δ	2013	2014	2015	2016	2017
Adults age 18-64	**1.31%**	**79.4**	**82.5**	**85.7**	**83.8**	**84.6**
Kaiser Sunnyside	8.0%	0.1	0.1	0.0	0.1	0.1
Providence Milwaukie[i]		-	-	-	-	0.1
Providence Willamette Falls[i]		-	-	-	-	-
Kaiser Westside[i]		-	-	-	-	-
Legacy Meridian Park[i]		-	-	0.0	0.1	0.0
Providence St Vincent	-1.3%	3.6	3.8	3.5	3.1	3.4
Tuality	23.1%	0.1	0.1	0.1	0.1	0.2
Cedar Hills Hospital	1.4%	75.6	78.6	82.1	80.4	80.8

Source:
Oregon Inpatient Discharge Data, 2008-2017, Cedar Hills Hospital Inpatient Data, 2012-2019

Notes:

Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements. 22 bed Providence Willamette Falls Medical Center opened an inpatient child and adolescent (C&A) unit in 2013 and closed its 16 bed unit in Portland. Medical centers with the superscript i indicate hospitals with censored discharge and patient day data not shown and not included in the service area total. These hospitals include Kaiser Westside and Legacy Meridian Park. Average annual growth rates are only calculated for those hospitals and years with positive discharge counts.

Table 28 - Average Daily Census at Adolescent Psychiatric Inpatient Providers, Clackamas, Multnomah, and Washington Counties, 2013 – 2017.

Clackamas-Multnomah-Washington Psychiatric Patient Days	Average annual % Δ	2013	2014	2015	2016	2017
Adolescents age 12 to 17	**4.17%**	**23.5**	**23.7**	**26.7**	**24.9**	**28.3**
Kaiser Sunnyside		-	-	-	-	-
Providence Milwaukie		-	-	-	-	-
Providence Willamette Falls	61.6%	2.5	9.1	11.1	10.6	10.1
Adventist Health Portland[i]		-	-	-	-	-
Legacy Emanuel	-15.3%	13.6	13.2	14.0	13.2	3.2
Legacy Good Samaritan[i]		-	-	-	-	-
Legacy Mount Hood		-	-	-	-	-
Legacy Unity Behavioral Health		-	-	-	-	14.0
OHSU	0.3%	1.1	0.9	1.1	0.9	1.1
Providence Portland	-20.0%	6.3	-	-	-	-
Shriners Hospital for Children		-	-	-	-	-
Kaiser Westside		-	-	-	-	-
Legacy Meridian Park[i]		-	-	-	-	-
Providence St Vincent[i]		-	0.4	0.4	0.3	-
Tuality		-	-	-	-	-

Source:
Oregon Inpatient Discharge Data, 2008-2017

Notes:
Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements. 22 bed Providence Willamette Falls Medical Center opened an inpatient child and adolescent (C&A) unit in 2013 and closed its 16 bed unit in Portland. Cells with "1-9 discharges" indicate data which has been censored by the Oregon Health Authority since there were fewer than 10 discharges. Medical centers with the superscript i indicate hospitals with censored discharge and patient day data not shown and not included in the service area total. These hospitals include Providence Milwaukie, Providence Willamette Falls, Legacy Mount Hood, Kaiser Westside and Legacy Meridian Park. Average annual growth rates are only calculated for those hospitals and years with positive discharge counts.

Table 29 - Average Daily Census at Older Adult Psychiatric Inpatient Providers, Clackamas, Multnomah, and Washington Counties, 2013 – 2017.

Clackamas-Multnomah-Washington Psychiatric Patient Days	Average annual % Δ	2013	2014	2015	2016	2017
Geriatrics age 65+	**14.20%**	**25.9**	**26.1**	**27.8**	**36.3**	**44.2**
Kaiser Sunnyside	33.7%	0.4	0.6	1.0	1.0	1.0
Providence Milwaukie[i]		-	-	0.2	-	11.0
Providence Willamette Falls[i]	-20.0%	0.1	-	0.1	0.1	-
Adventist Health Portland	-15.8%	2.6	2.2	2.0	2.7	0.6
Legacy Emanuel	-2.0%	0.8	0.9	1.0	0.7	0.8
Legacy Good Samaritan	164.7%	1.0	1.1	2.4	10.4	9.5
Legacy Mount Hood[i]	26.1%	0.2	0.2	0.7	0.2	0.5
Legacy Unity Behavioral Health		-	-	-	-	2.5
OHSU	-11.7%	2.1	1.7	1.9	1.7	0.9
Providence Portland	0.0%	0.1	0.1	0.1	0.1	0.1
Shriners Hospital for Children		-	-	-	-	-
Kaiser Westside[i]		-	0.2	0.5	0.3	0.3
Legacy Meridian Park	35.8%	0.2	0.3	0.6	0.6	0.6
Providence St Vincent	1.2%	3.2	3.6	4.2	3.0	3.4
Tuality	-2.5%	15.1	15.2	13.0	15.5	13.2

Source:
Oregon Inpatient Discharge Data, 2008-2017

Notes:
Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements. 22 bed Providence Willamette Falls Medical Center opened an inpatient child and adolescent (C&A) unit in 2013 and closed its 16 bed unit in Portland. Cells with "1-9 discharges" indicate data which has been censored by the Oregon Health Authority since there were fewer than 10 discharges. Medical centers with the superscript i indicate hospitals with censored discharge and patient day data not shown and not included in the service area total. These hospitals include Adventist Health Portland, Legacy Good Samaritan, and Legacy Meridian Park. Average annual growth rates are only calculated for those hospitals and years with positive discharge counts.

In conformance with OAR 333-615-0030(2), annual patient days and ADC figures for adult inpatient psychiatric providers in the Clackamas-Washington Service Area, and adolescent and older adult psychiatric providers in the Clackamas-Multnomah-Washington Service Area, are given below in Table 30 (adults), Table 31 (adolescents), and Table 32 (older adults). These tables also include the number of beds designated for inpatient psychiatric care, as well as the calculated average annual occupancy.

Table 30 - Occupancy Rates at Adult Psychiatric Inpatient Providers, Clackamas and Washington Counties, 2017.

Clackamas-Washington Occupancy Rates	Patient Days, 2017, IP Psych.	Average Daily Census, 2017	Adult Psych. Beds	Occupancy, 2017
Adults age 18-64	**38,911**	**106.6**	**127**	**83.9%**
Kaiser Sunnyside	101	0.3	-	NA
Providence Milwaukie[i]	524	1.4	-	NA
Providence Willamette Falls[i]	-	-	-	NA
Kaiser Westside[i]	-	-	-	NA
Legacy Meridian Park[i]	36	0.1	-	NA
Providence St Vincent	7,938	21.7	33	65.9%
Tuality	819	2.2	-	NA
Cedar Hills Hospital	29,493	80.8	94	86.0%

Source:
Oregon Inpatient Discharge Data, 2008-2017, Cedar Hills Hospital Inpatient Data, 2012-2019

Notes:

Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements. 22 bed Providence Willamette Falls Medical Center opened an inpatient child and adolescent (C&A) unit in 2013 and closed its 16 bed unit in Portland. Medical centers with the superscript i indicate hospitals with censored discharge and patient day data not shown and not included in the service area total. These hospitals include Kaiser Westside and Legacy Meridian Park. Hospitals without designated inpatient psychiatric beds may "convert" existing acute care capacity to inpatient psychiatric capacity, so some hospitals with no listed psychiatric beds may nevertheless have inpatient psychiatric discharges.

Table 31 - Occupancy Rates at Adolescent Psychiatric Inpatient Providers, Clackamas, Multnomah, and Washington Counties, 2017.

Clackamas-Multnomah-Washington Occupancy Rates	Patient Days, 2017, IP Psych.	Average Daily Census, 2017	Adolescent Psych. Beds	Occupancy, 2017
Adolescents age 12 to 17	**10,347**	**28.3**	**38**	**74.6%**
Kaiser Sunnyside	-	-	-	NA
Providence Milwaukie	-	-	-	NA
Providence Willamette Falls	3,702.0	10.1	16.0	63.4%
Adventist Health Portland[i]	-	-	-	NA
Legacy Emanuel	1,157.0	3.2	-	NA
Legacy Good Samaritan[i]	-	-	-	NA
Legacy Mount Hood	-	-	-	NA
Legacy Unity Behavioral Heal	5,092.0	14.0	22.0	63.4%
OHSU	396.0	1.1	-	NA
Providence Portland	-	-	-	NA
Shriners Hospital for Children	-		-	NA
Kaiser Westside	-	-	-	NA
Legacy Meridian Park[i]	-	-	-	NA
Providence St Vincent[i]	-	-	-	NA
Tuality	-	-	-	NA

Source:
Oregon Inpatient Discharge Data, 2008-2017

Notes:
Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements. 22 bed Providence Willamette Falls Medical Center opened an inpatient child and adolescent (C&A) unit in 2013 and closed its 16 bed unit in Portland. Cells with "1-9 discharges" indicate data which has been censored by the Oregon Health Authority since there were fewer than 10 discharges. Medical centers with the superscript i indicate hospitals with censored discharge and patient day data not shown and not included in the service area total. These hospitals include Providence Milwaukie, Providence Willamette Falls, Legacy Mount Hood, Kaiser Westside and Legacy Meridian Park. Hospitals without designated inpatient psychiatric beds may "convert" existing acute care capacity to inpatient psychiatric capacity, so some hospitals with no listed psychiatric beds may nevertheless have inpatient psychiatric discharges.

Table 32 - Occupancy Rates at Older Adult Psychiatric Inpatient Providers, Clackamas, Multnomah, and Washington Counties, 2017.

Clackamas-Multnomah-Washington Occupancy Rates	Patient Days, 2017, IP Psych.	Average Daily Census, 2017	Geriatric Psych. Beds	Occupancy, 2017
Geriatrics age 65+	**16,143.0**	**44.2**	**42**	**105.3%**
Kaiser Sunnyside	352.0	1.0	-	NA
Providence Milwaukie[i]	4,017.0	11.0	20.0	55.0%
Providence Willamette Falls[i]	-	-	-	NA
Adventist Health Portland	201.0	0.6	-	NA
Legacy Emanuel	277.0	0.8	-	NA
Legacy Good Samaritan	3,472.0	9.5	-	NA
Legacy Mount Hood[i]	173.0	0.5	-	NA
Legacy Unity Behavioral Heal	914.0	2.5	-	NA
OHSU	313.0	0.9	-	NA
Providence Portland	35.0	0.1	-	NA
Shriners Hospital for Children	-	-	-	NA
Kaiser Westside[i]	100.0	0.3	-	NA
Legacy Meridian Park	223.0	0.6	-	NA
Providence St Vincent	1,232.0	3.4	-	NA
Tuality	4,834.0	13.2	22.0	60.2%

Source:
Oregon Inpatient Discharge Data, 2008-2017

Notes:
Psychiatric DRGs used were 056-057, 876, 880-887. Cedar Hills Hospital utilization not included as specialty hospitals are exempt from state data reporting requirements. 22 bed Providence Willamette Falls Medical Center opened an inpatient child and adolescent (C&A) unit in 2013 and closed its 16 bed unit in Portland. Cells with "1-9 discharges" indicate data which has been censored by the Oregon Health Authority since there were fewer than 10 discharges. Medical centers with the superscript i indicate hospitals with censored discharge and patient day data not shown and not included in the service area total. These hospitals include Adventist Health Portland, Legacy Good Samaritan, and Legacy Meridian Park. Hospitals without designated inpatient psychiatric beds may "convert" existing acute care capacity to inpatient psychiatric capacity, so some hospitals with no listed psychiatric beds may nevertheless have inpatient psychiatric discharges.

STEP 4: Subtract the total service area bed supply from Step 3 from "gross demand" estimates calculated in Step 2. The resulting value represents the estimates of net need for psychiatric beds, by year, for the adult, adolescent, and older adult age groups.

Tables 33, 34, and 35 present the net bed need for psychiatric care at the adult (Table 33), adolescent (Table 34), and older adult (Table 35) age groups.

Table 33 - Inpatient Psychiatric Need Model, Adults aged 18 to 64

	Base Year	Year 1	Year 3	Year 5	Year 10
	2019	2020	2022	2024	2029
Service Area Resident Population, 18 to 64 Year Olds	636,078	640,038	653,252	666,899	700,664
Total Planning Area Psychiatric Beds (Clackamas and Washing	127	127	127	127	127
Existing Psych Bed Ratio (Per 100,000 Residents)	20.0	19.8	19.4	19.0	18.1
Forecast Psychiatric Bed Need--Proposed Ratio--2016 NW Average					
Target Bed Ratio Per 100,000 Residents	32.5	32.5	32.5	32.5	32.5
Gross Bed Need at Target Ratio	206.7	208.0	212.3	216.7	227.7
Current Supply	127	127	127	127	127
Psych Bed Net Need	**79.7**	**81.0**	**85.3**	**89.7**	**100.7**

Table 34 - Inpatient Psychiatric Need Model, Adolescents aged 12 to 17

	Base Year	Year 1	Year 3	Year 5	Year 10
	2019	2020	2022	2024	2029
Service Area Resident Population, 12 to 17 Year Olds	128,250	129,197	131,009	132,863	137,550
Total Planning Area Psychiatric Beds (Clackamas, Multnomah,	38	38	38	38	38
Existing Psych Bed Ratio (Per 100,000 Residents)	29.6	29.4	29.0	28.6	27.6
Forecast Psychiatric Bed Need--Proposed Ratio--2016 NW Average					
Peak ADC, Clackamas, Multnomah, Washington Counties	32.5	32.5	32.5	32.5	32.5
Gross Bed Need at Target Ratio	41.7	42.0	42.6	43.2	44.7
Current Supply	38	38	38	38	38
Psych Bed Net Need	**3.7**	**4.0**	**4.6**	**5.2**	**6.7**

Table 35 - Inpatient Psychiatric Need Model, Older Adults, aged 65+

	Base Year	Year 1	Year 3	Year 5	Year 10
	2019	2020	2022	2024	2029
Service Area Resident Population, 65+ Years Old	272,161	281,219	302,312	325,595	367,827
Total Planning Area Psychiatric Beds (Clackamas, Multnomah,	42	42	42	42	42
Existing Psych Bed Ratio (Per 100,000 Residents)	15.4	14.9	13.9	12.9	11.4
Forecast Psychiatric Bed Need--Proposed Ratio--2016 NW Average					
Peak ADC, Clackamas, Multnomah, Washington Counties	32.5	32.5	32.5	32.5	32.5
Gross Bed Need at Target Ratio	88.5	91.4	98.3	105.8	119.5
Current Supply	42	42	42	42	42
Psych Bed Net Need	**46.5**	**49.4**	**56.3**	**63.8**	**77.5**

From Table 33, Table 34, and Table 35, there is clear need in the Clackamas, Multnomah, and Washington counties for inpatient psychiatric beds, across all surveyed age groups. Need for adult inpatient psychiatric care is greatest, with current need for an additional 80 inpatient psychiatric beds, followed by older adult inpatient psychiatric care (46 beds) and adolescent inpatient psychiatric care (4 beds). In Year 3, these numbers rise to about 85, 56, and 5, for a total net need of 146 inpatient psychiatric beds.

Further evidence of inpatient psychiatric need

Service Area Migration Analysis

As presented in Table 36, 2017 Oregon inpatient data for psychiatric DRGs in the Clackamas, Multnomah, and Washington Counties shows out-migration for adults, adolescents, or older adults of about 1.2% and, 0.4%, and 1% of resident discharges, respectively. Ratios using patient days were essentially the same. Although there has been very little out-migration, in-migration to the three counties has been substantial for all three age groups. About 16% of all adult inpatient psychiatric discharges came from out-of-area residents, and almost half of all adolescent and a third of all older adult discharges came from out-of-area residents.[78] Across all age groups, but especially for adolescents and older adults, these out- and in-migration rates result from very little inpatient psychiatric supply outside of the Clackamas, Multnomah, or Washington counties.

[78] In-migration is calculated by subtracting the number of psychiatric patient days for Service Area residents at Service Area providers from the overall number of patient days at Service Area providers regardless of residency, and dividing this figure by the overall number of patient days at Service Area providers regardless of residency.

Table 36 - Clackamas-Multnomah-Washington Counties Migration Analysis, 2017.

Psychiatric Inpatient Discharges, 2017	Adults, aged 18-64	Adolescents, aged 12-17	Geriatrics, age 65+
Area	**Clackamas-Washington-Multnomah**	**Clackamas-Washington-Multnomah**	**Clackamas-Washington-Multnomah**
Resident discharges	4117	466	955
Resident discharges at Area Providers	4,066	464	946
% Out-migration	1.2%	0.4%	0.9%
Area Provider discharges	4,842	896	1,306
% In-migration	16.03%	48.21%	27.57%

Psychiatric Inpatient Patient Days, 2017	Adults, aged 18-64	Adolescents, aged 12-17	Geriatrics, age 65+
Area	**Clackamas-Washington-Multnomah**	**Clackamas-Washington-Multnomah**	**Clackamas-Washington-Multnomah**
Resident patient days	42,591	5,374	12,906
Resident patient days at Area Providers	42,049	5,366	12,782
% Out-migration	1.3%	0.1%	1.0%
Area Provider patient days	49,981	10,380	17,857
% In-migration	15.87%	48.30%	28.42%

Source:
Oregon Inpatient Discharge Data, 2008-2017

Cedar Hills Hospital Occupancy and Deflection Statistics

Table 37 provides Cedar Hills' inpatient discharge data for 2016 through June 10, 2019. As mentioned previously, Cedar Hills Hospital is excluded from Oregon inpatient statistics. The Cedar Hills data from 2018 shows that around 44% to 47% of its discharges are from residents of Clackamas, Multnomah, or Washington counties, while over half of its discharges represent in-migration, or utilization by residents living outside of these three counties. Furthermore, a fourth

or more of inpatient discharges come from outside Oregon State. Many of these in-migrants originate in Washington State, with its few psychiatric inpatient beds and population which Cedar Hills provides specialty services for. There are also a substantial number of patients from Joint Base Lewis McCord ("JBLM"). This, and the fact that resident data suggests there is little out-migration, indicates that accurate bed need models should reasonably account for in-migration.

Table 37 - Cedar Hills Hospital, Patient Origin by County.

	2016		2017		2018		2019 (Partial Year)	
County	Disch.	Pct.	Disch.	Pct.	Disch.	Pct.	Disch.	Pct.
Clackamas	222	9.7%	253	10.4%	269	11.1%	120	13.3%
Multnomah	704	30.8%	771	31.6%	785	32.3%	287	31.8%
Washington	355	15.5%	312	12.8%	318	13.1%	112	12.4%
Subtotal	**1,059**	**46.4%**	**1,083**	**44.4%**	**1,104**	**45.3%**	**399**	**44.2%**
In-migration to CHH from outside Clackamas, Multnomah, or Washington counties	**1,225**	**53.6%**	**1,357**	**55.6%**	**1,330**	**54.7%**	**504**	**55.8%**
In-migration to CHH from outside OR state	624	27.3%	614	25.2%	577	23.7%	191	21.2%
In-migration to CHH from other OR counties	601	26.3%	742	30.4%	753	30.9%	313	34.7%
Total	**2,284**		**2,440**		**2,434**		**903**	

Source:
Cedar Hills Internal Data, 2012-2019

Notes:
Statistics shown are for only those discharges with identifiable patient original zip codes. 2019 reflects discharge data up to June 10, 2019

Cedar Hills Occupancy Statistics

As noted above, Cedar Hills Hospital inpatient statistics are not publicly available. For completeness, we have included 2017 inpatient statistics for some of the prior tables. A full reporting of Cedar Hills Hospital occupancy statistics from the Hospital's internal inpatient data is presented in Table 38, which demonstrates extremely high occupancy at Cedar Hills over the last six years. In fact, the facility has been at maximum capacity every year since 2013.

Cedar Hills began operations at the end of April 2009 with 37 beds and has grown to a hospital with 94 inpatient psychiatric beds. However, despite incremental increases in bed numbers, Cedar Hills has consistently and continues to operate near maximum capacity. Clearly, growth in inpatient psychiatric utilization has been constrained by the lack of available beds. At the end of 2013, Cedar Hills operated at 95.7% occupancy. Five beds were added in 2014, which corresponded with an increase in utilization. Another four beds were added in 2018, reducing occupancy rates to 85%. However, data for 2019 so far suggest further utilization increases.

Table 38 - Cedar Hills Hospital, Discharges, Patient Days and Occupancy Statistics, 2013 - 2018

Cedar Hills Hospital	Average annual % Δ	2012	2013	2014	2015	2016	2017	2018	2019
Discharges	5.2%	370	2,374	2,546	2,844	2,916	3,122	3,113	1,204
Patient Days	0.9%	4,560	27,599	28,686	29,963	29,362	29,493	29,088	13,018
ALOS*	-3.3%	12.32	11.63	11.27	10.54	10.07	9.45	9.34	10.81
Surveyed Days		102	365	365	365	365	365	365	160
Avg. Daily Census	1.1%	44.71	75.61	78.59	82.09	80.44	80.80	79.69	81.36
Beds		78	79	89	89	89	89	94	94
Occupancy Rate	85.8%	57.3%	95.7%	88.3%	92.2%	90.4%	90.8%	84.8%	86.6%

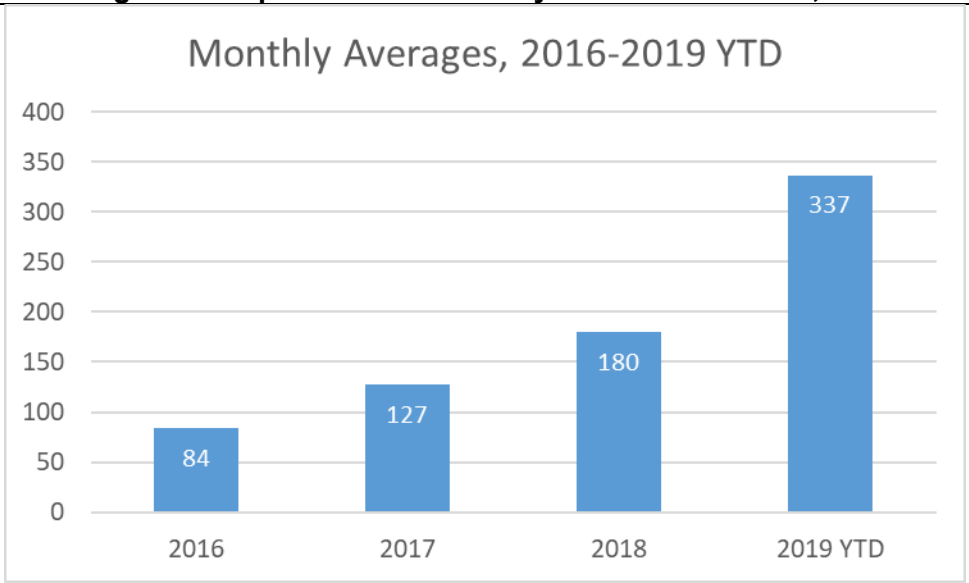
Source:
Cedar Hills Internal Data, 2012-2019

Notes:
Inpatient discharge data runs from September 20, 2012 to June 10, 2019. 2012 and 2019 thus represent partial years. The ADC statistics reflect these partial years, and average annual percent changes for Discharges and Patient Days are constrained to the 2013-2018 period.

Cedar Hills Inpatients - Sources of Admission and deflections

As evidenced in Table 38, Cedar Hills Hospital has been operating at capacity for the past five years. This fact is already reflected in its transfers and deflections data. Figure 6 plots average monthly turn-away statistics for Cedar Hills Hospital from July 2016 through May 2019.

Figure 6. Average annual patients turned away and not recovered, 2016 to May 2019



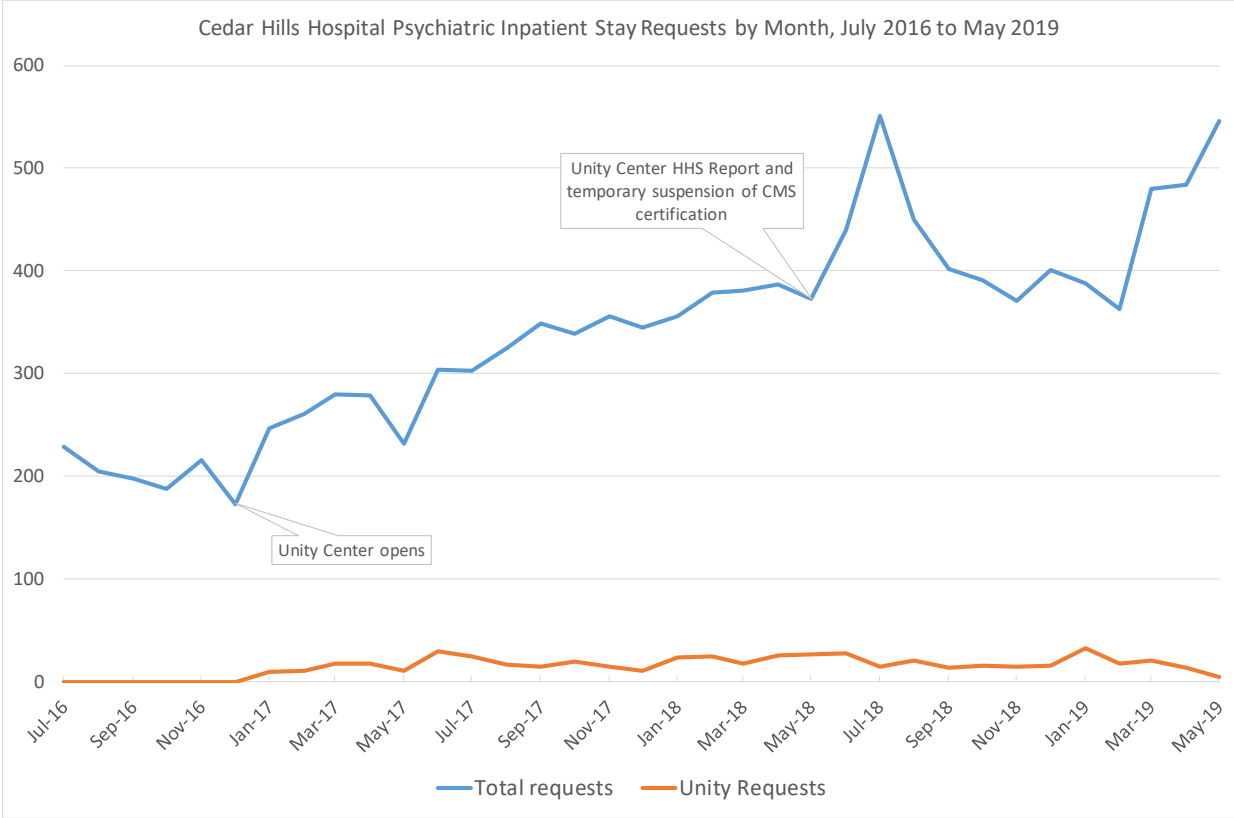
Source:
Cedar Hills Hospital Inpatient Transfers and Deflections Data, 2016 to May 2019

From Figure 6, the number of patients turned away and not recovered at Cedar Hills Hospital has increased constantly over the last four years such that by 2019, Cedar Hills Hospital has turned away and not recovered about 337 patients per month on average. This represents more than 3,600 patient days in an average month in 2019, for an average daily census of about 119. Even

given no further increases in the Cedar Hills Hospital patient deflection trends, the proposed hospital could fill its 100 beds simply with those patients deflected. This alone demonstrates the extreme unmet inpatient psychiatric need in the Clackamas-Multnomah-Washington area, and the need for the proposed hospital.

Part of these trends has been driven by the presence of the Unity Center for Behavioral Health. With the Cedar Hills data on patient requests by month, we can identify both the opening of the Unity Center in January 2017, as well as the CMS suspension of its certification in May 2018 pending corrections and re-evaluation. Figure 7 plots monthly inpatient stay requests from July 2016 to May 2019. Since the Unity Center opened in 2017, transfer requests have increased considerably at Cedar Hills. This trend has continued, with a short-term spike in patient requests following the initial report by the Department of Health and Human Services on the Unity Center's failure to provide a safe and stable environment. The most recent data suggests a further surge patient requests, which Cedar Hills Hospital is unable to meet.

Figure 7. Cedar Hills Hospital Psychiatric Inpatient Stay Requests, July 2016 to May 2019



Source:
Cedar Hills Hospital Inpatient Transfers and Deflections Data, 2016 to 2019

OAR 333-615-0040.
Availability of Alternative Uses for Resource

The following principles shall be applicable to the interpretation of OAR 333-580-0050(1) and (2). The term "quality unit" is explained in OAR 333-615-0050:

(1) The methods of meeting acute psychiatric bed need, in order of preference, shall be:

(a) Conversion of existing licensed space to purposes of psychiatric treatment where such conversion is feasible to provide an adequate inpatient program at less cost than building new licensed space, especially when the average daily census for the facility as a whole for the most recent year ending September 30, converted to expected peak occupancy under the methods of OAR 333-590-0050(8) and (9), does not exceed the current licensed number of beds at the facility;

(b) A project resulting in the smallest feasible net increase in acute licensed capacity within an existing general hospital or specialty hospital license, especially when the average daily census to the facility as a whole, for the most recent year ending September 30, converted to expected peak occupancy under the methods of OAR 333-590-0050(8) and (9), equals or exceeds the current licensed number of beds at the facility;

(c) A separately licensed new psychiatric hospital, not part of a general hospital, that will provide adequate psychiatric inpatient care at the most reasonable charges per day and per spell of treatment, for care that must be rendered on an inpatient basis, taking into consideration the factors in OAR 333-615-0000(2).

Please see our discussion of Unusual Circumstances, psychiatric bed need, and alternatives analysis that provides evidence warranting application of paragraph (1)(c) above for OHA to approve a new licensed psychiatric hospital.

(2) A proposed psychiatric inpatient bed project shall be related to alternatives, as defined in OAR 333-615-0010(1), with preference given in the following order:

(a) Projects which include development of alternative care resources as part of the project, if an unmet need for such resources in the service area is demonstrated;

(b) Projects for which formal arrangements, together with triage criteria and mechanisms, are documented in the application with respect to all levels of low cost alternative care resources listed in OAR 333-615-0010(1). Documentation of triage criteria and mechanisms should include discussion of the relation of such criteria to the level of placement criteria developed by the Office of Health Policy and insurers under ORS 743.556(16)(b). Applicants should show that their triage criteria and mechanisms will be consistent with such level of care screening criteria.

Willamette Valley Behavioral Health will provide alternative care resources as established under OAR 333-615-010(1), including day and partial hospitalization and outpatient treatment by a qualified mental health professional. Therefore, the proposed facility is one of preference according to paragraph (2)(a) above.

(3) If, in the service area defined in OAR 333-615-0030(1), there does not exist a quality unit of minimum economically viable size, sections (1) and (2) of this rule apply.

According to paragraph (5) of this section, paragraph (3) does not apply to the current application given there are ≥2 inpatient psychiatric units within the defined service area.

(4) If, in the service area defined in OAR 333-615-0030(1), there does exist one quality unit, and its occupancy (from the designated service area) is above the appropriate criterion in Table 1 for the year ending September 30 preceding the formal application, and available private acute beds do not exceed the interim population-based limit indicated in OAR 333-615-0030(2), a minimum economically viable increment may be needed. In addition to sections (1) and (2) of this rule, the following options will be considered, in order of preference:

(a) The existing quality unit may be expanded;

(b) An additional unit in the service area may be developed, provided that considerations of cost, access and quality outweigh the estimated economic advantages, if any, of expansion of the existing unit.

Please see discussion provided in our response to requirements under 333-580-0050.

(5) If, in the service area defined in OAR 333-615-0030(1), there exist two or more units, sections (1), (2) and (4) of this rule apply, preference being given to expansion of the highest quality existing unit unless consideration of the factors in subsection (4)(b) of this rule leads to preference for an additional unit.

Please see discussion provided in our response to requirements under 333-580-0050.

(6) In evaluating the relationship of any proposed project to the existing health care system of the service area, the division shall address possible compromising of quality of care. The division shall consider the conformity to state safety and program standards of both the proposed project and existing, related health services now provided to the population of the service area; the impact of the project, once completed and operational, upon the financial ability of providers of related services to maintain present quality; and the feasibility that the proposed project will be sufficiently efficient to maintain quality standards at reasonable cost. Impact on total community health care costs, not merely charges per day or charges per stay, shall be considered.

Please see discussion provided in our response to requirements under 333-580-0050.

OAR 333-615-0050
Quality and Costs.

All proposed psychiatric beds must meet the licensure, certification and accreditation criteria of the Public Health Division, Medicare and the Joint Commission on Accreditation of Health-care Organizations, as appropriate. "Quality" for purposes of review of certificate of need proposals is a description of threshold factors to be considered, not a presumption of clinical judgment, nor a substitute for the licensing or accreditation functions. ***A proposal for a quality psychiatric unit shall include explicit policies, and specific examples and detail regarding each factor below:***

Overview and Summary of Key Policies and Procedures at WVBH.

UHS' proposed facility will accept all patients, based on medical need, over the age of twelve (12) requiring inpatient and/or outpatient psychiatric care.[79] Its exclusion criteria will be adopted from Cedar Hills hospital as appropriate and applied uniformly to all prospective patients, based on well-defined guidelines.[80] Cedar Hills has well-defined exclusion criteria for inpatients, which absent a waiver by the admitting physician, excludes patients who are younger than 18 years of age; those who are so behaviorally or cognitively impaired they cannot benefit from treatment; those who are sufficiently functionally impaired; those with infectious diseases requiring isolation or quarantine; those who are medically unstable such that their safety requires treatment in a medical-surgical hospital; those who require specialized care beyond the scope of the psychiatric hospital; those at high risk for medical decompensation; and those with less than six hours free of restraint/seclusion prior to transfer.[81]

Willamette Valley Behavioral Health will also voluntarily apply for and maintain Joint Commission (formerly known as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)) accreditation, which requires the accredited hospital to maintain policies and procedures assuring coordination of care and treatment and discharge planning to assure patients receive the least restrictive and appropriate level of care, based on individual patient needs.

Appropriate management and use of scarce resources and particularly the use of the least restrictive care for psychiatric patients, based on each patient's needs is also an essential element of quality delivery. WVBH will actively monitor patient care and progress toward recovery and

[79] Please see Appendix 2 for a copy of all Cedar Hills Hospital's admissions policies for inpatients and outpatients aged 18+. WVBH's policies will follow the same form and include the same content, but will include adolescent patients.
[80] Appendix 2,_, Cedar Hills Hospital, "Admission Criteria, IP," pp. 1-2.
[81] Cedar Hills Hospital, "Medical Exclusionary Policy, IP," Revised January 2018, pp 1-3. Appendix 2.

discharge or transition to outpatient programs.[82] This includes active evaluation of the clinical effectiveness of care provided, treatment recommendations and recommendations for transition to less restrictive programs, such as partial hospitalization, intensive outpatient programs or outpatient programs.[83]

In addition, WVBH will undertake discharge planning virtually the day the patient is admitted.[84] It will utilize Discharge Planning Policies[85] that will detail the planning required for patients to reach goals reflecting the highest level of functioning the patient is expected to achieve during their episode of care, as determined by clinicians, balanced by the least restrictive setting possible. This will be utilized for both for inpatients and outpatients from the date of admission forward. This optimizes patient access and quality of care. It also optimizes efficient, effective resource utilization.

(1) Triage criteria and mechanisms, including documentation that such criteria and mechanisms will be consistent with the level of placement criteria developed by the Office of Health Policy and insurers under ORS 743.556(16)(b);

The policies and procedures of Cedar Hills Hospital describe Cedar Hills' conformance to applicable statutes regarding appropriate screening and intake, initial assessment and evaluation, treatment, and discharge.

It should also be noted that Cedar Hills has transfer policies and ancillary service agreements with Providence St. Vincent Hospital (ED transfer agreement and evacuation agreement); Metro West (ambulance transport agreement); Diagnostic Laboratories (x-ray, ultrasound and EKG imaging); Pathology Associates Medical Laboratories LLC (clinical lab specimens); and Northwest Secure transport (secure transport of patients). WVBH would develop the same type of agreements with the same or similar providers.

Cedar Hills Hospital accepts referrals from the professional community, including emergency departments, physicians, courts, community agencies, education systems, psychologists and counselors, as well as by self, or significant others. This is also discussed above. Intake screening and evaluations are performed by qualified assessment counselors or by a member of the clinical supervisory staff, social services staff, registered nurse or active member of the Medical Staff, 24 hours a day, 7 days a week.

If admission criteria are not met or if Cedar hills does not offer a program to meet the patient's needs, recommendations will be made for assistance available elsewhere in the community.[86]

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[82] Cedar Hills Hospital, "Clinical Services Plan, IP," revised 2017. Discharge planning begins the first day of admission. Page 10. Appendix 3. Please also see Cedar Hills Policy and Procedure, "Step Down Process, IP to OP." Appendix 3. WVBH's policies will follow the same form and include the same content.
[83] Please see Cedar Hills Hospital, "Clinical Services Plan, OP," p. 3 for a description of these levels of care. Appendix 3.
[84] Cedar Hills Hospital, "Clinical Services Plan, IP," revised 2017. Discharge planning begins the first day of admission. Page 10.Appendix 3.
[85] See Appendix 5 for Cedar Hills Hospital's discharge policies.
[86] Cedar Hills Hospital, "Admission IP Divert Status." Appendix 2.

Further, all patient care is coordinated internally and externally. Internal care coordination occurs via on-going treatment review within the multidisciplinary team as well as via concurrent review by utilization management staff and patient care performance monitors. With external providers, care is coordinated at the time of admission, during treatment, and at discharge. The Medical Director and Medical Staff continuously evaluate care delivery, lengths-of-stay and medical record documentation.[87] All patient admissions at Cedar Hills include a complete medical history, a general physical examination and a neurological assessment, which are provided by qualified physicians on the Medical Staff. When necessary, consulting medical specialists are requested to provide medical care to inpatients. Emergency psychiatric and medical services are provided 24 hours a day for inpatients. Cedar Hills also has a written transfer agreement with Providence St. Vincent Hospital for any patients needing care for urgent medical conditions that cannot be treated by Cedar Hills' Medical staff. Cedar Hills has all other necessary transfer protocols in place for needed triage.[88] WVBH will follow the same care and triage protocols.

In summary, Cedar Hills' Admission, Clinical Services Plan, Utilization Management and Discharge policies, discussed above, demonstrate Cedar Hills meets this criterion; WVBH will follow the same policies and procedures. Our focus is always on care delivery to allow patients to reach goals reflecting the highest level of functioning she or he is expected to achieve during the episode of care, as determined by clinicians, and balanced by the least restrictive setting possible.

In addition, as mentioned previously, WVBH will apply for Joint Commission accreditation as well as CMS accreditation.

(2) Data and record systems;

WVBH will utilize similar electronic data and records information systems used at Cedar Hills, upgraded, as needed, for technological improvements. Specific electronic medical record ("EMR") criteria and resource requirements will be determined during construction.

(3) Length of stay related to treatment goals, and averaging no more than 15 days for treatment of adults;

Please see above discussion. WVBH's utilization projections assume an average length of stay of 10.6 days, the same as Cedar Hills' YTD 2019 LOS of 10.6 days.

(4) Non-maintenance, high-level treatment goals beyond mere restoration to the level just permitting release;

This has been discussed above. Cedar Hills' Admission, Clinical Services Plan, Utilization Management and Discharge policies, discussed above, demonstrate that our focus is always for care delivery to allow patients to reach goals reflecting the highest level of expected functioning,

[87] Please see Cedar Hills Hospital, "Clinical Services Plan, IP" and "Clinical Care Plan, OP," Appendix 3, for details on the coordination of care.
[88] Cedar Hills Hospital, "Clinical Services Plan, IP." Appendix 3.

as determined by clinicians, and balanced by the least restrictive setting possible. WVBH will follow the same policies and procedures.

(5) Low recidivism; compare to data available;

This is not applicable. WVBH is a new hospital. It should be noted that over 2018, on average, Cedar Hills Hospital had 1.92% of its inpatient admissions readmitted within seven days and 6.25% of its inpatient admissions readmitted within 30 days following discharge. In terms of outpatient visits, over 2018, on average, 7.2% of Cedar Hills' outpatients were "readmitted" within 30 days. We fully anticipate WVBH would experience similar percentages, given it would follow the same policies and procedures and clinical protocols.

(6) Rates which reflect low capital and operating costs and a justifiable rate of return; and

This has been discussed above.

(7) Rapid access to quality general and multispecialty medical inpatient care.

Cedar Hills has patient transfer policies with Providence St. Vincent Hospital (ED transfer Agreement and evacuation agreement). It also transfers inpatients to other acute providers, as required for patient care exceeding its scope of practice, such as inpatients requiring acute medical care. Cedar Hills has an ambulance transport agreement with Metro West for such inpatient transfers. WVBH would develop the same type of agreements with the same or similar providers.

Appendix 1.

Universal Health Services' List of Facilities

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
	Acute Care Facilities	
1	Aiken Regional Medical Centers	302 University Parkway Aiken, SC 29801
2	Auburn Regional Medical Center	202 North Division St. Auburn, WA 98001
3	Centennial Hills Hospital Medical Center	6900 North Durango Dr. Las Vegas, NV 89149-4409
4	Corona Regional Medical Center	800 S. Main St. Corona, CA 92882
5	Desert Springs Hospital Medical Center	2075 E. Flamingo Rd. Las Vegas, NV 89119
6	Doctors Hospital of Laredo *Hospital is Co-Owned with Physician Investors*	10700 McPherson Rd Laredo, TX 78045
7	Fort Duncan Regional Medical Center	3333 N. Foster Maldonado Blvd. Eagle Pass, TX 78852
8	Inland Valley Medical Center	36485 Inland Valley Drive Wildomar, CA 92595
9	Lakewood Ranch Medical Center	8330 Lakewood Ranch Blvd Lakewood Ranch, FL 34202
10	Manatee Memorial Hospital	206 Second Street East Bradenton, FL 34208
11	Northern Nevada Medical Center	2375 E. Prater Way Sparks, NV 89434
12	Northwest Texas Healthcare System	1501 S. Coulter Amarillo, TX 79106
13	Palmdale Regional Medical Center	38600 Medical Center Drive Palmdale, CA 93551
14	Rancho Springs Medical Center	25500 Medical Center Dr. Murrieta, CA 92562
15	South Texas Health System	1400 W. Trenton Edinburg, TX 78539
16	Spring Valley Hospital Medical Center	5400 S. Rainbow Blvd Las Vegas, NV 89118
17	St. Mary's Regional Medical Center	305 South 5th Enid, OK 73701
18	Summerlin Hospital Medical Center	657 Town Center Drive Las Vegas, NV 89144

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
19	Temecula Valley Hospital	31700 Temecula Parkway Temecula, CA 92592
20	Texoma Medical Center	5016 South US Highway 75 Denison, TX 75020
21	The George Washington University Hospital	900 23rd St., NW Washington, DC 20037
22	Valley Hospital Medical Center	620 Shadow Lane Las Vegas, NV 89106
23	Wellington Regional Medical Center	10101 Forest Hill Blvd. Wellington, FL 33414
Behavioral Health Facilities		
24	Adolescent Substance Abuse Program *Florida Department of Juvenile Justice*	1015 Mar Walt Drive Building 100 Ft. Walton Beach, FL 32547
25	Alabama Clinical Schools	1221 Alton Drive P.O. Box 100968 Birmingham, AL 35210
26	Alhambra Hospital	4619 N. Rosemead Blvd. Rosemead, CA 91770-1478
27	Alliance Health Center	5000 Highway 39 N Meridian, MS 39301
28	Anchor Hospital	5454 Yorktowne Drive Atlanta, GA 30349
29	Arbour Counseling Services	*Plan, Malden, Woburn, Haverhill, Lawrence, Lowell, Fall River,*
30	Arbour Hospital	49 Robinwood Avenue Boston, MA 02130
31	Arbour Senior Care	100 Ledgewood Place, Suite 202 Rockland, MA 02370
32	Arbour-Fuller Hospital	200 May Street S. Attleboro, MA 02703
33	Arbour-HRI Hospital	227 Babcock Street Brookline, MA 02446
34	Arrowhead Behavioral Health	1725 Timber Line Road Maumee, OH 43537

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
35	Atlantic Shores Hospital	4545 N. Federal Highway Fort Lauderdale, FL 33308
36	Aurora Pavilion Behavioral Health Services	655 Medical Park Drive Aiken, SC 29801
37	Austin Lakes Hospital	1025 East 32nd Street at St. David's Pavilion 2nd & 3rd Floors Austin, TX 78705
38	Austin Oaks Hospital	1407 W Stassney Lane Austin, TX 78745-2947
39	Behavioral Hospital of Bellaire	5314 Dashwood Drive, Suite 200 Houston, TX 77081-4603
40	Belmont Pines	615 Churchill-Hubbard Road Youngstown, OH 44505
41	Benchmark Behavioral Health Systems Psychiatric Hospital	592 W 1350 S Woods Cross, UT 84010
42	Bloomington Meadows Hospital	3600 N. Prow Road Bloomington, IN 47404
43	Boulder Creek Academy	378 Emerson Lane Bonners Ferry, ID 83805
44	Brentwood Behavioral Healthcare of Mississippi	3531 Lakeland Drive Flowood, MS 39232
45	Brentwood Hospital	1006 Highland Avenue Shreveport, LA 71101
46	Bristol Youth Academy *Florida Department of Juvenile Justice*	12422 NW Gordon Truett Revell Rd. Bristol, FL 32321
47	Brooke Glen Behavioral Hospital	7170 Lafayette Avenue Fort Washington, PA 19034
48	Brynn Marr Hospital	192 Village Drive Jacksonville, NC 28546
49	Calvary Addiction Recovery Center	720 East Montebello Ave. Phoenix, AZ 85014
50	Canyon Ridge Hospital	5353 G Street Chino, CA 91710-5249
51	Cedar Grove Treatment Center	1640 Lascassas Highway Murfreesboro, TN 37130
52	Cedar Hills Hospital	10300 SW Eastridge Street Portland, OR 97225

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
53	Cedar Ridge Hospital	6501 NE 50th St Oklahoma City, OK 73141
54	Cedar Ridge Residential Treatment Center Psychiatric Hospital	6501 N.E. 50th Oklahoma City, OK 73141
55	Cedar Springs Behavioral Health Services	2135 Southgate Road Colorado Springs, CO 80906
56	Centennial Peaks Hospital	2255 S. 88th Street Louisville, CO 80027
57	Center For Change	1790 North State Street Orem, UT 84057
58	Central Florida Behavioral Hospital	6601 Central Florida Parkway Orlando, FL 32821
59	Chicago Children's Center for Behavioral Health	Saints Mary and Elizabeth Medical Center 1431 N. Claremont, 3rd Floor Chicago, IL 60622
60	Clarion Psychiatric Center	Two Hospital Drive Clarion, PA 16214
61	Coastal Behavioral Health	633 Stephenson Avenue Savannah, GA 31405
62	Coastal Harbor Treatment Center	1150 Cornell Avenue Savannah, GA 31406
63	Columbus Behavioral Center for Children and Adolescents	2223 Poshard Drive Columbus, IN 47203
64	Compass Intervention Center	7900 Lowrance Road Memphis, TN 38125
65	Copper Hills Youth Center	5899 W. Rivendell Drive West Jordan, UT 84081
66	Cottonwood Treatment Center	1100 West 3300 South South Salt Lake City, UT 84119
67	Crescent Pines Hospital	1000 Eagles Landing Parkway Stockbridge, GA 30281
68	Cumberland Hall Hospital	210 West 17th St. Hopkinsville, KY 42240
69	Cumberland Hospital for Children and Adolescents	9407 Cumberland Road New Kent, VA 23124
70	Cypress Creek Hospital	17750 Cali Drive Houston, TX 77090

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
71	Del Amo Behavioral Health	23700 Camino del Sol Torrance, CA 90505
72	Diamond Grove Center	P.O. Box 848 2311 Highway 15 S Louisville, MS 39339
73	Dover Behavioral Health System	725 Horsepond Rd. Dover, DE 19901
74	Emerald Coast Behavioral Hospital	1940 Harrison Ave. Panama City, FL 32405
75	Fairfax Hospital	10200 NE 132nd St Kirkland, WA 98034
76	Fairmount Behavioral Health System	561 Fairthorne Avenue Philadelphia, PA 19128
77	FHCHS of Puerto Rico	Metro Office Park, 165 Street Lot #1 Valencia BPPR Building 5th Floor Guaynabo, PR 00968
78	Fieldston Preparatory School	2940 Columbia Blvd. Titusville, FL 32780
79	First Home Care – VA	*Several Locations in Portsmouth, Newport News, Painter, Richmond, Alexandria, Roanoke*
80	Forest View Hospital	1055 Medical Park Drive SE Grand Rapids, MI 49546
81	Fort Lauderdale Hospital	1601 E. Las Olas Blvd. Fort Lauderdale, FL 33301
82	Foundations Behavioral Health	833 E. Butler Avenue Doylestown, PA 18901
83	Foundations for Living: Residential Treatment for Youth	1451 Lucas Road Mansfield, OH 44903
84	Fox Run Center for Children and Adolescents	67670 Traco Dr. St. Clairsville, OH 43950
85	Fremont Hospital	39001 Sundale Drive Fremont, CA 94538-2005
86	Friends Hospital	4641 Roosevelt Blvd. Philadelphia, PA 19124
87	Garfield Park Hospital	520 North Ridgeway Avenue Chicago, IL 60624

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
88	Glen Oaks Hospital	301 E. Division Street Greenville, TX 75402
89	Good Samaritan Counseling Center	3230 C Street, 2nd Floor Anchorage, AK 99503
90	Gulf Coast Treatment Center	1015 Mar Walt Drive Fort Walton Beach, FL 32547
91	Gulf Coast Youth Academy *Florida Department of Juvenile Justice*	1015 Mar Walt Drive Fort Walton Beach, FL 32547
92	Hampton Behavioral Health Center	650 Rancocas Road Westampton Twp, NJ 08060
93	Harbor Point Behavioral Health Center	301 Fort Lane Portsmouth, VA 23704
94	Hartgrove Hospital	5730 W. Roosevelt Road Chicago, IL 60644
95	Havenwyck Hospital	1525 University Drive Auburn Hills, MI 48326
96	Heartland Behavioral Health Services	1500 W. Ashland Street Nevada, MO 64772
97	Heritage Oaks Hospital	4250 Auburn Boulevard Sacramento, CA 95481
98	Hermitage Hall	1220 8th Avenue South Nashville, TN 37203
99	Hickory Trail Hospital	2000 N. Old Hickory Trail DeSoto, TX 75115
100	High Point Treatment Center	5960 SW 106th Avenue Cooper City, FL 33328
101	Highlands Behavioral Health System	8565 S. Poplar Way Littleton, CO 80130
102	Hill Crest Behavioral Health Services	6869 5th Avenue S Birmingham, AL 35212-1866
103	Holly Hill Hospital	3019 Falstaff Road Raleigh, NC 27610
104	Horace Mann Academy	555 Solutions Way Rockledge, FL 32955
105	Horizon Health Management	2941 South Lake Vista Drive Lewisville, TX 75067
106	Intermountain Hospital	303 N. Allumbaugh Street Boise, ID 83704

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
107	Kempsville Center for Behavioral Health	860 Kempsville Road Norfolk, VA 23502
108	Keystone Center	2001 Providence Ave. Chester, PA 19013
109	Kingwood Pines Hospital	2001 Ladbrook Drive Kingswood, TX 77339
110	La Amistad Behavioral Health – Adult Program	1600 Dodd Road Winter Park, FL 32792
111	La Amistad Behavioral Health Services	1650 Park Avenue North Maitland, FL 32751
112	Lake Bridge Behavioral Health	3500 Riverside Drive Macon, GA 31210
113	Lakeside Behavioral Health System	2911 Brunswick Road Memphis, TN 38133
114	Laurel Heights Hospital	934 Briarcliff Road, NE Atlanta, GA 30306
115	Laurel Oaks Behavioral Health Center	700 E. Cottonwood Road Dothan, AL 36301-3644
116	Laurel Ridge Treatment Center	17720 Corporate Woods Drive San Antonio, TX 78259
117	Liberty Point Behavioral Healthcare	1110 Montgomery Avenue Staunton, Virginia 24401
118	Lighthouse Care Center of Augusta	3100 Perimeter Parkway Augusta, GA 30909
119	Lighthouse Care Center of Conway	152 Waccamaw Medical Park Drive Conway, SC 29526
120	Lincoln Prairie Behavioral Health Center	5230 S. Sixth Street Springfield, IL 62703
121	Lincoln Trail Behavioral Health System	3909 S. Wilson Road Radcliff, KY 40160
122	Manatee Palms Youth Services	4480 51st Street West Bradenton, FL 34210
123	Mayhill Hospital	2809 S. Mayhill Road Denton, TX 76208
124	McDowell Center for Children	711 US Highway 51, Byp S Dyersburg, TN 38024
125	Meridell Achievement Center	12550 W Hwy 29 Liberty Hill, TX 78642

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
126	Mesilla Valley Hospital	3751 Del Rey Blvd. Las Cruces, NM 88012
127	Michiana Behavioral Health Center	1800 N. Oak Drive Plymouth, IN 46563
128	Midwest Center for Youth and Families	1012 W. Indiana Street PO Box 669 Kouts, IN 46347
129	Millwood Hospital	1011 North Cooper Street Arlington, TX 76011
130	Milton Girls Juvenile Residential Facility *Florida Department of Juvenile Justice*	5770 East Milton Road Milton, FL 32583
131	Mountain Youth Academy	332 Hospital Road Mountain City, TN 37683
132	Natchez Trace Youth Academy	415 Seven Hawks Lane Waverly, TN 37185
133	National Deaf Academy	19650 US Highway 441 Mount Dora, FL 32757
134	Newport News Behavioral Health Center	17579 Warwick Boulevard Newport News, VA 23603
135	North Spring Behavioral Healthcare	42009 Victory Lane Leesburg, VA 20176
136	North Star Hospital—Bragaw Campus	1650 South Bragaw Anchorage, AK 99508
137	North Star Hospital – Debarr Campus	2530 DeBarr Road Anchorage, AK 99508
138	Northwest Academy	PO Box 370 Naples, ID 83847
139	NorthWest Academy	410 East Streamwood Boulevard Streamwood, IL 60107
140	Oak Plains Academy	1751 Oak Plains Road Ashland City, TN 37015
141	Okaloosa Youth Academy *Florida Department of Juvenile Justice*	4455 Straight Line Road Crestview, FL 32539-6720
142	Okaloosa Youth Development Center *Florida Department of Juvenile Justice*	4449 Straight Line Road Crestview, FL 32539-6720

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
143	Old Vineyard Behavioral Health Services	3637 Old Vineyard Road Winston-Salem, NC 27104
144	Palmetto Pee Dee Behavioral Health	601 Gregg Avenue Florence, SC 29501
145	Palmetto Lowcountry Behavioral Health	2777 Speissegger Dr. North Charleston, SC 29405
146	Palmetto Summerville Behavioral Health	225 Midland Parkway Summerville, SC 29485
147	Panamericano Hospital	P.O. Box 1400, State Road #787 Cidra, Puerto Rico
148	Parkwood Behavioral Health System	8135 Goodman Road Olive Branch, MS 38654
149	Peachford Hospital	2151 Peachford Road Atlanta, GA 30338
150	Pembroke Hospital	199 Oak Street Pembroke, MA 02359
151	Pinnacle Point Behavioral HealthCare	11501 Financial Centre Parkway Little Rock, AR 72211-3715
152	Poplar Springs Hospital	350 Poplar Drive Petersburg, VA 23805
153	Prairie St. John's	510 4th Street South Fargo, ND 58103
154	PRIDE Institute	14400 Martin Drive Eden Prairie, MN 55344
155	Professional Probation Services	1770 Indian Trail Road Suite 350 Norcross, GA 30093
156	Provo Canyon Behavioral Hospital	1350 East 750 North Orem, UT 84097
157	Provo Canyon School	4501 North University Ave. Provo, UT 84604
158	Provo Canyon School Sommerset Program	763 North 1650 West Springville, UT 84663
159	Rivendell Behavioral Health Services	1035 Porter Pike Road Bowling Green, KY 42103
160	Rivendell Behavioral Health Services of Arkansas	100 Rivendell Drive Benton, AR 72105
161	River Crest Hospital	1636 Hunters Glen San Angelo, TX 76901

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
162	River Oaks Hospital	1525 River Oaks Road West Harahan, LA 70123
163	River Park Hospital	1230 6th Avenue Huntington, WV 25701
164	River Point Behavioral Health	6300 Beach Blvd. Jacksonville, FL 32216
165	Riverdale Country School	1975 Palm Bay Rd NE Ste 6 & 7 Palm Bay, FL 32907
166	Riveredge Hospital	8311 W. Roosevelt Road Forest Park, IL 60130
167	Rock River Academy	3445 Elmwood Road Rockford, IL 61101-9529
168	Rockford Center	100 Rockford Drive Newark, DE 19713
169	Rolling Hills Hospital	2014 Quail Hollow Circle Franklin, TN 37067
170	Roxbury Treatment Center	601 Roxbury Road Shippensburg, PA 17257
171	Salt Lake Behavioral Health	3802 South 700 East Salt Lake City, UT 84106
172	San Marcos Treatment Center	120 Bert Brown Road San Marcos, TX 78666
173	Sandy Pines Serving Children & Adolescents	11301 S.E. Tequesta Terrace Tequesta, FL 33469
174	Schick Shadel	12101 Ambaum Blvd SW Seattle, WA 98146
175	Shadow Mountain Behavioral Health System	6262 S. Sheridan Road Tulsa, OK 74133
176	Shadow Mountain Riverside	1027 East 66th Place Tulsa, OK 74136
176	Sierra Vista Hospital	8001 Bruceville Road Sacramento, CA 95823
177	South Texas Behavioral Health Center	2102 W. Trenton Rd. Edinburg, TX 78539
178	Spring Mountain Sahara	5460 W. Sahara Avenue Las Vegas, NV 89146
179	Spring Mountain Treatment Center	7000 W. Spring Mountain Road Las Vegas, NV 89117

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
180	Springwoods Behavioral Health	1955 W. Truckers Drive Fayetteville, AR 72704
181	St. Louis Behavioral Medicine Institute	1129 Macklin Ave St. Luois, MO 63110
182	St. Simons By-the-Sea	2927 Demere Road St. Simons, GA 31522
183	Stonington Institute	75 Swantown Hill Road North Stonington, CT 06359
184	Streamwood Hospital	1400 E. Irvin Park Road Streamwood, IL 60107
185	Summit Oaks Hospital	19 Prospect Street Summit, NJ 07902
186	SummitRidge Hospital	250 Scenic Highway Lawrenceville, GA 30046
187	Talbott Recovery	5448 Yorktowne Drive Atlanta, GA 30349
188	Texas Neurorehab Center	1106 W. Dittmar Road Austin, TX 78745
189	The Bridgeway	21 Bridgeway Road North Little Rock, AR 72113
190	The Brook Hospital – DuPont	1405 Browns Lane Louisville, KY 40207
191	The Brook Hospital - KMI	8521 LaGrange Road Louisville, KY 40242
192	The Carolina Center for Behavioral Health	2700 E. Phillips Road Greer, SC 29650
193	The Horsham Clinic	722 Butler Pike Ambler, PA 19002
194	The Hughes Center	1601 Franklin Turnpike Danville, VA 24540
195	The Meadows Hospital Universal Community Behavioral Health	132 The Meadows Drive Centre Hall, PA 16828
196	The Pavilion	1501 S. Coulter Amarillo, TX 79106
197	The Pavilion Behavioral Health System	809 W. Church Street Champaign, IL 61820
198	The Recovery Center	2501 Taylor Street Wichita Falls, TX 76309

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
199	The Ridge Behavioral Health System	3050 Rio Dosa Drive Lexington, KY 40509
200	The Vines Hospital	3130 SW 27th Avenue Ocala, FL 33471
201	Three Rivers Behavioral Health—Main Campus	2900 Sunset Boulevard West Columbia, SC 29169
202	Three Rivers Residential Treatment – Midlands Campus	200 Ermine Road West Columbia, SC 29170
203	Timberlawn Mental Health System	4600 Samuell Blvd. Dallas, TX 75228
204	TMC Behavioral Health Center	2601 Cornerstone Dr. Sherman, TX 75092
205	Turning Point Hospital	3015 Veterans Parkway Moultrie, GA 31788
206	Turning Point Youth Center	101 Townsend Rd. St. Johns, MI 48879
207	Two Rivers Psychiatric Hospital	5121 Raytown Road Kansas City, MO 64133
208	University Behavioral Center	2500 Discovery Drive Orlando, FL 32826
209	University Behavioral Health of Denton	2026 W. University Drive Denton, TX 76201
210	University Behavioral Health of El Paso	1900 Denver Avenue El Paso, TX 79902
211	Upper East Tennessee Regional Juvenile Detention Center	307 Wesley St Johnson City, TN 37601
212	Valle Vista Health System	898 E. Main Street Greenwood, IN 46143
213	Valley Hospital	3550 East Pinchot Ave Phoenix, AZ 85018
214	Virgin Islands Behavioral Services	183 Anna's Hope Christiansted St. Croix, VI 00820
215	Virginia Beach Psychiatric Center	1100 First Colonial Road Virginia Beach, VA 23454
216	Walton Youth Development Center *Florida Department of Juvenile Justice*	286 Gene Hurley Road De Funiak Springs, FL 32435

Universal Health Services
List of Acute Care, Behavioral Health and Ambulatory Care Facilities

Number	Facility Name	Address
217	Wekiva Springs Center	3947 Salisbury Road Jacksonville, FL 32216
218	Wellstone Regional Hospital	2700 Vissing Park Road Jeffersonville, IN 47130
219	West Hills Hospital	1240 E. Ninth Street Reno, NV 89512
220	West Oaks Hospital	6500 Hornwood Houston, TX 77074
221	Westwood Lodge	45 Clapboardtree Street Westwood, MA 02090
222	Willow Springs Center	690 Edison Way Reno, NV 89502
223	Windmoor Healthcare	11300 U.S. 19 North Clearwater, FL 33764
224	Windsor-Laurelwood Center	35900 Euclid Avenue Willoughby, OH 44094
225	Wyoming Behavioral Institute	2521 E. 15th Street Casper, WY 82609
Ambulatory Care Facilities		
226	Northwest Texas Surgery Center *Co-Owned with Physician Investors*	3501 Soncy Rd, Suite 118 Amarillo, Texas 79119
227	Palms Wellington Surgery Center	460 North State Road 7 Royal Palm Beach, FL 33411
228	Temecula Valley Day Surgery	25495 Medical Center Drive, Ste 101 Murrieta, CA 92562

Source: Universal Health Services

Appendix 2.

Cedar Hills Hospital Admissions Policies

Policy and Procedure

Cedar Hills Hospital
Cedar Hills Outpatient Services

Admission Criteria IP

Original Policy Date: 11/8/2008
Revision Date(s):
10/12, 01/14
Last Review Date:
01/2017

Responsible Department: Clinical Services

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

Key Words:

SCOPE

To outline the admission criteria within the Cedar Hills Hospital continuum of care.

POLICY

It is the policy of Cedar Hills Hospital to follow criteria for admission to all programs to ensure that each patient is treated in the least restrictive environment that will allow them to attain an optimal functional level.

PROCEDURE(S)

At least one of the following must be met:

A. Behavior which is life threatening, destructive, or disabling to self or others.
B. Symptoms/behaviors indicative of need for 24 hours monitoring and assessment of the patient's condition.
C. Active psychiatric disorder with potential to interfere with treatment of serious medical condition.
D. Failure at outpatient or partial hospitalization treatment evidenced by clinical instability of a MD consult indicates a condition which precludes safe treatment at a lesser level of care.
E. Condition requires a medically monitored detoxification process.
F. Severe deterioration of level of functioning.

Note: For involuntary patients needing medical treatment or clearance, the following considerations should be noted:

- CHH will notify the county responsible or the patient's custody to inform them of the pending transfer.
- CHH will arrange for transfer of the patient to the nearest medical hospital for treatment and inform them that the patient is under involuntary custody.
- Prior to or at the time of the transfer, CHH will provide copies of any relevant medical records needed for care and treatment of the transferred patient.
- At the time of the transfer, CHH will provide contact information of CHH staff for the purpose of return transfer. This information is recorded on the "Memorandum of Transfer" interagency form.
- CHH will send a staff person to the medical hospital with the patient. This staff person will assist in monitoring the patient for safety while waiting for medical treatment.
- Should the patient be admitted to the receiving medical hospital, CHH staff will notify the county of custody responsibility to inform them of the admission and will complete and submit any legal documentation required to formally transfer care of the patient to the medical hospital.
- CHH will accept involuntary patients back from the medical hospital once they have been medically cleared. CHH will notify the county of custody that the patient has safely returned to the care of CHH.

REFERENCES / CITATIONS

Policy and Procedure

Cedar Hills Hospital
Cedar Hills Outpatient Services

Admission Criteria, OP

Original Policy Date:	11/2008
Revision Date(s):	10/2012, 1/2013
Last Review Date:	2/21/17
Responsible Department:	Outpatient
Policy Approvals:	PI Committee Medical Executive Committee Governing Board
Key Words:	Admit, Outpatient, Level of Care

SCOPE
To outline the admission criteria within the Cedar Hills Outpatient Services continuum of care.

POLICY
It is the policy of Cedar Hills Outpatient Services to follow criteria for admission, continued stay, and discharge to all programs to ensure that each patient is treated in the least restrictive environment that will allow them to attain an optimal functional level.

PROCEDURE(S)

Partial Hospitalization
The patient is not an imminent danger to self or others and is able to remain free of life-threatening psychiatric symptoms outside of a 24-hour, supervised or acute inpatient setting, and one or more of the following:

A. Symptoms/behaviors manifestations of such severity that there is interference with social, family, vocational function.
B. Symptoms/behaviors indicative of need for increased intensity and frequency of services or requires multi-modal psychotherapeutic interventions.
C. For those patients no longer requiring 24-hours acute care but are not capable of assuming responsibility for their lives. Without partial hospitalization there would be an exacerbation of symptoms.
D. Failure of treatment at lesser level of care (i.e., unmanageable in outpatient treatment requiring protected observation and coordination of therapeutic resources of an active partial program).
E. Demonstration of alcohol/drug use resulting in impairment of functioning.
F. Moderate deterioration of usual level of functioning.

Intensive Outpatient
The patient is not an imminent danger to self or others and is able to remain free of life threatening psychiatric symptoms outside of a 24-hour, supervised or acute inpatient setting, and one or more of the following.

A. Symptoms/behaviors require multi-modal psychotherapeutic intervention.
B. Presents minimal risk of severe withdrawal symptoms.
C. Medical conditions/complications do not distract from treatment and are manageable on an outpatient basis.
D. Mild to moderate emotional/behavioral disturbances which have the potential of disrupting recovery at a less intensive level of care.
E. Resistance to treatment requires a structured program to support sobriety.
F. High likelihood of relapse or continued use without close monitoring and support.
G. Coping skills sufficient to maintain sobriety in spite of social support which may be unsupportive of recovery.

Outpatient
At least one or more of the following must be met:

A. Impaired to the degree that there are mild manifestations of disability in interpersonal and/or occupational functioning.
B. Failure of other treatment programs, aftercare, support groups, etc.
C. Increase in alcohol/drug use.
D. Minimal deterioration of usual level of functioning.

Criteria that may prevent admission to outpatient services include:

- Active Homicidal Ideation
- Active Suicidal Ideation or refusal to contract
- Severe un-stabilized behavior that presents a danger to others
- Withdrawal symptoms that require inpatient stabilization
- Medical conditions that are beyond the ability of the program to provide care (including but not limited to IV's indwelling catheters, central lines etc.
- Intellectual functioning that is too low to benefit from the programming.
    - (including but not limited to IQ less than 70, and Pervasive Developmental disorder)
- Physical disability beyond the ability of the program to care for (including paraplegia,
    - inability to feed self or care basic ADL's without minimal assistance)

REFERENCES / CITATIONS

Policy and Procedure

Cedar Hills Hospital
Cedar Hills Outpatient Services

Admission Guidelines	Original Policy Date: 11/2008 Revision Date(s): Last Review Date: 01/2017 Responsible Department: Administration/Intake Policy Approvals: PI Committee Medical Executive Committee Governing Board Key Words:

SCOPE

POLICY

Cedar Hills Hospital / Cedar Hills Outpatient Services (aka *Cedar Hills)* will comply with all regulatory standards related to the admission of patients to a psychiatric hospital.

PROCEDURE(S)

1. Patients must meet the hospital admission criteria that are applied uniformly to all prospective patients.
2. Patients must be screened to prevent the admission of a prospective patient who requires specialized care not available at the hospital or one who has a physical medical condition that is unstable which might reasonably be expected to require inpatient for the condition.
3. Patient may be screened for admission by a Qualified Mental Health Professional (physician, physician assistant, registered nurse, licensed psychologist, psychological associate, licensed master social worker, licensed social worker, licensed professional counselor or licensed marriage and family therapist), or person meeting Qualified Mental Health Professional with Master Degree in Psychology, Social Work or other related field.. If the QMHP determined that the prospective patient needs an admission examination, a physician must conduct this examination.

4. The patient must have the capacity to consent for treatment as determined by the physician or civil commitment proceedings must be initiated in accordance with Oregon Administrative Rules (OAR).
5. The request for admission must be in writing and signed by the individual making the request
6. The patient must be informed of the person's rights as a voluntary patient prior to admission.
7. The administrator or administrative designee must sign a written statement agreeing to admit the prospective patient.

REFERENCES / CITATIONS

Policy and Procedure

Cedar Hills Hospital
Cedar Hills Outpatient Services

Admission IP Divert Status

Original Policy Date: 4/2019
Revision Date(s):
2/2017
Last Review Date:

Responsible Department: Admission IP

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

Key Words:

SCOPE

POLICY

Cedar Hills Hospital in keeping with its continuous and ongoing focus on patient and staff safety will provide a direct care RN with the ability to initiate a process for evaluating the need to limit admissions which could include the decision by the CEO or AOC to divert potential patients to another facility.

PROCEDURE(S)

1. If in the judgment of the direct care RN responsible for an inpatient unit there is an inability to meet patient care needs, or risk of harm to existing or new patients, that RN will inform the Nursing Supervisor to assure immediate response to the unit.

2. The Nursing Supervisor will respond directly to the unit to address the concern, call additional staff to the unit and confer with the direct care RN to assist with the immediate concern for safety.

3. The RN Supervisor will then call the CEO and DON to review the status of staffing, acuity, and potential admissions.

4. Based on the information provided the CEO will determine the need to place the Assessment Center on divert status and contact the staff of the assessment.

5. The Nursing Supervisor / DON will continue to communicate with the RN who raised the concern to assure that this nurse now feels that he/she, the patients and the environment are safe. Information will also be provided on the CEO's decision.

6. The Nursing Supervisor and DON will continue to closely monitor the staffing and acuity to make the needed staffing adjustments.

7. Any request to place the facility on divert will be reviewed by the Leadership Team on the next business day.

A. Review will focus on identifying causes.
B. Actions taken as a result of the request.
C. RN's perception of the actions related to safety.
D. Plans to prevent a reoccurrence.
E. Documented review will be forwarded to the Nurse Staff Committee, the P.I. and Medical Executive Committee for review or further action.

REFERENCES / CITATIONS

Admission Process IP

Original Policy Date: 11/2008
Revision Date(s):01/13, 01/15, 10/18, 12/4/18
Last Review Date: 12/4/18

Responsible Department: Administration/Intake

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

Key Words:

SCOPE

The overall goal is to admit a patient, who is either voluntary or involuntary, in the most expeditious manner, ensuring that the patient's rights are protected and that the patient is treated with respect and dignity.

POLICY

It is the policy of Cedar Hills Hospital to provide guidelines for the admission process.

PROCEDURE(S)

Patients will arrive three (3) possible ways; transfers from Emergency Departments, scheduled appointments and walk-ins. Prior to the arrival of transferring patients and scheduled appointments, the Assessment Center staff will identify preliminary precautions for high risk symptoms. These preliminary precautions will be placed on the appointment board in the Assessment Center. When the patient arrives at this facility, these precautions will be marked on the Patient Observation Rounds form for 15 minute observation rounds. During any point in the assessment process, Assessment Center staff should evaluate patient risks and consider additional preliminary precautions as well as increased observation levels based on clinical presentation and any new information presented.

I. Voluntary Patients:

1. When the patient presents to the hospital lobby they are greeted by the receptionist who then contacts the Assessment Center staff. The Assessment Center staff escort the patient to the secured assessment hallway. The receptionist will provide the patient with screening paperwork which includes: demographic information, patient privacy rights, consents for assessment and release of information, and a patient medical history form to be completed in the assessment room, not in the lobby area.
2. Once back in the secured assessment area, vital signs are taken and the patient is assigned to an assessment room. If a room is unavailable, patients will wait in assessment waiting area room (assessment room #2) until a room is available. When patient is placed in the room, an assessment staff member will wand the patient, and their belongings will be locked in storage cabinets in the room.
3. A Medical Screen is completed by a nurse shortly after arrival, and -- if stable -- the patient is then assessed by the Assessment Center clinician. If the patient is not medically stable, arrangements are made to transfer patient to a nearby emergency room for medical clearance.
4. Clinician assesses patient and determines appropriate level of care:
    a. Inpatient
    b. Partial Hospitalization Program
    c. Intensive Outpatient Program
    d. Makes a referral for outpatient care.
5. Following the assessment, the clinician will make a recommendation to the patient based on the findings of the assessment. If the patient chooses to follow the recommendation and admit to one of Cedar Hills Hospital's programs, the clinician will:
    a. Contact the on call provider. If the provider agrees with the assessment, orders are given to the nursing staff for admission and care.
    b. For Cedar Hills Hospital's outpatient programs admissions and for outpatient referrals, the clinician will provide the patient basic information regarding location, hours, care, treatment and services.
    c. For Cedar Hills Hospital inpatient admissions, the nurse and clinician will assist patient with the admission process (contraband search, belongings inventory, completion of consent /administrative/financial paperwork).
    d. The Assessment Center Nurse gives report to the unit nurse.
    e. Patient is escorted to the nursing unit and a handoff occurs to the unit nursing staff with the Visual Cue Sheet.

II. Involuntary Patients

1. Patient is brought by secure transportation, transferred from another hospital or facility, or placed on a psychiatric hold upon assessment at CHH. For all involuntary transferred patients, Assessment Center staff must obtain documentation from the transferring facility showing that the NMI hold has been transferred to CHH. If the documentation cannot be obtained, AC staff contact the on-call medical staff to place the patient on a NMI hold at CHH.

2. Upon arrival at the facility, patient is met at the lobby and escorted to an assessment room in the secured assessment area behind two locked doors. If escorted by police, ambulance or secured transport, the escorting personnel should accompany the patient to the secured area before releasing them from handcuffs, gurney, etc. If all secured assessment rooms behind two locked doors are occupied, the contingency plan is to place the patient in the hallway chair in the secured assessment area, while the most appropriate patient is expedited to the unit, clearing a room for the arriving patient. When patient is placed in the room, a staff member will then wand the patient and the patients' belongings are locked in storage cabinets in the room.
3. Patients who arrive as transfers that are combative and/or displaying violence may be admitted directly to the Crisis Stabilization Unit through one of the designated admitting areas on the unit. This is approved by the House Supervisor on duty, in collaboration with the Assessment Center Staff. The CSU unit provides treatment for our most acute and high risk patients. The North and South units serve as overflow units for the CSU designated admissions. When the North or South units admit a patient who requires Crisis stabilization level of care, additional resources are allocated to ensure patient safety.
4. Whether a direct admission from another hospital or admission through the CHH assessment center, Staff accept the patient and sign any necessary paperwork for the transporting personnel. Secure transport is escorted out of the secured area. If a patient is waiting in the secured assessment hallway for a secure assessment room, assessment center staff must stay with them until they can be placed in an assessment room.
5. 'Alert' status signage is posted on the doors into the secure hallway to the appropriate level to match the acuity level of patients in the secured assessment area.
6. Patient is informed of patient rights and a copy of the Patient Rights given. A signed copy of the patient rights is placed in the patient's chart.
7. Patient is informed that anything he/she says or does in front of a mental health professional may be used in proceedings for further detention.
8. Patient safety observations which include precautions are conducted from time of patient arrival at the hospital and documented every 15 minutes via direct staff observation.
9. Vital signs are completed; if the vital signs are unstable, arrangements are made to transfer patient to an area emergency room for medical clearance.
10. If the patient is determined to be medically stable, a significant portion of the admission process for involuntary patients may occur on the unit rather than in the Assessment Center. To reduce the amount of time involuntary patients are held in the assessment area, Assessment Center staff will perform only those actions required to get the patient safely admitted (skin check / legal consents / admit order, Visual Cue Sheet) in the Assessment Center, other admission processes can be completed on the admission unit. Assessments and other tasks will be completed within 24 hours or per regulatory mandates.
11. The Assessment Center Nurse gives report to the unit nurse.
12. If patient is admitted under involuntarily custody put in place by physician at Cedar Hills Hospital, the physician (or designee) will file the Notification of Mental Illness (NMI) with the appropriate county jurisdiction.

III. Triage Process

Patients presenting for assessment will be triaged to determine the need for an urgent or non-urgent screening. A brief medical screen that includes the individual's legal status, their immediate presenting problem, presenting mental state, and any immediate medical needs is completed.
This brief screening is to determine a triage level of urgent or non-urgent. It is not based on appointment times of patients. If two or more patients present at the same time this brief screen will help determine the needs of the patient and the urgency of risk. The following guidelines are to assist in the determination of triage level based on level of risk.

LEVEL 1: Immediate defined as medically unstable, required immediate medical care or interventions including and up to transportation to a medical hospital via ambulance for life saving measure. Acute medical problems that are beyond the capabilities or capacity of Cedar Hills Hospital are transferred to a medical hospital.

LEVEL 2: Defined as psychiatrically unstable transfer patients from local EDs that are on an involuntary status. These patients are pre-assessed as a danger to themselves or others and determined as high risk for safety. This assessment includes collateral information from the ED and patient.

LEVEL 3: This level includes voluntary transfer patients who have been Pre-determine to be in crisis and prescreened patients who have been instructed to come in immediately for an assessment and/or walk in patients that are in crisis. These patients are actively suicidal with a plan, present as impulsive and/or appear very disorganized or delusional and are at risk to harm themselves or others.

LEVEL 4: These are patients that have been screen through a phone call and have set up an appointment. They may not be in immediate medical or safety crisis. These could also be walk-in patients that are in need of a non-urgent assessment.

At any time a patient may go from non-urgent to urgent level if their medical and mental status change.

REFERENCES / CITATIONS

Policy and Procedure

Cedar Hills Hospital
Cedar Hills Outpatient Services

Admission Process, OP

Original Policy Date:	9/23/14
Revision Date(s):	2/20/17
Last Review Date:	
Responsible Department:	Outpatient
Policy Approvals:	PI Committee Medical Executive Committee Governing Board
Key Words:	Outpatient, Admission

SCOPE
To provide guidelines for admitting criteria in the outpatient department.

POLICY
All patients admitted to Cedar Hills Outpatient Services will receive a full psychosocial assessment by a Qualified Mental Health Professional (QMHP). Admissions to the outpatient services program at any level of care – Partial Hospitalization Program (PHP) or Intensive Outpatient Program (IOP) – can be made in one of three means: as a result of step-down from Cedar Hills Hospital's (CHH) inpatient programs, as a direct admission via CHH's inpatient assessment center, or as a direct admission via the outpatient Admissions Department.

PROCEDURE(S)
1. Initial Intake Call
    a. Initial Intake is the process of determining the treatment needs of a patient and coordinating a referral to proper programming within Outpatient Services. An Inquiry Call Sheet is completed by the staff member responding to the phone call and the caller information and call disposition is entered into an electronic log on MS4 for follow up as needed (i.e. to reference admission information or other tracking purposes, such as the patient not showing up for a scheduled appointment).
        i. The information obtained on the Inquiry Call Sheet includes:
            1. Patient demographics
            2. Presenting problem(s)
            3. High Risk Factors
            4. Medical Status
            5. Guarantor/Legal Guardian information
            6. Primary Insurance Information

7. Secondary Insurance Information
8. Emergency Contact
9. Previous Hospitalizations
10. Referral source

2. Direct Admission to Cedar Hills Outpatient Services
    a. Designated Staff answering an initial call for intake will complete an Inquiry Call Sheet and add the call to MS4 with information obtained on the form.
    b. Consult the Outpatient (OP) shared Outpatient Assessment Board for an open appointment time/day with the caller while on the phone.
        i. Provide the caller with the address for the OP location and directions as needed:

            Cedar Hills Outpatient Services
            1815 SW Marlow Ave, Suite 218, Portland OR 97225
            Phone: 971-228-8000

        ii. Review the cancellation and missed appointment policy with the caller
            1. (see separate policy: Cancellation and Missed Appointment Policy)
    c. Designated staff (e.g. Assessment Counselor, reception staff, etc) will enter the call into MS4 and complete the Verification of Benefits (VOB) prior to the patient arriving for the scheduled appointment
    d. The receptionist will place the first reminder call of the initial appointment to the potential client. The assessment counselor will place follow up calls for "no-shows" to the scheduled appointment or following assessment.
    e. Day of Assessment for Direct Admissions:
        1. Front end/support staff (i.e. reception, techs, program lead, admissions coordinator, etc.) will:
            a. review orientation packet if not already done with front end staff
            b. provide patient handbook and schedules
            c. complete financial paperwork with patient prior to patient leaving for the day
            d. arrange for payment of copays/deductibles/etc.
        2. An RN and QMHP, or other designated staff (i.e. Assessment Counselor) documents initial assessment information on the Clinical Assessment. This information will include:
            a. Chief complaint/precipitating event emphasizing events that may have occurred over the past 24-72 hours resulting in need for assessment
            b. Visual cue sheet (if appropriate) to alert the treatment team to special precautions (eg. Self injury risk, etc)
            c. Psychosocial history including but not limited to: review of major life areas, suicidal/homicidal thoughts/gestures, previous treatment and outcome, current and past substance use and/or abuse
            d. Mental status exam
            e. Risk assessment
            f. DSM Diagnoses
            g. Level of care and treatment program recommendations
            h. Initial treatment plan

i. Master Treatment Plan Part I
j. Medical History
    i. Nurse will secure H&P that was done within 30 days from admission to OP
    ii. If there is no H&P available, the OP nurse does one of two things:
        1. Secures an ROI and contacts community provider to obtain the H&P
        2. Gives referrals to patient to obtain an H&P and document the attempt
k. Nursing assessment: completed within the first two days of admission by a Registered Nurse. This includes:
    i. Health history
    ii. Current medications
    iii. Hospitalizations and surgeries
    iv. Fall assessment

3. A Psychiatrist will complete admit orders (within 24 hours from the first official start day of treatment) if the patient is PHP level of care or a Medicare patient respectively
4. OP Nurse will contact MD on call to receive admission orders via phone if no MD on site at time of admission
5. For those patients with Medicare or who are admitted to the PHP level of programming, a psychiatric evaluation will be completed within 2 treatment days from date of admission. For patients admitted to an IOP level of care they will have a psychiatric evaluation completed if it is identified that the patient is seeking medication management from our on-site providers and/or needs a medication consult pending recommendation from an CHOS clinical staff member. The evaluation will include:
    - Identifying data (name, age, race, religion, occupation, etc)
    - Behavior and attitude
    - Chief complaint
    - Justification for admission
    - History of present illness (onset and course)
    - Past history of psychiatric problems
    - History of treatment (inpatient and outpatient)
    - Past medical history
    - Family relationships
    - Legal and substance abuse history
    - Developmental history
    - Psycho-social history
    - Mental status exam
    - Strengths and assets
    - Diagnostic impression
    - Initial treatment plan
    - Estimated length of stay
    - Discharge criteria
6. Program lead:

a. Completes the admission in MS4 for appropriate OP Service. Support staff (i.e. reception, techs, etc.) make initial contact to the referent. Information provided to the referent includes the disposition of their referral, the name of the therapist assigned and the contact number, within 24 hours from when the assessment was completed.

7. Assessment Counselor:
    a. Conducts Pre-Authorization as needed and enters notes into Midas
    b. Creates a red folder with the following documents for the UR staff/BO Director and CHOS Admissions Department collateral file for use such as :to complete ongoing treatment authorizations and insurance verifications for the duration of the patient's enrollment in outpatient services, gather admission data, and maintain record of non-admits respectively:
        i. Copy of the face sheet
        ii. Copy of the insurance and ID cards
        iii. Financial agreement
        iv. VOB
    c. Individuals must attend a first treatment day within 5 days from the completed intake assessment otherwise an assessment update will need to be completed; front end staff signs treatment consents with the patient on day one
8. Other remaining clinical documentation to be completed by a Master's Level Clinician, or appropriate designee (by day 3 of attendance)
    a. Substance Abuse Assessment
        i. This assessment is completed with each patient who has identified problems with substance abuse and utilizes ASAM criteria evaluation including: information regarding person drug history, usage, support for using drugs or alcohol, family history of substance abuse, problems resulting from use, periods of sobriety, legal problems, patient's personal view of problems with using drugs and/or alcohol, etc.
    b. Master Treatment Plan (MTP Part II)
9. Primary clinician follows up with current providers to secure collateral information no later than the 3rd day from admission.

3. Direct Admissions to Outpatient Services requiring a higher level of care
    a. Outpatient Admissions Staff determining that the individual participating in the intake requires a higher level of care (eg. Inpatient hospitalization) will take the following steps to ensure proper transition:
        i. Notify the Care Center of the need for a bed
        ii. Complete the full intake process
        iii. Secure VOB for IP admission

iv. Forward all intake documentation including clinical assessment, risk assessment, medication list and VOB information to the Care Center staff
v. Admissions coordinator for CHOS will secure insurance authorizations needed and forward information to the Care Center Staff
vi. Arrange for safe transport from Cedar Hills Outpatient Services to Cedar Hills Hospital
vii. In the event that CHH is at capacity then the nearest hospital (eg. Providence St. Vincent's) will be called by the OP Admissions Coordinator to determine bed availability. A nurse to nurse will occur as needed and all of the other steps above will be followed
viii. Admissions coordinator in CHOS will update the call/notes in MS4 to reflect the need for higher level of care

4. Walk-Ins for Outpatient Admission
    i. Admission staff will do the following at their earliest appointment time available:
        1. complete an Inquiry Call Sheet with the walk-in
        2. conduct full clinical assessment
        3. secure VOB and complete financial counseling with the patient
        4. schedule for first full day/evening of outpatient groups OR admit to Inpatient Level of care as needed
    ii. If there are no available appointments, walk-ins will be scheduled for the next earliest appointment on the following day.
5. No-Show Direct Admits
    a. Admissions Coordinator will call and follow up same day with any patient who did not show for their scheduled intake appointment
        i. New appointment will be rescheduled as appropriate OR patient will be referred to higher level of care, be given other resources or welfare check performed (pending the outcome of the call following the No Show)
        ii. Update will be placed on notes in MS4
        iii. Referring professional will be notified of the No Show
        iv. Maximum of 3 calls will be placed to No Shows
6. Step-down to Cedar Hills Outpatient Services
    a. Patients who are discharged from Cedar Hills Hospital inpatient may continue treatment in the outpatient setting at a PHP or IOP level which is determined by their discharge plans while in inpatient.
    b. The CHOS Admissions Coordinator, or other designee (eg. Program Manager, Director) will screen current IP patients ready for discharge for appropriateness for ongoing CHOS services; daily communication on the part of the IP social service team and the CHOS Admissions Team regarding discharging patients is the catalyst for the CHOS Admissions Team to begin the screening process.
    c. Master's level therapist, or other appropriate designee will meet with the patient to complete clinical documentation within 3 treatment days of the patient enrolling in outpatient services. Documentation includes:
        i. Updated Clinical Formulation
        ii. Substance Abuse assessment with ASAM criteria (if patient has a diagnosis ofsubstance abuse/dependence)
        iii. Primary Treatment Plan

iv. Risk assessment- as a patient stepping down from inpatient level of care (aka Higher Risk Patient), this document will be completed in its entirety as an "update" of risk potential, with the patient being assessed by a clinical staff member prior to leaving treatment on their first outpatient day

d. If the patient is a PHP or Medicare patient, they will be seen by a provider for an updated psychiatric evaluation within 2 treatment days. Ongoing weekly or monthly follow up for medication management will occur as needed until the patient discharges from outpatient programming to an outside provider.

REFERENCES / CITATIONS

Policy and Procedure

Cedar Hills Hospital
Cedar Hills Outpatient Services

Original Policy Date:	11/29/08
Revision Date(s):	2/14/17
Last Review Date:	2/14/17

Responsible Department: Admission

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

Key Words: Declaration

Declaration for Mental Health Treatment

SCOPE

To establish a policy and procedure which ensures that every person who may become incapacitated by mental illness and unable to consent to treatment is educated about the Declaration for Mental Health Treatment at the time of admission to the hospital (OAR 309-033-0220 (3).

POLICY

It is the policy of Cedar Hills Hospital / Cedar Hills Outpatient Services (aka *Cedar Hills)* to educate person's who may become incapacitated by mental illness about the Declaration for Mental Health Treatment.

PROCEDURE(S)

1. Each person who is admitted to *Cedar Hills* to any level of care will be provided information regarding the Declaration for Mental Health Treatment (Advance Directives for Mental Health Treatment).
2. The individual will be asked to complete the 'Advance Directive / Healthcare Proxy Acknowledgment' form and indicate if they have an Advance Directive for Mental Health. Each person will be provided the 'Guide to Declaration for Mental Health Treatment' handout, updated January, 2002.
3. The assessing staff person will review the 'Advance Directive / Healthcare Proxy Acknowledgement' form with the individual to ensure that it was completed and determine if the person has any questions.

4. If the individual indicates that they do not have advance directions for mental health but are interested in executing an advance directive, the staff person will assist the individual with the guide's instructions in executing an advance directive for mental health.
5. The signed 'Advance Directive / Healthcare Proxy Acknowledgement' form is placed in the person's medical record; a copy of the declaration will be provided to the individual.

REFERENCES / CITATIONS

OAR 309-033-0220 (3).

Original Policy Date:	11/2008
Revision Date(s):	07/2012; 05/2015; 01/2017
Last Review Date:	01/23/2017
Responsible Department:	Clinical Services
Policy Approvals:	PI Committee Medical Executive Committee Governing Board
Key Words:	Notice of Mental Illness; NMI; Hold; Involuntary; Admissions

Involuntary Admissions, IP

SCOPE
Inpatient admissions

POLICY
It is the policy of Cedar Hills Hospital to involuntarily admit patients for care and treatment consistent with the requirements of the OAR Involuntary Commitment Procedure, and establish guidelines and procedures for the involuntary admission of individuals consistent with the Oregon Administrator Rules, Department of Human Services, Addiction and Mental Health Division; Mental Health, Division 33, 309-033-0200 through 0970.

PROCEDURE(S)
When a physician with hospital privileges states a person is in imminent danger to themselves of others and in need of emergency care, they may do the following:

A. After consulting with another physician or Qualified Mental Health Professional (QMHP), the physician may detain the person and admit them to Cedar Hills Hospital. If the person is already admitted, the physician may cause the person to be retained at the hospital for a period of no greater than five (5) judicial days (see "Involuntary/NMI Hold IP" policy).

B. If a person is placed on an NMI hold, the physician, nurse or QMHP must give the following warning: "You are being held in this hospital because someone is concerned that you may hurt yourself or someone else. Anything the staff of this hospital observes you do or say while you are in custody here may be used as evidence in a court of law to determine whether you should be committed as a mentally ill person. You have a right to legal counsel. If you cannot afford an attorney, one will be provided for you by the court." The warning is given at the time of admission, given a time when it is determined that the person will reasonably understand the notice, and given as often as it is determined necessary to assure that the person has been had an opportunity to be aware of the notice. This notice will be provided in writing to the person and an attempt shall be made to have the person sign the written warning. A copy will be given to the person and the original shall be kept in the clinical record. The person's inability to sign the warning or refusal to sign the warning shall be documented on the written form below where the person's signature would be normally found. Documentation should clearly state the reasons the signature was not obtained. The written warning shall also include a place where the person, by making a mark, may request legal counsel.

C. Follow CHH's "Involuntary-NMI Admissions' policy.

REFERENCES / CITATIONS

- Oregon Administrator Rules, Department of Human Services, Addiction and Mental Health Division; Mental Health, Division 33, 309-033-0200 through 0970.
- Involuntary/NMI Hold IP policy

Medical Exclusionary Criteria, IP

Original Policy Date: 4/2015
Revision Date(s): 2/2016, 1/2018
Last Review Date: 3/2017, 02/2018

Responsible Department: Admission

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

Key Words: Exclusionary Criteria

SCOPE

To outline the Admission Exclusion Criteria for Cedar Hills Hospital.

POLICY

Each potential admission to Cedar Hills Hospital will be screened on an individual case basis to assure they meeting applicable admission criteria and that the services they require are within the scope of care provided at Cedar Hills Hospital.

Specific exclusionary criteria may be waived by the admitting physician, in consultation with the Chief Nursing Officer or designee, if it is determined that appropriate care and services can be made available to the patient.

PROCEDURE(S)

The following criteria may prevent admission to Cedar Hills Hospital's Inpatient Programs:

General exclusionary criteria:

- Younger than 18 years of age

Cognitive exclusions:

- Diagnosed dementia with mini-mental status score <18

- Intellectual capacity that will not allow patient to benefit from process oriented group therapy

Functional Exclusions:

- Inability to independently perform activities of daily living
- Requires two people to transfer from bed to chair or bathroom
- Requires hospital medical bed (exclusion cannot be waived)
- Reference Function Assessment Policy for more detail

Infectious Disease Exclusions:

- Active tuberculosis
- Conditions requiring isolation or quarantine

Medical Instability Exclusions (requires medical clearance for admission):

- Unstable vital signs
- Temp >103
- BP > 180/110, BP < 90/60
- Respiration < 12
- Pulse <55, Pulse >120
- SA O2 on room air less than 90%
- Overdose without medical clearance
- Current cardiac symptoms
- Head injury within past 72 hours without CT
- Stimulant abuse with history of cardiac problems or seizures
- Type I diabetes and CBG >400 (Transfers)
- Critical abnormal laboratory values (Transfers)

Care exclusions (Has need of medical devices, equipment, or specialized care beyond the scope of Cedar Hills Hospital):

- Less than 48 hrs post-op
- Open and weeping wounds with active MRSA infections
- Wounds that nursing intervention sterile dressings
- Requires suctioning
- Requires IV therapy; has heparin locks, subclavian lines, or mediports requiring ongoing maintenance; or has implanted medication pump requiring refills
- Requires O2 therapy
- Requires peritoneal or renal dialysis
- Requires physical therapy or physical rehabilitative services

High Risk for Medical Decompensation Exclusions:

- Has severe sleep apnea (STOP-BANG > 5) and is requiring detox from alcohol or opiates
- Pregnant and not under the verified care of an OB/Gyn
- Pregnant, in third trimester, and requiring CSU

Behavior Exclusions:

- If Seclusion / Restraint was required in referring agency, must have demonstrated at least 6 hours free of restraint/seclusion prior to transfer

REFERENCES / CITATIONS

Policy and Procedure

Cedar Hills Hospital
Cedar Hills Outpatient Services

Wait listing Patients, IP

Original Policy Date:
7/2014

Revision Date(s):
1/2017

Last Review Date:

Responsible Department: Intake

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

Key Words:

SCOPE

Cedar Hills Hospital (CHH) is responsible to provide a system that ensures safety for patients upon leaving the facility when the individual is assessed as appropriate for in-patient treatment, but there is no bed available.

POLICY

The intent of this policy is to establish a chain of command and accurate documentation for those circumstances where the outcome of the assessment guides staff towards recommending delayed admission for the patient when hospital is at capacity or patient choice to delay and admit within 3 days of the initial assessment.

PROCEDURE(S)

1.0 The Assessment Counselor discusses the case and clinical information, as well as presents the ideas for safety planning with the on-duty/on-call physician.
- 1.1 If the assessing Assessment Counselor cannot contact the on-call physician, the Medical Director is contacted.

2.0 The Assessment Counselor will complete a 'Crisis / Safety Plan' form with the patient. .
- 2.1 The patient and any others present sign the 'Crisis / Safety Plan' form.
- 2.2 The original stays with the patient's chart in Admissions; a copy goes with the patient.

3.0 The Assessment Counselor must notify the following executive staff as outlined below *before allowing the patient to leave the facility:*

- The Administrator On-Call (AOC) after normal business hours
- The Admissions Director during normal business hours
- When in doubt, contact the Admissions Director 24/7

3.1 The Assessment Counselor discusses the disposition of the assessment at this time. In addition, the 'Crisis / Safety Plan' information is reviewed and discussed with the executive staff member contacted (whether it's the AOC, AD or CEO).

3.2 Documentation of these discussions are noted on the Clinical Assessment form.

4.0 The Assessment Counselor makes an appointment for the following day or within 3 days of initial assessment and instructs the patient about required items to bring for admission.

5.0 In the event there is more than one person who has been waitlisted, slots are determined based on clinical acuity. If triage assistance is needed, the Assessment Counselor will contact the Admissions Director or the Administrator On Call.

6.0 Waitlisted patients are called on the day they are scheduled to admit to ensure safety and keep advised of bed availability.

7.0 If it appears that there will not be a bed available with-in 48 hours, or the patient is in need of immediate services, the Assessment Counselor will work with him/her to find an alternate placement.

REFERENCES / CITATIONS

Appendix 3.

Clinical Services Plan, Inpatient & Outpatient

Cedar Hills Hospital

Clinical Services Plan, Inpatient

2017

INTRODUCTION

Cedar Hills Hospital is a private, free-standing health care facility that specializes in psychiatric and chemical dependency treatment. Inpatient acute care is provided on a 24-hour basis, seven days a week, in a 89 bed acute care psychiatric setting. Partial hospitalization services, intensive outpatient services and traditional outpatient services are provided days and evenings in our outpatient offices.

ORGANIZATION

Cedar Hills Hospital functions independently with a separate Governing Board, CEO, Nurse Executive, and management team. The Governing Board, as the governing body of Cedar Hills Hospital, has ultimate responsibility and authority for all patient care services provided as described fully in its Bylaws.

The Board strives to assure that a comparable level of care is provided to patients in all units, areas or departments throughout the facility.

The Medical Executive Committee, as the executive body of the medical staff, is accountable to the Governing Body for clinical and administrative aspects of patient care, as well as performance improvement activities. The committee is chaired by the president of the medical staff and provides a forum for discussion and review of clinical activities. Medical staff accountability to the Medical Executive Committee is defined fully in the Medical Staff Bylaws.

The management team consists of the CEO, CNO/COO, Director of Performance Improvement, Director of Risk Management, Director of Utilization Review, Director of Human Resources, Director of Assessment Services, Director of Social Services, Director of Plant Operations, and Director of Business Development. The management team functions as the organizational planning body for budget, staffing and programmatic direction and patient care.

Cedar Hills Hospital utilizes the "program model" for patient treatment with a strong emphasis on interdisciplinary input in terms of screening, evaluation, diagnosis and treatment of patients. Within the program model, population-specific programming is offered. Examples of population-specific programming at Cedar Hills Hospital include: Mental Health, Chemical Dependency, Women's Program, Pain Management Program, and Freedom Care Military Program. Staff members provide treatment as part of an interdisciplinary team comprised of the psychiatrist, nurse(s), therapist, and individual case manager. Substance abuse counselors participate as members of the treatment team as appropriate. All team members are responsible to the team leader, who is the attending physician. General functions of team members are described for employees by their respective job descriptions. Physicians and therapists, who are independent practitioners, provide treatment consistent with clinical privileges defined through the medical staff credentialing process.

Cedar Hills Hospital utilizes the Directors who are accountable for the overall functioning of their

organizational units within each facility, including, but not limited, to programmatic direction and client care, performance improvement activities, budgeting, staff competency and in-service education, staffing, and other areas of human resource management.

The management team participates in the development and implementation of the annual management plan and budget. A thorough assessment is conducted of the internal and external environment. This assessment is used to develop a strategic plan for the year which outlines organizational priorities, goals and objectives.

Treatment teams are organized in accordance with the services provided. All treatment programs are segregated according to the type and level of care. The attending psychiatrist supervises the clinical work of his or her team members. Nurses are also responsible to the nurse executive for competency and supervision. The Director of Social Services supervises various social service functions.

Each department has a director who is responsible to the CEO and the Medical Director. Department directors are accountable for the overall functioning of their departments, especially in the areas of competency, maintaining high standards of ethics, timely performance evaluation, providing appropriate inservice education and performance improvement activities.

The organizational relationship of the programs, channels of staff communication, responsibility, authority and supervisory relationships are depicted in the organizational chart attached and made a part hereof. Each department has a description of its organizational structure, channels of communication and interdisciplinary collaboration relative to the overall philosophy and goals of Cedar Hills Hospital.

PROGRAMS

The staff at Cedar Hills Hospital provides an individualized treatment approach for each client and family. Each program's services are appropriate to the scope and level of care required by the client population served. Each program has specified admission, continued stay, and discharge criteria as outlined by the Continuum of Care Policy and Procedure.

The clinical goals for each program are as follows:

To provide comprehensive, timely and quality assessment for the client and his/her family;

To target specific symptoms and behaviors which require stabilization and need improvement;

To improve the functioning of the client in his/her family and community;

To utilize psychodynamic, cognitive, behavioral, family, environmental, and psychopharmacological interventions as indicated;

To provide a safe and nurturing therapeutic environment to

foster the development of a healthier self;

To teach the client and his/her family the identified skills needed to improve functioning.

In all programs, comprehensive treatment-oriented activities are provided by a multi-disciplinary staff. Clinical staff provides group therapy, family therapy, activities therapy, recreational therapy, expressive therapy and educational services. All clinical services are delivered by qualified professional staff including, but not limited to psychiatrists, registered nurses, mental health workers, clinical social workers, psychologists, teachers, a dietitian, pharmacist, substance abuse counselors and recreational or activity therapists. Clinical services that are not available with the facility may be provided through referral, consultation or contractual agreements with area professionals and other health care facilities.

Specialty Programs

Cedar Hills Hospital programs are designed for the treatment of adult clients, ages 18 and over, with psychiatric and chemical dependency issues. Patients must meet criteria for medically supervised inpatient treatment. Programs utilize a level system which supports the patient's progression through treatment stages toward stabilization.

Inpatient programs at Cedar Hills Hospital include:

- Psychiatric
- Chemical Dependency
- Freedom Care Military Program: a 28-day intensive therapy program for active-duty soldiers
- Women's Program: a group therapy program for women whose psychological issues are best served in a women's-only milieu
- Pain Management Program: a group therapy program for individuals seeking treatment for chronic pain and related addictions issues
- Crisis Services Unit: a 10-bed unit for the brief stabilization of highly acute patients, with treatment sometimes occurring on an involuntary basis (i.e., psychiatric holds)

STAGES OF CARE

Screening and Intake

Cedar Hills Hospital accepts referrals from the professional community (physicians, courts, community agencies, education systems, psychologists and counselors), as well as by self or significant others. Intake screening and evaluations are performed by qualified Assessment counselors or by a member of the clinical supervisory staff, Social Services staff, registered nurse or active member of the Medical Staff, 24 hours per day, seven days per week. The individual is advised of the program structure at the time of the evaluation and receives a recommendation for the appropriate level of treatment according to admission criteria and physician recommendation. Financial information is provided. If admission criteria are not met or if Cedar Hills Hospital does not offer a program to meet the patient's needs recommendations will be made for assistance

available elsewhere in the community. As needed, provision for a safe transfer to an accepting facility and physician will be arranged.

Admission to an inpatient program may be voluntary or court-ordered or hold Patients are admitted to inpatient, residential treatment, partial hospitalization and intensive outpatient programs under the care of a psychiatrist. Individuals not receiving care from a psychiatrist are asked if they have a preference of an attending physician. If a preferred physician is named, that doctor, or the physician on call, is contacted, and given clinical/behavioral information to determine the need for treatment. If a preferred physician is not named, the on-call psychiatrist is contacted to assess the need for treatment and to accept care.

Initial Assessment and Evaluation Procedures

Assessment of all patients begins on admission and is integral to the treatment process. Treatment planning is individualized according to individual needs identified through assessments. Primary assessments include the following:

Psychiatric Evaluation: Performed by the attending psychiatrist within 24 hours of admission. Includes a history of the present disorder, brief psychiatric history, including history of substance abuse, brief family history, brief medical history, mental status exam, diagnostic impression, strengths and weaknesses, and initial plan of care.

Medical History and Physical: Performed by the physician within 24 hours of admission. Includes review of all symptoms, history of previous medical problems, present illness, family medical history and review of systems.

Nursing Assessment: Performed by a registered nurse within 8 hours of admission and includes the patient's physical/mental health, a nutritional screening, a falls assessment, and a pain screening. Additional age-specific assessments will be conducted on all geriatric patients. The nurse initiates the preliminary treatment plan based upon findings of the assessment.

Psychosocial History: Performed with the patient and, when possible, family members/significant others by social services staff within 72 hours of admission and includes a complete family history, interpersonal relationships, medical/ psychiatric history, ethnic/cultural and religious issues affecting treatment, abuse history, discharge planning and an integrated clinical summary.

Adjunctive Expressive Therapy Assessment: Performed by a certified activities therapist within 72 hours of admission and includes a vocational assessment screening.

Discharge Needs Assessment: Performed by a qualified mental health professional within 24 hour of admission to ensure that aftercare needs are identified and met. Reviewed with patient within 24 hours of admission and again 24 hours prior to patient’s discharge.

ASAM-Based CD/Co-occurring Evaluation: Performed when indicated by the psychiatrist, psychiatric nurse practitioner, attending physician or Chemical Dependency Counselor within 72 hours of order or admission to program. Includes history of alcohol/drug use, history of physical problems associated with dependence, use of alcohol and other drugs by family members, spiritual orientation, types of previous treatment and responses to that treatment, history of physical or sexual abuse as the abuser or the abused, and sexual orientation.

As-Needed Assessments:
As indicated by patient need, physician/psychiatric nurse practitioner and treatment team assessment, the following assessments may be provided:

Psychological Assessment: Performed by a psychologist as ordered by the physician/psychiatric nurse practitioner to assist the treatment team in understanding the nature of the illness. May include personality, intellectual and neuropsychological testing as ordered by the physician.

Nutrition Assessment: Performed by the Registered Dietitian within 48 hours of a written order by the physician/psychiatric nurse practitioner or notification by nursing that nutritional screening criteria established by the medical staff have been met. Includes dietary needs, assessment of lab results, preferences, habits and recommendations.

Other Assessments: Laboratory, radiology, MRI, EKG/EEG, CT Scan, vocational, rehabilitation and other specialized consultations are ordered on an individualized basis to assure optimal utilization of resources.

Admission Process

Upon receipt of physician's orders and signed consent for treatment, the patient meeting admission criteria will be admitted to the appropriate unit/program. An initial assessment will be completed by a registered nurse. The physician's admission orders and the nursing assessment then guide the preliminary treatment plan.

The patient's family, if available, will be interviewed by a member of the staff to obtain information for collateral family information. The unit program will be explained to the patient and family and a copy of the program handbook will be provided

The patient and belongings will be searched for unsafe items. All dangerous items will be secured, labeled and placed for safekeeping on the unit if not taken home by the family. The patient will be oriented to the unit to which he is admitted, to staff and peers and to program treatment schedules with an explanation of the patient's rights. The patient will be introduced into the unit/program activity in progress at the time of admission, as appropriate.

Treatment

Individualized treatment is based on the findings of the completed assessments and is

provided by a multi-disciplinary team of professional staff. This team includes, but is not limited to, the psychiatrist, psychiatric nurse practitioner, psychologist, nursing staff, social services staff, dietitian, recreational therapist and educational staff. The primary objective of the treatment team is the assessment, treatment and rehabilitation of the patient in an environment that promotes positive behavioral change. Specific interventions include:

Treatment Planning: An overview of the patient's treatment goals and the planned steps to achieve these goals. It addresses biological, psychological, and social aspects of the patient's functioning.

Psychopharmacology: Medications are prescribed by an assigned psychiatrist or psychiatric nurse practitioner. Medications are adjusted as appropriate throughout the patient's stay to maximize efficacy.

Therapy: Psychotherapy and adjunctive therapy are provided according to a schedule each day by Masters-level clinicians. Therapy is primarily offered in a group setting, though supplemental individual and family sessions are offered as appropriate.

Education: Information regarding symptom management and treatment is provided during groups. Educational interventions are also conducted outside structured group times by therapists, physicians, and nurses.

Discharge

Discharge Planning: With the assistance of a Case Manager, the patient begins creating a discharge plan on the first day of admission. The goal of discharge planning is to assure a safe and supportive return to the community, with resources identified to meet the patient's ongoing needs.

Aftercare Appointments: The Case Manager/Therapist assists the patient in arranging appointments with outpatient providers, to ensure continuity of care on an outpatient basis.

THERAPY TYPES

Cedar Hills Hospital offers a wide variety of therapeutic interventions. These include:

Group Therapy

The group process is used to provide both therapeutic and educative services in a context which allows the client to experience peer feedback and support. Groups of varying purpose are conducted daily by a number of different professionals, including but not limited to psychiatrists, psychologists, clinical therapists, nursing staff, clergy, dieticians, chemical dependency counselors, and activity therapists. The type and frequency of groups varies by unit, as well as by identified needs of current clients. Current program schedules are attached.

Activity Therapy

Provides a variety of experiences to enhance the physical, social, cultural and

recreational health of each client. Therapeutic recreation assists the client in working on psychological and physical development through involvement in structured and unstructured activities. These services assist in the formation and development of new behavioral patterns, problem-solving abilities, goal setting, and internalization of adaptive responses to internal and environmental stressors. Recreational outlets are used to promote new coping skills, anger management techniques and leisure skills development. Activity therapy is provided by activity therapy staff which includes a certified therapist and expressive therapist. Opportunities for promoting health through leisure counseling and vocational options are provided.

Individual Therapy

The purpose of individual therapy is to assist the client to gain an understanding of emotional and/or behavioral problems that have led to his present life situation. Individual therapy provides an opportunity for clients to give input into their treatment plan by identifying problems, strengths and weaknesses, by developing personal goals, and by making plans for interventions while in the hospital (e.g. family involvement, AA attendance, etc.). Discharge needs are also addressed. Individual therapy is conducted by a psychiatrist, clinical therapist, and/or a chemical dependency counselor.

Family Therapy

The purpose of family therapy is to address the patient's emotional and/or behavioral problems in the context of the family system. Family therapy provides an opportunity for the patient and family to identify and address issues contributing to dysfunction in the home environment. Interventions include psychotherapeutic counseling as well as education to assist both patient and family.

Milieu Therapy

Provides a predictable, structured and safe treatment setting. Uniform and consistent limits, set by the clinical staff, assist in the management of behaviorally expressed feelings. Special emphasis is placed on the learning of appropriate behavior. Clinical staff act as role models and help patients through daily routines such as mealtimes and bedtime. Interpersonal skills in building and maintaining appropriate relationships with peers and authority figures are stressed. Patients and treatment staff meet in community sessions in all treatment programs.

THERAPY GROUPS

Patients are involved in specific therapy groups according to their individual needs and level of care. These may include:

Process Group

Helps alleviate interpersonal and social dysfunction to develop communication and relationship skills, to develop group cohesion and to foster pro-treatment attitude and behaviors. This group clarifies the current focus of change and amelioration of dysfunction in addressing and beginning to work through certain problematic issues. Age appropriate techniques are used to facilitate identification/expression of feelings and adaptive social interactions. Process group is facilitated by a clinical therapist or nursing staff.

Education Group

Provides an opportunity for learning, peer discussion and support on various topics of relevance to current clients on the unit. Topics may include:

Medication Education
Stress Management
Suicide Education
Awareness and Prevention
Family Issues
Spirituality
Sexual Abuse
Communication Skills
Sex Education
Drug and Alcohol
Problem Solving
Nutrition
Grief and Loss
Life Skills Development

Video presentations may be included, along with workbooks or experiential exercises. Topic groups are facilitated by a number of different professionals, including but not limited to, psychiatrists, psychiatric nurse practitioner psychologists, clinical therapists, nursing staff, dieticians, activity therapists, chemical dependency counselors and/or clergy.

Adjunctive Therapy

Art Therapy, Music Therapy, and Recreational Therapy are examples of Adjunctive Therapy provided by Cedar Hills Hospital. The primary purpose of Adjunctive Therapy is to provide activity-based, person-centered services that integrate function, quality, and meaning to life activities.

Goals or Target Group

Helps the client focus on a concrete goal or behavior which is relevant to the treatment plan and/or discharge plan. This group is central to the client's involvement in treatment on a daily basis, and provides the opportunity to give and receive feedback from unit staff and peers. This group is facilitated by nursing staff. Patient's self-inventory forms if appropriate are turned in at this time.

Community Meeting

Enhances the cohesion and therapeutic value of the milieu for each client by engaging clients and staff in discussion, planning and problem-solving of issues facing the community as a whole. This group is often tied in with Goals or Target Group due to the natural relationship between the goals of the group and of each individual. This group is facilitated by nursing staff.

Self-help Support Group

AA, NA, AL-ANON, ACOA, etc., are support groups for the client and family dealing with various addictive disease issues. These meetings are usually open to the general public and are led by a volunteer from the recovering community in various community locations.

Multi Family Group

This group provides opportunities to educate parents about their adult child's developmental level and appropriate behavioral expectations and limit setting techniques and to provide emotional support for the youth's caretaker.

PHARMACOTHERAPY

Can be initiated for the treatment of severe emotional disturbances or chemical abuse/addiction upon written order of the attending physician/psychiatric nurse

practitioner. The use of medication is judiciously individualized for each patient. The pharmacy and therapeutics function of the medical staff monitors utilization through ongoing monitoring and evaluation activities, which may include peer review.

The general guidelines for utilization of pharmacotherapy include detoxification, achieving rapid behavioral control, reducing the risk of violence and/or injury in such cases where physical management alone is ineffective, augmenting the effect of other treatment modes, providing symptom relief when other modes are unavailable or ineffective, the existence of an accompanying psychiatric disorder, the necessary treatment of minor medical problems, and the reasonable use of mild chemical agents on an "as need to" basis.

Medications may be administered only by physicians, registered nurses, licensed practical nurses in the inpatient, partial hospitalization and crisis stabilization program. Licensed nurses may accept verbal or telephone orders from a qualified physician. Any such orders must be countersigned by the physician within the time frame specified in the Medical Staff Rules and Regulations

CLIENT AND FAMILY EDUCATION

The interdisciplinary treatment team uses a collaborative effort to provide education with clients and with family members when appropriate, to assist is the development of knowledge and skills needed to foster rapid stabilization, make informed decisions regarding treatment and follow-up care, and to promote wellness. Client/family education is based on an assessment of the client and family needs as well as an assessment of factors and barriers that may influence teaching modalities and focus.

TREATMENT PLANNING

Each program has a multidisciplinary approach to treatment planning. Those involved in the treatment planning process, based on the program, may include the patient's physician, psychiatric nurse practitioner nursing staff, social workers, counselors, certified substance abuse counselors, mental health technicians, teachers and activity therapists. The team is responsible for development of the individualized treatment plan and the review and evaluation of ongoing treatment.

Initial Treatment Plan

The initial treatment plan is initiated upon admission for patients who admit via the care center; for other patients who may not admit via the care center the intial treatment plan is initiated by the therapist conducting the initial clinical assessment. It is based on the intake assessment, nursing assessment and physician's orders. It includes the following:

Identification of initial problems, symptomatic behavior of the problem and assessment of the cause of the problem.

Goals of treatment.

Measurable, short-term objectives based on the goals of treatment.

Therapeutic approaches (interventions) to be used with the patient.

Master Treatment Plan

The master treatment plan is formalized no later than 3 days after admission for acute care, within 5 treatment days for the PHP and by the 5th visit to IGP, with subsequent treatment plan reviews/updates every 7 days. The treatment plan is a reflection of our philosophy of treatment and reflects the interdisciplinary input and collaboration of all team members. It includes the following:

Identification of physical, psychological and social problems the patient is experiencing.

Prioritization of patient needs and care.

Achievable long-term goals of treatment stated in behavioral terms.

Measurable short-term goals stated in behavioral terms that will reflect progress toward the goal achievement.

Therapeutic approaches (interventions) used by each discipline to assist the patient in meeting the treatment goals.

The individual or discipline accountable for assisting the patient with therapeutic approaches.

Patient progress in meeting the treatment plan goal is documented in the progress notes.

The nursing staff and case manager, or therapist in the outpatient settings, are responsible for noting the treatment method, as well as decisions and revisions of the treatment plan by the treatment team, both at meetings and on an on-going basis.

The patient, and family when appropriate, are encouraged to participate in the treatment planning process by providing input and acknowledging agreement with the plan in writing. Conflicts in care decisions and resolutions of dilemmas about care decisions are addressed cooperatively by the team members and the patient and/or family.

Treatment plans are reviewed and reassessed by the team at regular intervals at least every 7 days from the date of admission and revised as needed.

CLINICAL SERVICES

Coordination of Care

We coordinate patient care with internal as well as external providers. Internally, Coordination of Care occurs via on-going treatment review within the multi-disciplinary team, as well as via concurrent review by utilization management staff and patient care performance improvement monitors. With external providers, we coordinate patient care at the time of admission, during the patient's stay, as well as at the time of discharge. Every effort is made to notify community partners of the patient's inpatient treatment plan and aftercare plan.

The Medical Director and medical staff evaluate selected admissions, lengths of stay criteria and documentation. Notification of appropriateness of admission, treatment and length of stay is carried out according to approved criteria related to the patient's severity of illness and the intensity of the services provided.

Psychiatric Services

Each program is directed by a board certified or board eligible psychiatrist who is responsible for the planning, supervision and implementation of clinical services for patients. This physician is responsible for the quality of the total treatment delivered to patients of the program. The director works with other qualified physicians, who directly treat, supervise, participate in management and/or staffing conferences and works in conjunction with the multidisciplinary team responsible for the patient's care.

The Service Director provides clinical supervision for the program and clinical staff who render direct psychiatric services to patients. Each attending psychiatrist attends treatment planning meetings to develop and update treatment plans for his patients and is also responsible for the total medical management of the patient. The Service Director is responsible directly to the Medical Director.

Social Services

Social workers (clinical coordinators), professional counselors and marriage and family therapists assume a responsible role in the delivery of clinical services as described elsewhere in this plan. These services include but are not limited to: assessment, discharge planning, group therapy, family therapy, individual therapy and education. Clinical services are provided in cooperation with and under supervision of an active medical staff member who has ultimate responsibility for patient care.

Medical Services

Medical services may be provided by a qualified physician under the direction of the admitting psychiatrist/psychiatric nurse practitioner. The consulting physician is responsible for a complete medical history and general physical examination, and a neurological assessment. A laboratory work-up including a drug screen, blood chemistry, and tuberculin skin test may be ordered. A chest x-ray, HCG, HIV, pregnancy test, pelvic exam with Pap smear and culture for venereal disease and/or other clinically appropriate diagnostic tests will be provided as indicated from the medical history and clinical evaluation. The physician is also responsible for the diagnostic work-up and test evaluation of any detected or suspected medical disorders, as well as their clinical management. Qualified medical specialist may be requested to consult on the care of any patient with specific medical needs.

Nursing Services

Nursing care services are organized under the direction of the CNO as defined in the hospital plan for nursing care. Nursing care is provided by registered nurses, licensed vocational nurses, and mental health technicians who are qualified by education and experience to assume the responsibilities for patient care. The primary goal of nursing service is to provide planned, comprehensive, therapeutic, safe and consistent nursing care 24 hours a day, seven days a week.

Psychiatric nursing is a specialized area of professional nursing practice which employs theories of human behavior and interpersonal relationships. One of the primary activities of nursing staff is the establishment of a trusting, therapeutic relationship with individual patients accomplished through daily, consistent contact. Additional responsibilities of nursing staff include, but are not limited to: providing therapeutic context (milieu) concerned largely with the sociopsychological aspects of the patient's environment providing a positive model of interpersonal relationships; providing opportunities for learning about self and exploring pattern of interaction within a safe environment; on-going patient assessment and observation; support and education for self- care; proper nutrition and appropriate sleep patterns; detection and care for somatic aspects of the patient's health problems, including responses to medications and other treatments; providing assistance in participating in therapeutic activities concerned with improvement or recreational, occupational and social competence; providing continuity of patient care from admission to discharge; participating in planned and informal group meetings to identify the process of interaction; and active participation in the multidisciplinary treatment team in cooperative planning for the implementation and evaluation of patient care. The nursing staff maintains on-going contact with the patient's family, as appropriate. Nursing services provided will be defined according to the patient's level of care.

Adjunctive Therapy

The activities therapy program provided for inpatient, residential and partial hospitalization patients include a variety of services to meet the physical, social, cultural and recreational health maintenance and rehabilitation needs of each patient. Examples of adjunctive therapy include: art therapy, music therapy, recreational therapy, Tai Chi, yoga, acupuncture, and acupressure. These services assist in the formation and development of new behavior patterns, problem-solving abilities and the internalization of healthy adaptive responses to internal and environmental stressors.

Consultations and Referrals

The attending medical staff is responsible for requesting consultations when indicated. Members of the consulting staff are used for these services unless the services are not immediately available or additional outside expert opinions are needed. A satisfactory consultation includes examination of the patient and documentation of findings and follow-up in the medical record.

Diagnostic Testing and Procedures

Cedar Hills Hospital provides for limited diagnostic tests and procedures within the facility. Other diagnostic tests, including radiology, EEG's, emergency and laboratory services, are provided by contracted services.

Dietary Services

Dietary services are available to all patients seven days a week with three meals per day during regularly scheduled hours for all inpatients. Dietary services to PHP and IOP will be program specific. Nutritious snacks are also available in unit galleys. The Dietary Department also provides meals for staff at economical rates.

Patients are served nutritionally balanced meals planned under the supervision of registered dieticians and in accordance with the written orders of the attending psychiatrist. Special consideration is made in food preparation and appealing presentation. Individual patient food preferences and nutritional needs are also taken into consideration. Consultation and education for patients on special diets are provided by the dietitian.

The Dietary Department provides services under the direction of the food service manager with consultation and direction by a contract dietitian.

Emergency Services

Emergency psychiatric and medical services are provided by the medical staff 24

hours per day for patients in in-patient care. Those admitted to outpatient services are instructed to call 911 or go to their nearest emergency room with any medical crises after regular business hours. For psychiatric crises, patients are encouraged to call or go to Cedar Hills Hospital's in-patient facility. A written plan for management of medical and psychiatric emergencies has been developed to provide emergency services to those patients requiring immediate medical

evaluation and treatment for urgent conditions. The plan includes, but is not limited to, the following:

A written agreement with Tuality Community Hospital provides for transfer of any patient in need of treatment for an urgent medical condition that cannot be treated by Cedar Hills Hospital. Non emergency medical care will be provided by Tuality Community Hospital.

A contract with Metro West ambulance transport of a patient when 911 is not necessary. The attending physician or on-call physician shall authorize the use of emergency services and secure an accepting physician at the receiving facility.

The nursing supervisor shall assure administrative approval from Cedar Hills Hospital and the receiving facility, assure that a Memorandum of Transfer is completed, the accepting facility has been notified and the patient's family or significant other has been informed of the need for emergency treatment.

Pharmacy Services

Pharmaceutical services are provided by a licensed pharmacist. The dispensing of medication is performed by the licensed pharmacist. Cedar Hills Hospital stocks only Schedule II drugs. An out-of-formulary medication not stocked within the pharmacy is obtained from the pharmacy service according to individual patient need.

Physical Therapy

Physical and occupational therapy services are typically not provided within the Facility Plan but may be accessed upon written physician order by referral to a local facility.

Pastoral Services

If requested by the patient, pastoral services will be provided by the facility through contact with a local minister.

Discharge and Post-Discharge Planning Process

The process of discharge planning begins at admission and occurs throughout the patient's stay. A therapist conducts a Discharge Needs Assessment within 24 hours of admission, to identify relevant discharge needs. During the

remainder of treatment, the patient's progress and the continuing applicability of the on-going treatment plan are reviewed at regular intervals. There are both formal and informal mechanisms to accomplish this. The treatment plan may be revised or refined during multi-disciplinary team reviews.

Consideration of discharge plans for the patient is an integral part of the treatment planning process. Discharge criteria are established during the treatment planning conference and reviewed and revised as necessary during treatment. Possible discharge dates and post-treatment goals are discussed as the patient moves toward achieving the criteria set for discharge.

The physician and clinical coordinator coordinate the discharge arrangements with the patient and family. Case managers facilitate the implementation of the discharge plan which may include a return to the home, placement in a group or foster home or an institutional placement, partial hospitalization, intensive outpatient involvement, outpatient therapy, community programs and support groups, transportation, medical follow-up and aftercare programs. The therapist reviews the Discharge Needs Assessment 24 hours prior to discharge to ensure discharge and aftercare needs have been met.

The facility ensures that appropriate patient care and clinical information is exchanged when patients are referred, transferred, or discharged to include: reason for transfer, referral or discharge, patient's physical and psychosocial status, summary of care provided and progress toward goals, and community resources and referrals provided to the patient. Transitions between levels of care are smooth and coordinated involving communication to facilitate family support, social work, nursing care, consultations, and referrals.

Aftercare Services

Aftercare groups are provided by Cedar Hills Hospital to support patients who have recently returned to living in the community. Patients anticipating discharge may attend the groups in order to prepare for returning to the community. Groups are led by qualified staff under the direction of the Program Directors.

EVALUATION OF ANNUAL PLAN

Monitoring and evaluation of the effectiveness of patient care and support services are maintained on an on-going basis through a well-defined program for improving organizational performance. The program emphasizes the analysis of the appropriateness of care, evaluation of problems and concerns identified, as well as opportunities for improvement of services and patient care. These activities provide a mechanism to effectively assure a comparable level of care for all patients.

This plan for provision of patient care is reviewed and revised as necessary, but not less than annually. The following elements are taken into consideration in

conducting the annual review:

1. The facility's mission;
2. Strategic and budget planning process;
3. Findings from performance improvement, risk management, utilization review and other evaluation activities;
4. Changes in patient care needs/community needs;
5. Outcomes and effectiveness measures.

Findings from the annual review will be reported to the Performance Improvement Committee, Medical Executive Committee and Governing Board.

GENERAL GOALS AND OBJECTIVES

We believe that mind and body are closely interrelated with pathology in one affecting the level of functioning in the other. We view each person as a synergistic balance of emotional, intellectual, physical and spiritual dimensions. Our responsibility is to treat the total person. Psychiatric disorders result in disturbances in thought, behavior and affective processes. These disturbances impair the patient's ability to perform basic life roles and severely disrupt family, social, work and education relationships which can be ameliorated by prompt psychiatric care.

Cedar Hills Hospital serves adult individuals experiencing psychiatric disorders as noted above. Specific diagnostic categories addressed include thought disorders, mood disorders, anxiety disorders, and personality disorders. Cedar Hills also serves individuals with active substance disorders. Medical detoxification and aftercare are services Cedar Hills commonly provides. Cedar Hills Hospital excludes from all inpatient programs those clients who are so medically unstable that their safety requires treatment in a medical-surgical hospital. Also excluded are those who are so behaviorally or cognitively impaired that they cannot benefit from treatment; those who meet criteria for less restrictive treatment; or those with chronic organic brain dysfunction without treatable psychiatric symptoms.

Cedar Hills Hospital is committed to the provision of quality behavioral health services to our community. This commitment is demonstrated through the facility's mission and supported through effective strategic and budget planning efforts. Resources are utilized to meet individual patient, family and staff goals in the most effective and efficient manner possible. The best principles and most current information available about human behavior have been incorporated into a plan of care for each program.

Cedar Hills Hospital provides a total therapeutic environment through an individualized treatment program for each patient. The emphasis is on group, family, educational, and activity therapies, and the focus is on the patient as a unique individual. Care is provided according to an established code of ethical conduct and strict adherence to patient rights. Involvement of the family, whenever possible, is encouraged to promote support for the patient's recovery.

Patient care is centered upon a holistic philosophy meeting the full continuum of care. Treatment services and resources are tailored to each patient through the development of an individualized, comprehensive treatment plan. The patient's strengths provide the cornerstone of the treatment plan and are mobilized from admission, throughout hospitalization and into discharge. Patient well-being and responsibility for change are fostered consistent with each patient's unique capacities and level of functioning.

2017 SPECIFIC GOALS AND OBJECTIVES

1) Approach patients from a holistic perspective by treating the whole person, including thoughts, behavior, and the affective process. This goal is achieved through a multidisciplinary approach to include physicians, psychiatric nurse practitioners, nurses, therapists, and adjunctive therapist.
2) Provide top-quality behavioral health services using the most current information available concerning human behavioral and psychiatric care.
3) Provide individualized treatment focusing on ethical conduct and patient rights.
4) Through alternate scheduling, increase full time, regular therapist presence on the weekend. This will increase continuity of care for patients who remain in house on weekends.
5) Increase patient satisfaction, as measured by patient survey scores, related to questions; “The therapy groups were helpful to me.” and “Overall, I was very satisfied with my treatment.”

2016 PERFORMANCE MEASURES

The 2016 Performance Improvement Plan performance measures will be:

1) Master Treatment Plan (MTP) contains individualized problems and goals for each patient; Target Goal is $\geq$ 90% compliance.

2) MTP is completed within 72 hours of admission; Target Goal is $\geq$ 90% compliance.

3) MTP is updated weekly via Treatment Plan Updates; Target Goal is $\geq$ 90% compliance.

4) MTP is completed within 72 hours of admission with patient involvement (as evidenced by patient signature). Target Goal is $\geq$ 90% compliance.

5) Patient outcomes based on decreased symptomology. Target is $\geq$ 90% of patients with decreased symptomology.

6) Documentation that patients are informed of their rights; Target Goal is ≥ 90% compliance. Not met.

7) Documentation of transmission of clinical collateral information to outside providers; Target Goal is ≥ 90% compliance.

2017 PERFORMANCE MEASURES

The 2017 Performance Improvement Plan performance measures will be:

1) MTP is completed within 72 hours of admission, with patient involvement; Target Goal is ≥ 90% compliance.

2) Patients will attend two therapy groups per day, as measured by documented group notes. To be audited monthly with B-Tag methodology.

3) Rate of unplanned discharges will decrease by 15% from baseline.

4) Patient outcomes based on decreased symptomology. Target is ≥ 90% of patients with decreased symptomology.

5) Patient satisfaction scores for items #7 and #15; Target Goal is ≥ 4.6.

Clinical Care Plan, OP

Original Policy Date:	04/2012
Last Revision Date:	01/21/16, 2/23/17

INTRODUCTION

The Outpatient Clinical Care Plan describes the clinical programs offered at Cedar Hills Outpatient Services. These programs are designed to stabilize patients' psychiatric and/or substance use symptoms during their treatment using a multidisciplinary approach. The Clinical Care Plan addresses the specific needs of patients, and is based on current risk assessments as well as the annual evaluation of the previous year's program. Clinical programs are designed to assure compliance with applicable codes and regulations as applied to the services at Cedar Hills Outpatient Services.

ORGANIZATION AND RESPONSIBILITIES

Cedar Hills Outpatient Services is an outpatient level of care associated with Cedar Hills Hospital.

The **Governing Board**, as the governing body of Cedar Hills Hospital, has ultimate responsibility and authority for all patient care services provided as described fully in its Bylaws. The Governing Board strives to assure that a comparable level of care is provided to patients in all units, areas or departments throughout the facility.

The **Medical Executive Committee**, as the executive body of the medical staff, is accountable to the Governing Body for clinical and administrative aspects of patient care, as well as performance improvement activities. The committee is chaired by the president of the medical staff and provides a forum for discussion and review of clinical activities. Medical staff accountability to the Medical Executive Committee is defined fully in the Medical Staff Bylaws.

The **Management Team** consists of the CEO, CNO, Director of Performance Improvement / Risk Management, Manager of Utilization Management, Director of Human Resources, Director of Assessment Services, Director of Social Services, Director of Environment of Care, and the Director of Business Development. The management team functions as the organizational planning body for budget, staffing and programmatic direction and patient care.

Cedar Hills Outpatient Services utilizes the "program model" for patient treatment with a strong emphasis on interdisciplinary input in terms of screening, evaluation, diagnosis and treatment of patients. Staff members provide treatment as part of an interdisciplinary team comprised of the psychiatrist/MD/psychiatric mental health nurse practitioner/nurse(s), and therapist. All team members are responsible to the team leader, who is the attending physician. General functions of team members are described for employees by their respective job descriptions. Physicians, nurse practitioners, and therapists provide treatment consistent with clinical privileges defined through the medical staff credentialing process and human resources policies.

Cedar Hills Outpatient Services utilizes a **Director of Outpatient Services** who is accountable

for the overall functioning of the organizational programs within the facility – including, but not limited to – programmatic direction and client care, performance improvement activities, budgeting, staff competency, in-service education, staffing, other areas of human resource management, and maintaining high standards of ethics. The Outpatient Director is responsible to the CEO and the Medical Director, and directly reports to the Director of Clinical Services.

The management team participates in the development and implementation of the annual management plan and budget. A thorough assessment is conducted of the internal and external environment. This assessment is used to develop a strategic plan for the year which outlines organizational priorities, goals and objectives.

Treatment teams are organized in accordance with the services provided. The attending provider supervises the clinical work of his or her team members. Nurses are also responsible to the nurse executive for competency and supervision.

The organizational relationship of the programs, channels of staff communication, responsibility, authority and supervisory relationships are depicted in the organizational chart attached and made a part hereof. Each department has a description of its organizational structure, channels of communication and interdisciplinary collaboration relative to the overall philosophy and goals of Cedar Hills Hospital and Outpatient Services.

PHILOSOPHY AND PURPOSE

We believe that mind and body are closely interrelated with pathology in one affecting the level of functioning in the other. We view each person as a synergistic balance of emotional, intellectual, physical and spiritual dimensions. Our responsibility is to treat the total person. Psychiatric disorders result in disturbances in thought, behavior and affective processes. These disturbances impair the patient's ability to perform basic life roles and severely disrupt family, social, work and education relationships which can be ameliorated by prompt psychiatric care.

Cedar Hills Outpatient Services is committed to the provision of quality behavioral health services to our community. This commitment is demonstrated through the facility's mission and supported through effective strategic and budget planning efforts. Resources are utilized to meet individual patient, family and staff goals in the most effective and efficient manner possible. The best principles and most current information available about human behavior have been incorporated into a plan of care for each program.

Cedar Hills Outpatient Services provides a total therapeutic environment through an individualized treatment program for each patient. The emphasis is on group, family, educational, and adjunctive therapies, and the focus is on the patient as a unique individual. Care is provided according to an established code of ethical conduct and strict adherence to patient rights. Involvement of the family, whenever possible, is encouraged to promote support for the patient's recovery.

Patient care is centered upon a holistic philosophy meeting the full continuum of care. Treatment services and resources are tailored to each patient through the development of an individualized, comprehensive treatment plan. The patient's strengths provide the cornerstone of the treatment plan and are mobilized from admission, throughout hospitalization and into discharge. Patient well-being and responsibility for change are fostered consistent with each

patient's unique capacities and level of functioning.

LEVELS OF CARE

Cedar Hills Outpatient Services offers two levels of care that clients may be enrolled in including: Partial Hospitalization and Intensive Outpatient. Under these two levels of care are various program specialties pending the client's individual clinical issues and needs.

Partial Hospitalization

Partial Hospitalization is the most intensive level of outpatient treatment in that clients are expected to participate in a minimum of 20 hours per week/4 hours of treatment per day of structured group therapy Monday through Friday. This level of care was designed to meet the increasing need for variations in psychiatric care. The intention is to assist clients who are transitioning from an inpatient level of care back into their day to day routine while minimizing relapse potential. Clients who also require the additional oversight and stabilization that comes from this higher level of outpatient care due to the severity of their illness may also enroll in a Partial Hospitalization level of program. Medication management is provided to all clients at this level of care as part of the stabilization process. The overall goal is to maximize therapeutic gains to avoid the need for hospitalization. Schedules and program rules are outlined in the program handbook.

Intensive Outpatient

This level of care is designed as a step-down program for clients who need more than traditional outpatient care but less than a full day's programming to maintain sobriety, recovery goals or stabilization of psychiatric symptoms. This level of care offers daily group therapy in 3 hour treatment blocks for a minimum of 3 days per week. Intensive Outpatient is designed and coordinated to maximize and strengthen client functioning within a flexible structure of weekday and evening scheduling options.

Outpatient

This level of care is currently only offered in the DUII Alcohol & Drug Treatment Program. This level of care is intended for individuals that are considered lower risk, and need a more traditional outpatient level of support. In this level of care, patients will attend 1-2 days per week, for two hours per day in a group therapy format. The duration and frequency of care is determined by the primary therapist/clinical team. Further description will be provided below under the DUII Program.

PROGRAMS

The staff at Cedar Hills Outpatient Services provides an individualized treatment approach for each client and family. As part of this individualized approach, programs within our Outpatient Services include the following:

> **Chemical Dependency:** adults who need therapeutic intervention to address their substance abuse or addiction issues are the focus of this particular program. We embrace a multitude of outside supports for patients to engage in in order to solidify sobriety/abstinence such as: 12-step, SMART Recovery, Celebrate Recovery, etc. Curriculum is designed using Integrated Therapy and ACT approaches. This program is offered at both PHP and IOP levels.

Mental Health: patients with primary mental health issues learn how to identify and cope with symptoms as well as the challenges that come along with having a mental illness. Curriculum is designed with an Integrated Therapy approach as well as ACT. This program is offered at both PHP and IOP levels.

Women's Program: for women who have experienced a significant trauma in their life and may be diagnosed with PTSD may participate in this group. It is a co-occurring group meaning that these women have a diagnosis of either a mental health or chemical dependence issue or both. The women's program is structured around ACT but also uses DBT approaches to help reduce symptoms and encourage the use of more adaptive coping skills. This program is offered at both PHP and IOP levels.

Behavioral Pain Program: an afternoon IOP level of program that focuses on teaching patients how to effectively reduce their pain by means of behavioral strategies. Patients in this group program identify concepts related to pain including pain identification, rating, and other perceptive components as well as learn strategies such as time based pacing. The reliance on medication is decreased when possible, while the emphasis on behavioral management strategies to reduce or better cope with pain is introduced.

Co-Occurring Disorders: patients who cannot attend a morning program due to work, school or other barriers, have the option to participate in this evening IOP program. The focus is on mental health and substance abuse/addiction issues in this group. Patients are encouraged to participate in 12 step or recovery meetings and or attend other support groups depending on their treatment issues. Integrated Therapy approach is used to guide the curriculum.

Impaired Professionals: an evening IOP level of programming uniquely designed to assist professionals struggling with a primary chemical dependency issue but who may also have underlying mental health issues. Many of these patients enter into this program by way of an EAP referral or other work related consequence, This program offers a family group once weekly and utilizes an approach based on Shame and Resilience. There is also expectation of active engagement in an outside support group, twelve step or otherwise, and upon discharge from the Impaired Professionals Program, further participation in a continuing care group held on site for up to 2 years.

DUII Program: An evening and weekend program, the DUII Program is offered to clients who have received the charge of DUII. DUII clients require a referral and/or approval by Alcohol and Drug Evaluation Services (ADES). An ADES counselor will refer clients to one of two tracts. The first option is Education/Information Only, this tract requires attendance once per week, for two hours. The "Education" classes last for 6 weeks. The Treatment/Rehabilitation tract offers two different levels of care, Outpatient or Intensive Outpatient. The final determination between these two tracts is made by the CHOS clinician that provides the intake assessment.

Each program's services are appropriate to the scope and level of care required by the client population served. Each program has specified admission, continued stay, and discharge criteria as outlined by the Continuum of Care Policy and Procedure.

The clinical goals for each program are as follows:

To provide comprehensive, timely and quality assessment for the client and his/her family;

To target specific symptoms and behaviors which require stabilization and need improvement;

To improve the functioning of the client in his/her family and community;

To utilize psychodynamic, cognitive, behavioral, family, environmental, and psychopharmacological interventions as indicated;

To provide a safe and nurturing therapeutic environment to foster the development of a healthier self;

To teach the client and his/her family the identified skills needed to improve functioning.

In all levels of care and programs, comprehensive treatment-oriented activities are provided by a multi-disciplinary staff. Clinical staff provides group therapy, family, couples, and individual therapy as needed, adjunctive therapy, and educational services. All clinical services are delivered by qualified professional staff including, but not limited to psychiatrists, certified addictionologists, psychiatric mental health nurse practitioners, registered nurses, licensed mental health therapists, licensed clinical social workers, psychologists, and adjunctive therapists. Clinical services that are not available with the facility may be provided through referral, consultation or contractual agreements with area professionals and other healthcare facilities.

STAGES OF CARE

Screening and Intake

Cedar Hills Outpatient Services accepts referrals from other inpatient facilities upon discharge, the professional community (physicians, courts, community agencies, education systems, psychologists and counselors), as well as by self or significant others. Intake screening and evaluations are performed in one of two ways: either through the Care Center or via a Direct Admission in Outpatient Services. Care Center intakes are performed by qualified Assessment counselors or by a member of the clinical supervisory staff, Social Services staff, registered nurse or active member of the Medical Staff, 24 hours per day, seven days per week. Direct Admission in Outpatient Services occurs on site at the outpatient facility during one available appointment times Monday through Friday. These direct admissions are evaluated by a clinical staff member, a nurse and a physician as needed, in order to make treatment recommendations.

The individual is advised of the program structure at the time of the evaluation and receives a recommendation for the appropriate level of treatment according to admission criteria and physician recommendation. Financial information is provided. If admission criteria are not met, or if Cedar Hills Hospital or Outpatient Services does not offer a program to meet the patient's needs, recommendations will be made for assistance available elsewhere in the community. As needed, provisions for a safe transfer to an accepting facility and physician will be arranged.

Admission to an inpatient program may be voluntary, court-ordered, or a hold. Patients are admitted to inpatient, residential treatment, partial hospitalization and intensive outpatient programs

under the care of a psychiatrist. Individuals not receiving care from a psychiatrist are asked if they have a preference of an attending physician. If a preferred physician is named, that doctor, or the physician on call, is contacted, and given clinical/behavioral information to determine the need for treatment. If a preferred physician is not named, the on-call psychiatrist is contacted to assess the need for treatment and to accept care.

Initial Assessment and Evaluation Procedures

Assessment of all patients begins on admission and is integral to the treatment process. Treatment planning is individualized according to individual needs identified through assessments. Primary assessments include the following:

Partial Hospitalization

Psychiatric Evaluation: Performed by the attending psychiatrist or psychiatric nurse practitioner , who is under the documented supervision of the psychiatrist, within 2 treatment days from admission. Includes a history of the present disorder, brief psychiatric history, including history of substance abuse, brief family history, brief medical history, mental status exam, diagnostic impression, strengths and weaknesses, and initial plan of care. An updated psychiatric evaluation, aka an addendum, may be completed for step-downs from inpatient.

Medical History and Physical: A physical examination or health care screening is performed within 2 treatment days from admission. Includes review of all symptoms, history of previous medical problems, present illness, family medical history and review of systems. Patients admitted directly from an inpatient service, the current physical examination may be included in the patient's record (if conducted within the previous 30 days). The physical examination is reviewed, approved, and recorded as acceptable by the responsible physician or psychiatric nurse practitioner for the PHP. Outpatient staff will attempt to secure a recent H&P as necessary, from the patient's outside PCP; otherwise, referrals will be made for a new PCP in order to obtain the most recent H&P on the patient.

Nursing Assessment: Performed by a registered nurse within 1 treatment day from admission and includes the patient's physical/mental health, a nutritional screening, and immunization status for children/adolescents. For patients not admitting through the care center, nursing assessments will still be completed within 1 treatment day from admission by the registered nurse on site.

Psychosocial History/Clinical Formulation: Performed with the patient and, when possible, family members/significant others by Social Services staff within 3 treatment days from admission and includes a complete family history, interpersonal relationships, medical/psychiatric history, ethnic/cultural and religious issues affecting treatment, abuse history, discharge planning and an integrated summary. For patients stepping down from inpatient hospitalization at Cedar Hills Hospital, an updated case management note is indicated in lieu of a new psychosocial history or clinical formation to identify significant changes of information.

Substance Abuse Assessment/ASAM Based CD/Co-occurring Evaluation – Performed by a qualified CDAC/LCSW/LPC for an in depth assessment of CD/and or CD and mental health needs Performed when indicated by the psychiatrist, psychiatric nurse practitioner, attending physician or Chemical Dependency Counselor within 3 treatment days from admission to program. Includes history of alcohol/drug use, history of physical problems associated with dependence, use of alcohol and other drugs by family members, spiritual orientation, types of previous treatment and responses to that treatment, history of physical or sexual abuse as the abuser or the abused, and sexual orientation.

Medical Summary List: Completed by the Registered Nurse on admission and includes known significant medical diagnosis and conditions, know adverse and allergic drug reactions, medications known to be prescribed for or used by the patient, and any known significant operative or invasive procedures.

Discharge Needs Assessment: Performed by a licensed therapist/QMHA within one day from admission to determine the patient's discharge aftercare needs are. Identified needs are then incorporated into the treatment plan for the patient.

Intensive Outpatient

Nursing Assessment: Performed by a registered nurse within 1 day of admission and includes the patient's physical/mental health, a nutritional screening, and immunization status for children/adolescents. For patients not admitting through the care center, nursing assessments will still be completed within 1 day from admission by the registered nurse on site. Includes known significant medical diagnoses and conditions, known adverse and allergic drug reactions, medications known to be prescribed for or used by the patient, and any known significant operative or invasive procedures.

Medical History and Physical: A physical examination or health care screening is performed within 2 treatment days from admission. Includes review of all symptoms, history of previous medical problems, present illness, family medical history and review of systems. Patients admitted directly from an inpatient service, the current physical examination may be included in the patient's record (if conducted within the previous 30 days). The physical examination is reviewed, approved, and recorded as acceptable by the responsible physician or psychiatric nurse practitioner for the PHP. Outpatient staff will attempt to secure a recent H&P as necessary, from the patient's outside PCP; otherwise, referrals will be made for a new PCP in order to obtain the most recent H&P on the patient.

Substance Abuse Assessment/ASAM Based CD/Co-occurring Evaluation – Performed by a qualified CDAC/LCSW/LPC for an in depth assessment of CD/and or CD and mental health needs Performed when indicated by the psychiatrist, psychiatric nurse practitioner, attending physician or Chemical Dependency Counselor within 3 treatment days from admission to program. Includes history of alcohol/drug use, history of physical problems associated with dependence, use of alcohol and other drugs by family members, spiritual orientation, types of previous treatment and responses to that treatment, history of physical or sexual abuse as the abuser or the abused, and sexual orientation.

Medical Summary List: Completed by the Registered Nurse on admission and includes known significant medical diagnosis and conditions, know adverse and allergic drug reactions, medications known to be prescribed for or used by the patient, and any known significant operative or invasive procedures.

Discharge Needs Assessment: Performed by a licensed therapist/QMHA within one day from admission to determine the patient's discharge aftercare needs are. Identified needs are then incorporated into the treatment plan for the patient.

Additional Assessments – All Levels of Care

As indicated by patient need, physician/psychiatric nurse practitioner and treatment team assessment, the following assessments may be provided:

Psychological Assessment: Performed by a psychologist as ordered by the physician/psychiatric nurse practitioner to assist the treatment team in understanding the nature of the illness. May include personality, intellectual and neuropsychological testing as ordered by the physician.

Nutrition Assessment: Performed by the Registered Dietitian within 48 hours of a written order by the physician/psychiatric nurse practitioner or notification by nursing that nutritional screening criteria established by the medical staff have been met. Includes dietary needs, assessment of lab results, preferences, habits and recommendations.

Other Assessments: Laboratory, radiology, MRI, EKG/EEG, CT Scan, vocational, rehabilitation and other specialized consultations are ordered on an individualized basis to assure optimal utilization of resources.

Admission Process

Upon receipt of signed consent for treatment, the patient meeting admission criteria will be admitted to the appropriate program and scheduled for attendance at the next treatment

day or provided appointment information.

The therapist or RN will complete a health screening and collect key medical information. This information, along with the initial needs assessment, will be the basis for the treatment plan. If indicated, the patient's family will be interviewed by the therapist to obtain collateral family information.

The patient will receive an orientation to therapy expectations, program schedule, and the physical layout of the facility, together with a review and clarification of patient rights. A copy of the patient handbook, schedule and any other informational sheets will be provided.

THERAPY TYPES

Individualized treatment is based on the findings of the completed assessments and is provided by a multi-disciplinary team of professional staff. This team includes, but is not limited to, the psychiatrist, psychiatric nurse practitioner, psychologist, nursing staff, social services staff, adjunctive therapist and educational staff. The primary objective of the treatment team is the assessment, treatment and rehabilitation of the patient in an environment that promotes positive behavioral change. This may include, but is not limited to, the following therapeutic modalities:

Group Therapy

The group process is used to provide both therapeutic and educative services in a context which allows the client to experience peer feedback and support. Groups of varying purpose are conducted daily by a number of different professionals, including but not limited to, licensed clinical therapists, nursing staff , chemical dependency counselors, and adjunctive therapists. The type and frequency of groups varies by program, as well as by identified needs of current clients. Current program schedules are attached.

Adjunctive Therapy

Adjunctive therapy provides a variety of experiences to enhance the physical, social, cultural and recreational health of each client. Therapeutic recreation assists the client in working on psychological and physical development through involvement in structured and unstructured activities. These services assist in the formation and development of new behavioral patterns, problem-solving abilities, goal setting, and internalization of adaptive responses to internal and environmental stressors. Recreational outlets are used to promote new coping skills, anger management techniques and leisure skills development. Adjunctive therapy is provided by adjunctive therapy staff which includes a certified therapist and expressive therapist. Opportunities for promoting health through leisure counseling and vocational options are provided.

Individual Therapy/Family/Couples

The purpose of individual therapy is to assist the client to gain an understanding of emotional and/or behavioral problems that have led to his/her present life situation.

Individual therapy provides an opportunity for clients to give input into their treatment plan by identifying problems, strengths and weaknesses, by developing personal goals, and by making plans for interventions while in the hospital (e.g. family involvement, AA attendance, etc.). Discharge needs are also addressed. Individual therapy is conducted by your primary therapist in outpatient.

The purpose of family and couples therapy is to address the patient's emotional and/or behavioral problems in the context of the family system. Family therapy provides an opportunity for the patient and the family/couple to identify and address issues contributing to the dysfunction in the home or relationship. Interventions include psychotherapeutic counseling as well as education to assist the patient, and the family/couple.

Self-help Support Group

Alumni Group meetings are peer led support groups for the client who has completed treatment with either Cedar Hills Hospital or Outpatient Services. These meetings are open to either mental health, or substance use disordered "alumni" who wish to continue working on their health and wellness gained while in treatment.

THERAPY GROUPS

Patients are involved in specific therapy groups according to their individual needs and level of care. These may include:

Process Group

Helps alleviate interpersonal and social dysfunction to develop communication and relationship skills, to develop group cohesion and to foster pro-treatment attitude and behaviors. This group clarifies the current focus of change and amelioration of dysfunction in addressing and beginning to work through certain problematic issues. Age appropriate techniques are used to facilitate identification/expression of feelings and adaptive social interactions. Process group is facilitated by a licensed therapist.

Education Group

Provides an opportunity for learning, peer discussion, and support on various topics of relevance to current clients in the group. Video presentations may be included, along with workbooks or experiential exercises. Topic groups are facilitated by a number of different professionals, including but not limited to, licensed therapists, nursing staff, adjunctive therapists, and/or chemical dependency counselors.

Goals or Target Group

Helps the client focus on a concrete goal or behavior which is relevant to the treatment plan and/or discharge plan. This group is central to the client's involvement in treatment on a daily basis, and provides the opportunity to give and receive feedback from unit staff and peers. This group is facilitated by licensed therapists.

PHARMACOTHERAPY

Prescriptions for medications can be initiated for the treatment of severe emotional disturbances or chemical abuse/addiction upon written order of the attending physician/psychiatric nurse practitioner. The use of medication is judiciously individualized for each patient.

The general guidelines for utilization of pharmacotherapy include achieving rapid behavioral control, reducing the risk of violence and/or injury in such cases where physical management alone is ineffective, augmenting the effect of other treatment modes, providing symptom relief when other modes are unavailable or ineffective, the existence of an accompanying psychiatric disorder, and the reasonable use of mild chemical agents on an "as need to" basis.

Medications are not administered at any time on site in the outpatient setting; patients are provided with prescriptions only circumstances under which outpatient patients may necessitate a prescription are: 1) as a bridge if their outpatient provider cannot see them for a first appointment prior to the current prescription running out, 2) if a patient has no outside provider and is in the process of obtaining one but needs medication management in the interim.

CLIENT AND FAMILY EDUCATION

The interdisciplinary treatment team uses a collaborative effort to provide education with clients and with family members when appropriate, to assist is the development of knowledge and skills needed to foster rapid stabilization, make informed decisions regarding treatment and follow-up care, and to promote wellness. Client/family education is based on an assessment of the client and family needs as well as an assessment of factors and barriers that may influence teaching modalities and focus.

TREATMENT PLANNING

Each program has a multi disciplinary approach to treatment planning. Those involved in the treatment planning process, based on the program, may include the patient's physician, psychiatric nurse practitioner nursing staff, registered nurse, licensed therapist and/or adjunctive therapists. The team is responsible for development of the individualized treatment plan and the review and evaluation of ongoing treatment.

Initial Treatment Plan

The initial treatment plan is initiated upon admission by the admitting nurse for patients who admit via the care center; for other patients who may not admit via the care center (i.e. Direct Admissions to Outpatient), the initial treatment plan is initiated by the outpatient nurse or assessment counselor conducting the initial clinical assessment. It is based on the intake assessment, nursing assessment and physician's orders. It includes the

following:

Identification of initial problems, symptomatic behavior of the problem and assessment of the cause of the problem, goals of treatment, and measurable, short-term objectives based on the goals of treatment. Therapeutic approaches (interventions) to be used with the patient.

My Safety and Crisis Plan is a separate document initiated for all patients at the beginning of their treatment. It is designed to be a working document helping patients to identify triggers, warning signs for relapse, support persons, and coping skills to help manage a crisis. Prior to discharge from outpatient services, the patient and therapist review the information on the plan; a copy of the plan is provided to the patient and when possible a support person.

Master Treatment Plan

The master treatment plan is formalized within 3 treatment days for the PHP and IOP, with subsequent treatment plan reviews/updates once monthly for IOP patients and once weekly for PHP patients. The treatment plan is a reflection of our philosophy of treatment and reflects the interdisciplinary input and collaboration of all team members. It includes the following:

Identification of physical, psychological and social problems the patient is experiencing;

Prioritization of patient needs and care;

Achievable long-term goals of treatment stated in behavioral terms;

Measurable short-term goals stated in behavioral terms that will reflect progress toward the goal achievement;

Therapeutic approaches (interventions) used by each discipline to assist the patient in meeting the treatment goals;

The individual or discipline accountable for assisting the patient with therapeutic approaches;

Patient progress in meeting the treatment plan goal is documented in the progress notes.

The therapist in outpatient services is responsible for noting the treatment method, as well as decisions and revisions of the treatment plan by the treatment team, both at meetings and on an on-going basis.

The patient, and family when appropriate, are encouraged to participate in the treatment planning process by providing input and acknowledging agreement with the plan in writing. Conflicts in care decisions and resolutions of dilemmas about care decisions are addressed cooperatively by the team members and the patient and/or family.

Treatment Plan Updates

Treatment plans are reviewed with the patient and are reassessed by the team at regular monthly intervals for IOP level patients and weekly intervals for PHP admissions starting from the date of admission. The patient takes an active role in the review process to help determine completion of goals, modifications needed or identification of new treatment goals as they progress in therapy.

Clinical care evaluation of the patient is conducted by on-going treatment review by the multi-disciplinary team, by concurrent review by utilization management staff and patient care performance improvement monitors.

The treatment team as a whole evaluates all patients' ongoing treatment, lengths of stay criteria and documentation. Notification of appropriateness of treatment and length of stay is carried out according to approved criteria related to the patient's severity of illness and the intensity of the services provided.

Discharge and Post-Discharge Planning Process

During the remainder of treatment, the patient's progress and the continuing applicability of the on-going treatment plan are reviewed at regular intervals.

There are both formal and informal mechanisms to accomplish this. The treatment plan may be revised or refined during multi-disciplinary team reviews.

Consideration of discharge plans for the patient is an integral part of the treatment planning process. Discharge planning begins at the point of admission and continues throughout treatment as a multi-disciplinary effort. Discharge criteria are established during the treatment planning conference and reviewed and revised as necessary during treatment. Possible discharge dates and post-treatment goals are discussed as the patient moves toward achieving the criteria set for discharge.

The primary therapist for each group program coordinates the discharge arrangements with the patient and family. The primary therapist also facilitates the implementation of the discharge plan which may include outpatient therapy, community programs and support groups, medical follow-up and aftercare programs.

The facility ensures that appropriate patient care and clinical information is exchanged when patients are referred out, or discharged including but not limited to: psychiatric evaluation, My Safety and Crisis Plan, medication list, discharge aftercare plans, discharge summary. Transitions between levels of care are smooth and coordinated involving communication to facilitate family support, social work, nursing care, consultations, and/or referrals.

DESCRIPTON OF CLINICAL SERVICES

Coordination of Care

We coordinate patient care with internal as well as external providers. Internally, Coordination of Care occurs via on-going treatment review within the multi-disciplinary team, as well as via concurrent review by utilization management staff and patient care performance improvement monitors. With external providers, we coordinate patient care at the time of admission, during the patient's stay, as well as at the time of discharge. Every effort is made to notify community partners of the patient's inpatient treatment plan and aftercare plan.

Psychiatric Services

Cedar Hills Outpatient Services has as its medical director a certified psychiatrist. In addition, psychiatric services are provided under the care of board certified psychiatrists, and psychiatric mental health nurse practitioners. All of these providers work in conjunction with the Director of Outpatient Services and the multidisciplinary team in order to ensure all patients who require provider care are treated.

Social Services

Social workers (clinical coordinators), professional counselors and marriage and family therapists assume a responsible role in the delivery of clinical services as described elsewhere in this plan. These services include but are not limited to: assessment, discharge planning, group therapy, family therapy, individual therapy and education. Clinical services are provided in cooperation with and under supervision of an active medical staff member who has ultimate responsibility for patient care.

Medical Services

Medical services are not provided at Cedar Hills Outpatient with the exception of minor medical issues requiring first aide. Qualified outpatient staff (i.e. RN, MD, PMHNP) may provide initial consult and recommend a higher level of medical care or encourage the patient follow up with the outside PCP. Pending the medical issue, patients may be transported via ambulance, family/other support persons, or our outpatient van for more complicated medical care at the nearest emergency room. Medical clearance may be necessary prior to returning to treatment in outpatient services.

Adjunctive Therapy

The adjunctive therapy groups provided for Partial and Intensive Outpatient participants include a variety of services to meet the physical, social, cultural and recreational health maintenance and rehabilitation needs of each patient. These services assist in the formation and development of new behavior patterns, problem-solving abilities and the internalization of healthy adaptive responses to internal and environmental stressors.

Consultations and Referrals

The attending medical staff is responsible for requesting consultations when indicated.

Members of the consulting staff are used for these services unless the services are not immediately available or additional outside expert opinions are needed. A satisfactory consultation includes examination of the patient and documentation of findings and follow-up in the medical record.

Diagnostic Testing and Procedures

Cedar Hills Outpatient Services provides for limited diagnostic tests and procedures within the facility. Other diagnostic tests, including radiology, EEG's, emergency and laboratory services, are provided by contracted services.

Emergency Services

Cedar Hills Outpatient Services is not a 24 hour emergency or crisis facility. Emergency psychiatric and medical services are however provided by staff at our main hospital24 hours per day every day of the year. Those admitted to outpatient services are instructed to call 911 or go to their nearest emergency room with any medical crises after regular business hours. For psychiatric crises, patients are encouraged to call or go to Cedar Hills Hospital's in-patient facility. A written plan for management of medical and psychiatric emergencies has been developed to provide emergency services to those patients requiring immediate medical evaluation and treatment for urgent conditions. The plan includes, but is not limited to, the following:

A written agreement with Tuality Community Hospital provides for transfer of any patient in need of treatment for an urgent medical condition that cannot be treated by Cedar Hills Hospital. Non emergency medical care will be provided by Tuality Community Hospital.

A contract with Metro West ambulance transport of a patient when 911 is not necessary. The attending physician or on-call physician shall authorize the use of emergency services and secure an accepting physician at the receiving facility.

The nursing supervisor shall assure administrative approval from Cedar Hills Hospital and the receiving facility, assure that a Memorandum of Transfer is completed, the accepting facility has been notified and the patient's family or significant other has been informed of the need for emergency treatment.

Pharmacy Services

Pharmaceutical services are not provided in the outpatient facility at this juncture. As indicated previously in the care plan, prescriptions may be provided as needed by on site providers for patients requiring medication management.

Physical/Occupational Therapy

Basic Physical therapy and yoga services are now offered as a part of
the Behavioral Pain Program. These services take place between two and three times weekly specifically in the Behavioral Pain Program.

Discharge and Post-Discharge Planning Process

The process of discharge planning begins at admission and occurs throughout the patient's stay. A therapist conducts a Discharge Needs Assessment within 24 hours of admission, to identify relevant discharge needs. During the remainder of treatment, the patient's progress and the continuing applicability of the on-going treatment plan are reviewed at regular intervals. There are both formal and informal mechanisms to accomplish this. The treatment plan may be revised or refined during multi-disciplinary team reviews.

Consideration of discharge plans for the patient is an integral part of the treatment planning process. Discharge criteria are established during the treatment planning conference and reviewed and revised as necessary during treatment. Possible discharge dates and post-treatment goals are discussed as the patient moves toward achieving the criteria set for discharge.

The physician and clinical coordinator coordinate the discharge arrangements with the patient and family. Case managers facilitate the implementation of the discharge plan which may include a return to the home, placement in a group or foster home or an institutional placement, partial hospitalization, intensive outpatient involvement, outpatient therapy, community programs and support groups, transportation, medical follow-up and aftercare programs. The therapist reviews the Discharge Needs Assessment 24 hours prior to discharge to ensure discharge and aftercare needs have been met.

The facility ensures that appropriate patient care and clinical information is exchanged when patients are referred, transferred, or discharged to include: reason for transfer, referral or discharge, patient's physical and psychosocial status, summary of care provided and progress toward goals, and community resources and referrals provided to the patient. Transitions between levels of care are smooth and coordinated involving communication to facilitate family support, social work, nursing care, consultations, and referrals.

Aftercare Services

Aftercare groups referred to as Alumni groups are available through Cedar Hills Outpatient Services to support patients who have participated in any level of care either inpatient or outpatient with Cedar Hills. Patients may use these groups as another level of structure and support for managing daily life. Groups are peer led and voluntary.

STAFFING

General Staffing

Staffing patterns are determined by a combination of employees per attendance expectations (PHP, IOP) and patient acuity, with consideration given to individual patient needs in each program. Core staffing for outpatient services is determined based on the scope of services offered, attendance and program size.

STAFF QUALIFICATIONS AND COMPETENCY

Cedar Hills Outpatient Services actively maintains on-going processes to assure that only qualified and competent staff provides patient care, administrative or support services.

Facility employees are credentialed through an internal mechanism supervised by the Director of Human Resources. Each employee performs his/her duties according to a criteria-based job description that reflects patient age and population-specific needs and defines required qualifications and competency standards. A performance appraisal is conducted for each employee upon completion of the probationary period and at least annually thereafter. Clinical staff are also required to complete a competency assessment and orientation upon hire and annually thereafter in selected areas to assure that on-going competency requirements are met.

Credentialing for members of the medical staff and affiliate staff is provided through the medical staff credentialing and privileging process for appointment as previously noted. This process is defined in the Medical Staff Credentialing Plan and Medical Staff Bylaws.

EVALUATION OF ANNUAL PLAN

Monitoring and evaluation of the effectiveness of patient care and support services are maintained on an on-going basis through a well-defined program for improving organizational performance. The program emphasizes the analysis of the appropriateness of care, evaluation of problems and concerns identified, as well as opportunities for improvement of services and patient care. These activities provide a mechanism to effectively assure a comparable level of care for all patients.

This plan for provision of patient care is reviewed and revised as necessary, but not less than annually. The following elements are taken into consideration in conducting the annual review:

1. The facility's mission;
2. Strategic and budget planning process;
3. Findings from performance improvement, risk management, utilization review and other evaluation activities;
4. Changes in patient care needs/community needs;
5. Patient requirements and implications for staffing;
Relevant information from staging variance reports and;
6. Adequacy of staff recruitment and development activities.

Findings from the annual review will be reported to the Performance Improvement Committee, Medical Executive Committee and Board of Trustees.

PLAN OBJECTIVES FOR 2017

The 2017 Clinical Care Plan objectives for Outpatient will be:

1. Provide comprehensive, timely and quality assessment for the client and his/her family. (Psychiatric Evaluations, History & Physical)

2. Provide quality and satisfactory patient care/outcomes. (Patient Satisfaction Survey, Patient Rights, Attendance Rates, and Routine Discharge Rates).
3. Provide timely treatment planning (Master Treatment Planning and Treatment Plan Updates)
4. Provide safe patient care (Suicide Attempts, Self-Harm Incidents)
5. Provide coordinated care (Outreach at Time of Admission, Communication at Time of Discharge)

PERFORMANCE MEASURES FOR 2017

The 2017 Performance Improvement Plan performance measures will be:

1. Comprehensive, Timely Assessments
   a. Timely Completion of History and Physical Examinations
      i. Target ≥ 90% within 3 treatment days
   a. Timely Completion of Psychiatric Evaluations
      i. Target ≥ 90% within 2 treatment days
2. Patient Outcomes
   a. Patient Satisfaction Survey
      i. Target ≥ 4.5
   b. Patient Satisfaction Survey Response Rate
      i. Target ≥ 50%
   c. Attendance Conversion; rate of attended scheduled appointments.
      i. Target ≥ 75%
   d. Routine Discharge Rate; the rate of discharged patients as "graduated" or "routine."
      i. Target ≥ 45%
3. Multi-Disciplinary Team / Multi-Theoretical Approach
   a. Master Treatment Planning
      i. Target ≥ 90% by third treatment day
   b. Master Treatment Plan Weekly Review / Updates
      i. Target ≥ 90% updates every two weeks of treatment for PHP patients, or once monthly for IOP patients
4. Patient Safety
   a. Suicidal attempts Target = 0
   b. Self-harming incidents Target ≤ 10
5. Communication with Aftercare Providers
   a. Outreach to Referent/Community Providers at Time of Admission
      i. Target ≥ 90% by next business day
   b. Notification of Discharge to Community Providers
      i. Target ≥ 75% within three days of discharge.

Appendix 4.

Cedar Hills Hospital Utilization Management Policies

CEDAR HILLS HOSPITAL
CEDAR HILLS OUTPATIENT SERVICES

Utilization Management Plan

Plan Year: 2015
2014 Plan Review Date: 1/14/15
Last Revision Date: 1/14/15

Required Approvals:
- UM Committee
- PI Committee
- Medical Executive Committee
- Governing Board

Responsible Party: Director, Utilization Management

Scope Statement

All clinical and identified non-clinical disciplines of Cedar Hills Hospital / Cedar Hills Outpatient Services (aka *Cedar Hills*) participate in the Utilization Management (UM) Program. This includes the Administration, Medical Staff and its committees, and each Department / Program / Service involved in direct patient care of patients. Medical Records and Business Office and/or other support services may also participate in UM related activities.

The Utilization Management Plan provides a mechanism for measurement and assessment of important processes and outcomes related to the utilization of *Cedar Hills* services. Utilization data are systematically collected as well as the continued measurement of those processes having the greatest impact on utilization, whether or not problems are suspected. Data and findings are communicated to the Utilization Management Committee, Performance Improvement Committee, Medical Executive Committee and the Governing Body at least quarterly.

The PI Plan is designed to assure compliance with applicable laws and regulations as applied to the services provided at *Cedar Hills*. The Plan is applied to all locations where patients are treated and/or employees perform work functions, including Cedar Hills Hospital and Cedar Hills Outpatient Services.

Organization and Responsibility

A. The **Governing Board**, as the governing body of the facility, has the ultimate responsibility and authority to establish, maintain and support an effective utilization management program. The Board assures that the necessary structures are established and processes are implemented to assess and continually improve utilization within the organization. It receives and acts upon recommendations regarding assessment and improvement activities. The Governing Board also provides financial and administrative support to facilitate the ongoing activities of the Utilization Management Committee.

B. The **Medical Executive Committee** provides the leadership for and actively participates in utilization management activities. It establishes criteria for measuring, assessing and improving utilization performance. This committee assures implementation of appropriate assessment and improvement activities and reports the results to the Governing Board. Non-medical staff members who may participate in Medical Executive Committee meetings include the Chief Executive Officer, Chief Nursing Officer, Medical Records Director, Pharmacy Director, and the Performance Improvement Director.

   The Medical Executive Committee performance improvement function is accomplished through a functional review process by the Medical Executive Committee, in collaboration with the Utilization Management Committee. Responsibilities of this function include:

   - evaluating utilization trends (by program, provider, and insurance company) including average length of stay patterns, over- and under-utilization cases, level of care utilization, documentation practices, payer activity, inefficient use of resources, denials of payment, and appeals efforts.

   - Receiving reports from the Utilization Management Committee concerning identified utilization problems which have not been resolved at that level and which the committee believes need additional action.

   - Recommending action or further study on any problem based primarily upon impact on utilization within available resources. Action or studies may be indicated by performance levels, patterns or trends in care or outcomes that are at significant variance with predetermined levels, benchmarks and/or patterns / trends in care or outcomes.

   - Focusing on problem prevention and identification of problems in utilization that may exist in any phase of health care delivery, using an objective, criteria-based system of measurement.

   - Pursuing opportunities to improve patient care outcomes and clinical performance through ongoing measurement of utilization activities.

   - Ensuring resolution and follow-up of identified problems.

- Report findings of ongoing utilization performance to the Governing Board and refer concerns to other committees as appropriate.

- Ensuring compliance with utilization standards and regulations that may affect the accreditation, licensure and certification of the hospital.

- Conducting and documenting an annual review of the effectiveness of the utilization management program.

The utilization management function is addressed by the Medical Executive Committee as a standing agenda item monthly with a quarterly reporting schedule for the Governing Board.

C. **Facility Leadership Staff** provides the resources, equipment, personnel, staff training, information systems, data management processes and other support necessary to maintain an ongoing, comprehensive utilization management program.

D. The **Medical Staff** is delegated the authority and accountability necessary for the delivery of all processes that contribute to the prevention of utilization problems and the continual improvement of the quality, appropriateness and efficiency of patient care outcomes. Medical Staff responsibilities, duty, and authority for utilization management activities are defined in the Medical Staff By-Laws.

The Medical Staff will:

- Adopt, subject to the approval of the Governing Board, a system designed to routinely collect and assess data related to important utilization processes and resulting outcomes. Objective criteria and appropriate statistical quality control techniques are utilized in the measurement and assessment processes to identify opportunities to improve utilization and organizational functions.

- Implement appropriate actions and assess the effectiveness of such actions when important problems in utilization or clinical performance or opportunities to improve care are identified.

- Document the findings and results of quality measures, concurrent chart audits, and other activities designed to measure and assess utilization practices. Actions taken to correct identified problems or to improve utilization will be documented when implemented and assessed for their effectiveness.

- Participate in developing mechanisms for assuring accountability of the medical staff for utilization practices, and for assuring the provision of the same level of quality of patient care by all professionals.

- Participate in and guide the utilization process improvement teams. In performing quality assessment and improvement functions, the minutes,

proceedings, records, reports, memoranda, statements, recommendations, letters, data and other communication of the committees and/or staff members shall be confidential, privileged and protected from discovery or admission into evidence to the fullest extent provided or permitted by state law.

E. The **Chief Executive Officer** (CEO) is responsible for assuring that the UM process is effectively managed, through supervision of UM staff. The CEO reviews UM activity and related statistics, becomes involved with problems related to inappropriate utilization, and assists in resolving the obstacles to providing services which may occur.

   The CEO is responsible for assuring that supporting activities related to UM occur; these include contract compliance and training for clinical staff and monitoring of clinical activities. Additionally, the CEO will promote the most efficient use of available resources. Finally, the CEO is responsible for assuring that proper communication mechanisms between the UM staff and key staff are developed and maintained.

F. The **Utilization Management Committee** is the steering committee for the Utilization Management Plan and is responsible to oversee and accomplish the following:

   - Establish policy, create and ensure organizational preparedness for utilization management activities by providing resources and training for program implementation.
   - Participate in development of the organization's mission, vision and policy statements.
   - Design, maintain, support and document evidence of an ongoing program to systematically measure, assess and improve patient outcomes and organizational performance related to utilization.
   - Assure that intensive assessment is initiated when statistical analysis indicates undesirable variations in utilization.
   - Assure that appropriate actions are implemented to effectively resolve identified problems or improve existing processes.
   - Provide a mechanism for progress review and coordination.
   - Report findings to the Performance Improvement Committee, Medical Executive Committee, Governing Board, hospital leadership, and other organization committees as appropriate.

   Membership in the Utilization Management Committee includes – but is not limited to – the CEO, CFO, Medical Director, one additional Medical Staff member, UM Manager, Chief Nursing Officer, Assessment Center Director, IP Clinical Director, OP

Clinical Director, and other members of the management team, as designated. The Committee shall meet as often as required to meet its responsibilities (but at least quarterly). The Committee records its activities and reports to the PI Committee, Medical Executive Committee, and Governing Board at least quarterly.

G. The **Utilization Management Manager** is the chairperson of the UM Committee and is tasked to assist the organization's leadership, medical staff, and the UM Committee in designing, planning, implementing and overseeing a comprehensive and integrated program. The authority and responsibility of the UM Manager includes – but is not limited to – the following:

- Supervising and supporting utilization activities on a daily basis and assuring that action is taken as needed and as authorized by organization policies and procedures.
- Assuring that the medical records of patients support utilization communication with insurance companies and third parties. This includes the documentation of medical necessity using any required forms of regulatory bodies (i.e. CMS Certification / Recertification forms).
- Receiving and reviewing department / service utilization measures and documentation to evaluate activities and coordinating reports of findings to the UM Committee, Performance Improvement Committee, Medical Executive Committee, and the Governing Board.
- Maintaining records of the utilization performance measures and statistical tools used to describe evaluations performed and/or methodology.
- Advising and assisting all departments / services and committees accountable for utilization activities.
- Maintaining a record of all completed reviews, evaluations and process improvement activities.
- Attending and participating in appropriate committee and department or service meetings in which utilization activities occur.
- Sharing data and information with appropriate committees and departments / services.

Plan Evaluation

The Utilization Management Plan is reviewed and evaluated annually to ensure that the program is comprehensive, is cost efficient, results in improved utilization care outcomes / clinical performance, and meets the needs of the organization and the community it serves. Findings of the review are appropriately documented and reported to the CEO, the Performance Improvement Committee, the Medical Executive Committee, and the Governing Board.

The UM Plan may be amended or revised at any time that it is determined to be incomplete or ineffective by the CEO, the UM Committee, the Performance Improvement Committee, the Medical Executive Committee, and/or the Governing Board. Amendments or revisions are not put into effect until final approval is given by the CEO, the Performance Improvement Committee, the Medical Executive Committee, and the Governing Board.

Confidentiality of Utilization Activities / Documentation

The Utilization Management Plan and any / all documentation which is an integral part of the program is confidential. Information is maintained in a manner that will preserve its confidentiality. The confidential nature of utilization records must be respected by participants. All staff must be committed to the maintenance of strict confidentiality. Policies pertaining to confidentiality are strictly enforced.

This information is maintained in the utilization management department and/or in designated locations in other departments that have individual utilization management responsibilities. Subject to the foregoing, collected data is available only to those who are responsible for evaluation and participation in the utilization management program and those organizations responsible for surveying the facility in order to assure the existence and effectiveness of the program for accreditation and licensing activities. Any other use or distribution of utilization data must be expressly authorized by the CEO, the Performance Improvement Committee, the Medical Executive Committee, or the Governing Board.

2015 Utilization Management Plan Objectives

The 2015 Utilization Management Plan objectives will be:

- Coordination of care with managed care companies and outside utilization management companies.
- Evaluation of patterns of care and resource use including over utilization and under utilization of resources.
- Implementation of corrective action as needed to increase the effectiveness of resource.
- Monitoring the results of corrective actions implemented and evaluation of their effectiveness.
- Identification of needed resources with input into strategic planning.

2015 Utilization Management Plan Performance Measures

The 2015 Utilization Management Plan performance measures will be:

1. Readmissions By Program / Provider / Insurance
   a. 72 Hour IP Readmissions
   b. 30 Day IP/OP Readmissions

2. Medicare Certifications By Provider
   a. IP Medicare Initial IP Certification
   b. IP Medicare Re-Certifications

3. Unplanned Discharges By Program / Provider / Insurance
   a. IP/OP AMA Discharges
   b. IP/OP Patient Request Discharges

4. IP/OP Average Length of Stay By Program / Provider / Insurance
   a. IP/OP Average Length of Stay

5. Over- and Under-Utilization By Program / Provider / Insurance
   a. IP/OP Over-Utilization
   b. IP/OP Under-Utilization

6. Transitions To Other Levels of Care
   a. IP Step-Up Admissions
   b. OP Step-Down Admissions

7. Insurance Company Denials By Program / Provider / Insurance
   a. IP/OP Denials

8. Denial Appeals By UM Staff / Provider / Insurance
   a. IP/OP Physician Appeals
   b. IP/OP Written Appeals

Appendix 5.

Cedar Hills Hospital Discharge Planning Policies

Policy and Procedure

Cedar Hills Hospital
Cedar Hills Outpatient Services

Original Policy Date:	11/2008
Revision Date(s):	10/2012, 01/2013, 01/2017
Last Review Date:	01/23/2017
Responsible Department:	Clinical Services
Policy Approvals:	PI Committee Medical Executive Committee Governing Board
Key Words:	Discharge; Criteria; aftercare

Discharge Criteria

SCOPE
Inpatient and outpatient services

POLICY
It is the policy of *Cedar Hills* Hospital to follow criteria for admission, continued stay, and discharge to all programs to ensure that each patient is treated in the least restrictive environment that will allow them to attain an optimal functional level.

PROCEDURE(S)
To be applied across all programs and age groups.

A. The goals of the treatment have been substantially met at this level of care (unless transfer to another hospital setting is indicated), and a discharge plan is in the place that meets any continuing needs.
B. The patient's identified "lay-caregiver" has been notified of planned discharge, and has been educated on the aftercare plan for the patient.
C. Follow-up goals and treatment plans for a lesser level of care have been established.
D. Releasing or transferring the patient to a less intensive level of care does not pose a threat to him/her, others, or property.
E. The patient decompensates to a level of emotional or mental instability requiring a higher level of care.

*The patient requires medical care that cannot be provided by *Cedar Hills*. In this instance, the patient would be discharged to a medical hospital for care of their medical condition. Upon being medically cleared, *Cedar Hills* can re-evaluate the patient to determine if criteria is present to re-admit the patient to one of their programs.

REFERENCES / CITATIONS

Original Policy Date:	5/2011
Revision Date(s):	3/6/2017; 5/21/18
Last Review Date:	5/21/18

Routine Discharge Process, IP

Responsible Department: Clinical Services

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

SCOPE

Cedar Hills Inpatient

POLICY

Cedar Hills Hospital will have a procedure to ensure a patient's timely and organized routine discharge from the hospital.

PROCEDURE(S)

1. Discharge planning begins during the admission process. An Assessment Counselor completes Part 1 of the 'Discharge Needs Assessment', where information regarding existing providers is documented. The patient's referral source is verified in MS4. The Assessment Counselor completes the 'Release of Information (ROI)' with the patient, adding existing providers and any family members participating in the patient's treatment.

2. Within 72 hours of admission, the assigned Primary Therapist meets with the patient. During this session, the Therapist initiates the 'Discharge Checklist', completes Part 2 of the 'Discharge Needs Assessment', provides the patient with a location-specific resource suggestions, and introduces the patient to the 'My Crisis / Safety Plan' form.

3. Within 72 hours of admission, the Therapist completes the Master Treatment Plan, which includes adding the findings / patient discharge needs to the plan.

4. The social services team documents on-going discharge planning efforts in the patient record. Discharge efforts that should be documented include collaboration with previous and existing providers, family members, as well as aftercare appointment scheduling.

5. On the day prior to the scheduled date of discharge, the Attending Medical Staff meets with the patient and completes the discharge 'Risk Assessment' form. The patient is given education on suicide and relapse prevention and the completed 'My Safety / Crisis Plan' is reviewed with the Therapist. The Social Services section of the 'Aftercare Plan' is completed and reviewed with the patient. The Therapist signs off on all items completed on the 'Discharge Checklist' form.

6. If the discharge 'Risk Assessment' identifies weapons, lethal medications, or any other means of self-harm in the patient's home, the therapist notifies a family member or friend in the patient's support system. The therapist recommends the safe removal of any dangerous items in the patient's home (to be conducted by someone other than the patient) and documents the family/friend's response to this intervention.

7. On the day prior to the scheduled date of discharge, the Primary Therapist will determine whether the patient is a candidate for 'Post-Discharge Follow-Up Program' enrollment. The Therapist will offer this service to the patient, and complete the enrollment process if the patient consents to participate.

8. On the day of discharge, the patient is seen by a Provider and a 'Face-to-Face Risk Assessment' is completed. The provider completes their section of the 'Discharge Checklist' form.

9. On the day of discharge, the Provider writes a prescription for medications, not to exceed a 30-day supply. If applicable, the Provider will write an order specifying medications to be destroyed or returned to family. Education is provided to the patient / family regarding the emergence of symptoms associated with SSRI medications.

10. At the time of discharge, a Nurse meets with the patient and completes the 'Medication Reconciliation' and 'Aftercare Plan' forms. The nurse will review all 'Property Inventory' forms with the patient to ensure that all personal belongs are accounted for. The patient is given a 'Patient Satisfaction Survey' to complete prior to exiting the hospital. When the patient is prepared to exit the unit, the completed 'Discharge Communication' form is given to the receptionist. The discharging Nurse will complete the nursing section for the "Discharge Checklist" form.

11. Medical Records staff will fax relevant collateral information, within 24 hours of discharge, to the identified aftercare providers. If the patient's aftercare appointments occur within 24 hours of discharge, the Primary Therapist is responsible for faxing these documents on the day of discharge and placing a copy of the fax confirmation sheet in the patient medical record.

12. The provider's 'Discharge Summary' will be faxed to aftercare providers within 30 days of discharge.

13. Medical Records staff will complete their portion of the 'Discharge Checklist' form and forward the checklist to the PI Department for process analysis.

Unplanned Discharges, IP

Original Policy Date:	11/2008
Revision Date(s):	3/10/2017, 5/10/17
Last Review Date:	3/2017

Responsible Department: Clinical Services

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

SCOPE

This policy applies to Cedar Hills Hospital (aka *Cedar Hills*) and its inpatient patients.

POLICY

Discharges may occur in one of the following five ways:

- **Routine** - the patient has achieved treatment goals, is stable, and patient and treatment team agree that discharge is appropriate.

- **Patient Request** - the patient may not have achieved all treatment goals; however, is stable and can safely be discharged from the hospital.

- **Against Medical Advice (AMA)** - the patient has not achieved treatment goals, is not stable, and it is the physician's opinion that discharge from the hospital at this time may have a negative outcome. However, the patient is not a danger to self or others and there is not sufficient legal criteria to warrant the patient be held at the facility on an involuntary basis.

- **Transfer To Medical** – the patient has a medical condition and is transferred to an inpatient medical facility for treatment. These patients often return to *Cedar Hills* upon medical clearance at the medical facility.

- **Step-Down** (aka 'Therapeutic') – the patient has been stabilized at the inpatient level of care and is 'stepped down' to a lower level of care, generally Partial Hospitalization Program (PHP) or Intensive Outpatient Program (IOP).

It is the policy of *Cedar Hills* to attempt at all times to make discharge from the facility a planned event with a defined aftercare and follow-up plan. However, in the event that discharge occurs without prior planning, a framework exists to ensure that the patient has some resources available for follow-up.

PROCEDURE(S)

Procedures for 'unplanned' discharges' – 'Patient Request' Discharges, 'AMA' Discharges, and 'Transfer to Medical' Discharges – are as follows:

1. Patient Request discharge - the patient and/or family has initiated a discharge request in writing. The physician and treatment team believe that the patient could benefit from additional time in the hospital; however, extenuating circumstances may exist that make continued hospital stay a hardship on the patient and/or family. The patient is provided with prescriptions and a follow-up psychiatrist appointment, if possible.

2. Against Medical Advice (AMA) - the patient and/or family has initiated a discharge request in writing. The physician and treatment team do not believe that the patient is stable, has not achieved treatment goals and that discharge at this time may have negative outcomes. However, the patient does not present criteria to hold on an involuntary basis.

3. Transfer To Medical – refer to 'Hospital To Hospital Transfer' policy and procedure.

If the treatment team believes that it is in the patient's best interest not to be discharged; however, criteria does not exist to keep the patient in the hospital on an involuntary basis. Follow up appointments are made, and time permitting - the patient is given, at the physician's discretion, prescriptions.

REFERENCES / CITATIONS

'Hospital To Hospital Transfer' P&P
'Step Down Process, IP To OP' P&P

Unplanned Discharge Requests, IP

Original Policy Date:	11/2008
Revision Date(s):	3/2017
Last Review Date:	3/11/2017; 5/10/17
Responsible Department:	IP Clinical Services
Policy Approvals:	PI Committee Medical Executive Committee Governing Board

SCOPE

This policy applies to Cedar Hills Hospital (aka *Cedar Hills*) and patients in the inpatient programs.

POLICY

Patients and legal guardians requesting discharge prior to treatment team recommendations will be considered unplanned discharges and categorized as either 'Against Medical Advice' or 'Patient Request / Treatment Incomplete'.

PROCEDURE(S)

I. When a patient, and/or a patient's legal guardian, makes a request to be discharged, the nursing supervisor, therapist and case manager will be notified.

II. The patient or guardian will be informed by nursing staff that the request must be in writing, signed, timed and dated by the patient or guardian. If necessary and as soon as possible, the nurse will assist the patient / guardian in creating a written request for discharge (see 'Request for Early Discharge' form).

III. Efforts will be made, by nursing and therapy, to assist the patient and/or legal guardian in identifying their reasons for wanting to leave, the possible consequences for doing so, and the benefits to be gained by completing the program.

IV. If this is refused, the house supervisor, program director and administrator on call will be notified of patient's request to leave.

V. A safety analysis will be conducted by nursing or social services staff. This analysis will include :

- Review of the patient's history from the intake staff admitting the patient, and the patient's treatment progress during this admission.

- Consultation with friends and/or family with the patient's permission in order to determine /confirm safety factors before release.

VI. All the above factors will be collected and synthesized so that they can be communicated with the attending physician or the physician on-call.

VII. The attending physician or physician on-call shall be notified. For psychiatric patients, if the physician who is notified has not met with the patient that day, they must come to the hospital to conduct a face-to-face risk assessment. For substance abuse patients, the physician can order a discharge without coming in to the hospital as long as they have seen the patient that day.

The following are the options for the physician once the patient has been assessed:

1. If there is reasonable cause to believe that the patient meets the criteria for a Notice of Mental Illness hold, the physician shall place the patient on an NMI Involuntary Hold.
2. If the patient does not meet criteria for a hold, the following should occur:
    a. Discharge the patient as an 'AMA' discharge if there is moderate to high risk of self harm or harm to others.
    b. Discharge the patient as a 'Patient Request / Treatment Incomplete' discharge if the patient is at low risk of self harm or harm to others.

VIII. If the patient is discharged AMA or Patient Request, then the patient / guardian will be asked to sign an 'Unplanned Discharge Release' form. After this signature is obtained, then procedure is the same as with a regular discharge.

XI. An incident report will be completed by the discharging nurse who will include reason for discharge request and efforts to encourage the patient to continue needed care.

Policy and Procedure

Cedar Hills Hospital
Cedar Hills Outpatient Services

Original Policy Date:	8/15/2014
Revision Date(s):	3/10/2017
Last Review Date:	3/2017

Step Down Process, IP to OP

Responsible Department: Clinical Services

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

SCOPE

Cedar Hills Inpatient and Outpatient Services

POLICY

It is the policy of Cedar Hills Hospital staff to provide information on Cedar Hills Outpatient Services and encourage all willing and able patients to admit into Cedar Hills Outpatient Services after inpatient hospitalization.

The overall goal is to step-down patients to Cedar Hills Outpatient Services in the most expeditious manner, ensuring the patients' experience is smooth and furthering the therapeutic process.

PROCEDURE(S)

A. Assessment:

a. At time of admission to inpatient, Assessment Center Staff will educate patients on CHH "Next Step" levels of care. This will include providing patients with Cedar Hills Outpatient Services materials and information

b. All "ready charts" will also include a Cedar Hills Outpatient Services Approval Sheet

B. Inpatient Social Services:

a. Will direct, encourage, and support the step down process for all patients capable of attending Cedar Hills Outpatient Services (CHOS)

i. This will include "stepping-down" to Outpatient Services after hospitalization as an expectation for patients when clinically appropriate

ii. CHOS will be discussed and offered from the time of admission to inpatient

b. During Treatment Team, Social Service (SS) Staff will discuss the potentiality or progress of engagement into Cedar Hills Outpatient Services for all patients

c. Upon identification of potential step-down patients, Social Services Staff will inform Outpatient Services Admissions Coordinator as needed to further review or schedule the potential step down for outpatient admission.

d. Discharge plans and dates will be clearly documented in Midas and updated as needed on a daily basis and in a timely manner

C. Physicians:

a. The attending Physician will direct, encourage, and support the step down process

b. During Treatment Team, Physicians will discuss the potentiality or progress of engagement into Cedar Hills Outpatient Services for all patients

c. For patients stepping down to OP the day of discharge, Physicians will write discharge orders the day of by 8:30am

d. If the Attending Physician is not available by 8:30am the day of discharge, the Charge Nurse will call the On Call Physician to write discharge orders. If the Attending Physician will knowingly be unable to meet with their patient before 9:00am the day of discharge, the Physician will write discharge orders the day prior to discharge and ask the On Call Physician to meet with their patient the day of discharge to OP

D. Nursing:

a. All Nursing Staff will have available Outpatient Services materials to provide to patients upon their request

b. Evening Nursing Supervisor will refer to the Discharge Calendar daily to identify the following day step-down patients. They will then collect patients' belongings from the safe and medications from the pharmacy and deliver to the appropriate units

c. Morning Nursing Staff including MHT's need to identify patients stepping down to OP and prepare them for discharge by 8:30am

d. Step-down patients requiring medications will be given first priority at the morning med pass

E. Utilization Management (UM):

a. Utilization Management Staff will update patient discharge dates in Midas in a prompt manner based upon UM coordination with managed care providers

b. UM Staff will obtain prior authorization for step-down patients and document in Midas accordingly

c. UM Staff will distribute the daily Discharge Calendar to all pertinent staff on a daily basis no later than 5:30pm

F. Business Office:

a. Upon receiving the daily Discharge Calendar, Business Office Staff will meet with identified step-down patients for the following day between 5:30 and 6:30 pm to review and sign pertinent documentation. BO Staff are also available to meet with patients for financial counseling during the day at the request of Nursing or Clinical Staff

b. Signed BO documentation is valid for 3 business days. If step-down patient is admitting to OP outside this time frame, the patient must resign the BO documentation at time of admission into OP

c. BO Staff will immediately alert clinical staff if issues arise during financial counseling with step-down patients prohibiting admission

G. Reception:

a. After step-down patient is discharged, they will be escorted to the lobby where Reception will call to notify OP Staff when patient is ready to be transported to Outpatient

b. Business Office will be notified of the discharge

H. Outpatient Staff:

a. OP Drivers utilize CHOS van to pick-up step-down patients to begin their first day of treatment at outpatient

b. OP Staff will provide an orientation to new step-down patients upon arrival and coordinate any relevant transportation needs

c. OP Staff can provide transportation assistance the day of step-down as well as a step-down within 72 business hours of discharge from inpatient with prior communication from inpatient Social Services and approval from the OP Director or other designated staff

I. Medical Records:

a. Each morning Medical Records Staff will review the charts of the previous day's discharged patients and make copies of remaining pertinent documents for all step-down patients (eg. MD progress notes)

b. Copied documents will be ready by 10:00am each morning and ready for the Outpatient courier to pick up for delivery to OP

DATE ISSUED	**11/2008**	**Hand-Off Communication Guidelines, IP**
DATE REVISED	**01/2010**	
FUNCTION	**Patient Care / Treatment / Services**	
ISSUED BY	**Clinical Services / Nursing Services**	

Policy

Cedar Hills Hospital ensures that handoff communication follows a standardized approach and includes the opportunity to ask and respond to questions.

Purpose

To define hospital standard for meeting patient safety goal 2E (National Patient Safety Goals, 2007) and provide accurate information about a patient's care, treatment and services, current condition and any recent or anticipated changes. The information communication during hand off must be interactive and accurate.

Definitions

- Hand off communication is interactive, allowing the opportunity for questioning between the giver and receiver of patient/client/resident information.
- Hand off communication includes up to date information regarding the patient care, treatment and service, condition of any recent or anticipated changes.
- Interruptions are to be minimized to limit the possibility that information would fail to be conveyed or would be forgotten.
- Hand off communication requires process for verification of the received information including repeat-back or read-back as appropriate.
- The receiver of the hand off information has the opportunity to review relevant patient historical data, which includes previous care, treatment, or services.
- Hand off communication is required for all patients who are deemed to be at risk for elopement, suicide, combative destructive issues, seizures, seclusion or restraint who are currently on precautions as well as those patients who have just been removed from precautions and/or those patients with special care needs.

Procedures

Department Specific Guidelines

Nursing:

- Oncoming and off going staff are to attend shift report
- Time is provided to allow for questions and answers

DATE ISSUED	**11/2008**	**Hand-Off Communication Guidelines, IP**
DATE REVISED	**01/2010**	
FUNCTION	**Patient Care / Treatment / Services**	
ISSUED BY	**Clinical Services / Nursing Services**	

- Nursing shift report is not to be interrupted except for emergencies to allow for time to exchange information
- Nurse to nurse hand off during lunch breaks and in-service times; nurse who is taking break gives brief verbal report on patients allowing for questions and answers by relieving nurse. Upon return, nurse covering updates nurse who took break.
- During the nursing report, each patient admitted and/or evaluated will be review.
- The Charge nurse will review each patient on the unit with the nursing team, giving the other team members the opportunity to provide updates and clarify questions related to the patient's progress toward goals.
- The following standardized guideline will be utilized when the nursing team meets:
    1. Patient name and room number
    2. MD name/attending/consultant
    3. Chief complaint/diagnosis/admission date
    4. Any pertinent medical history
    5. Allergies
    6. Procedures
    7. Health acquired infections
    8. Family/legal issues
    9. Need for interpreter/cultural, spiritual concerns
    10. Patient mobility (fall precaution, activity tolerance, disabilities, special equipment)

Admission Department:

- New admission information exchange: Verbal report is given to unit RN from Care Center staff before patient goes to unit

Social Services:

- Social service staff asks RN for status report on patients before escorting off unit
- Social service staff reports any significant observations to unit staff upon return/following group and is available for exchange of information at that time.

Case Management:

- Case managers will be knowledgeable of sufficient clinical information to provide continuity.
- Hand off communication is expected for vacation coverage.

DATE ISSUED	**11/2008**	**Hand-Off Communication Guidelines, IP**
DATE REVISED	**01/2010**	
FUNCTION	**Patient Care / Treatment / Services**	
ISSUED BY	**Clinical Services / Nursing Services**	

Medical Staff:

For Planned Absences:

- Physicians will provide a hand off communication, face to face, to the covering physician. The hand off communication will contain pertinent information about current treatment and condition as well as about any recent or anticipated changes.
- The information will be provided within a time frame sufficient for the receiving physician to review the information and request any additional information needed.
- A similar hand off communication will be provided by the covering physician on the return of the physician taking leave.

For the On-Call Period:

- Physicians will be available on call for any patient hat is anticipated to require monitoring or intervention during the on call period.
- The physician may request by entering an order that certain events or information such as lab values, be communicated to the on call resident during the on call period.

Transfer to Another Hospital

- The process of completion of a Memorandum of Transfer defines expected communication between Cedar Hills Hospital physician, nursing and administrative staff to the receiving facility.

Multidisciplinary Communication

- Occurs as needed to promote the planning for care and the prompt resolution of issues as they are recognized.
- To facilitate multi-communication, formal (morning communication meetings) and informal communication will be used.
- These disciplines will be involved as necessary to progress the patient's plan of care:
    1. Nursing
    2. Physicians
    3. Administration
    4. Case Managers

DATE ISSUED	**11/2008**	**Hand-Off Communication Guidelines, IP**
DATE REVISED	**01/2010**	
FUNCTION	**Patient Care / Treatment / Services**	
ISSUED BY	**Clinical Services / Nursing Services**	

5. Court Liaison
6. Social Services

Procedures for Multidisciplinary Communications

- The Charge Nurse will review each patient on the unit with the multidisciplinary team, giving the other disciplines the opportunity to provide updates and clarify questions related to the patient's progress toward goals.

- The following standardized guideline will be utilized when the multidisciplinary team meets:
    1. Patient Name
    2. MD name/attending/consultant
    3. Chief complaint/diagnosis/admission date
    4. Any pertinent medical history
    5. Any pertinent psychiatric history
    6. Allergies
    7. Procedures
    8. Health acquired infections
    9. Family/legal issues
    10. Need for interpreter/cultural, spiritual concerns
    11. Patient mobility (fall precaution, activity tolerance, disabilities, special equipment)

Policy and Procedure

Cedar Hills Hospital
Cedar Hills Outpatient Services

Original Policy Date:	11/18/08
Revision Date(s):	1/26/17; 5/24/17
Last Review Date:	6/06/17

Responsible Department: Clinical Services

Discharge Planning

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

Key Words: Discharge; Aftercare; Lay Caregiver

SCOPE

This policy applies to both Cedar Hills Hospital / Cedar Hills Outpatient Services (aka *Cedar Hills*).

POLICY

Discharge Planning begins on admission. The patient's demonstrated readiness for discharge should be linked to the achievement of treatment goals, although some long-term goals may be continued at another level of care, following hospital discharge. Long-term goals represent the highest level of functioning which the patient is expected to achieve during this current episode of illness. The longer-term goals may not be accomplished completely by the time of discharge from current level of care. These goals should reflect the expectation for the patient's highest level of functioning.

Discharge goals represent the achievements expected, for the identified problem, by the time of discharge when the patient is ready to step down to a less intensive level of care. Shorter-term objectives represent the stepping stones toward achieving the discharge goals. They are much more specific, objective, and measurable in comparison to discharge and long-term goals.

PROCEDURE(S)

As a component of the assessment process, aftercare treatment recommendations are formulated. These recommendations include the various levels of care indicated to ensure that patients are treated at the appropriate level of care.

A. The Discharge Plan should:
    1. Prepare the patient and family/lay-caregiver for the transition to the next level of care.
    2. Address the patient's and family's/ lay-caregiver's need for instructions about continued treatment.
    3. Delineate how progress made in the current level of care will continue after discharge.
    4. Identify problems to be addressed in the next level of care.
    5. Identify the responsibility for ensuring that the prescribed follow-up is accomplished.

B. One of the best predictors of sustained response to treatment is compliance with treatment after discharge. The discharge plan should take into account the continuation or completion of those treatments which were generated in the current level of care, and the initiation of those treatments which are needed but were deferred to another phase of treatment.

C. At admission, the patient is asked if they would like to identify a family member, friend, or other support person ("lay caregiver") who will provide assistance to the patient following their discharge from the hospital.
    1. All patients are provided a handout describing what a 'lay caregiver' is and encouraging them to identify someone that can serve as their lay caregiver.
    2. 'If a lay caregiver is identified, the caregiver's name and contact information is noted on the Clinical Assessment as well as documented on a 'Release of Information' form signed by the patient. The lay caregiver is then included in conversations along with the patient about discharge needs and continuing care appointments.
    3. The patient's primary therapist contacts the lay caregiver and invites their participation in the patient's discharge needs assessment, discharge and aftercare appointment setting, the discharge process on the day of discharge, and successful transition to outside providers that have been recommended / arranged.

D. In developing discharge / aftercare plans, the following is considered during the discharge needs assessment conducted by the patient's primary therapist:
    1. Patient's capacity for self-care
    2. Family relationships and support;
    3. Physical and psychiatric needs;
    4. Financial needs;

5. Appropriateness of current housing; housing needs;
6. Employment needs;
7. Educational / vocational needs;
8. Social and recreational needs;
9. Accessibility to community resources; need for referrals;
10. Personal support systems;
11. Spiritual needs;
12. Transportation problems related to discharge and aftercare treatment;
13. Ability to access prescribed medications;
14. Potential for recidivism.

E. The discharge / aftercare plan should define the following:
    1. Final diagnosis
    2. The level of care which the patient will be discharged to (i.e., partial hospitalization, intensive outpatient, RTC, outpatient, etc.).
    3. A listing of all medications that patient is to continue taking after discharge.
    4. All professionals who will follow-up with the patient, including medical follow-up to monitor medications.
    5. Referrals to self-help groups, support groups, peer support, or community resources.
    6. Follow up appointments that are based upon the patient's clinical need and that occur within seven (7) days of discharge.

F. Aftercare plans are communicated to the patient and family / lay-caregiver, as appropriate, and documented on the Continuing Care Discharge Plan.
    1. The therapist will complete the Continuing Care discharge plan except for sections dealing with physical problems and medications that will be completed by the Nurse.
    2. The Therapist will explain to the patient and lay caregiver the details of the final discharge / aftercare plan, including what to expect from their outpatient providers. Instructions address what assistance the patient may need post discharge, the securing and administering medications, safety plans, name and location of follow-up appointment and community resources, or any other anticipated assistance relating to the patient's condition.
    3. The patient / guardian will signify understanding the of the aftercare plan by signing the Continuing Care Discharge Plan.
    4. The therapist will fax the Continuing Care Discharge Plan to receiving and referring mental and medical health providers within 24 hours.
    5. Utilization Management staff the faxes Continuing Care Discharge Plan to requesting managed care companies.

G. When appropriate, Case Management staff will assist patients in applying for benefits for which they are qualified.

REFERENCES / CITATIONS

OR HB2023, *Discharge Planning From IP Mental Health Facilities*
OR HB3378, *Lay Caregivers*
OR HB2948, *Disclosure of Protected Health Information*

Policy and Procedure

Cedar Hills Hospital
Cedar Hills Outpatient Services

Original Policy Date:	6/2013
Revision Date(s):	2/2017
Last Review Date:	2/28/2017

Post Discharge Follow Up Program

Responsible Department: IP Clinical Services

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

SCOPE

Cedar Hills Inpatient and Outpatient Services

POLICY

The development of a Discharge Plan begins on admission. The patient's demonstrated readiness for discharge should be linked to the achievement of treatment goals, although some longer-term goals may be continued at another level of care following hospital discharge. Long-term goals represent the highest level of functioning which the patient is expected to achieve.

Considering that the longer-term goals may not be completed at the time of discharge from the current level of care; the facility has put in place a program that follows certain patients' progress towards these goals. The follow up program is coordinated through the organization, Lines for Life.

PROCEDURE(S)

I. As a component of the assessment process, treatment recommendations are formulated. These recommendations include various levels of care and the Lines for Life follow up program should be considered for all patients.
II. Please see the decision tree below. This tool is intended to assist members of the treatment team in the decision making process for recommending patients to participate in this program.
III. Therapists are responsible for recommending patients to participate in this program.

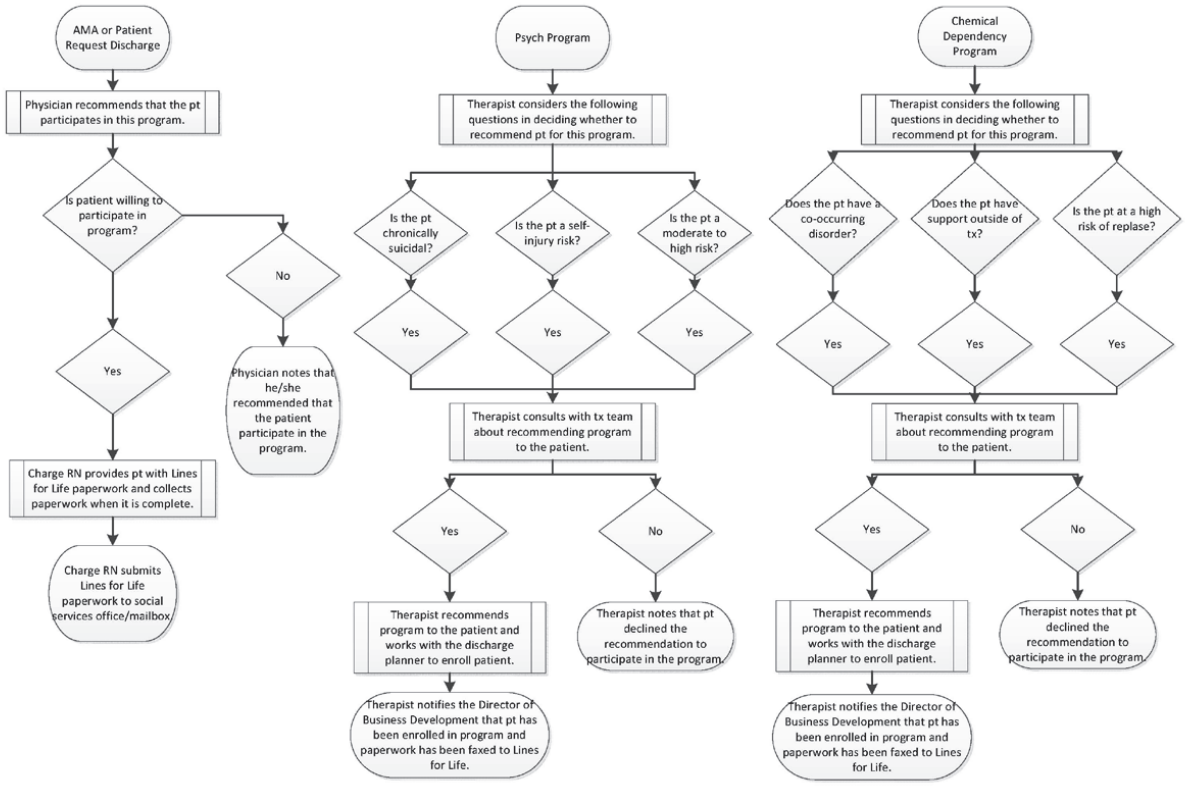
IV. Once a therapist decides a patient is a good candidate for the program he/she should bring their recommendation to the treatment team.

V. The treatment team is responsible for making the final decision to recommend a patient be chosen for this program.

VI. If the treatment team agrees that a patient should be recommended for this program it is the responsibility of the therapist to speak with the patient.

VII. If the patient agrees to participate in the program he/she should work with the therapist to enroll the patient in the program.

VIII. The therapist should scan/email the appropriate forms to Lines for Life.



Appendix 6.

Cedar Hills Hospital Financial Assistance Policy (Charity Care)

Charity Care

Original Policy Date: 6/20/19
Revision Date(s):
Last Review Date:

Responsible Department: Finance

Policy Approvals:
PI Committee
Medical Executive Committee
Governing Board

Key Words: Charity

SCOPE

Applicable for inpatient and outpatient medically necessary patient care.

POLICY

Cedar Hills Hospital is committed to the provision of health care services to all persons in need of medically necessary care regardless of ability to pay. In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of financial assistance and charity care, consistent with federal and state laws and regulations relating to patient financial assistance and charity care, are established.

PROCEDURE(S)

1.) Information about the hospital's financial assistance and charity care policy shall be made publicly available as follows:

- A notice advising patients that the hospital provides charity care shall be posted in key public areas of the hospital, including the patient assessment lounge and individual patient assessment rooms.

- Written notice about the hospital's charity care policy shall be made available to any person who requests the information by mail, telephone, or in person. The hospital's sliding fee schedule shall also be made available upon request.

2.) The Patient Account Representative will identify any uninsured, underinsured, or self-pay patients during the admissions process or as soon after the admission as possible. The charity care application shall be furnished to the responsible party when financial assistance is requested, when need is indicated, or when financial screening indicated potential need.

3.) The patient or responsible party will complete the Financial Application that includes employment, co-applicant, dependent, monthly living expenses, other expenses, other assets, and proof of income information. Proof of income is defined as the previous year tax return, or last three current pay stubs or bank statements.

4.) In the event that the responsible party is unable to provide any of the documentation described above, the hospital shall rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person.

5.) The hospital will allow a patient to apply for charity care at any point from pre-admission to final payment of the bill.

6.) Charity care is considered secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare, Medicaid, other state, federal, or military programs.

7.) Patients will be granted charity care regardless of race, creed, color, national origin, sex, sexual orientation, or the presence of any sensory, mental, or physical disability. Charity care shall be limited to medically necessary care.

8.) In those situations where appropriate financial resources are not available, patients shall be considered for charity care under this policy based on the following criteria:

- The full amount of uncovered hospital charges will be determined to be charity care for a patient whose gross family income is at or below 200% of the federal poverty level.

- For patients with income between 201% and 250% of the federal poverty level, the discount will be 75%.

- For patients with income between 251% and 300% of the federal poverty level, the discount will be 50%.

9.) The hospital may write off as charity care amounts for patients with family income in excess of 300%.

10.) If the hospital becomes aware of factors that might qualify the patient for charity care, it shall advise the patient of the potential and make an initial determination that such an account is to be treated as qualified to receive charity care.

11.) The responsible party's financial obligation which remains after the application of the sliding fee schedule shall be payable as negotiated between the hospital and the responsible party.

12.) Each charity applicant who has been initially determined eligible for charity care shall be provided with at least 14 calendar days to secure and present documentation in support of his/her application and supporting documents.

13.) The hospital shall notify the applicant of the final determination within fourteen days of receipt of the application and supporting documentation.

14.) When the applicant for charity care is denied, the responsible party shall receive a written notice of denial that includes the reason for the denial, the date of the decision, and instructions for appeal. If the denial was due to lack of information, the denial notice must also include: a description of the information that was requested and not provided; a statement that eligibility for charity cannot be established based on the information available to the hospital; and that eligibility will be determined if, within 30 days from the date of the denial notice, the applicant provides all specified information previously requested but not provided.

15.) The responsible party may appeal a denial of eligibility for charity care by providing additional verification of income or family size to the Patient Account Representative within thirty days of receipt of notification. The Patient Account Representative will review all appeals with the Chief Financial Officer. If this review affirms the previous denial of charity care, written notification will be sent to the responsible party.

ATTACHMENTS:

Charity Care Eligibility Determination Sliding Fee Schedule
Charity Care Notice

REFERENCES / CITATIONS

Appendix 7.

Property Tax Statement

AltusGroup

Tax Bill Transmittal
Statement 1
October 31, 2018
Scott Loots

Altus Group U.S , Inc.
50 California Street, Suite 1500
San Francisco, CA 94111

Voice: 415.229.7005
Fax:
Email: scott.loots@altusgroup.com

UHS of Delaware, Inc.
Attn: David Geisel
Manager - Non Income Tax
367 South Gulph Road
King of Prussia, PA 19406

610.382.3325

Email: David Geisel

Client: **Universal Health Services, Inc.**
Property: **Newco Oregon - Wilsonville**
Location Code: **88**
9470 Southwest Day Road
Sherwood, OR 97140

Assessor: Washington County
Lien Date: January 1, 2018
Tax Year: 2018

Discounts Available

3% Discount granted if payment is made in FULL by 11/15. 2% Discount granted if 2/3's of total payment is made by 11/15 and the remaining 1/3 by 5/15. No discount granted if payment is made in 3 installments.

Make Checks Payable To:

Washington County
Property Tax Payment Center
PO Box 3587
Portland, OR 97208-3587

Postmark Accepted

	Due	Delinquent	Amount
Total Taxes	**Nov/15/2018**	**Nov/16/2018**	**12,324.65**
Discount:	**Nov/15/2018**		**11,954.91**
Installment 1	Nov/15/2018	Nov/16/2018	4,108.22
Installment 2	Feb/15/2019	Feb/16/2019	4,108 22
Installment 3	May/15/2019	May/16/2019	4,108.21

	Account	Type	Market / Assessed	3.00% Discount if paid by Nov/15/2018	Total Taxes
RE	R584683		1,492,400 1,492,400	6,521.60	6,723.30
RE	R584692		535,650 535,650	3,147.31	3,244.65
RE	R584709	Land	1,030,620 1,030,620	2,286.00	2,356.70
3 Bills Included with this Transmittal				**$ 11,954.91**	**$ 12,324.65**

[86140]

ALTUS GROUP U.S. INC.

7/1/18 TO 6/30/19 REAL PROPERTY TAX STATEMENT

WASHINGTON COUNTY OREGON * 155 N FIRST AVE., RM 130 * HILLSBORO, OREGON 97124

PROPERTY DESCRIPTION | **MAP:** 3S12B-00400 | **ACCOUNT NO:** R584683

SITUS: 9500 SW DAY RD,

LEGAL DESCRIPTION | **CODE AREA:** 088.45

ACRES 4.24

VALUES:	LAST YEAR	THIS YEAR
MARKET VALUES:		
LAND	646,560	1,491,400
STRUCTURE	2,000	1,000
TOTAL RMV VALUE:	648,560	1,492,400
TAXABLE VALUES:		
ASSESSED VALUE	363,290	374,180
PROPERTY TAXES:	$6,544.70	$6,723.30

APPEAL DEADLINE	December 31, 2018
Value Questions	503-846-8826
Tax Questions	503-846-8801
Business Personal Property Questions	503-846-8838
Other Questions	503-846-8741

PROPERTY TAX PAYMENT OPTIONS

(See back of Statement for payment instructions.)

	Due	Discount	Net Amount Due
Pay In Full	11/15/18	201.70	$6,521.60
2/3	11/15/18	89.64	$4,392.56
1/3	11/15/18	NONE	$2,241.10

MAKE PAYABLE TO: Washington County
Online - https://ecomm.co.washington.or.us/propertytax
Pay By Phone: 1(888) 510-9274

2018-2019 CURRENT TAX BY DISTRICT:

COLLEGE-PORTLAND COMMUNITY	98.60
ESD-NW REGIONAL	52.20
SCH-SHERWOOD	1,648.08
EDUCATION TAXES:	$1,798.88
WASHINGTON COUNTY	783.79
REG-METRO SERVICE DISTRICT	29.07
PORT-PORTLAND	21.10
FIRE-TV FIRE & RESCUE	458.18
CITY-WILSONVILLE	757.90
UR-WILSONVILLE-DOT	534.40
REG-METRO-AFTER 1/1/2013	35.92
FIRE-TV FIRE & RESCUE-AFTER 1	168.38
WASHINGTON COUNTY LOL AFTER 1	239.48
SWC-TUALATIN	24.10
GENERAL GOVERNMENT TAXES:	$3,052.32
BOND-TV FIRE & RESCUE AFTER	40.67
BOND-WASHINGTON COUNTY AFTER	26.16
BOND-SCH-SHERWOOD-AFTER	1,549.07
BOND-METRO SERVICE-AFTER	104.81
BOND-PCC-AFTER	151.39
BOND AND MISC TAX:	$1,872.10
2018-19 TAX (Before Discount)	$6,723.30

APPROVED OCT - 2018 Altus Group

DELINQUENT TAXES: NO DELINQUENT TAXES DUE

(See back for explanation of taxes marked with an asterisk (*).
Delinquent Tax Total is included in payment options to the left.)

TOTAL (After Discount): $6,521.60

We have moved back to the Public Services Building!

Located at: 155 N First Ave., Suite 130, Hillsboro, OR 97124

All Payments Processed Upon Receipt

Tear Here — Tear Here

RETURN THIS PORTION WITH PAYMENT - SEE BACK OF STATEMENT FOR INSTRUCTIONS

2018-2019 Property Tax Payment Stub — WASHINGTON COUNTY, OREGON — **ACCOUNT NO:** R584683

SITUS: 9500 SW DAY RD,

☐ Mailing address change on back of stub.

FULL PAYMENT (Includes 3% Discount)
2/3 PAYMENT (Includes 2% Discount)
1/3 PAYMENT (No Discount Offered)

UNPAID DELINQUENT TAX IS INCLUDED IN PAYMENT OPTIONS

DUE: 11-15-18	$6,521.60
DUE: 11-15-18	$4,392.56
DUE: 11-15-18	$2,241.10

DISCOUNT IS LOST & INTEREST APPLIES AFTER DUE DATE

Make Payable to:
WASHINGTON COUNTY
Property Tax Payment Center
P O Box 3587
Portland, OR 97208-3587

ENTER AMOUNT PAID
Due Date: 11/15/2018

3400001584683000065216000004392560000224110 4

7/1/18 TO 6/30/19 REAL PROPERTY TAX STATEMENT

WASHINGTON COUNTY OREGON * 155 N FIRST AVE., RM 130 * HILLSBORO, OREGON 97124

PROPERTY DESCRIPTION | **MAP:** 3S12B-00500 | **ACCOUNT NO:** R584692

SITUS: 9500 SW DAY RD,

LEGAL DESCRIPTION | **CODE AREA:** 088.45

ACRES 1.52

VALUES:	LAST YEAR	THIS YEAR
MARKET VALUES:		
LAND	231,780	534,650
STRUCTURE	1,000	1,000
TOTAL RMV VALUE.	232,780	535,650
TAXABLE VALUES:		
ASSESSED VALUE	175,330	180,580
PROPERTY TAXES:	$3,158.59	$3,244.65

APPEAL DEADLINE	December 31, 2018
Value Questions	503-846-8826
Tax Questions	503-846-8801
Business Personal Property Questions	503-846-8838
Other Questions	503-846-8741

PROPERTY TAX PAYMENT OPTIONS

(See back of Statement for payment instructions.)

	Due	Discount	Net Amount Due
Pay In Full	11/15/18	97.34	$3,147.31
2/3	11/15/18	43.26	$2,119.84
1/3	11/15/18	NONE	$1,081.55

MAKE PAYABLE TO: Washington County
Online - https://ecomm.co.washington.or.us/propertytax
Pay By Phone: 1(888) 510-9274

2018-2019 CURRENT TAX BY DISTRICT:

COLLEGE-PORTLAND COMMUNITY	47.58
ESD-NW REGIONAL	25.19
SCH-SHERWOOD	795.36
EDUCATION TAXES:	$868.13
WASHINGTON COUNTY	378.26
REG-METRO SERVICE DISTRICT	14.03
PORT-PORTLAND	10.18
FIRE-TV FIRE & RESCUE	221.12
CITY-WILSONVILLE	365.76
UR-WILSONVILLE-DOT	257.90
REG-METRO-AFTER 1/1/2013	17.34
FIRE-TV FIRE & RESCUE-AFTER 1	81.26
WASHINGTON COUNTY LOL AFTER 1	115.57
SWC-TUALATIN	11.63
GENERAL GOVERNMENT TAXES:	$1,473.05
BOND-TV FIRE & RESCUE AFTER	19.63
BOND-WASHINGTON COUNTY AFTER	12.62
BOND-SCH-SHERWOOD-AFTER	747.58
BOND-METRO SERVICE-AFTER	50.58
BOND-PCC-AFTER	73.06
BOND AND MISC TAX.	$903.47
2018-19 TAX (Before Discount)	$3,244.65

APPROVED OCT . 2018 KH Altus Group

DELINQUENT TAXES: NO DELINQUENT TAXES DUE

(See back for explanation of taxes marked with an asterisk (*).
Delinquent Tax Total is included in payment options to the left.)

TOTAL (After Discount): $3,147.31

We have moved back to the Public Services Building!

Located at: 155 N. First Ave., Suite 130, Hillsboro, OR 97124

All Payments Processed Upon Receipt

Tear Here — Tear Here

RETURN THIS PORTION WITH PAYMENT - SEE BACK OF STATEMENT FOR INSTRUCTIONS

2018-2019 Property Tax Payment Stub — WASHINGTON COUNTY, OREGON — **ACCOUNT NO:** R584692

SITUS: 9500 SW DAY RD,

☐ Mailing address change on back of stub.

FULL PAYMENT (Includes 3% Discount)
2/3 PAYMENT (Includes 2% Discount)
1/3 PAYMENT (No Discount Offered)

UNPAID DELINQUENT TAX IS INCLUDED IN PAYMENT OPTIONS

DUE: 11-15-18	$3,147.31
DUE: 11-15-18	$2,119.84
DUE: 11-15-18	$1,081.55

DISCOUNT IS LOST & INTEREST APPLIES AFTER DUE DATE

Make Payable to:
WASHINGTON COUNTY
Property Tax Payment Center
P. O. Box 3587
Portland, OR 97208-3587

ENTER AMOUNT PAID
Due Date: 11/15/2018

3400001584692000031473100002119840000108155O

7/1/18 TO 6/30/19 REAL PROPERTY TAX STATEMENT

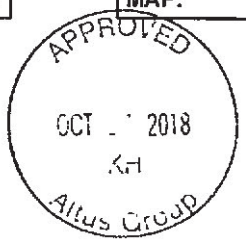
WASHINGTON COUNTY OREGON * 155 N FIRST AVE., RM 130 * HILLSBORO, OREGON 97124

PROPERTY DESCRIPTION

SITUS: 9500 SW DAY RD,

MAP: 3S12B-00501

ACCOUNT NO: R584709



LEGAL DESCRIPTION

ACRES 2.93

CODE AREA: 088.45

VALUES:	LAST YEAR	THIS YEAR
MARKET VALUES:		
LAND	446,800	1,030,620
STRUCTURE		
TOTAL RMV VALUE:	446,800	1,030,620
TAXABLE VALUES:		
ASSESSED VALUE	127,340	131,160
PROPERTY TAXES:	$2,294.04	$2,356.70

APPEAL DEADLINE	December 31, 2018
Value Questions	503-846-8826
Tax Questions	503-846-8801
Business Personal Property Questions	503-846-8838
Other Questions	503-846-8741

PROPERTY TAX PAYMENT OPTIONS

(See back of Statement for payment instructions.)

Pay	Due	Discount	Net Amount Due
In Full	11/15/18	70.70	$2,286.00
2/3	11/15/18	31.42	$1,539.72
1/3	11/15/18	NONE	$785.57

MAKE PAYABLE TO: Washington County
Online - https://ecomm.co.washington.or.us/propertytax
Pay By Phone: 1(888) 510-9274

2018-2019 CURRENT TAX BY DISTRICT:

COLLEGE-PORTLAND COMMUNITY	34.56
ESD-NW REGIONAL	18.30
SCH-SHERWOOD	577.69
EDUCATION TAXES:	$630.55
WASHINGTON COUNTY	274.74
REG-METRO SERVICE DISTRICT	10.19
PORT-PORTLAND	7.40
FIRE-TV FIRE & RESCUE	160.61
CITY-WILSONVILLE	265.66
UR-WILSONVILLE-DOT	187.32
REG-METRO-AFTER 1/1/2013	12.59
FIRE-TV FIRE & RESCUE-AFTER 1	59.02
WASHINGTON COUNTY LOL AFTER 1	83.94
SWC-TUALATIN	8.45
GENERAL GOVERNMENT TAXES:	$1,069.92
BOND-TV FIRE & RESCUE AFTER	14.26
BOND-WASHINGTON COUNTY AFTER	9.17
BOND-SCH-SHERWOOD-AFTER	542.99
BOND-METRO SERVICE-AFTER	36.74
BOND-PCC-AFTER	53.07
BOND AND MISC TAX:	$656.23
2018-19 TAX (Before Discount)	$2,356.70

DELINQUENT TAXES: NO DELINQUENT TAXES DUE

(See back for explanation of taxes marked with an asterisk (*).
Delinquent Tax Total is included in payment options to the left.)

TOTAL (After Discount): $2,286.00

We have moved back to the Public Services Building!

Located at: 155 N First Ave., Suite 130, Hillsboro, OR 97124

All Payments Processed Upon Receipt

Tear Here — Tear Here

RETURN THIS PORTION WITH PAYMENT - SEE BACK OF STATEMENT FOR INSTRUCTIONS

2018-2019 Property Tax Payment Stub — WASHINGTON COUNTY, OREGON

ACCOUNT NO: R584709

SITUS: 9500 SW DAY RD,

☐ Mailing address change on back of stub.

FULL PAYMENT (Includes 3% Discount)
2/3 PAYMENT (Includes 2% Discount)
1/3 PAYMENT (No Discount Offered)

UNPAID DELINQUENT TAX IS INCLUDED IN PAYMENT OPTIONS

DUE 11-15-18	$2,286.00
DUE 11-15-18	$1,539.72
DUE 11-15-18	$785.57

DISCOUNT IS LOST & INTEREST APPLIES AFTER DUE DATE

Make Payable to:
WASHINGTON COUNTY
Property Tax Payment Center
P O. Box 3587
Portland, OR 97208-3587

ENTER AMOUNT PAID
Due Date: 11/15/2018

3400001584709000022860000001539720000078557 2

* denotes an Estimate
\+ Based on Prior Year

Property:	Newco Oregon - Wilsonville				Land	378,536 sf	Built:
Client:	Universal Health Services, Inc.	Address:	9470 Southwest Day Road	Type:		8.690 ac	Units:
Location	88		Sherwood, OR 97140	Real Estate	Imp:	sf	L/B Ratio:

Assessor:	Washington County	Address:	9470 Southwest Day Road	Type:	Land:	184,694	GBA:	1,287	Built:	1987
Account:	R584683		Sherwood, OR 97140	Real Estate	Acreage:	4.240	NLA:		Units:	
Parcel:	Newco Oregon - Wilsonville	Owner:	Newco Oregon, Inc.				L/B Ratio:			
Consultant:	Loots			Legal:						

	2017 Value	2018 Proposed	2018 Final
Land:	646,560	1,491,400	
Imp:	2,000	1,000	
PP:	0	0	
Total:	648,560	1,492,400	
Ass'd:	648,560	1,492,400	
Taxable Value	363,290	374,180	

Jurisdiction	2017 Rate	2018 Rate	2017 Taxes	2018 Taxes	2018 Savings
Washington TC 088.45*	1.801510	1.796810	6,544.71	6,723.30 *	
* - Taxable Value	1.801510	1.796810	6,544.71	6,723.30	

Status: Proposed Value Received

Assessor:	Washington County	Address:	9630 Southwest Day Road	Type:	Land:	66,211	GBA:	1,056	Built:	1962
Account:	R584692		Sherwood, OR 97140	Real Estate	Acreage:	1.520	NLA:		Units:	
Parcel:	Newco Oregon - Wilsonville	Owner:	Newco Oregon, Inc.				L/B Ratio:			
Consultant:	Loots			Legal:						

	2017 Value	2018 Proposed	2018 Final
Land:	231,780	534,650	
Imp:	1,000	1,000	
PP:	0	0	
Total	232,780	535,650	
Ass'd:	232,780	535,650	
Taxable Value	175,330	180,580	

Jurisdiction	2017 Rate	2018 Rate	2017 Taxes	2018 Taxes	2018 Savings
Washington TC 088.45*	1.801510	1.796810	3,158.59	3,244.65 *	
* - Taxable Value	1.801510	1.796810	3,158.59	3,244.65	

Status Proposed Value Received

* denotes an Estimate
\+ Based on Prior Year

Property:	Newco Oregon - Wilsonville				Land:	378,536 sf	Built:
Client:	Universal Health Services, Inc.	Address:	9470 Southwest Day Road	Type:		8.690 ac	Units:
Location	88		Sherwood, OR 97140	Real Estate	Imp:	sf	L/B Ratio:

Assessor:	Washington County	Address:	9470 Southwest Day Road	Type:	Land	Land:	127,631	GBA:	Built:
Account:	R584709		Sherwood, OR 97140		Real Estate	Acreage:	2.930	NLA:	Units:
Parcel:	Newco Oregon - Wilsonville (Land Only)	Owner:	Newco Oregon, Inc					L/B Ratio:	
Consultant:	Loots								

Legal:

	2017 Value	2018 Proposed	2018 Final
Land:	446,800	1,030,620	
Imp:	0	0	
PP:	0	0	
Total:	446,800	1,030,620	
Ass'd:	446,800	1,030,620	
Taxable Value	127,340	131,160	

Status: Proposed Value Received

Jurisdiction	2017 Rate	2018 Rate	2017 Taxes	2018 Taxes	2018 Savings
Washington TC 088.45*	1.801510	1.796810	2,294.04	2,356.70 *	
* - Taxable Value	1.801510	1.796810	2,294.04	2,356.70	

Summary for Newco Oregon - Wilsonville

Washington County
3 Accounts

	2017 Value	2018 Proposed	2018 Final
Land:	1,325,140	3,056,670	
Imp:	3,000	2,000	
RE:	1,328,140	3,058,670	
PP:	0	0	
Total	1,328,140	3,058,670	
Ass'd:	1,328,140	3,058,670	

Jurisdiction	2017 Rate	2018 Rate	2017 Taxes	2018 Taxes	2018 Savings
Washington TC 088.45	1.801510	1.796810	11,997.34	12,324.65 *	
Total	1.801510	1.796810	11,997.34	12,324.65	

Appendix 8.

Universal Health Services' Letter of Financial Commitment

Universal Health Services, Inc.
UHS of Delaware, Inc.

June 2, 2019

Oregon State Public Health Division
Center for Health Protection
Certificate of Need
800 NE Oregon Street, Suite 305
Portland OR 97232

RE: NEWCO Oregon Inc. Certificate of Need Application for a 100-Bed Psychiatric Hospital, With an Estimated Capital Expenditure of $47.04 Million

Dear Sir or Madam:

Please accept this letter as evidence of financial support for the certificate of need application by NEWCO Oregon Inc., an operating subsidiary of Universal Health Services, Inc. ("UHS"). NEWCO requests approval to establish a 100-bed psychiatric hospital in Wilsonville Oregon.

Universal Health Services is pleased to commit from its corporate reserves, the funding for the estimated capital expenditures required for this health care facility. Universal Health Services has sufficient cash reserves to fully fund the intended project from development through operations.

Sincerely,

Steve G. Filton
Executive Vice President and Chief Financial Officer
Universal Health Services, Inc.

Appendix 9.

Universal Health Services' 2018 Annual Report, Including 10-K and Audited Financial Statements

UNIVERSAL HEALTH SERVICES, INC.

2018 ANNUAL REPORT



UHS®

DELIVERING SUPERIOR QUALITY CARE

UNIVERSAL HEALTH SERVICES, INC.

2018 BY THE NUMBERS

2.6
MILLION
TOTAL PATIENTS SERVED

87,000
EMPLOYEES, GLOBALLY

$665
MILLION
INVESTMENT IN EQUIPMENT, FACILITY EXPANSIONS AND RENOVATIONS

18
JOINT VENTURE PARTNERSHIPS

ACUTE CARE

303,985
patient admissions

1.4 million
patient days

1.2 million
outpatient visits

6,232
licensed beds

33,018 births

236,758 surgeries

5 Accountable Care Organizations (ACOs)

BEHAVIORAL HEALTH

345
freestanding facilities

23,509 licensed beds

508 inpatient beds added via expansion projects

27 newly acquired or opened facilities

482,658
inpatients served

6.4 million
patient days

24 facilities offering Patriot Support Programs

Pictured on the front cover are faces of patients whom we have been privileged to serve.

FINANCIAL HIGHLIGHTS

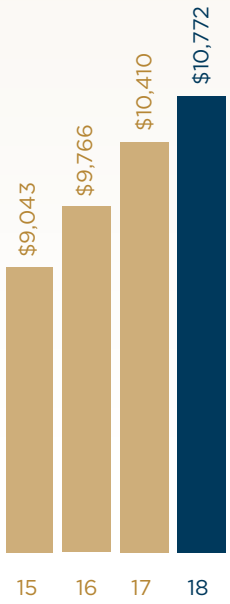
Year Ended December 31	2018	2017	Percentage Increase	2016
Net revenues	$10,772,278,000	$10,409,865,000	3.5%	$9,766,210,000
Adjusted net income attributable to UHS (1)	$894,350,000	$725,459,000	23%	$720,239,000
Adjusted diluted earnings per share attributable to UHS (1)	$9.53	$7.53	27%	$7.32

Year Ended December 31	2018	2017	Percentage Increase	2016
Patient days	7,795,322	7,694,021	1%	7,255,577
Admissions	786,643	765,212	3%	730,126
Average number of licensed beds	29,741	29,278	2%	27,763

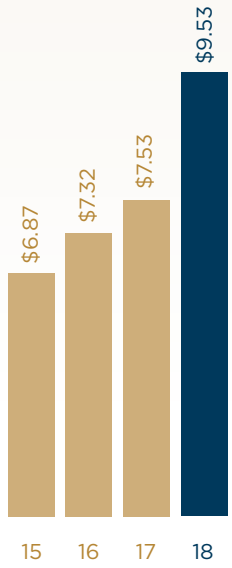
	2018		2017		2016		2015	
(1) Calculation of Adjusted Net Income Attributable to UHS (in thousands except per share amounts)	Amount	Per Diluted Share	Amount	Per Diluted Share	Amount	Per Diluted Share	Amount	Per Diluted Share
Net income attributable to UHS	$779,705	$8.31	$752,303	$7.81	$702,409	$7.14	$680,528	$6.76
Other combined adjustments	114,645	1.22	(26,844)	(0.28)	17,830	0.18	11,519	0.11
Adjusted net income attributable to UHS	$894,350	$9.53	$725,459	$7.53	$720,239	$7.32	$692,047	$6.87

The "Other combined adjustments" neutralize the effect of items in each year that are nonrecurring or non-operational in nature including items such as: reserves for various matters, settlements, legal judgments and lawsuits, our adoption of ASU 2016-09, gains/losses on sales of assets and businesses, impairments of long-lived and intangible assets, the impact of the electronic health records applications and other amounts that may be reflected in a given year that relate to prior periods. Since "adjusted net income attributable to UHS" is not computed in accordance with generally accepted accounting principles ("GAAP"), investors are encouraged to use GAAP measures when evaluating our financial performance. To obtain a complete understanding of our financial performance the information provided above should be examined in connection with our consolidated financial statements and notes thereto, as contained in this report.

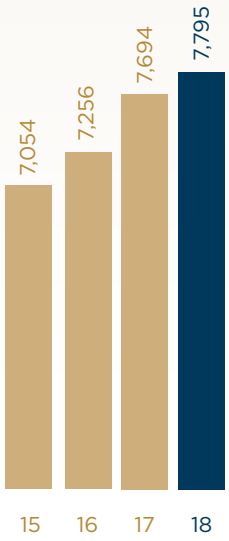
Net revenues
(in millions)



Adjusted net income per diluted share attributable to UHS (1)



Hospital patient days
(in thousands)



UHS' PURPOSE-DRIVEN MISSION

At UHS, superior quality patient care is our top priority. Our continued growth and development are testament to the positive impact we have on the patients and communities we serve.

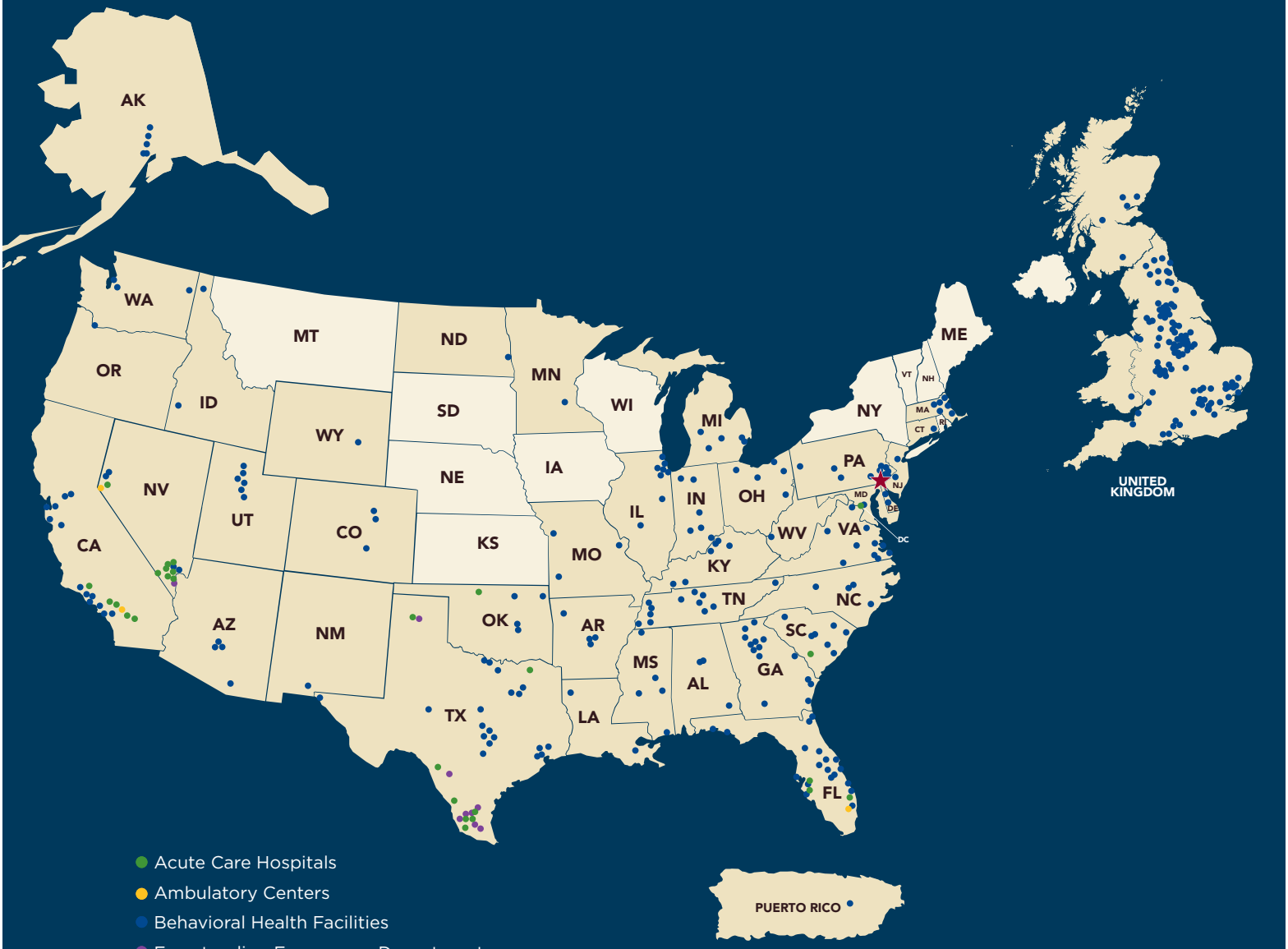
Our Mission statement has been repeatedly praised by industry experts for being honest and authentic, and for identifying value offered to all key stakeholders from our patients and employees to our investors.

OUR MISSION

To provide superior quality healthcare services that:
Patients recommend to family and friends,
Physicians prefer for their patients,
Purchasers select for their clients,
Employees are proud of, and
Investors seek for long-term returns.

Founded in 1979 by Alan B. Miller, Universal Health Services is one of the nation's largest and most respected healthcare management companies, operating through its subsidiaries, behavioral health facilities, acute care hospitals and ambulatory centers throughout the United States, the United Kingdom and Puerto Rico. UHS maintains one of the strongest balance sheets and is rated among the highest in the hospital services industry by Moody's and Standard & Poor's. This strong capital position has enabled the company to develop and acquire many new facilities over the past few years.

The UHS strategy is to build or purchase healthcare properties in rapidly growing markets and create a strong franchise based on exceptional service and effective cost control. UHS owes its success to a responsive management style and to a service philosophy that is based on integrity, competence and compassion. The healthcare industry remains a place of rapid change and uncertainty. But with strength, experience and foresight to chart its own course, UHS has every reason to face the future with optimism.



For a full state-by-state list of facilities, visit **www.uhsinc.com**

INDEX

Acute Care Division
8-15

Behavioral Health Division
16-21

Form 10K
10K: **1-134**

Corporate Information/ Officers and Senior Management

UHS is a registered trademark of UHS of Delaware, Inc., the management company for Universal Health Services, Inc. and a wholly owned subsidiary of Universal Health Services. Universal Health Services, Inc. is a holding company and operates through its subsidiaries including its management company, UHS of Delaware, Inc. All healthcare and management operations are conducted by subsidiaries of Universal Health Services, Inc. Any reference to "UHS or UHS facilities" including any statements, articles or other publications contained herein which relates to healthcare or management operations is referring to Universal Health Services' subsidiaries including UHS of Delaware. Further, the terms "we," "us," "our" or "the company" in such context similarly refer to the operations of Universal Health Services' subsidiaries including UHS of Delaware. Any reference to employment at UHS or employees of UHS refers to employment with one of the subsidiaries of Universal Health Services, Inc., including its management company, UHS of Delaware, Inc.

"UHS Facilities" refers to subsidiaries of Universal Health Services, Inc.

BOARD OF DIRECTORS



Seated left to right: Lawrence S. Gibbs, Elliot J. Sussman, M.D. and Warren J. Nimetz. Standing left to right: Robert H. Hotz, Marc D. Miller, Alan B. Miller and Eileen C. McDonnell.

Alan B. Miller[3,4]
Chairman of the Board
Chief Executive Officer

Marc D. Miller[3,4]
President

Lawrence S. Gibbs[1,2,5]
Chief Investment Officer at Erdos Capital. Previously served as Portfolio Manager at Ramius, LLC; and as Chief Investment Officer and Portfolio Manager at JP Morgan Chase Bank N.A.

Robert H. Hotz[1,2*,3,4,5*]
Senior Managing Director, Global Co-Head of Corporate Finance, and Vice Chairman of Houlihan Lokey Howard & Zukin. Prior thereto, Senior Vice Chairman, Investment Banking for the Americas, UBS LLC.

Eileen C. McDonnell[1*]
Chairman and Chief Executive Officer of The Penn Mutual Life Insurance Company. Served as president of New England Financial, a wholly owned subsidiary of MetLife, and senior vice president of the Guardian Life Insurance Company. Member of The Penn Mutual Board of Trustees.

Warren J. Nimetz[3,4]
Partner, Norton Rose Fulbright US LLP, New York, NY

Elliot J. Sussman, M.D.[1,2,5]
Chairman of The Villages Health. Previously served as President and Chief Executive Officer of Lehigh Valley Hospital and Health Network. Member, Board of Directors of iCAD, Inc.

Committees of the Board: [1]Audit Committee, [2]Compensation Committee, [3]Executive Committee, [4]Finance Committee, [5]Nominating/Corporate Governance Committee, *Committee Chairman

CORPORATE OFFICERS

Alan B. Miller
Chairman of the Board and Chief Executive Officer

Marc D. Miller
President

Steve G. Filton
Executive Vice President and Chief Financial Officer

Marvin G. Pember
Executive Vice President and President Acute Care Division

David F. Alexander
Senior Vice President of Finance, Acute Care

Charles F. Boyle
Senior Vice President and Controller

Geraldine Johnson Geckle
Senior Vice President Human Resources

Laurence L. Harrod
Senior Vice President of Finance, Behavioral Health

Matthew D. Klein
Senior Vice President and General Counsel

Michael S. Nelson
Senior Vice President Strategic Services

Victor J. Radina
Senior Vice President Corporate Development

Cheryl K. Ramagano
Senior Vice President and Treasurer

LETTER TO OUR SHAREHOLDERS

For Universal Health Services, 2018 marked another year of healthy performance. As one of the largest publicly traded healthcare management companies in the United States, with a strong and diverse portfolio of hospital-based care, ambulatory care, behavioral health, an insurance offering, a physician network and various related services, we believe we are well positioned for continued growth.



Dear Valued Shareholders,

As we reflect upon 2018, I am pleased to report another year of growth, expansion, excellence in care delivery and solid performance. We continue to execute on our long-term strategies of prioritizing high quality patient care, investing in our people, serving our local communities, driving operational excellence and growing profitably.

In 2018, UHS generated net revenues of $10.772 billion, an increase of 3.5% over 2017. On a same facility basis, adjusted admissions increased 2.1% for Acute Care hospitals and 3.0% for Behavioral Health facilities.

Highlights in Behavioral Health include the acquisition of The Danshell Group in the United Kingdom, complementing our existing assets operating under the Cygnet Health Care brand, now expanded with the addition of certain specialized services and a broadened geographical footprint. In the United States, we continued to engage with noted not-for-profit organizations in joint venture partnerships, leveraging our expertise and scale in behavioral health and substance abuse treatment. We opened two new joint-venture freestanding behavioral health facilities this year – Lancaster Behavioral Health Hospital (in partnership with Penn Medicine Lancaster General Health, part of the University of Pennsylvania Health System) and Inland Northwest Behavioral Health (in partnership with Providence Health Care) – and signed three new agreements, with over 40 promising projects in the pipeline. And among our existing facilities, we added a total of 508 new beds and expanded program offerings to help meet the growing needs of local community populations.

Among our Acute Care hospitals, we completed a number of significant facility expansions and renovations, added new service lines and acquired innovative technologies to support the advancement of care provided by our clinicians. We continued to invest in access points within our networks that provide increased convenience and choice to our patients. Eight freestanding emergency departments are currently operational, an additional seven are slated to open in 2019 and others across our markets have received investment approval and are on the future horizon. Looking ahead, broader ambulatory strategies are a key priority, whether through organic growth, acquisition or partnership.

I am proud of the reputation we have earned as a leader in the healthcare management industry. For the ninth consecutive year, UHS was recognized among the 'World's Most Admired Companies' by *Fortune* magazine. UHS is currently ranked #268 on the Fortune 500 list, and our employees and facilities continue to be honored by national, state and local organizations for achievement of high clinical quality outcomes, for their clinical expertise and for their commitment to serving our local communities.

We look ahead with great optimism. In 2019, we will continue to focus on our core strategies, remain adaptable to the changing healthcare environment and consistently deliver upon our mission. Simply said, we are committed to continuing our tradition of excellence.

Sincerely,



Alan B. Miller
Founder, Chairman of the Board
and Chief Executive Officer

40 YEARS 1979 - 2019 UHS
Honoring Our Past • Investing In Our Future

Since our founding 40 years ago, Universal Health Services has grown from a single hospital in Las Vegas to an expansive international network. We remain as committed today as we were in 1979 to providing superior quality care and being the preferred provider in our served markets.

UHS ACUTE CARE DIVISION





UHS **ACUTE CARE** DIVISION

We deliver superior quality care, aiming to be the preferred provider in the markets we serve.

2018 was another year of robust performance and exciting growth for the Acute Care division. We cared for more than two million patients, expanded our geographic reach and service lines, earned distinguished accolades from accrediting bodies, expanded our ACO offerings and delivered solid financial results.

Our dedication to delivering clinical excellence sets us apart in the communities we serve and has resulted in continued growth across the division. In 2018, adjusted admissions were up 4 percent; surgeries were up 2 percent; and we experienced earnings growth of 7 percent.

UHS Acute Care hospitals feature advanced technologies, from robotic surgical systems to complex imaging technology and infrared antibacterial lighting. As a leading user of Cerner information systems, we integrate data and automate processes resulting in increased standardization, reduced variability, clinical efficiency and improved outcomes.

Being a leader in the healthcare industry means providing the highest quality care each and every day. Our clinicians and hospital staff are committed to providing an excellent patient experience. Every patient is unique and special, and we are honored to have contributed on their journey.

DELIVERING CARE THAT SAVES LIVES



A resident of Victoria, British Columbia, Sheldon Mack traveled to Las Vegas in October 2017 to celebrate his 21st birthday at the Route 91 Harvest Festival. The concert evening turned to tragedy when shots were fired into the crowd. Sheldon was helping someone else when he was struck twice, in his abdomen and forearm. At **Desert Springs Hospital Medical Center** he underwent life-saving emergency surgery. Months later and back to enjoying life, Sheldon was featured in the Valley Health System's Living Proof campaign, returning to Desert Springs to meet with his care team and express his gratitude.

"Without the team at Desert Springs, I wouldn't be here today. I'm Living Proof that there are great people and a great hospital in Las Vegas." ~ Sheldon Mack

Kenneth Walker (left) and Charlie Ball were classmates who barely knew each other but who are now joined forever by the gift of life. Kenneth had been on dialysis for over a year and was in need of a new kidney. Classmate Charlie Ball was a match. They underwent transplant surgery at **The George Washington University Hospital** in Washington, DC. The procedure and recovery were a success – and Keith and Charlie now appreciate the new-found bond between them.



QUALITY DISTINCTIONS

We are honored to receive industry accolades that recognize the care and services we provide. In 2018, 11 UHS Acute Care hospitals earned an "A" safety grade from Leapfrog, recognizing our hospitals' efforts in protecting patients from harm and meeting the highest safety standards. In addition, two UHS Acute Care hospitals – **Henderson Hospital** and **Southwest Healthcare System** (Inland Valley Medical Center and Rancho Springs Medical Center) – were named Top General Hospitals by The Leapfrog Group. The Top Hospital award, given to just 35 hospitals nationally, is widely acknowledged as one of the most competitive honors American hospitals can receive.

The Centers for Medicare and Medicaid (CMS) created the *Five-Star Quality Rating System* to help consumers, their families and caregivers compare hospitals more easily and to help identify areas about which patients may want to ask questions. **St. Mary's Regional Medical Center** and **Temecula Valley Hospital** each received a 5-Star rating from CMS, recognizing the facilities' commitment to delivering high quality, safe care.



The clinical staff at Inland Valley Medical Center celebrate receiving an "A" rating from The Leapfrog Group in recognition of excellence in patient safety.

Award-winning care

UHS Hospitals Recognized with an "A" Safety Grade from Leapfrog in 2018



Aiken Regional Medical Centers



Henderson Hospital



Lakewood Ranch Medical Center



Northern Nevada Medical Center



South Texas Health System Edinburg



South Texas Health System McAllen



Southwest Healthcare System (Inland Valley)



Southwest Healthcare System (Rancho Springs)



St. Mary's Regional Medical Center



Temecula Valley Hospital



Texoma Medical Center

GROWTH AND EXPANSION

In 2018, we completed a number of expansions – increasing bed capacities, adding service lines, installing innovative technologies – to better meet the evolving healthcare needs of the communities we serve.

Manatee Memorial Hospital located in Bradenton, Florida, opened its new 33,000-square-foot emergency care center. The addition features 48 treatment spaces organized in four nursing clinical care areas. In addition, the Manatee Healthcare System launched a new app that leverages mobile technology to better engage patients and drive affinity and brand loyalty for the Health System.

Lakewood Ranch Medical Center located in Lakewood Ranch, Florida, added new operating rooms, a heart catheterization lab, and a new pre- and post-surgical area.

Wellington Regional Medical Center located in Wellington, Florida, added a new Weight Management Center which offers weight loss programs, dedicated treatment teams, health coaching, exercise physiologist/fitness instruction and nutrition management.

Doctors Hospital of Laredo, located in Laredo, Texas, completed an expansion which includes the renovation of the emergency department, the addition of eight new ICU beds, and a 4,000-square-foot cardiac rehabilitation unit including a walking track and specialized equipment.

Texoma Medical Center, located in Denison, Texas, opened its new emergency department and Level 3 trauma center, increasing capacity from 24 to 48 beds and now includes psychiatric treatment rooms, trauma rooms and a dedicated Fast Track for prompt treatment of minor injuries.

Fort Duncan Regional Medical Center, located in Eagle Pass, Texas, opened a new state-of-the-art cardiac catheterization lab which features a digital cardiovascular and interventional X-ray imaging system for coronary angiography and stent replacement. This will serve elective, urgent and emergency-level patients.



During 2018, Manatee Memorial Hospital commemorated its 65th anniversary of serving the local community. In addition, Manatee opened its brand-new Emergency Care Center that doubled the size of the prior ER. Processes are in place to provide faster, more streamlined care as the community's need for emergency services continues to grow.

South Texas Health System McAllen, located in McAllen, Texas, completed a multi-million dollar expansion which features enhanced patient rooms, nursing stations and dining facilities and also a renovation of the exterior façade.

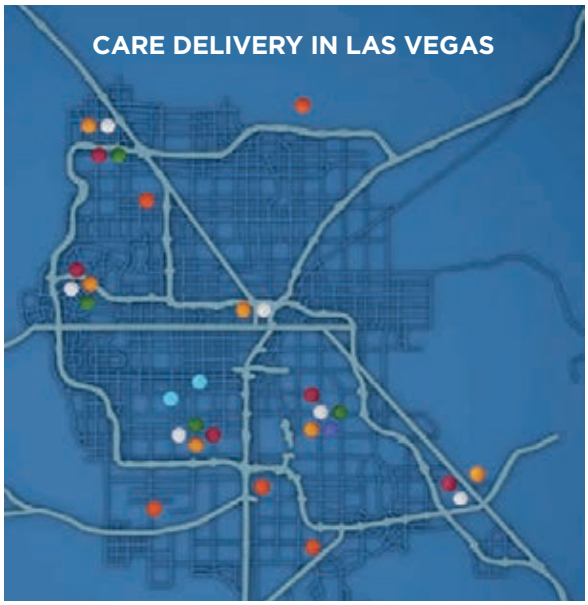
Temecula Valley Hospital, located in Temecula, California, completed a new 29,000-square-foot addition including two new cardiac catheterization labs, a neuro-interventional operating room, an endovascular hybrid operating room, seven additional Post-Anesthesia Care Unit bays, seven additional ambulatory care unit bays, an additional CT scanner and a large community room.

Henderson Hospital, located in Henderson, Nevada, opened a new advanced wound care and hyperbaric therapy center, which features hyperbaric chambers and treatment rooms. The hospital also added a 28-bed medical surgical unit and an 8-bed Level 2 neonatal intensive care unit.

Spring Valley Hospital Medical Center, located in Las Vegas, Nevada, opened two new medical-surgical units resulting in 72 additional beds. Further, the facility added 12 new intermediate beds.

Summerlin Hospital Medical Center, located in Las Vegas, Nevada, expanded its 6th floor to 36 medical-surgical beds and its OB unit on the 2nd floor to accommodate additional beds.

Finally, we have expanded our Accountable Care Organization initiatives to five ACOs across the country, covering 100,000 lives, serving over 3,000 providers, achieving $31.5 million in Medicare Shared Savings and over $5 million in preventative care revenue to the provider participants.



In Las Vegas, The Valley Health System currently comprises 6 acute care hospitals (white), 2 behavioral health facilities (blue), 4 CentRx pharmacy locations (green), 6 physician offices (red), a freestanding emergency department (orange), a bariatric care center (purple), 6 nearby medical office complexes (yellow) and home care including in-home nursing and therapy, wound care, cardiac care and respiratory care. Additionally, we operate a network of over 400 primary care physicians through our ACO; and Prominence Health Plan offers fully insured and self-funded commercial insurance and Medicare Advantage coverage.

INTEGRATED DELIVERY NETWORKS

Establishing clinically integrated, narrow networks in key markets is an important strategy as we provide our patients with improved access to a comprehensive range of services. The hospital serves as the hub, with affiliated outpatient and ancillary services conveniently located across the local geography. The expansion of ambulatory service offerings – whether owned or aligned through partnerships – keeps patients in-network and provides a coordinated care experience.

OPERATIONAL EFFICIENCIES YIELD RESULTS

In 2018, our process improvement efforts yielded 30 percent reduction in the patient's length of stay in the Emergency Department (ED). In part, this was achieved by shortening and streamlining the time it takes to move a patient from the ED to an inpatient bed – typically within a half hour of receiving the bed assignment versus waiting in excess of two hours in an ED holding bed. ED holding hours across the division have declined by 27 percent.

Along with improving the patient experience in the ED, we continue to make our Operating Rooms more efficient to provide a better experience for our surgeons. Operating room turnover declined from over 30 minutes to 25 minutes. Process improvement efforts in MRI continue across the division with 10 facilities reducing patient wait-time by 50 percent.

Pharmacy inflation was held to 0.72 percent yielding a $12.8 million cost avoidance across the division and an actual reduction of 6.32 percent in antimicrobial reflected in a significant reduction in antibiotic days of therapy signaling the positive effectiveness of our antimicrobial stewardship programs.

The Acute Inpatient Rehabilitation Units saw a 83 percent improvement in their Program Evaluation Model (PEM) score in 2018. PEM incorporates key quality and outcome elements to include discharge to community, which was 82 percent. Marketing efforts and operational improvements resulted in an increase in admissions and a $5.1 million increase in revenue over 2017.

In 2018, we saw a $3.5 million reduction in Registry/Agency nurse contract labor. At the same time, we also saw a five percent decrease in overtime for regular full-time staff as a percentage of total hours worked.

At each of our Acute Care hospitals across the nation, we are committed to continuous improvement – improving clinical outcomes, enhancing the patient experience, streamlining operations and supporting staff satisfaction.



Reaching our audiences

Utilizing multi-channel integration, our marketing efforts continue to reach key audiences with relevant meaningful content that differentiates our hospital brands in the minds of consumers. We seek to be top-of-mind in the markets in which we operate.

We measure digital engagement across all channels including websites, social media accounts and with online reviews – all of which is to recognize patient sentiment and to understand how we can continue to optimize the patient experience.

ENABLING MORE CONVENIENT ACCESS TO CARE

Our Freestanding Emergency Departments (also known as FEDs) provide additional, conveniently located access points for people requiring immediate medical attention.



ER at Green Valley Ranch, an extension of Henderson Hospital, opened for patient care in November and is already performing above proforma expectations.

An extension of its respective hospital or health system, the FED offers 24-hour emergency services comparable to that available in the hospital's onsite ED.

In 2018, we opened four new FEDs – one in Las Vegas and three in South Texas. We are on schedule to open seven additional FEDs across the network in 2019.

South Texas Health System FEDs opened in 2018

Ware Road

McColl

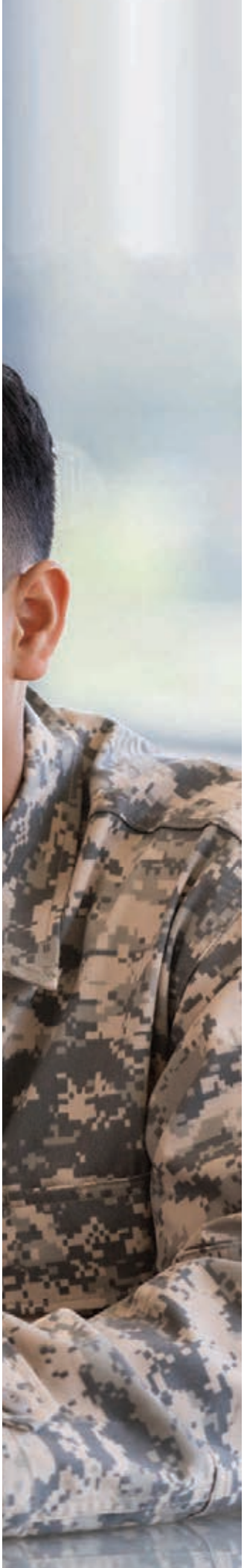
Monte Cristo

SOUTH TEXAS HEALTH SYSTEM



UHS BEHAVIORAL HEALTH DIVISION





UHS **BEHAVIORAL HEALTH** DIVISION

We provide compassionate, outcomes-focused care that transforms lives and families.

The Behavioral Health Division recorded another year of strong clinical quality outcomes, solid financial performance and continued growth trajectory in both the U.S. and the U.K.

In 2018, our dedicated clinicians and staff delivered compassionate care to over 600,000 patients, providing hope and healing to patients and families who struggle with mental health challenges. Through a variety of inpatient, partial and outpatient programs, we provide a broad range of services addressing behavioral health and substance use disorder needs for adults, adolescents and children.

The division continued to outperform the industry in several quality measures. And we continue to enhance our relationships with referral sources. In 2018, we collected more than 1,600 referral source satisfaction surveys with over 80 percent of respondents indicating that a UHS facility was their provider of choice.

As we continue to increase awareness and change the conversation about mental health and addiction issues, we remain committed to our top priority of taking care of patients – treating individuals with respect and operating with integrity. This is the philosophy that has powered past accomplishments and will continue to fuel our success into the future.

Pictured on left: UHS has a long-standing commitment to serving the behavioral health needs of the military.



Located in Kings Norton, Birmingham, United Kingdom, the Wast Hills facility provides assessment and treatment for adult men with autism and complex mental health needs.

GROWTH AND EXPANSION TO SERVE MORE PATIENTS

We continued to grow and expand the delivery of care nationally and internationally, providing more services to more patients. The cornerstone of the division's growth is the team's ability to identify and execute on strategic opportunities.

In the U.K., the company completed the acquisition of **The Danshell Group** in July, adding 25 behavioral health facilities with 288 licensed beds and providing care for adults living with learning disabilities who may also have a diagnosis of autism. Today, under the **Cygnet Health Care** brand name, the company is a leading provider in the U.K., offering a full spectrum of behavioral health services and treatments.

In response to the need for more acute inpatient psychiatric capacity in the U.S., we continued to execute on our growth plan, adding a total of 734 acute psychiatric beds in new and existing facilities during 2018.

On the de novo front, UHS opened **Palm Point Behavioral Health** in Titusville, Florida, an 80-bed facility that expands access to inpatient and outpatient mental health treatment across the region.

The division opened the new **Fort Lauderdale Behavioral Health Center** – replacing the previous location. This is the largest behavioral health facility in South Florida with 182 beds serving adolescents, adults and older adults. The division expanded capacity at facilities across the U.S. including at **Holly Hill Hospital**, located in Raleigh, North Carolina, which added 57 beds to serve more adult community members.

Emerald Coast Behavioral Hospital in Panama City, Florida added a new Outpatient Center offering a variety of programming to meet the needs of its civilian, veteran and active duty clients. Facilities that completed expansion and renovation projects during 2018 include **Cypress Creek Hospital** in Houston, Texas; **Poplar Springs Hospital** in Petersburg, Virginia; and **River Park Hospital** in Huntington, West Virginia.

AN EMPHASIS ON QUALITY MEASURES

At each of our behavioral health facilities, quality of care and patient satisfaction have been, and continue to be, our most important metrics. UHS is one of the few behavioral health providers voluntarily measuring clinical outcomes. Examining a variety of metrics, we are able to quantify changes in patients' conditions from admission to discharge.

A subsidiary of UHS, Mental Health Outcomes (MHO) is a leading consultancy specializing in the design and implementation of custom outcomes measurement, aggregating patient satisfaction surveys and outcomes.

In CMS' Inpatient Psychiatric Facility Quality Reporting requirements, our facilities are compared to approximately 1,500 other psychiatric providers across the country. Our results exceed the national averages in 12 out of 16 indicators.

We believe that patient satisfaction is a key indicator of the effectiveness of our treatment programs. In 2018, our patients rated their overall care as 4.5 out of 5 in our patient satisfaction surveys. More than 91 percent indicated they felt better following care at one of our facilities, and 87 percent would refer a friend or family member in need of care.

Some patients allow our hospitals to contact them after their discharge to assess how they are doing following treatment. Patient responses to the aftercare survey indicate that the vast majority of patients sustain the improvements made during treatment. Eighty-eight percent reported no re-hospitalization; 73 percent reported a positive quality of life.

SPECIALIZED CARE AND TREATMENT PROGRAMS

Our residential treatment facilities continue to enhance their therapeutic environments, clinical programming and educational services. Our innovative programs offer young individuals an educational opportunity that will place them on the road to success.

We are very proud that, in 2018, 330 youth receiving mental health treatment in our facilities obtained their high school diploma or GED, a 7 percent increase from the previous academic year.

Foundations Recovery Network (FRN), a premier provider of addiction treatment, is a national leader in co-occurring disorder treatment for patients who experience mental health and substance use issues. FRN operates 4 inpatient and 13 outpatient facilities.



"What Foundations did was show me how to live. Because I think it's that glimmer of hope you find when you walk in the door and somebody offers you a way out. And you're just so grateful. I owe them my life, I sincerely mean it. Everything I was looking for I found at Foundations to give me the tools I needed to live the life I've been blessed with today."

~ Margaret Phillips, former patient at The Oaks at La Paloma in Memphis, Tennessee

Universal Health Services, Inc. has a long-standing commitment to serving the behavioral health needs of the military, including active duty service members, veterans and their families. In 2018, we served over 7,500 service members through our Patriot Support Programs.

We also offer specialized programs dedicated to the needs of First Responders. For example, at **Cypress Creek Hospital**, in Houston, Texas, we launched a dedicated unit to care for and treat firefighters, police officers and EMS. The Honor Strong Program provides resiliency-focused, trauma-informed care for these uniformed professionals who may be experiencing mental health issues due to exposure to tragic circumstances.

Our Behavioral Health facilities continue to engage with local audiences, sharing the meaningful ways in which we serve patients, their families and our communities. Compelling content drives affinity and brand loyalty. In 2018, our facilities' social media content reached over 8 million people and drove thousands of click-throughs and phone calls to facilities for more information.

SUICIDE PREVENTION

As a partner of the National Action Alliance for Suicide Prevention, we are proud that close to 40 of our inpatient psychiatric facilities have adopted the Zero Suicide principles. Further, 92 percent of UHS Behavioral CEOs indicated that the Suicide Prevention Tool Kit was impactful in helping communities tap into key resources.

Our leadership of and partnership with the Action Alliance has provided many opportunities to demonstrate our commitment to suicide reduction using evidence-based resources and educating the community of their role in changing the conversation.

BEHAVIORAL HEALTH INTEGRATIONS

In response to the significant rise in demand for behavioral health services, the division is engaging in joint ventures, partnerships and other new care delivery models.



Lancaster Behavioral Health Hospital officially opened in June 2018 to serve the community.



Integration of behavioral health and physical health care services can decrease unnecessary emergency department visits, reduce unnecessary inpatient admissions, and enhance compliance with treatment leading to better clinical outcomes and increased patient satisfaction. The division currently has over 40 active integration projects in progress.

During the year, the division operationalized key joint venture partnerships. We opened **Lancaster Behavioral Health Hospital** – a new 126-bed facility in Lancaster, Pennsylvania, which is a collaboration with Penn Medicine Lancaster General Health, part of the University of Pennsylvania Health System. The facility provides a wide range of services including the county's only unit for adolescents, a unit for medically complex patients and a dedicated women's trauma unit.

In partnership with Providence Health and Services, we opened **Inland Northwest Behavioral Health**, a 100-bed de novo hospital in Spokane, Washington, with inpatient and outpatient services for children, adolescents, adults and older adults.

Beaumont Health and UHS formed a joint venture to address the growing, unmet need for accessible, high-quality and advanced mental health services in Southeast Michigan and across the state. Construction of the new facility will begin in 2019 and is expected to open in early to mid-2021.

The division also announced a joint venture with Mercy Medical Center Des Moines, Iowa, to build a new 100-bed facility in Clive, Iowa. This will be UHS' first facility in the state of Iowa. The new hospital is on schedule to open in 2020.

Leveraging today's advancements to improve the patient experience, UHS has extensive experience providing psychiatric and other clinical professional services through the use of secure televideo technology. We currently have over 168 behavioral health facilities with active telehealth projects.



Inland Northwest Behavioral Health
Spokane, Washington

DELIVERING **SUPERIOR QUALITY** CARE

We strive to provide superior quality care for each patient we are privileged to serve. Many of our patients face complex health challenges and we work hard to help them lead the fullest lives possible. Every patient interaction matters and we believe our patient-centric approach is reflected in our high patient-satisfaction scores and strong regulatory record.



Since his seven-bypass open-heart surgery, followed by intense cardiac rehabilitation, both at Doctors Hospital of Laredo, Aristeo Gonzalez has run 12 marathons and 15 half-marathons. ***"I'm very grateful to Dr. Santos, the nurses, and the whole team. I am going to continue training to see if I can get a Boston Marathon qualifying time. That's my goal."***

Alexis and Melina Garza are alive and thriving, thanks to life-saving fetal laser surgery performed at Wellington Regional Medical Center to treat twin-twin transfusion syndrome. ***"We knew Wellington was on the cutting edge of this. We are so fortunate."***



"I had a serious suicide attempt and was in a state of complete despair when I arrived. Fuller was here for me when I couldn't be here for myself and I will forever be grateful. I felt listened to, cared for and safe from the moment I arrived to the moment I was discharged."

~ I.M., former patient at Fuller Hospital

Please visit uhsinc.com/our-stories for the expanded versions of these and other patient testimonials.



Anthony Roosevelt Stokes knows first-hand that no two strokes are the same. In addition to receiving top-notch immediate medical care, he diligently completed the rehabilitation program, key to a complete recovery. ***"Palmdale Regional Medical Center saved me – twice."***



After a long-term and increasingly complex 'mystery' illness, including battling life-threatening complications from infection, Katie Wheeler was diagnosed with Superior Mesenteric Artery syndrome, a rare digestive condition. ***"There is no doubt in my mind that I would not be here to talk about this today if it weren't for Temecula Valley Hospital. I am truly humbled and cannot wait to apply to medical school and help others in their darkest times as the doctors and staff there did for me."***

Foundations Behavioral Health LifeWorks Schools are licensed specialty therapeutic day schools for students in middle and high school affected by social, emotional or behavioral health challenges. Mother Lillian Diaz concluded a long letter of gratitude with, ***"Thank You LifeWorks and your staff for impacting life in such a positive way!"***



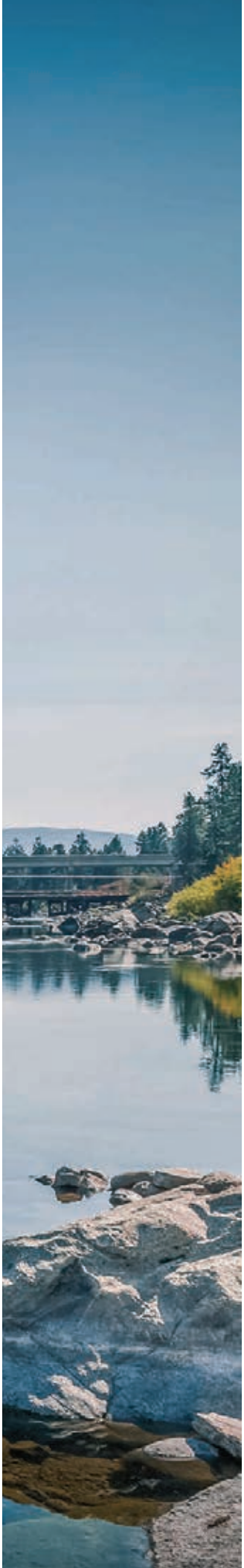
"I quickly learned that The BridgeWay was a safe place for me. My caregivers worked as a team to help me to get the right treatment for my diagnosis: bipolar disorder."

~ Barbara, former patient at The BridgeWay



A team of service users at Cygnet Hospital Bierley produced a film exploring stigma in and around mental health. ***"As a mental health patient, I have found that people who suffer with their mental health come from all different backgrounds and have all lived very different lives, and therefore should not be judged because you never really know someone just by looking at them,"*** says Deborah Henry. ***"I gained so much from the whole process of creating this film with my friends,"*** adds Hannah Christie.





CORPORATE SOCIAL RESPONSIBILITY

A shared commitment

UHS recognizes the need to protect the natural environment as well as serving patients and the communities in which we operate. Keeping our surroundings clean and minimizing pollution is of benefit to all. We are committed to implementing best practices when managing energy usage, consumption and waste disposal. Stewardship continues to play an important role in our commitment to a clean environment and strong communities.

UNCOMPENSATED CARE (CHARITY CARE AND UNINSURED DISCOUNTS):

Our commitment to corporate social responsibility is evident across the company in a number of ways, including the care that we provide to patients and their families, regardless of their ability to pay.

UHS Acute Care hospitals have recorded increasing charity care and uninsured discounts, based on charges at established rates, for the years ended December 31, 2018, 2017 and 2016:

	2018		2017		2016	
	Amount	%	Amount	%	Amount	%
Charity care	$761,783	40%	$887,136	50%	$733,585	50%
Uninsured discounts	$1,132,811	60%	$881,265	50%	$720,205	50%
Total uncompensated care	$1,894,594	100%	$1,768,401	100%	$1,453,790	100%

(dollar amounts in thousands)

Generally, patients treated at our hospitals for non-elective services, who have gross income less than 400 percent of the federal poverty guidelines, are deemed eligible for charity care. The federal poverty guidelines are established by the federal government and are based on income and family size.

ENERGY STAR® CERTIFICATION

In 2017, UHS had launched a four-year, $45 million energy reduction initiative to be implemented at all facilities. The project continues today and as such focuses on replacing fluorescent lighting with more efficient LED lighting and optimization of our large HVAC systems.

By the end of 2020, we are projected to have reduced our annual energy consumption by 125 million kilowatt hours and 98 million cubic feet of gas. This equates to 100,000 tons of CO2 emissions avoided, or 20,000 passenger vehicles removed from the roads, or 229 million miles not driven.

LEED / GREEN GLOBES CERTIFICATION

In continuing to enhance the efficient use of energy in the operations and maintenance of our hospitals and other medical facilities, as well as to incorporate environmentally sustainable practices, UHS is in the midst of recertifying five of our six hospitals located in Las Vegas as energy efficient properties. We had previously achieved the first LEED (Leadership in Energy and Environmental Design) for Existing Buildings Gold certifications for hospitals in Nevada, and are furthering our commitment to operating efficient and environmentally sustainable operations by recertifying these facilities under the globally recognized Green Globes green buildings rating system.

Green Globes is a science-based building rating system that supports a wide range of new construction and existing building project types, certifying that a building's operations are sustainable by both policy and design. Hospitals consume natural resources at an extraordinarily high rate, as they are occupied 24 hours a day, seven days a week. With hundreds of millions of square feet of space in the U.S. alone, there is an enormous opportunity for the industry to transform the impact of the built environment. UHS is proud to continue its commitment to the health and safety of its patients and employees by providing green and sustainable environments.

CULINARY AND NUTRITION

The Culinary and Nutrition Department seeks to deliver and utilize the right foods, for the right reasons, embedded into our menus and prepared using efficient equipment.

We expanded our mission to not only provide foods from sustainable sources, but do so with cleaner labels for a better world and a better body. We have successfully removed all trans-fatty acids and high-fructose corn syrup (HFCS) from ingredients we use in our recipes. We have considerably decreased the use of HFCS in our Behavioral Health division, serving more 100 percent juices and flavored water alternatives which provide a healthier choice for patients, as opposed to carbonated soft drinks.

In 2018, we set a goal to increase the use of seafood served from Best Aquaculture Practices (BAP) certified sources. We were able to increase the number of BAP-certified seafood items by 25 percent, but were limited by price volatility. This challenge inspired us to look at other protein opportunities, such as poultry.

Our use of 'Antibiotic Free' and 'No Antibiotics Ever' poultry items increased during 2018. Although there is a price difference, we consider it an investment in the health of our patients and our goal to move toward clearer label foods.

To make certain that these changes are sustained, we are utilizing Centralized Order Guide Management and increasing the number of Standardized Menu Cycles so the right product, for the right reason, is featured consistently.

For the coming year, we will expand upon the progress made with our Kitchen Equipment Initiative. Kitchens utilize large amounts of energy to cool, store and prepare food. Through a set of Standardized Kitchen Templates, equipment is now being selected not only for long term durability, but also for the ability to conserve energy. By selecting more technologically advanced and efficient equipment, we look to deliver a ten percent decrease in kitchen energy usage in our new and refurbished kitchens.

ENVIRONMENTAL SERVICES

In 2018, UHS continued to innovate the way we treat and protect hospital floors at our Acute Care hospitals. In both newly remodeled and expanded areas of the hospitals, we are installing no-wax floors to eliminate the need for protectant chemicals. In areas not under remodel, we are reducing the use of floor waxes and applying environmentally safer floor finishes, eliminating the need for caustic floor stripper products.

Partnering with chemical vendors, we also switched many cleaning agents to 'Green Seal Certified' floor care products within our Acute Care facilities.

Partnering with floor equipment vendors, at multiple facilities we began using floor cleaning equipment for non-patient areas which electrically charges water for cleaning purposes, drastically reducing the need for chemicals.

RESPONSIBLE PHARMACEUTICAL WASTE MANAGEMENT

Proper disposal of pharmaceutical waste is an essential component to reducing the presence of residual medications in our ecosystem and our groundwater. The Resource Conservation and Recovery Act (RCRA) is the law which provides the framework for the management of hazardous and non-hazardous solid waste. Pharmaceuticals are considered hazardous because they exhibit hazardous or toxic chemical properties or they may exhibit characteristics such as being ignitable, corrosive or reactive.

The UHS pharmaceutical waste management program focuses on utilizing special disposal containers serving several purposes specific to the safety of healthcare practitioners as well as the environment. These containers reduce the risk of needle-stick injuries in the healthcare setting while ensuring regulatory compliance by separating pharmaceutical waste based on hazard characteristic.

We expanded the scope of the pharmaceutical waste management program by incorporating the use of controlled substance waste disposal containers to safely and effectively manage the disposal of controlled substance waste generated by UHS facilities. The containers specifically designed to prevent diversion of controlled substances in addition to providing an environmentally friendly method for disposal.

Proper disposal of pharmaceutical and controlled substance waste generated at our hospitals provides an added degree of safety for our patients and employees while protecting our communities and the environment.

REPROCESSING AND WASTE DIVERSION

Through reprocessing and remanufacturing efforts with our business partners, UHS is able to decrease its environmental impact utilizing key programs. In 2018, our Acute Care division was able to divert 59,116 pounds of waste by collecting 487,857 items. UHS has been participating in reprocessing and remanufacturing programs for over 15 years.

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

FORM 10-K

(MARK ONE)

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

For the fiscal year ended December 31, 2018

OR

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

For the transition period from _____ to _____

Commission File No. 1-10765

UNIVERSAL HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

Delaware	**23-2077891**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**
UNIVERSAL CORPORATE CENTER **367 South Gulph Road** **P.O. Box 61558** **King of Prussia, Pennsylvania** **(Address of principal executive offices)**	**19406-0958** **(Zip Code)**

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

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

Title of each Class	**Name of each exchange on which registered**
Class B Common Stock, $.01 par value	**New York Stock Exchange**

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

Class D Common Stock, $.01 par value
(Title of each Class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☐ No ☒

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

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

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

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

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

The aggregate market value of voting stock held by non-affiliates at June 30, 2018 was $9.4 billion. (For the purpose of this calculation, it was assumed that Class A, Class C, and Class D Common Stock, which are not traded but are convertible share-for-share into Class B Common Stock, have the same market value as Class B Common Stock. Also, for purposes of this calculation only, all directors are deemed to be affiliates.)

The number of shares of the registrant's Class A Common Stock, $.01 par value, Class B Common Stock, $.01 par value, Class C Common Stock, $.01 par value, and Class D Common Stock, $.01 par value, outstanding as of January 31, 2019, were 6,577,100; 83,527,315; 661,688 and 18,653, respectively.

DOCUMENTS INCORPORATED BY REFERENCE:

Portions of the registrant's definitive proxy statement for our 2019 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission within 120 days after December 31, 2018 (incorporated by reference under Part III).

UNIVERSAL HEALTH SERVICES, INC.
2018 FORM 10-K ANNUAL REPORT

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This Annual Report on Form 10-K is for the year ended December 31, 2018. This Annual Report modifies and supersedes documents filed prior to this Annual Report. Information that we file with the Securities and Exchange Commission (the "SEC") in the future will automatically update and supersede information contained in this Annual Report.

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

PART I

ITEM 1. ***Business***

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

As of February 27, 2019, we owned and/or operated 350 inpatient facilities and 37 outpatient and other facilities including the following located in 37 states, Washington, D.C., the United Kingdom and Puerto Rico:

Acute care facilities located in the U.S.:

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

Behavioral health care facilities (324 inpatient facilities and 21 outpatient facilities):

Located in the U.S.:

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

Located in the U.K.:

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

Located in Puerto Rico:

- 3 inpatient behavioral health care facilities.

As a percentage of our consolidated net revenues, net revenues from our acute care hospitals, outpatient facilities and commercial health insurer accounted for 53% during each of 2018 and 2017 and 52% during 2016. Net revenues from our behavioral health care facilities and commercial health insurer accounted for 47% of our consolidated net revenues during each of 2018 and 2017 and 48% during 2016.

Our behavioral health care facilities located in the U.K. generated net revenues of approximately $505 million in 2018, $429 million in 2017 and $241 million in 2016. Total assets at our U.K. behavioral health care facilities were approximately $1.224 billion as of December 31, 2018, $1.098 billion as of December 31, 2017 and $965 million as of December 31, 2016.

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

2018 Acquisitions of Assets and Businesses:

2018 Acquisitions:

During 2018 we spent $110 million to acquire businesses and property consisting primarily of:

- The Danshell Group, consisting of 25 behavioral health facilities located in the U.K. (acquired during the third quarter of 2018), and;
- A 109-bed behavioral health care facility located in Gulfport, Mississippi (acquired during the first quarter of 2018).

Available Information

We are a Delaware corporation that was organized in 1979. Our principal executive offices are located at Universal Corporate Center, 367 South Gulph Road, P.O. Box 61558, King of Prussia, PA 19406. Our telephone number is (610) 768-3300.

Our website is located at http://www.uhsinc.com. Copies of our annual, quarterly and current reports that we file with the SEC, and any amendments to those reports, are available free of charge on our website. Our filings are also available to the public at the website maintained by the SEC, www.sec.gov. The information posted on our website is not incorporated into this Annual Report. Our

Board of Directors' committee charters (Audit Committee, Compensation Committee and Nominating & Governance Committee), Code of Business Conduct and Corporate Standards applicable to all employees, Code of Ethics for Senior Financial Officers, Corporate Governance Guidelines and our Code of Conduct, Corporate Compliance Manual and Compliance Policies and Procedures are available free of charge on our website. Copies of such reports and charters are available in print to any stockholder who makes a request. Such requests should be made to our Secretary at our King of Prussia, PA corporate headquarters. We intend to satisfy the disclosure requirement under Item 5.05 of Form 8-K relating to amendments to or waivers of any provision of our Code of Ethics for Senior Financial Officers by promptly posting this information on our website.

In accordance with Section 303A.12(a) of the New York Stock Exchange Listed Company Manual, we submitted our CEO's certification to the New York Stock Exchange in 2018. Additionally, contained in Exhibits 31.1 and 31.2 of this Annual Report on Form 10-K, are our CEO's and CFO's certifications regarding the quality of our public disclosures under Section 302 of the Sarbanes-Oxley Act of 2002.

Our Mission

Our company mission is:

To provide superior quality healthcare services that

PATIENTS recommend to families and friends,

PHYSICIANS prefer for their patients,

PURCHASERS select for their clients,

EMPLOYEES are proud of, and

INVESTORS seek for long-term returns.

To achieve this, we have a commitment to:

- service excellence
- continuous improvement in measurable ways
- employee development
- ethical and fair treatment of all
- teamwork
- compassion
- innovation in service delivery

Business Strategy

We believe community-based hospitals will remain the focal point of the healthcare delivery network and we are committed to a philosophy of self-determination for both the company and our hospitals.

Acquisition of Additional Hospitals. We selectively seek opportunities to expand our base of operations by acquiring, constructing or leasing additional hospital facilities. We are committed to a program of rational growth around our core businesses, while retaining the missions of the hospitals we manage and the communities we serve. Such expansion may provide us with access to new markets and new healthcare delivery capabilities. We also continue to examine our facilities and consider divestiture of those facilities that we believe do not have the potential to contribute to our growth or operating strategy. In recent years our behavioral health services segment has been focused on efforts to partner with non-UHS acute care hospitals to help operate their behavioral health services. These arrangements include hospital purchases, leased beds and joint venture operating agreements.

Improvement of Operations of Existing Hospitals and Services. We also seek to increase the operating revenues and profitability of owned hospitals by the introduction of new services, improvement of existing services, physician recruitment and the application of financial and operational controls.

We are involved in continual development activities for the benefit of our existing facilities. From time to time applications are filed with state health planning agencies to add new services in existing hospitals in states which require certificates of need, or CONs.

Although we expect that some of these applications will result in the addition of new facilities or services to our operations, no assurances can be made for ultimate success by us in these efforts.

Quality and Efficiency of Services. Pressures to contain healthcare costs and technological developments allowing more procedures to be performed on an outpatient basis have led payers to demand a shift to ambulatory or outpatient care wherever possible. We are responding to this trend by emphasizing the expansion of outpatient services. In addition, in response to cost containment pressures, we continue to implement programs at our facilities designed to improve financial performance and efficiency while continuing to provide quality care, including more efficient use of professional and paraprofessional staff, monitoring and adjusting staffing levels and equipment usage, improving patient management and reporting procedures and implementing more efficient billing and collection procedures. In addition, we will continue to emphasize innovation in our response to the rapid changes in regulatory trends and market conditions while fulfilling our commitment to patients, physicians, employees, communities and our stockholders.

In addition, our aggressive recruiting of highly qualified physicians and developing provider networks help to establish our facilities as an important source of quality healthcare in their respective communities.

Hospital Utilization

We believe that the most important factors relating to the overall utilization of a hospital include the quality and market position of the hospital and the number, quality and specialties of physicians providing patient care within the facility. Generally, we believe that the ability of a hospital to meet the health care needs of its community is determined by its breadth of services, level of technology, emphasis on quality of care and convenience for patients and physicians. Other factors that affect utilization include general and local economic conditions, market penetration of managed care programs, the degree of outpatient use, the availability of reimbursement programs such as Medicare and Medicaid, and demographic changes such as the growth in local populations. Utilization across the industry also is being affected by improvements in clinical practice, medical technology and pharmacology. Current industry trends in utilization and occupancy have been significantly affected by changes in reimbursement policies of third party payers. We are also unable to predict the extent to which these industry trends will continue or accelerate. In addition, our acute care services business is typically subject to certain seasonal fluctuations, such as higher patient volumes and net patient service revenues in the first and fourth quarters of the year.

The following table sets forth certain operating statistics for hospitals operated by us for the years indicated. Accordingly, information related to hospitals acquired during the five-year period has been included from the respective dates of acquisition, and information related to hospitals divested during the five year period has been included up to the respective dates of divestiture.

	2018	2017	2016	2015	2014
Average Licensed Beds:					
Acute Care Hospitals	6,232	6,127	5,934	5,832	5,776
Behavioral Health Centers	23,509	23,151	21,829	21,202	20,231
Average Available Beds (1):					
Acute Care Hospitals	6,056	5,954	5,759	5,656	5,571
Behavioral Health Centers	23,425	23,068	21,744	21,116	20,131
Admissions:					
Acute Care Hospitals	303,985	297,390	274,074	261,727	251,165
Behavioral Health Centers	482,658	467,822	456,052	447,007	426,510
Average Length of Stay (Days):					
Acute Care Hospitals	4.5	4.4	4.6	4.7	4.6
Behavioral Health Centers	13.3	13.6	13.2	13.1	12.9
Patient Days (2):					
Acute Care Hospitals (1)	1,376,988	1,312,265	1,251,511	1,218,969	1,167,726
Behavioral Health Centers	6,418,334	6,381,756	6,004,066	5,835,134	5,518,660
Occupancy Rate-Licensed Beds (3):					
Acute Care Hospitals	61%	59%	58%	57%	55%
Behavioral Health Centers	75%	76%	75%	75%	75%
Occupancy Rate-Available Beds (3):					
Acute Care Hospitals	62%	60%	59%	59%	57%
Behavioral Health Centers	75%	76%	75%	76%	75%

(1) "Average Available Beds" is the number of beds which are actually in service at any given time for immediate patient use with the necessary equipment and staff available for patient care. A hospital may have appropriate licenses for more beds than are in service for a number of reasons, including lack of demand, incomplete construction, and anticipation of future needs.
(2) "Patient Days" is the sum of all patients for the number of days that hospital care is provided to each patient.
(3) "Occupancy Rate" is calculated by dividing average patient days (total patient days divided by the total number of days in the period) by the number of average beds, either available or licensed.

Sources of Revenue

We receive payments for services rendered from private insurers, including managed care plans, the federal government under the Medicare program, state governments under their respective Medicaid programs and directly from patients. See *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Sources of Revenue* for additional disclosure. Other information related to our revenues, income and other operating information for each reporting segment of our business is provided in Note 12 to our Consolidated Financial Statements, *Segment Reporting.*

Regulation and Other Factors

Overview: The healthcare industry is subject to numerous laws, regulations and rules including, among others, those related to government healthcare participation requirements, various licensure and accreditations, reimbursement for patient services, health information privacy and security rules, and Medicare and Medicaid fraud and abuse provisions (including, but not limited to, federal statutes and regulations prohibiting kickbacks and other illegal inducements to potential referral sources, false claims submitted to federal or state health care programs and self-referrals by physicians). Providers that are found to have violated any of these laws and regulations may be excluded from participating in government healthcare programs, subjected to significant fines or penalties and/or required to repay amounts received from the government for previously billed patient services. Although we believe our policies, procedures and practices comply with governmental regulations, no assurance can be given that we will not be subjected to additional governmental inquiries or actions, or that we would not be faced with sanctions, fines or penalties if so subjected. Even if we were to ultimately prevail, a significant governmental inquiry or action under one of the above laws, regulations or rules could have a material adverse impact on us.

Licensing, Certification and Accreditation: All of our U.S. hospitals are subject to compliance with various federal, state and local statutes and regulations in the U.S. and receive periodic inspection by state licensing agencies to review standards of medical care, equipment and cleanliness. Our hospitals must also comply with the conditions of participation and licensing requirements of federal, state and local health agencies, as well as the requirements of municipal building codes, health codes and local fire departments. Various other licenses and permits are also required in order to dispense narcotics, operate pharmacies, handle radioactive materials and operate certain equipment. Our facilities in the United Kingdom are also subject to various laws and regulations.

All of our eligible hospitals have been accredited by The Joint Commission. All of our acute care hospitals and most of our behavioral health centers in the U.S. are certified as providers of Medicare and Medicaid services by the appropriate governmental authorities.

If any of our facilities were to lose its Joint Commission accreditation or otherwise lose its certification under the Medicare and Medicaid programs, the facility may be unable to receive reimbursement from the Medicare and Medicaid programs and other payers. We believe our facilities are in substantial compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, it may become necessary for us to make changes in our facilities, equipment, personnel and services in the future, which could have a material adverse impact on operations.

Certificates of Need: Many of the states in which we operate hospitals have enacted certificates of need ("CON") laws as a condition prior to hospital capital expenditures, construction, expansion, modernization or initiation of major new services. Failure to obtain necessary state approval can result in our inability to complete an acquisition, expansion or replacement, the imposition of civil or, in some cases, criminal sanctions, the inability to receive Medicare or Medicaid reimbursement or the revocation of a facility's license, which could harm our business. In addition, significant CON reforms have been proposed in a number of states that would increase the capital spending thresholds and provide exemptions of various services from review requirements. In the past, we have not experienced any material adverse effects from those requirements, but we cannot predict the impact of these changes upon our operations.

Conversion Legislation: Many states have enacted or are considering enacting laws affecting the conversion or sale of not-for-profit hospitals to for-profit entities. These laws generally require prior approval from the attorney general, advance notification and

community involvement. In addition, attorneys general in states without specific conversion legislation may exercise discretionary authority over these transactions. Although the level of government involvement varies from state to state, the trend is to provide for increased governmental review and, in some cases, approval of a transaction in which a not-for-profit entity sells a health care facility to a for-profit entity. The adoption of new or expanded conversion legislation and the increased review of not-for-profit hospital conversions may limit our ability to grow through acquisitions of not-for-profit hospitals.

Utilization Review: Federal regulations require that admissions and utilization of facilities by Medicare and Medicaid patients must be reviewed in order to ensure efficient utilization of facilities and services. The law and regulations require Peer Review Organizations ("PROs") to review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of diagnosis related group ("DRG") classifications and the appropriateness of cases of extraordinary length of stay. PROs may deny payment for services provided, assess fines and also have the authority to recommend to the Department of Health and Human Services ("HHS") that a provider that is in substantial non-compliance with the standards of the PRO be excluded from participating in the Medicare program. We have contracted with PROs in each state where we do business to perform the required reviews.

Audits: Most hospitals are subject to federal audits to validate the accuracy of Medicare and Medicaid program submitted claims. If these audits identify overpayments, we could be required to pay a substantial rebate of prior years' payments subject to various administrative appeal rights. The federal government contracts with third-party "recovery audit contractors" ("RACs") and "Medicaid integrity contractors" ("MICs"), on a contingent fee basis, to audit the propriety of payments to Medicare and Medicaid providers. Similarly, Medicare zone program integrity contractors ("ZPICs") target claims for potential fraud and abuse. Additionally, Medicare administrative contractors ("MACs") must ensure they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. The Centers for Medicare and Medicaid Services ("CMS") announced its intent to consolidate many of these Medicare and Medicaid program integrity functions into new unified program integrity contractors ("UPICs"), though it remains unclear what effect, if any, this consolidation may have. We have undergone claims audits related to our receipt of federal healthcare payments during the last three years, the results of which have not required material adjustments to our consolidated results of operations. However, potential liability from future federal or state audits could ultimately exceed established reserves, and any excess could potentially be substantial. Further, Medicare and Medicaid regulations also provide for withholding Medicare and Medicaid overpayments in certain circumstances, which could adversely affect our cash flow.

Self-Referral and Anti-Kickback Legislation

The Stark Law: The Social Security Act includes a provision commonly known as the "Stark Law." This law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship, unless an exception is met. These types of referrals are known as "self-referrals." Sanctions for violating the Stark Law include civil penalties up to $24,748 for each violation, and up to $164,992 for sham arrangements. There are a number of exceptions to the self-referral prohibition, including an exception for a physician's ownership interest in an entire hospital as opposed to an ownership interest in a hospital department unit, service or subpart. However, federal laws and regulations now limit the ability of hospitals relying on this exception to expand aggregate physician ownership interest or to expand certain hospital facilities. This regulation also places a number of compliance requirements on physician-owned hospitals related to reporting of ownership interest. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases and recruitment agreements that adhere to certain enumerated requirements.

We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Nonetheless, because the law in this area is complex and constantly evolving, there can be no assurance that federal regulatory authorities will not determine that any of our arrangements with physicians violate the Stark Law.

Anti-kickback Statute: A provision of the Social Security Act known as the "anti-kickback statute" prohibits healthcare providers and others from directly or indirectly soliciting, receiving, offering or paying money or other remuneration to other individuals and entities in return for using, referring, ordering, recommending or arranging for such referrals or orders of services or other items covered by a federal or state health care program. However, changes to the anti-kickback statute have reduced the intent required for violation; one is no longer required to "have actual knowledge or specific intent to commit a violation of" the anti-kickback statute in order to be found in violation of such law.

The anti-kickback statute contains certain exceptions, and the Office of the Inspector General of the Department of Health and Human Services ("OIG") has issued regulations that provide for "safe harbors," from the federal anti-kickback statute for various activities. These activities, which must meet certain requirements, include (but are not limited to) the following: investment interests, space rental, equipment rental, practitioner recruitment, personnel services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, freestanding

surgery centers, donation of technology for electronic health records and referral agreements for specialty services. The fact that conduct or a business arrangement does not fall within a safe harbor or exception does not automatically render the conduct or business arrangement illegal under the anti-kickback statute. However, such conduct and business arrangements may lead to increased scrutiny by government enforcement authorities.

Although we believe that our arrangements with physicians and other referral sources have been structured to comply with current law and available interpretations, there can be no assurance that all arrangements comply with an available safe harbor or that regulatory authorities enforcing these laws will determine these financial arrangements do not violate the anti-kickback statute or other applicable laws. Violations of the anti-kickback statute may be punished by a criminal fine of up to $100,000 for each violation or imprisonment, however, under 18 U.S.C. Section 3571, this fine may be increased to $250,000 for individuals and $500,000 for organizations. Civil money penalties may include fines of up to $100,000 per violation and damages of up to three times the total amount of the remuneration and/or exclusion from participation in Medicare and Medicaid.

Similar State Laws: Many of the states in which we operate have adopted laws that prohibit payments to physicians in exchange for referrals similar to the anti-kickback statute and the Stark Law, some of which apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties as well as loss of licensure. In many instances, the state statutes provide that any arrangement falling in a federal safe harbor will be immune from scrutiny under the state statutes. However, in most cases, little precedent exists for the interpretation or enforcement of these state laws.

These laws and regulations are extremely complex and, in many cases, we don't have the benefit of regulatory or judicial interpretation. It is possible that different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws, or the public announcement that we are being investigated for possible violations of one or more of these laws (see Item 3. Legal Proceedings), could have a material adverse effect on our business, financial condition or results of operations and our business reputation could suffer significantly. In addition, we cannot predict whether other legislation or regulations at the federal or state level will be adopted, what form such legislation or regulations may take or what their impact on us may be.

If we are deemed to have failed to comply with the anti-kickback statute, the Stark Law or other applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of our licenses to operate one or more facilities), and exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs. The imposition of such penalties could have a material adverse effect on our business, financial condition or results of operations.

Federal False Claims Act and Similar State Regulations: A current trend affecting the health care industry is the increased use of the federal False Claims Act, and, in particular, actions being brought by individuals on the government's behalf under the False Claims Act's qui tam, or whistleblower, provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government by alleging that the defendant has defrauded the Federal government.

When a defendant is determined by a court of law to have violated the False Claims Act, the defendant may be liable for up to three times the actual damages sustained by the government, plus mandatory civil penalties of between $11,181 to $22,363 for each separate false claim. There are many potential bases for liability under the False Claims Act. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The Fraud Enforcement and Recovery Act of 2009 ("FERA") has expanded the number of actions for which liability may attach under the False Claims Act, eliminating requirements that false claims be presented to federal officials or directly involve federal funds. FERA also clarifies that a false claim violation occurs upon the knowing retention, as well as the receipt, of overpayments. In addition, recent changes to the anti-kickback statute have made violations of that law punishable under the civil False Claims Act. Further, a number of states have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit on behalf of the state in state court. Recent changes to the False Claims Act require that federal healthcare program overpayments be returned within 60 days from the date the overpayment was identified, or by the date any corresponding cost report was due, whichever is later. Failure to return an overpayment within this period may result in additional civil False Claims Act liability.

Other Fraud and Abuse Provisions: The Social Security Act also imposes criminal and civil penalties for submitting false claims to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered, billing for services without prescribed documentation, misrepresenting actual services rendered in order to obtain higher reimbursement and cost report fraud. Like the anti-kickback statute, these provisions are very broad.

Further, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") broadened the scope of the fraud and abuse laws by adding several criminal provisions for health care fraud offenses that apply to all health benefit programs, whether or not payments under such programs are paid pursuant to federal programs. HIPAA also introduced enforcement mechanisms to prevent

fraud and abuse in Medicare. There are civil penalties for prohibited conduct, including, but not limited to billing for medically unnecessary products or services.

HIPAA Administrative Simplification and Privacy Requirements: The administrative simplification provisions of HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), require the use of uniform electronic data transmission standards for health care claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the health care industry. HIPAA also established federal rules protecting the privacy and security of personal health information. The privacy and security regulations address the use and disclosure of individual health care information and the rights of patients to understand and control how such information is used and disclosed. Violations of HIPAA can result in both criminal and civil fines and penalties.

We believe that we are in material compliance with the privacy regulations of HIPAA, as we continue to develop training and revise procedures to address ongoing compliance. The HIPAA security regulations require health care providers to implement administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of patient information. HITECH has since strengthened certain HIPAA rules regarding the use and disclosure of protected health information, extended certain HIPAA provisions to business associates, and created new security breach notification requirements. HITECH has also extended the ability to impose civil money penalties on providers not knowing that a HIPAA violation has occurred. We believe that we have been in substantial compliance with HIPAA and HITECH requirements to date. Recent changes to the HIPAA regulations may result in greater compliance requirements for healthcare providers, including expanded obligations to report breaches of unsecured patient data, as well as create new liabilities for the actions of parties acting as business associates on our behalf.

Red Flags Rule: In addition, the Federal Trade Commission ("FTC") Red Flags Rule requires financial institutions and businesses maintaining accounts to address the risk of identity theft. The Red Flag Program Clarification Act of 2010, signed on December 18, 2010, appears to exclude certain healthcare providers from the Red Flags Rule, but permits the FTC or relevant agencies to designate additional creditors subject to the Red Flags Rule through future rulemaking if the agencies determine that the person in question maintains accounts subject to foreseeable risk of identity theft. Compliance with any such future rulemaking may require additional expenditures in the future.

Patient Safety and Quality Improvement Act of 2005: On July 29, 2005, the Patient Safety and Quality Improvement Act of 2005 was enacted, which has the goal of reducing medical errors and increasing patient safety. This legislation establishes a confidential reporting structure in which providers can voluntarily report "Patient Safety Work Product" ("PSWP") to "Patient Safety Organizations" ("PSOs"). Under the system, PSWP is made privileged, confidential and legally protected from disclosure. PSWP does not include medical, discharge or billing records or any other original patient or provider records but does include information gathered specifically in connection with the reporting of medical errors and improving patient safety. This legislation does not preempt state or federal mandatory disclosure laws concerning information that does not constitute PSWP. PSOs are certified by the Secretary of the HHS for three-year periods and analyze PSWP, provide feedback to providers and may report non-identifiable PSWP to a database. In addition, PSOs are expected to generate patient safety improvement strategies.

Environmental Regulations: Our healthcare operations generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Infectious waste generators, including hospitals, face substantial penalties for improper disposal of medical waste, including civil penalties of up to $25,000 per day of noncompliance, criminal penalties of up to $50,000 per day, imprisonment, and remedial costs. In addition, our operations, as well as our purchases and sales of facilities are subject to various other environmental laws, rules and regulations. We believe that our disposal of such wastes is in material compliance with all state and federal laws.

Corporate Practice of Medicine: Several states, including Florida, Nevada, California and Texas, have laws and/or regulations that prohibit corporations and other entities from employing physicians and practicing medicine for a profit or that prohibit certain direct and indirect payments or fee-splitting arrangements between health care providers that are designed to induce or encourage the referral of patients to, or the recommendation of, particular providers for medical products and services. Possible sanctions for violation of these restrictions include loss of license and civil and criminal penalties. In addition, agreements between the corporation and the physician may be considered void and unenforceable. These statutes and/or regulations vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We do not expect these state corporate practice of medicine proscriptions to significantly affect our operations. Many states have laws and regulations which prohibit payments for referral of patients and fee-splitting with physicians. We do not make any such payments or have any such arrangements.

EMTALA: All of our hospitals are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law generally requires hospitals with an emergency department that are certified providers under Medicare to conduct a medical screening examination of every person who visits the hospital's emergency room for treatment and, if the patient is suffering from a medical emergency, to either stabilize the patient's condition or transfer the patient to a facility that can better handle the condition. Our obligation to screen and stabilize emergency medical conditions exists regardless of a patient's ability to pay for

treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program. In addition to any liabilities that a hospital may incur under EMTALA, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against the hospital unrelated to the rights granted under that statute.

The federal government broadly interprets EMTALA to cover situations in which patients do not actually present to a hospital's emergency room, but present for emergency examination or treatment to the hospital's campus, generally, or to a hospital-based clinic that treats emergency medical conditions or are transported in a hospital-owned ambulance, subject to certain exceptions. EMTALA does not generally apply to patients admitted for inpatient services; however, CMS has recently sought industry comments on the potential applicability of EMTALA to hospital inpatients and the responsibilities of hospitals with specialized capabilities, respectively. CMS has not yet issued regulations or guidance in response to that request for comments. The government also has expressed its intent to investigate and enforce EMTALA violations actively in the future. We believe that we operate in substantial compliance with EMTALA.

Health Care Industry Investigations: We are subject to claims and suits in the ordinary course of business, including those arising from care and treatment afforded by our hospitals and are party to various government investigations and litigation. Please see *Item 3. Legal Proceedings* included herein for additional disclosure. In addition, currently, and from time to time, some of our facilities are subjected to inquiries and/or actions and receive notices of potential non-compliance of laws and regulations from various federal and state agencies. Providers that are found to have violated these laws and regulations may be excluded from participating in government healthcare programs, subjected to potential licensure, certification, and/or accreditation revocation, subjected to fines or penalties or required to repay amounts received from the government for previously billed patient services.

We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Because the law in this area is complex and constantly evolving, governmental investigation or litigation may result in interpretations that are inconsistent with industry practices, including ours. Although we believe our policies, procedures and practices comply with governmental regulations, no assurance can be given that we will not be subjected to inquiries or actions, or that we will not be faced with sanctions, fines or penalties in connection with the investigations. Even if we were to ultimately prevail, the government's inquiry and/or action in connection with these matters could have a material adverse effect on our future operating results.

Our substantial Medicare, Medicaid and other governmental billings may result in heightened scrutiny of our operations. It is possible that governmental entities could initiate additional investigations or litigation in the future and that such matters could result in significant penalties as well as adverse publicity. It is also possible that our executives and/or managers could be included as targets or witnesses in governmental investigations or litigation and/or named as defendants in private litigation.

Revenue Rulings 98-15 and 2004-51: In March 1998 and May 2004, the IRS issued guidance regarding the tax consequences of joint ventures between for-profit and not-for-profit hospitals. As a result of the tax rulings, the IRS has proposed, and may in the future propose, to revoke the tax-exempt or public charity status of certain not-for-profit entities which participate in such joint ventures or to treat joint venture income as unrelated business taxable income to them. The tax rulings have limited development of joint ventures and any adverse determination by the IRS or the courts regarding the tax-exempt or public charity status of a not-for-profit partner or the characterization of joint venture income as unrelated business taxable income could further limit joint venture development with not-for-profit hospitals, and/or require the restructuring of certain existing joint ventures with not-for-profits.

State Rate Review: Some states where we operate hospitals have adopted legislation mandating rate or budget review for hospitals or have adopted taxes on hospital revenues, assessments or licensure fees to fund indigent health care within the state. In the aggregate, state rate reviews and indigent tax provisions have not materially, adversely affected our results of operations.

Medical Malpractice Tort Law Reform: Medical malpractice tort law has historically been maintained at the state level. All states have laws governing medical liability lawsuits. Over half of the states have limits on damages awards. Almost all states have eliminated joint and several liability in malpractice lawsuits, and many states have established limits on attorney fees. Many states had bills introduced in their legislative sessions to address medical malpractice tort reform. Proposed solutions include enacting limits on non-economic damages, malpractice insurance reform, and gathering lawsuit claims data from malpractice insurance companies and the courts for the purpose of assessing the connection between malpractice settlements and premium rates. Reform legislation has also been proposed, but not adopted, at the federal level that could preempt additional state legislation in this area.

Compliance Program: Our company-wide compliance program has been in place since 1998. Currently, the program's elements include a Code of Conduct, risk area specific policies and procedures, employee education and training, an internal system for reporting concerns, auditing and monitoring programs, and a means for enforcing the program's policies.

Since its initial adoption, the compliance program continues to be expanded and developed to meet the industry's expectations and our needs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities have been prepared and implemented to address the functional and operational aspects of our business. Specific areas identified through regulatory interpretation and enforcement activities have also been addressed in our program. Claims preparation and submission, including coding, billing, and cost reports, comprise the bulk of these areas. Financial arrangements with physicians and other referral sources, including compliance with anti-kickback and Stark laws and emergency department treatment and transfer requirements are also the focus of policy and training, standardized documentation requirements, and review and audit.

United Kingdom Regulation: Our operations in the United Kingdom are also subject to a high level of regulation relating to registration and licensing requirements, employee regulation, clinical standards, environmental rules as well as other areas. We are also subject to a highly regulated business environment, and failure to comply with the various laws and regulations applicable to us could lead to substantial penalties and other adverse effects on our business.

Employees and Medical Staff

Our facilities located in the U.S. had approximately 78,700 employees as of December 31, 2018, of whom approximately 55,800 were employed full-time. In addition, our facilities located in the U.K. had approximately 8,400 employees as of December 31, 2018. Our hospitals are staffed by licensed physicians who have been admitted to the medical staff of individual hospitals. In a number of our markets, physicians may have admitting privileges at other hospitals in addition to ours. Within our acute care division, approximately 250 physicians are employed by physician practice management subsidiaries of ours either directly or through contracts with affiliated group practices structured as 501A corporations. Members of the medical staffs of our hospitals also serve on the medical staffs of hospitals not owned by us and may terminate their affiliation with our hospitals at any time. In addition, within our behavioral health division, approximately 490 psychiatrists are employed by subsidiaries of ours either directly or through contracts with affiliated group practices structured as 501A corporations. Each of our hospitals is managed on a day-to-day basis by a managing director employed by a subsidiary of ours. In addition, a Board of Governors, including members of the hospital's medical staff, governs the medical, professional and ethical practices at each hospital. We believe that our relations with our employees are satisfactory.

Approximately 625 of our employees at five of our hospitals are unionized. At Valley Hospital Medical Center, unionized employees belong to the Culinary Workers and Bartenders Union and the International Union of Operating Engineers. Engineers at Desert Springs Hospital are represented by the International Union of Operating Engineers. At the Psychiatric Institute of Washington, clinical, clerical, support and maintenance employees are represented by the Communication Workers of America (AFL-CIO). Registered Nurses, Licensed Practical Nurses, certain technicians and therapists and some clerical employees at HRI Hospital in Boston are represented by the Service Employees International Union. At Brooke Glen Behavioral Hospital, unionized employees are represented by the Teamsters and the Northwestern Nurses Association/Pennsylvania Association of Staff Nurses and Allied Professionals.

Competition

The health care industry is highly competitive. In recent years, competition among healthcare providers for patients has intensified in the United States due to, among other things, regulatory and technological changes, increasing use of managed care payment systems, cost containment pressures and a shift toward outpatient treatment. In all of the geographical areas in which we operate, there are other hospitals that provide services comparable to those offered by our hospitals. In addition, some of our competitors include hospitals that are owned by tax-supported governmental agencies or by nonprofit corporations and may be supported by endowments and charitable contributions and exempt from property, sale and income taxes. Such exemptions and support are not available to us.

In some markets, certain of our competitors may have greater financial resources, be better equipped and offer a broader range of services than us. Certain hospitals that are located in the areas served by our facilities are specialty or large hospitals that provide medical, surgical and behavioral health services, facilities and equipment that are not available at our hospitals. The increase in outpatient treatment and diagnostic facilities, outpatient surgical centers and freestanding ambulatory surgical also increases competition for us. In addition, some of our hospitals face competition from hospitals or surgery centers that are physician owned.

The number and quality of the physicians on a hospital's staff are important factors in determining a hospital's success and competitive advantage. Typically, physicians are responsible for making hospital admissions decisions and for directing the course of patient treatment. We believe that physicians refer patients to a hospital primarily on the basis of the patient's needs, the quality of other physicians on the medical staff, the location of the hospital and the breadth and scope of services offered at the hospital's facilities. We strive to retain and attract qualified doctors by maintaining high ethical and professional standards and providing adequate support personnel, technologically advanced equipment and facilities that meet the needs of those physicians.

In addition, we depend on the efforts, abilities, and experience of our medical support personnel, including our nurses, pharmacists and lab technicians and other health care professionals. We compete with other health care providers in recruiting and retaining qualified hospital management, nurses and other medical personnel. Our acute care and behavioral health care facilities are experiencing the effects of a shortage of skilled nursing staff nationwide, which has caused and may continue to cause an increase in salaries, wages and benefits expense in excess of the inflation rate. In addition, in some markets like California, there are requirements to maintain specified nurse-staffing levels. To the extent we cannot meet those levels, we may be required to limit the healthcare services provided in these markets which would have a corresponding adverse effect on our net operating revenues.

Many states in which we operate hospitals have CON laws. The application process for approval of additional covered services, new facilities, changes in operations and capital expenditures is, therefore, highly competitive in these states. In those states that do not have CON laws or which set relatively high levels of expenditures before they become reviewable by state authorities, competition in the form of new services, facilities and capital spending is more prevalent. See "Regulation and Other Factors."

Our ability to negotiate favorable service contracts with purchasers of group health care services also affects our competitive position and significantly affects the revenues and operating results of our hospitals. Managed care plans attempt to direct and control the use of hospital services and to demand that we accept lower rates of payment. In addition, employers and traditional health insurers are increasingly interested in containing costs through negotiations with hospitals for managed care programs and discounts from established charges. In return, hospitals secure commitments for a larger number of potential patients. Generally, hospitals compete for service contracts with group health care service purchasers on the basis of price, market reputation, geographic location, quality and range of services, quality of the medical staff and convenience. The importance of obtaining contracts with managed care organizations varies from market to market depending on the market strength of such organizations.

A key element of our growth strategy is expansion through the acquisition of additional hospitals in select markets. The competition to acquire hospitals is significant. We face competition for acquisition candidates primarily from other for-profit health care companies, as well as from not-for-profit entities. Some of our competitors have greater resources than we do. We intend to selectively seek opportunities to expand our base of operations by adhering to our disciplined program of rational growth, but may not be successful in accomplishing acquisitions on favorable terms.

Relationship with Universal Health Realty Income Trust

At December 31, 2018, we held approximately 5.7% of the outstanding shares of Universal Health Realty Income Trust (the "Trust"). We serve as Advisor to the Trust under an annually renewable advisory agreement, which is scheduled to expire on December 31st of each year, pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. The advisory agreement was Amended and Restated effective January 1, 2019. Among other things, the Amended and Restated Advisory Agreement (the "Agreement") eliminated the 20% annual incentive fee clause which we were previously entitled to under certain conditions (the incentive fee requirements have never been achieved). In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting. The advisory agreement was renewed by the Trust for 2019 at the same rate as the prior three years. During 2018, 2017 and 2016, the advisory fee was computed at 0.70% of the Trust's average invested real estate assets. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $3.8 million during 2018, $3.6 million during 2017 and $3.3 million during 2016.

Our pre-tax share of income from the Trust was $1.4 million during 2018 which is included in other income, net, on the accompanying consolidated statements of income. Our pre-tax share of income from the Trust was $2.6 million during 2017 and $1.0 million during 2016, which are included in net revenues in the accompanying consolidated statements of income for each year. Included in our share of the Trust's income for 2018, is income realized by the Trust in connection with hurricane-related insurance proceeds received in connection with the damage sustained from Hurricane Harvey in August, 2017. Included in our share of the Trust's income for 2017 was a gain realized by the Trust in connection with a divestiture of property that was completed during the first quarter of 2017, as well as insurance proceeds in excess of damaged Trust property. We received dividends from the Trust amounting to $2.1 million during each of 2018 and 2017 and $2.0 million during 2016.

The carrying value of our investment in the Trust was $7.5 million and $8.2 million at December 31, 2018 and 2017, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $48.3 million at December 31, 2018 and $59.2 million at December 31, 2017, based on the closing price of the Trust's stock on the respective dates.

The Trust commenced operations in 1986 by purchasing certain hospital properties from us and immediately leasing the properties back to our respective subsidiaries. Most of the leases were entered into at the time the Trust commenced operations and provided for initial terms of 13 to 15 years with up to six additional 5-year renewal terms. Each hospital lease also provided for

additional or bonus rental, as discussed below. The base rents are paid monthly and the bonus rents are computed and paid on a quarterly basis, based upon a computation that compares current quarter revenue to a corresponding quarter in the base year. The leases with those subsidiaries are unconditionally guaranteed by us and are cross-defaulted with one another.

Total rent expense under the operating leases on the three hospital facilities with the Trust was $16.0 million during each of 2018 and 2017 and $15.9 million in 2016. Pursuant to the terms of the three hospital leases with the Trust, we have the option to renew the leases at the lease terms described above by providing notice to the Trust at least 90 days prior to the termination of the then current term. We also have the right to purchase the respective leased hospitals at the end of the lease terms or any renewal terms at their appraised fair market value as well as purchase any or all of the three leased hospital properties at the appraised fair market value upon one month's notice should a change of control of the Trust occur. In addition, we have rights of first refusal to: (i) purchase the respective leased facilities during and for 180 days after the lease terms at the same price, terms and conditions of any third-party offer, or; (ii) renew the lease on the respective leased facility at the end of, and for 180 days after, the lease term at the same terms and conditions pursuant to any third-party offer. During the second quarter of 2018, we exercised our 5-year renewal option on McAllen Medical Center which extended the lease term on this facility, at the existing lease rate, through December, 2026.

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

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

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

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

Executive Officers of the Registrant

The executive officers, whose terms will expire at such time as their successors are elected, are as follows:

Name and Age	Present Position with the Company
Alan B. Miller (81)	Chairman of the Board and Chief Executive Officer
Marc D. Miller (48)	President and Director
Steve G. Filton (61)	Executive Vice President, Chief Financial Officer and Secretary
Marvin G. Pember (65)	Executive Vice President, President of Acute Care Division

Mr. Alan B. Miller has been Chairman of the Board and Chief Executive Officer since inception and also served as President from inception until May, 2009. Prior thereto, he was President, Chairman of the Board and Chief Executive Officer of American Medicorp, Inc. He currently serves as Chairman of the Board, Chief Executive Officer and President of Universal Health Realty Income Trust. He is the father of Marc D. Miller, our President and Director.

Mr. Marc D. Miller was elected President in May, 2009 and prior thereto served as Senior Vice President and co-head of our Acute Care Hospitals since 2007. He was elected a Director in May, 2006 and Vice President in 2005. He has served in various capacities related to our acute care division since 2000. He was elected to the Board of Trustees of Universal Health Realty Income Trust in December, 2008. In August, 2015, he was appointed to the Board of Directors of Premier, Inc., a publicly traded healthcare performance improvement alliance. See Note 9 to the Consolidated Financial Statements-*Relationship with Universal Health Realty Income Trust and Other Related Party Transactions* for additional disclosure regarding the Company's group purchasing organization agreement with Premier, Inc. Marc D. Miller is the son of Alan B. Miller, our Chairman of the Board and Chief Executive Officer.

Mr. Filton was elected Executive Vice President in 2017 and continues to serve as Chief Financial Officer since his appointment in 2003. He has also served as Secretary since 1999. He had served as Senior Vice President since 2003, as Vice President and Controller since 1991, and as Director of Corporate Accounting since 1985.

Mr. Pember was elected Executive Vice President in 2017 and continues to serve as President of our Acute Care Division since commencement of his employment with us in 2011. He had served as Senior Vice President since 2011. He was formerly employed

for 12 years at Indiana University Health, Inc. (formerly known as Clarian Health Partners, Inc.), a nonprofit hospital system that operates multiple facilities in Indiana, where he served as Executive Vice President and Chief Financial Officer.

ITEM 1A. *Risk Factors*

We are subject to numerous known and unknown risks, many of which are described below and elsewhere in this Annual Report. Any of the events described below could have a material adverse effect on our business, financial condition and results of operations. Additional risks and uncertainties that we are not aware of, or that we currently deem to be immaterial, could also impact our business and results of operations.

A significant portion of our revenue is produced by facilities located in Texas, Nevada and California.

Texas: We own 7 inpatient acute care hospitals and 22 inpatient behavioral healthcare facilities as listed in *Item 2. Properties*. On a combined basis, these facilities contributed 16% in 2018, 15% in 2017 and 16% in 2016 of our consolidated net revenues. On a combined basis, after deducting an allocation for corporate overhead expense, these facilities generated 12% in 2018, 11% in 2017 and 7% in 2016, of our income from operations after net income attributable to noncontrolling interest.

Nevada: We own 8 inpatient acute care hospitals and 4 inpatient behavioral healthcare facilities as listed in *Item 2. Properties*. On a combined basis, these facilities contributed 17% of our consolidated net revenues during each of 2018 and 2017 and 16% in 2016. On a combined basis, after deducting an allocation for corporate overhead expense, these facilities generated 24% in 2018, 20% in 2017 and 13% in 2016, of our income from operations after net income attributable to noncontrolling interest.

California: We own 5 inpatient acute care hospitals and 8 inpatient behavioral healthcare facilities as listed in *Item 2. Properties*. On a combined basis, these facilities contributed 11% of our consolidated net revenues during each of 2018, 2017 and 2016. On a combined basis, after deducting an allocation for corporate overhead expense, these facilities generated 16% in 2018, 13% in 2017 and 15% in 2016, of our income from operations after net income attributable to noncontrolling interest.

The significant portion of our revenues and earnings derived from these facilities makes us particularly sensitive to legislative, regulatory, economic, environmental and competition changes in Texas, Nevada and California. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in these states could have a disproportionate effect on our overall business results.

Our revenues and results of operations are significantly affected by payments received from the government and other third party payers.

We derive a significant portion of our revenue from third-party payers, including the Medicare and Medicaid programs. Changes in these government programs in recent years have resulted in limitations on reimbursement and, in some cases, reduced levels of reimbursement for healthcare services. Payments from federal and state government programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease program payments, as well as affect the cost of providing service to patients and the timing of payments to facilities. We are unable to predict the effect of recent and future policy changes on our operations. In addition, the uncertainty and fiscal pressures placed upon federal and state governments as a result of, among other things, deterioration in general economic conditions and the funding requirements from the federal healthcare reform legislation, may affect the availability of taxpayer funds for Medicare and Medicaid programs. In addition, the vast majority of the net revenues generated at our behavioral health facilities located in the United Kingdom are derived from governmental payers. If the rates paid or the scope of services covered by governmental payers in the United States or United Kingdom are reduced, there could be a material adverse effect on our business, financial position and results of operations.

We receive Medicaid revenues in excess of $100 million annually from each of Texas, California, Washington, D.C., Nevada, Pennsylvania and Illinois, making us particularly sensitive to reductions in Medicaid and other state based revenue programs as well as regulatory, economic, environmental and competitive changes in those states.

In addition to changes in government reimbursement programs, our ability to negotiate favorable contracts with private payers, including managed care organizations, significantly affects the revenues and operating results of our hospitals. Private payers, including managed care organizations, increasingly are demanding that we accept lower rates of payment.

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

Reductions or changes in Medicare and Medicaid funding could have a material adverse effect on our future results of operations.

On January 3, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012 (the "2012 Act"). The 2012 Act postponed for two months sequestration cuts mandated under the Budget Control Act of 2011. The postponed sequestration cuts include a 2% annual reduction over ten years in Medicare spending to providers. Medicaid is exempt from sequestration. In order to offset the costs of the legislation, the 2012 Act reduces payments to other providers totaling almost $26 billion over ten years. Approximately half of those funds will come from reductions in Medicare reimbursement to hospitals. Although the Bipartisan Budget Act of 2013 has reduced certain sequestration-related budgetary cuts, spending reductions related to the Medicare program remain in place. On December 26, 2013, President Obama signed into law H.J. Res. 59, the Bipartisan Budget Act of 2013, which includes the Pathway for SGR Reform Act of 2013 ("the Act"). In addition, on February 15, 2014, Public Law 113-082 was enacted. The 2012 Act and subsequent federal legislation achieves new savings by extending sequestration for mandatory programs—including Medicare—through 2027. Please see *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, Sources of Revenue-Medicare*, for additional disclosure.

The 2012 Act includes a document and coding ("DCI") adjustment and a reduction in Medicaid disproportionate share hospital ("DSH") payments. Expected to save $10.5 billion over 10 years, the DCI adjustment decreases projected Medicare hospital payments for inpatient and overnight care through a downward adjustment in annual base payment increases. These reductions are meant to recoup what Medicare authorities consider to be "overpayments" to hospitals that occurred as a result of the transition to Medicare Severity Diagnosis Related Groups. The reduction in Medicaid DSH payments was expected to save $4.2 billion over 10 years. This provision extends the changes regarding DSH payments established by the Legislation and determines future allotments off of the rebased level. On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018, which eliminated the DSH cuts scheduled for 2018 and 2019 but added additional DSH reductions of $4 billion in 2020 and $8 billion a year between 2021 and 2025.

We are subject to uncertainties regarding health care reform.

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

Although it was expected that as a result of the Legislation there would be a reduction in uninsured patients, which would reduce our expense from uncollectible accounts receivable, the Legislation makes a number of other changes to Medicare and Medicaid which we believe may have an adverse impact on us. It has been projected that the Legislation will result in a net reduction in Medicare and Medicaid payments to hospitals totaling $155 billion over 10 years. The Legislation revises reimbursement under the Medicare and Medicaid programs to emphasize the efficient delivery of high quality care and contains a number of incentives and penalties under these programs to achieve these goals. The Legislation provides for decreases in the annual market basket update for federal fiscal years 2010 through 2019, a productivity offset to the market basket update beginning October 1, 2011 for Medicare Part B reimbursable items and services and beginning October 1, 2012 for Medicare inpatient hospital services. The Legislation and subsequent revisions provide for reductions to both Medicare DSH and Medicaid DSH payments. The Medicare DSH reductions began in October, 2013 while the Medicaid DSH reductions are scheduled to begin in 2020. The Legislation implements a value-based purchasing program, which will reward the delivery of efficient care. Conversely, certain facilities will receive reduced reimbursement for failing to meet quality parameters; such hospitals will include those with excessive readmission or hospital-acquired condition rates.

A 2012 U.S. Supreme Court ruling limited the federal government's ability to expand health insurance coverage by holding unconstitutional sections of the Legislation that sought to withdraw federal funding for state noncompliance with certain Medicaid coverage requirements. Pursuant to that decision, the federal government may not penalize states that choose not to participate in the Medicaid expansion program by reducing their existing Medicaid funding. Therefore, states can choose to accept or not to participate without risking the loss of federal Medicaid funding. As a result, many states, including Texas, have not expanded their Medicaid programs without the threat of loss of federal funding. CMS has granted, and is expected to grant additional, section 1115 demonstration waivers providing for work and community engagement requirements for certain Medicaid eligible individuals. It is anticipated this will lead to reductions in coverage, and likely increases in uncompensated care, in states where these demonstration waivers are granted.

The various provisions in the Legislation that directly or indirectly affect Medicare and Medicaid reimbursement are scheduled to take effect over a number of years. The impact of the Legislation on healthcare providers will be subject to implementing regulations, interpretive guidance and possible future legislation or legal challenges. Certain Legislation provisions, such as that

creating the Medicare Shared Savings Program creates uncertainty in how healthcare may be reimbursed by federal programs in the future. Thus, we cannot predict the impact of the Legislation on our future reimbursement at this time and we can provide no assurance that the Legislation will not have a material adverse effect on our future results of operations.

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

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

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

In addition to legislative changes, the Legislation can be significantly impacted by executive branch actions. In relevant part, President Trump has already taken executive actions: (i) requiring all federal agencies with authorities and responsibilities under the Legislation to "exercise all authority and discretion available to them to waiver, defer, grant exemptions from, or delay" parts of the Legislation that place "unwarranted economic and regulatory burdens" on states, individuals or health care providers; (ii) the issuance of a final rule in June, 2018 by the Department of Labor to enable the formation of association health plans that would be exempt from certain Legislation requirements such as the provision of essential health benefits; (iii) the issuance of a final rule in August, 2018 by the Department of Labor, Treasury, and Health and Human Services to expand the availability of short-term, limited duration health insurance, (iv) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level; (v) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and lead to additional enrollment in short-term, limited duration insurance and association health plans; and (vi) the issuance of a proposed rule by the Department of Labor, Treasury, and Health and Human Services that would incentivize the use of health reimbursement accounts by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these Executive Branch policies has led to reduced Exchange enrollment in 2018 and 2019 and is expected to further worsen the individual and small group market risk pools in future years. It is also anticipated that these and future policies may create additional cost and reimbursement pressures on hospitals.

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

While attempts to repeal the entirety of the ACA have not been successful to date, a key provision of the ACA was repealed as part of the Tax Cuts and Jobs Act and, on December 14, 2018, a federal U.S. District Court judge in Texas ruled the entire ACA is unconstitutional. While that ruling is stayed and has been appealed, it has caused greater uncertainty regarding the future status of the ACA. If all or any parts of the ACA are found to be unconstitutional, it could have a material adverse effect on the Company.

We are required to treat patients with emergency medical conditions regardless of ability to pay.

In accordance with our internal policies and procedures, as well as the Emergency Medical Treatment and Active Labor Act, or EMTALA, we provide a medical screening examination to any individual who comes to one of our hospitals while in active labor and/or seeking medical treatment (whether or not such individual is eligible for insurance benefits and regardless of ability to pay) to determine if such individual has an emergency medical condition. If it is determined that such person has an emergency medical condition, we provide such further medical examination and treatment as is required to stabilize the patient's medical condition, within the facility's capability, or arrange for transfer of such individual to another medical facility in accordance with applicable law and the treating hospital's written procedures. Our obligations under EMTALA may increase substantially going forward; CMS has sought stakeholder comments concerning the potential applicability of EMTALA to hospital inpatients and the responsibilities of hospitals with specialized capabilities, respectively, but has yet to issue further guidance in response to that request. If the number of indigent and charity care patients with emergency medical conditions we treat increases significantly, or if regulations expanding our obligations to inpatients under EMTALA is proposed and adopted, our results of operations will be harmed.

If we are not able to provide high quality medical care at a reasonable price, patients may choose to receive their health care from our competitors.

In recent years, the number of quality measures that hospitals are required to report publicly has increased. CMS publishes performance data related to quality measures and data on patient satisfaction surveys that hospitals submit in connection with the Medicare program. Federal law provides for the future expansion of the number of quality measures that must be reported. Additionally, the Legislation requires all hospitals to annually establish, update and make public a list of their standard charges for products and services. If any of our hospitals achieve poor results on the quality measures or patient satisfaction surveys (or results that are lower than our competitors) or if our standard charges are higher than our competitors, our patient volume could decline because patients may elect to use competing hospitals or other health care providers that have better metrics and pricing. This circumstance could harm our business and results of operations.

An increase in uninsured and underinsured patients in our acute care facilities or the deterioration in the collectability of the accounts of such patients could harm our results of operations.

Collection of receivables from third-party payers and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill that is the patient's responsibility, which primarily includes co-payments and deductibles. However, we also have substantial receivables due to us from certain state-based funding programs. We estimate our provisions for doubtful accounts based on general factors such as payer mix, the agings of the receivables, historical collection experience and assessment of probability of future collections. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions that might ultimately affect the collectability of the patient accounts and make adjustments to our allowances as warranted. Significant changes in business office operations, payer mix, economic conditions or trends in federal and state governmental health coverage could affect our collection of accounts receivable, cash flow and results of operations. If we experience unexpected increases in the growth of uninsured and underinsured patients or in bad debt expenses, our results of operations will be harmed.

Our hospitals face competition for patients from other hospitals and health care providers.

The healthcare industry is highly competitive, and competition among hospitals, and other healthcare providers for patients and physicians has intensified in recent years. In all of the geographical areas in which we operate, there are other hospitals that provide services comparable to those offered by our hospitals. Some of our competitors include hospitals that are owned by tax-supported governmental agencies or by nonprofit corporations and may be supported by endowments and charitable contributions and exempt from property, sales and income taxes. Such exemptions and support are not available to us.

In some markets, certain of our competitors may have greater financial resources, be better equipped and offer a broader range of services than we offer. The number of inpatient facilities, as well as outpatient surgical and diagnostic centers, many of which are fully or partially owned by physicians, in the geographic areas in which we operate has increased significantly. As a result, most of our hospitals operate in an increasingly competitive environment.

We also operate health care facilities in the United Kingdom where the National Health Service (the "NHS") is the principal provider of healthcare services. In addition to the NHS, we face competition in the United Kingdom from independent sector providers and other publicly funded entities for patients.

If our competitors are better able to attract patients, recruit physicians and other healthcare professionals, expand services or obtain favorable managed care contracts at their facilities, we may experience a decline in patient volume and our business may be harmed.

Our performance depends on our ability to recruit and retain quality physicians.

Typically, physicians are responsible for making hospital admissions decisions and for directing the course of patient treatment. As a result, the success and competitive advantage of our hospitals depends, in part, on the number and quality of the physicians on the medical staffs of our hospitals, the admitting practices of those physicians and our maintenance of good relations with those physicians. Physicians generally are not employees of our hospitals, and, in a number of our markets, physicians have admitting privileges at other hospitals in addition to our hospitals. They may terminate their affiliation with us at any time. If we are unable to provide high ethical and professional standards, adequate support personnel and technologically advanced equipment and facilities that meet the needs of those physicians, they may be discouraged from referring patients to our facilities and our results of operations may decline.

It may become difficult for us to attract and retain an adequate number of physicians to practice in certain of the non-urban communities in which our hospitals are located. Our failure to recruit physicians to these communities or the loss of physicians in these communities could make it more difficult to attract patients to our hospitals and thereby may have a material adverse effect on our business, financial condition and results of operations.

Generally, the top ten attending physicians within each of our facilities represent a large share of our inpatient revenues and admissions. The loss of one or more of these physicians, even if temporary, could cause a material reduction in our revenues, which could take significant time to replace given the difficulty and cost associated with recruiting and retaining physicians.

If we do not continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.

The technology used in medical equipment and related devices is constantly evolving and, as a result, manufacturers and distributors continue to offer new and upgraded products to health care providers. To compete effectively, we must continually assess our equipment needs and upgrade when significant technological advances occur. If our facilities do not stay current with technological advances in the health care industry, patients may seek treatment from other providers and/or physicians may refer their patients to alternate sources, which could adversely affect our results of operations and harm our business.

If we fail to continue to meet the promoting interoperability criteria related to electronic health record systems ("EHR"), our operations could be harmed.

Pursuant to HITECH regulations, hospitals that did not qualify as a meaningful user of EHR by 2015 were subject to a reduced market basket update to the inpatient prospective payment system ("IPPS") standardized amount in 2015 and each subsequent fiscal year. In the 2019 IPPS final rule, CMS re-named the meaningful use program to "promoting interoperability". We believe that all of our acute care hospitals have met the applicable promoting interoperability criteria and therefore are not subject to a reduced market basked update to the IPPS standardized amount. However, under the HITECH Act, hospitals must continue to meet the applicable criteria in each fiscal year or they will be subject to a market basket update reduction in a subsequent fiscal year. Failure of our acute care hospitals to continue to meet the applicable meaningful use criteria would have an adverse effect on our future net revenues and results of operations.

Our performance depends on our ability to attract and retain qualified nurses and medical support staff and we face competition for staffing that may increase our labor costs and harm our results of operations.

We depend on the efforts, abilities, and experience of our medical support personnel, including our nurses, pharmacists and lab technicians and other healthcare professionals. We compete with other healthcare providers in recruiting and retaining qualified hospital management, nurses and other medical personnel.

The nationwide shortage of nurses and other medical support personnel has been a significant operating issue facing us and other healthcare providers. This shortage may require us to enhance wages and benefits to recruit and retain nurses and other medical support personnel or require us to hire expensive temporary personnel. In addition, in some markets like California, there are

requirements to maintain specified nurse-staffing levels. To the extent we cannot meet those levels, we may be required to limit the healthcare services provided in these markets, which would have a corresponding adverse effect on our net operating revenues.

We cannot predict the degree to which we will be affected by the future availability or cost of attracting and retaining talented medical support staff. If our general labor and related expenses increase, we may not be able to raise our rates correspondingly. Our failure to either recruit and retain qualified hospital management, nurses and other medical support personnel or control our labor costs could harm our results of operations.

Increased labor union activity is another factor that could adversely affect our labor costs. Union organizing activities and certain potential changes in federal labor laws and regulations could increase the likelihood of employee unionization in the future, to the extent a greater portion of our employee base unionized, it is possible our labor costs could increase materially.

If we fail to comply with extensive laws and government regulations, we could suffer civil or criminal penalties or be required to make significant changes to our operations that could reduce our revenue and profitability.

The healthcare industry is required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things: hospital billing practices and prices for services; relationships with physicians and other referral sources; adequacy of medical care and quality of medical equipment and services; ownership of facilities; qualifications of medical and support personnel; confidentiality, maintenance, privacy and security issues associated with health-related information and patient medical records; the screening, stabilization and transfer of patients who have emergency medical conditions; certification, licensure and accreditation of our facilities; operating policies and procedures, and; construction or expansion of facilities and services.

Among these laws are the federal False Claims Act, the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), the federal anti-kickback statute and the provision of the Social Security Act commonly known as the "Stark Law." These laws, and particularly the anti-kickback statute and the Stark Law, impact the relationships that we may have with physicians and other referral sources. We have a variety of financial relationships with physicians who refer patients to our facilities, including employment contracts, leases and professional service agreements. We also provide financial incentives, including minimum revenue guarantees, to recruit physicians into communities served by our hospitals. The Office of the Inspector General of the Department of Health and Human Services, or OIG, has enacted safe harbor regulations that outline practices that are deemed protected from prosecution under the anti-kickback statute. A number of our current arrangements, including financial relationships with physicians and other referral sources, may not qualify for safe harbor protection under the anti-kickback statute. Failure to meet a safe harbor does not mean that the arrangement necessarily violates the anti-kickback statute, but may subject the arrangement to greater scrutiny. We cannot assure that practices that are outside of a safe harbor will not be found to violate the anti-kickback statute. CMS published a Medicare self-referral disclosure protocol, which is intended to allow providers to self-disclose actual or potential violations of the Stark law. Because there are only a few judicial decisions interpreting the Stark law, there can be no assurance that our hospitals will not be found in violation of the Stark Law or that self-disclosure of a potential violation would result in reduced penalties.

Federal regulations issued under HIPAA contain provisions that require us to implement and, in the future, may require us to implement additional costly electronic media security systems and to adopt new business practices designed to protect the privacy and security of each of our patient's health and related financial information. Such privacy and security regulations impose extensive administrative, physical and technical requirements on us, restrict our use and disclosure of certain patient health and financial information, provide patients with rights with respect to their health information and require us to enter into contracts extending many of the privacy and security regulatory requirements to third parties that perform duties on our behalf. Additionally, recent changes to HIPAA regulations may result in greater compliance requirements, including obligations to report breaches of unsecured patient data, as well as create new liabilities for the actions of parties acting as business associates on our behalf.

These laws and regulations are extremely complex, and, in many cases, we do not have the benefit of regulatory or judicial interpretation. In the future, it is possible that different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws (see *Item 3—Legal Proceedings*), or the public announcement that we are being investigated for possible violations of one or more of these laws, could have a material adverse effect on our business, financial condition or results of operations and our business reputation could suffer significantly. In addition, we cannot predict whether other legislation or regulations at the federal or state level will be adopted, what form such legislation or regulations may take or what their impact on us may be. See *Item 1 Business—Self-Referral and Anti-Kickback Legislation*.

If we are deemed to have failed to comply with the anti-kickback statute, the Stark Law or other applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of our licenses to operate one or more facilities), and exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state

healthcare programs. The imposition of such penalties could have a material adverse effect on our business, financial condition or results of operations.

We also operate health care facilities in the United Kingdom and have operations and commercial relationships with companies in other foreign jurisdictions and, as a result, are subject to certain U.S. and foreign laws applicable to businesses generally, including anti-corruption laws. The Foreign Corrupt Practices Act regulates U.S. companies in their dealings with foreign officials, prohibiting bribes and similar practices, and requires that they maintain records that fairly and accurately reflect transactions and appropriate internal accounting controls. In addition, the United Kingdom Bribery Act has wide jurisdiction over certain activities that affect the United Kingdom.

Our operations in the United Kingdom are also subject to a high level of regulation relating to registration and licensing requirements employee regulation, clinical standards, environmental rules as well as other areas. We are also subject to a highly regulated business environment, and failure to comply with the various laws and regulations, applicable to us could lead to substantial penalties, and other adverse effects on our business.

We are subject to occupational health, safety and other similar regulations and failure to comply with such regulations could harm our business and results of operations.

We are subject to a wide variety of federal, state and local occupational health and safety laws and regulations. Regulatory requirements affecting us include, but are not limited to, those covering: (i) air and water quality control; (ii) occupational health and safety (e.g., standards regarding blood-borne pathogens and ergonomics, etc.); (iii) waste management; (iv) the handling of asbestos, polychlorinated biphenyls and radioactive substances; and (v) other hazardous materials. If we fail to comply with those standards, we may be subject to sanctions and penalties that could harm our business and results of operations.

We may be subject to liabilities from claims brought against our facilities.

We are subject to medical malpractice lawsuits, product liability lawsuits, class action lawsuits and other legal actions in the ordinary course of business. Some of these actions may involve large claims, as well as significant defense costs. We cannot predict the outcome of these lawsuits or the effect that findings in such lawsuits may have on us. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement. Amounts we pay to settle any of these matters may be material. All professional and general liability insurance we purchase is subject to policy limitations. We believe that, based on our past experience and actuarial estimates, our insurance coverage is adequate considering the claims arising from the operations of our hospitals. While we continuously monitor our coverage, our ultimate liability for professional and general liability claims could change materially from our current estimates. If such policy limitations should be partially or fully exhausted in the future, or payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our operations.

We may be subject to governmental investigations, regulatory actions and whistleblower lawsuits.

The federal False Claims Act permits private parties to bring qui tam, or whistleblower, lawsuits against companies. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of whistleblower lawsuits that have been filed against providers has increased significantly in recent years. Because qui tam lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. Please see *Item 3. Legal Proceedings* for disclosure of current related matters.

The failure of certain employers, or the closure of certain facilities, could have a disproportionate impact on our hospitals.

The economies in the communities in which our hospitals operate are often dependent on a small number of large employers. Those employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our hospitals and other health care facilities for their care. The failure of one or more large employer or the closure or substantial reduction in the number of individuals employed at facilities located in or near the communities where our hospitals operate, could cause affected employees to move elsewhere to seek employment or lose insurance coverage that was otherwise available to them. The occurrence of these events could adversely affect our revenue and results of operations, thereby harming our business.

If any of our existing health care facilities lose their accreditation or any of our new facilities fail to receive accreditation, such facilities could become ineligible to receive reimbursement under Medicare or Medicaid.

The construction and operation of healthcare facilities are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection. Additionally, such facilities are subject to periodic inspection by government authorities to assure their continued compliance with these various standards.

All of our hospitals are deemed certified, meaning that they are accredited, properly licensed under the relevant state laws and regulations and certified under the Medicare program. The effect of maintaining certified facilities is to allow such facilities to participate in the Medicare and Medicaid programs. We believe that all of our healthcare facilities are in material compliance with applicable federal, state, local and other relevant regulations and standards. However, should any of our healthcare facilities lose their deemed certified status and thereby lose certification under the Medicare or Medicaid programs, such facilities would be unable to receive reimbursement from either of those programs and our business could be materially adversely effected.

Our growth strategy depends, in part, on acquisitions, and we may not be able to continue to make acquisitions that meet our target criteria. We may also have difficulties acquiring hospitals from not-for-profit entities due to regulatory scrutiny.

Acquisitions in select markets are a key element of our growth strategy. We face competition for acquisition candidates primarily from other for-profit healthcare companies, as well as from not-for-profit entities. Some of our competitors have greater resources than we do. Also, suitable acquisitions may not be accomplished due to unfavorable terms.

In addition, many states have enacted, or are considering enacting, laws that affect the conversion or sale of not-for-profit hospitals to for-profit entities. These laws generally require prior approval from the state attorney general, advance notification and community involvement. In addition, attorneys general in states without specific conversion legislation may exercise discretionary authority over such transactions. Although the level of government involvement varies from state to state, the trend is to provide for increased governmental review and, in some cases, approval of a transaction in which a not-for-profit entity sells a healthcare facility to a for-profit entity. The adoption of new or expanded conversion legislation, increased review of not-for-profit hospital conversions or our inability to effectively compete against other potential purchasers could make it more difficult for us to acquire additional hospitals, increase our acquisition costs or make it difficult for us to acquire hospitals that meet our target acquisition criteria, any of which could adversely affect our growth strategy and results of operations.

Further, an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired properties results of operations, allocation of the purchase price, effects of subsequent legislation and limits on rate increases.

We may fail to improve or integrate the operations of the assets we acquire, which could harm our results of operations and adversely affect our growth strategy.

We may be unable to timely and effectively integrate the assets or entities that we acquire with our ongoing operations. We may experience delays in implementing operating procedures and systems in newly acquired operations. Integrating an acquisition could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel. In addition, acquisition activity requires transitions from, and the integration of, operations and, usually, information systems that are used by acquired operations. In addition, some of the acquisitions we have made had significantly lower operating margins than the assets we operated prior to the time of our acquisition. If we fail to improve the operating margins of the operations we acquire, operate such assets profitably or effectively integrate the acquired operations, our results of operations could be harmed.

The trend toward value-based purchasing may negatively impact our revenues.

We believe that value-based purchasing initiatives of both governmental and private payers tying financial incentives to quality and efficiency of care will increasingly affect the results of operations of our hospitals and other healthcare facilities and may negatively impact our revenues if we are unable to meet expected quality standards. The Legislation contains a number of provisions intended to promote value-based purchasing in federal healthcare programs. Medicare now requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically. In addition, hospitals that meet or exceed certain quality performance standards will receive increased reimbursement payments, and hospitals that have "excess readmissions" for specified conditions will receive reduced reimbursement. Furthermore, Medicare no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions unless the conditions were present at admission. Beginning in federal fiscal year 2015, hospitals that rank in the worst 25% of all hospitals nationally for hospital acquired conditions in the previous year were subject to reduced Medicare reimbursements. The Legislation also prohibits the use of federal funds under the Medicaid program to reimburse providers for treating certain provider-preventable conditions.

There is a trend among private payers toward value-based purchasing of healthcare services, as well. Many large commercial payers require hospitals to report quality data, and several of these payers will not reimburse hospitals for certain preventable adverse events. We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenues if we are unable to meet quality standards established by both governmental and private payers.

If we acquire assets or entities with unknown or contingent liabilities, we could become liable for material obligations.

Assets or entities that we acquire may have unknown or contingent liabilities, including, but not limited to, liabilities for failure to comply with applicable laws and regulations. Although we typically attempt to exclude significant liabilities from our acquisition transactions and seek indemnification from the sellers for these matters, we could experience difficulty enforcing those obligations or we could incur material liabilities for the past activities of assets or entities we acquire. Such liabilities and related legal or other costs and/or resulting damage to an acquired asset's or entities' reputation could harm our business.

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

We, our subsidiaries, PSI, and its subsidiaries, are subject to pending legal actions, governmental investigations and regulatory actions (see *Item 3-Legal Proceedings*).

Defending ourselves against the allegations in the lawsuits and governmental investigations, or similar matters and any related publicity, could potentially entail significant costs and could require significant attention from our management and our reputation could suffer significantly. We are unable to predict the outcome of these matters or to reasonably estimate the amount or range of any such loss; however, these lawsuits and the related publicity and news articles that have been published concerning these matters could have a material adverse effect on our business, financial condition, results of operations and/or cash flows which in turn could cause a decline in our stock price.

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

In particular, government investigations, as well as qui tam and stockholder lawsuits, may lead to material fines, penalties, damages payments or other sanctions, including exclusion from government healthcare programs. Settlements of lawsuits involving Medicare and Medicaid issues routinely require both monetary payments and corporate integrity agreements, each of which could have a material adverse effect on our business, financial condition, results of operations and/or cash flows.

State efforts to regulate the construction or expansion of health care facilities could impair our ability to expand.

Many of the states in which we operate hospitals have enacted Certificates of Need, or ("CON"), laws as a condition prior to hospital capital expenditures, construction, expansion, modernization or initiation of major new services. Our failure to obtain necessary state approval could result in our inability to complete a particular hospital acquisition, expansion or replacement, make a facility ineligible to receive reimbursement under the Medicare or Medicaid programs, result in the revocation of a facility's license or impose civil or criminal penalties on us, any of which could harm our business.

In addition, significant CON reforms have been proposed in a number of states that would increase the capital spending thresholds and provide exemptions of various services from review requirements. In the past, we have not experienced any material adverse effects from those requirements, but we cannot predict the impact of these changes upon our operations.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by managed care plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Although we cannot predict the effect these changes will have on our operations, significant limits on the scope

of services reimbursed and on reimbursement rates and fees could have a material adverse effect on our business, financial position and results of operations.

Our revenues and volume trends may be adversely affected by certain factors over which we have no control.

Our revenues and volume trends are dependent on many factors, including physicians' clinical decisions and availability, payer programs shifting to a more outpatient-based environment, whether or not certain services are offered, seasonal and severe weather conditions, including the effects of extreme low temperatures, hurricanes and tornados, earthquakes, current local economic and demographic changes. In addition, technological developments and pharmaceutical improvements may reduce the demand for healthcare services or the profitability of the services we offer.

A pandemic, epidemic or outbreak of a contagious disease in the markets in which we operate or that otherwise impacts our facilities could adversely impact our business.

If a pandemic or other public health crisis were to affect our markets, our business could be adversely affected. Such a crisis could diminish the public trust in healthcare facilities, especially hospitals that fail to accurately or timely diagnose, or that are treating (or have treated) patients affected by contagious diseases. If any of our facilities were involved in treating patients for such a contagious disease, other patients might cancel elective procedures or fail to seek needed care at our facilities. Further, a pandemic might adversely impact our business by causing a temporary shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. Although we have disaster plans in place and operate pursuant to infectious disease protocols, the potential impact of a pandemic, epidemic or outbreak of a contagious disease with respect to our markets or our facilities is difficult to predict and could adversely impact our business.

A worsening of the economic and employment conditions in the United States could materially affect our business and future results of operations.

Our patient volumes, revenues and financial results depend significantly on the universe of patients with health insurance, which to a large extent is dependent on the employment status of individuals in our markets. Worsening of economic conditions may result in a higher unemployment rate which may increase the number of individuals without health insurance. As a result, our facilities may experience a decrease in patient volumes, particularly in less intense, more elective service lines, or an increase in services provided to uninsured patients. These factors could have a material unfavorable impact on our future patient volumes, revenues and operating results.

In addition, as of December 31, 2018, we had approximately $3.8 billion of goodwill recorded on our consolidated balance sheet. Should the revenues and financial results of our acute care and/or behavioral health care facilities be materially, unfavorably impacted due to, among other things, a worsening of the economic and employment conditions in the United States that could negatively impact our patient volumes and reimbursement rates, a continued rise in the unemployment rate and continued increases in the number of uninsured patients treated at our facilities, we may incur future charges to recognize impairment in the carrying value of our goodwill and other intangible assets, which could have a material adverse effect on our financial results.

Legal uncertainty or a worsening of the economic conditions in the United Kingdom could materially affect our business and future results of operations.

On June 23, 2016, the United Kingdom affirmatively voted in a non-binding referendum in favor of the exit of the United Kingdom from the European Union (the "Brexit") and it has been approved by vote of the British legislature. On March 29, 2017, the United Kingdom triggered Article 50 of the Lisbon Treaty, formally starting negotiations regarding its exit from the European Union, scheduled for March 29, 2019. In November 2018, the United Kingdom and the European Union agreed upon a draft Withdrawal Agreement that set out the terms of the United Kingdom's departure, including commitments on citizen rights after Brexit, a financial settlement from the United Kingdom, and a transition period from March 29, 2019 through December 31, 2020 to allow time for a future trade deal to be agreed. On January 15, 2019, the draft Withdrawal Agreement was rejected by the British legislature, creating significant uncertainty about the terms and timing under which the United Kingdom will leave the European Union.

If the United Kingdom leaves the European Union with no agreement (a "hard Brexit"), it will likely have an adverse impact on labor and trade in addition to creating further currency volatility. In the absence of a future trade deal, the United Kingdom's trade with the European Union and the rest of the world would be subject to tariffs and duties set by the World Trade Organization. These changes to the trading relationship between the United Kingdom and the European Union would likely result in increased cost of goods imported into the United Kingdom. Additional currency volatility could result in a weaker British pound, which may decrease the profitability of our operations in the United Kingdom. A weaker British pound versus the U.S. Dollar also causes local currency results of our United Kingdom operations to be translated into fewer U.S. Dollars during a reporting period.

Brexit could lead to legal and regulatory uncertainty as the United Kingdom determines which European Union laws to replace or replicate. The exit of the United Kingdom from the European Union could also create future economic uncertainty, both in the United Kingdom and globally, especially in the event of a hard Brexit. The actual exit of the United Kingdom from the European Union could cause disruptions to and create uncertainty surrounding our business. Any of these effects of Brexit (and the announcement thereof), and others we cannot anticipate, could harm our business, financial condition or results of operations.

Fluctuations in our operating results, quarter to quarter earnings and other factors may result in decreases in the price of our common stock.

The stock markets have experienced volatility that has often been unrelated to operating performance. These broad market fluctuations may adversely affect the trading price of our common stock and, as a result, there may be significant volatility in the market price of our common stock. If we are unable to operate our hospitals as profitably as we have in the past or as our stockholders expect us to in the future, the market price of our common stock will likely decline as stockholders could sell shares of our common stock when it becomes apparent that the market expectations may not be realized.

In addition to our operating results, many economic and seasonal factors outside of our control could have an adverse effect on the price of our common stock and increase fluctuations in our quarterly earnings. These factors include certain of the risks discussed herein, demographic changes, operating results of other hospital companies, changes in our financial estimates or recommendations of securities analysts, speculation in the press or investment community, the possible effects of war, terrorist and other hostilities, adverse weather conditions, the level of seasonal illnesses, managed care contract negotiations and terminations, changes in general conditions in the economy or the financial markets, or other developments affecting the health care industry.

Our financial results may be adversely affected by fluctuations in foreign currency exchange rates.

We are exposed to currency exchange risk with respect to the U.S. Dollar in relation to the Pound sterling, because a portion of our revenue and expenses are denominated in Pounds. We monitor changes in our exposure to exchange rate risk. While we may elect to enter into hedging arrangements to protect our business against certain currency fluctuations, these hedging arrangements do not provide comprehensive protection, and our results of operations could be adversely affected by foreign exchange fluctuations.

We are subject to significant corporate regulation as a public company and failure to comply with all applicable regulations could subject us to liability or negatively affect our stock price.

As a publicly traded company, we are subject to a significant body of regulation, including the Sarbanes-Oxley Act of 2002. While we have developed and instituted a corporate compliance program based on what we believe are the current best practices in corporate governance and continue to update this program in response to newly implemented or changing regulatory requirements, we cannot provide assurance that we are or will be in compliance with all potentially applicable corporate regulations. For example, we cannot provide assurance that, in the future, our management will not find a material weakness in connection with its annual review of our internal control over financial reporting pursuant to Section 404 of the Sarbanes-Oxley Act. We also cannot provide assurance that we could correct any such weakness to allow our management to assess the effectiveness of our internal control over financial reporting as of the end of our fiscal year in time to enable our independent registered public accounting firm to state that such assessment will have been fairly stated in our Annual Report on Form 10-K or state that we have maintained effective internal control over financial reporting as of the end of our fiscal year. If we fail to comply with any of these regulations, we could be subject to a range of regulatory actions, fines or other sanctions or litigation. If we must disclose any material weakness in our internal control over financial reporting, our stock price could decline.

A cyber security incident could cause a violation of HIPAA, breach of member privacy, or other negative impacts.

We rely extensively on our information technology ("IT") systems to manage clinical and financial data, communicate with our patients, payers, vendors and other third parties and summarize and analyze operating results. In addition, we have made significant investments in technology to adopt and utilize electronic health records and to become meaningful users of health information technology pursuant to the American Recovery and Reinvestment Act of 2009. A cyber-attack that bypasses our IT security systems causing an IT security breach, loss of protected health information or other data subject to privacy laws, loss of proprietary business information, or a material disruption of our IT business systems, could have a material adverse impact on our business and result of operations. In addition, our future results of operations, as well as our reputation, could be adversely impacted by theft, destruction, loss, or misappropriation of public health information, other confidential data or proprietary business information.

Different interpretations of accounting principles could have a material adverse effect on our results of operations or financial condition.

Generally accepted accounting principles are complex, continually evolving and may be subject to varied interpretation by us, our independent registered public accounting firm and the SEC. Such varied interpretations could result from differing views related to specific facts and circumstances. Differences in interpretation of generally accepted accounting principles could have a material adverse effect on our financial position or results of operations.

We continue to see rising costs in construction materials and labor. Such increased costs could have an adverse effect on the cash flow return on investment relating to our capital projects.

The cost of construction materials and labor has significantly increased. As we continue to invest in modern technologies, emergency rooms and operating room expansions, the construction of medical office buildings for physician expansion and reconfiguring the flow of patient care, we spend large amounts of money generated from our operating cash flow or borrowed funds. Although we evaluate the financial feasibility of such projects by determining whether the projected cash flow return on investment exceeds our cost of capital, such returns may not be achieved if the cost of construction continues to rise significantly or the expected patient volumes are not attained.

The deterioration of credit and capital markets may adversely affect our access to sources of funding and we cannot be certain of the availability and terms of capital to fund the growth of our business when needed.

We require substantial capital resources to fund our acquisition growth strategy and our ongoing capital expenditure programs for renovation, expansion, construction and addition of medical equipment and technology. We believe that our capital expenditure program is adequate to expand, improve and equip our existing hospitals. We cannot predict, however, whether financing for our growth plans and capital expenditure programs will be available to us on satisfactory terms when needed, which could harm our business.

To fund all or a portion of our future financing needs, we rely on borrowings from various sources including fixed rate, long-term debt as well as borrowings pursuant to our revolving credit facility and accounts receivable securitization program. If any of the lenders were unable to fulfill their future commitments, our liquidity could be impacted, which could have a material unfavorable impact our results of operations and financial condition.

In addition, global capital markets have experienced volatility that has tightened access to capital markets and other sources of funding. In the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

The LIBOR calculation method may change and LIBOR is expected to be phased out after 2021.

Our Credit Agreement permits interest on borrowings to be calculated based on LIBOR, and a number of our interest rate swaps are based on LIBOR. On July 27, 2017, the United Kingdom Financial Conduct Authority (the "FCA") announced that it will no longer require banks to submit rates for the calculation of LIBOR after 2021. In the meantime, actions by the FCA, other regulators, or law enforcement agencies may result in changes to the method by which LIBOR is calculated. At this time, it is not possible to predict the effect of any such changes or any other reforms to LIBOR that may be enacted in the United Kingdom or elsewhere.

We depend heavily on key management personnel and the departure of one or more of our key executives or a significant portion of our local hospital management personnel could harm our business.

The expertise and efforts of our senior executives and key members of our local hospital management personnel are critical to the success of our business. The loss of the services of one or more of our senior executives or of a significant portion of our local hospital management personnel could significantly undermine our management expertise and our ability to provide efficient, quality healthcare services at our facilities, which could harm our business.

The number of outstanding shares of our Class B Common Stock is subject to potential increases or decreases.

At December 31, 2018, 24.2 million shares of Class B Common Stock were reserved for issuance upon conversion of shares of Class A, C and D Common Stock outstanding, for issuance upon exercise of options to purchase Class B Common Stock and for issuance of stock under other incentive plans. Class A, C and D Common Stock are convertible on a share for share basis into Class B Common Stock. To the extent that these shares were converted into or exercised for shares of Class B Common Stock, the number of

shares of Class B Common Stock available for trading in the public market place would increase substantially and the current holders of Class B Common Stock would own a smaller percentage of that class.

In addition, from time-to-time our Board of Directors approve stock repurchase programs authorizing us to purchase shares of our Class B Common Stock on the open market at prevailing market prices or in negotiated transactions off the market. Such repurchases decrease the number of outstanding shares of our Class B Common Stock. Conversely, as a potential means of generating additional funds to operate and expand our business, we may from time-to-time issue equity through the sale of stock which would increase the number of outstanding shares of our Class B Common Stock. Based upon factors such as, but not limited to, the market price of our stock, interest rate on borrowings and uses or potential uses for cash, repurchase or issuance of our stock could have a dilutive effect on our future basic and diluted earnings per share.

The right to elect the majority of our Board of Directors and the majority of the general shareholder voting power resides with the holders of Class A and C Common Stock, the majority of which is owned by Alan B. Miller, our Chief Executive Officer and Chairman of our Board of Directors.

Our Restated Certificate of Incorporation provides that, with respect to the election of directors, holders of Class A Common Stock vote as a class with the holders of Class C Common Stock, and holders of Class B Common Stock vote as a class with holders of Class D Common Stock, with holders of all classes of our Common Stock entitled to one vote per share.

As of March 20, 2018, the shares of Class A and Class C Common Stock constituted 7.7% of the aggregate outstanding shares of our Common Stock, had the right to elect five members of the Board of Directors and constituted 86.8% of our general voting power as of that date. As of March 20, 2018, the shares of Class B and Class D Common Stock (excluding shares issuable upon exercise of options) constituted 92.3% of the outstanding shares of our Common Stock, had the right to elect two members of the Board of Directors and constituted 13.2% of our general voting power as of that date.

As to matters other than the election of directors, our Restated Certificate of Incorporation provides that holders of Class A, Class B, Class C and Class D Common Stock all vote together as a single class, except as otherwise provided by law.

Each share of Class A Common Stock entitles the holder thereof to one vote; each share of Class B Common Stock entitles the holder thereof to one-tenth of a vote; each share of Class C Common Stock entitles the holder thereof to 100 votes (provided the holder of Class C Common Stock holds a number of shares of Class A Common Stock equal to ten times the number of shares of Class C Common Stock that holder holds); and each share of Class D Common Stock entitles the holder thereof to ten votes (provided the holder of Class D Common Stock holds a number of shares of Class B Common Stock equal to ten times the number of shares of Class D Common Stock that holder holds).

In the event a holder of Class C or Class D Common Stock holds a number of shares of Class A or Class B Common Stock, respectively, less than ten times the number of shares of Class C or Class D Common Stock that holder holds, then that holder will be entitled to only one vote for every share of Class C Common Stock, or one-tenth of a vote for every share of Class D Common Stock, which that holder holds in excess of one-tenth the number of shares of Class A or Class B Common Stock, respectively, held by that holder. The Board of Directors, in its discretion, may require beneficial owners to provide satisfactory evidence that such owner holds ten times as many shares of Class A or Class B Common Stock as Class C or Class D Common Stock, respectively, if such facts are not apparent from our stock records.

Since a substantial majority of the Class A shares and Class C shares are controlled by Mr. Alan B. Miller and members of his family, one of whom (Marc D. Miller) is also a director and officer of our company, and they can elect a majority of our company's directors and effect or reject most actions requiring approval by stockholders without the vote of any other stockholders, there are potential conflicts of interest in overseeing the management of our company.

In addition, because this concentrated control could discourage others from initiating any potential merger, takeover or other change of control transaction that may otherwise be beneficial to our businesses, our business and prospects and the trading price of our securities could be adversely affected.

ITEM 1B. ***Unresolved Staff Comments***

None.

ITEM 2. ***Properties***

Executive and Administrative Offices and Commercial Health Insurer

We own various office buildings in King of Prussia and Wayne, Pennsylvania, Brentwood, Tennessee, Denton, Texas and Reno, Nevada.

Facilities

The following tables set forth the name, location, type of facility and, for acute care hospitals and behavioral health care facilities, the number of licensed beds:

Acute Care Hospitals

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Aiken Regional Medical Centers	Aiken, South Carolina	211	Owned
Aurora Pavilion	Aiken, South Carolina	62	Owned
Centennial Hills Hospital Medical Center	Las Vegas, Nevada	250	Owned
Corona Regional Medical Center	Corona, California	238	Owned
Desert Springs Hospital	Las Vegas, Nevada	293	Owned
Desert View Hospital	Pahrump, Nevada	25	Owned
Doctors' Hospital of Laredo (7)	Laredo, Texas	183	Owned
Doctor's Hospital ER South	Laredo, Texas	—	Leased
Fort Duncan Regional Medical Center	Eagle Pass, Texas	101	Owned
The George Washington University Hospital (1)	Washington, D.C.	385	Leased
Henderson Hospital	Henderson, Nevada	166	Owned
ER at Green Valley Ranch	Henderson, Nevada	—	Owned
Lakewood Ranch Medical Center	Bradenton, Florida	120	Owned
Manatee Memorial Hospital	Bradenton, Florida	295	Owned
Northern Nevada Medical Center	Sparks, Nevada	108	Owned
Northwest Texas Healthcare System	Amarillo, Texas	405	Owned
The Pavilion at Northwest Texas Healthcare System	Amarillo, Texas	90	Owned
NWTH FED	Amarillo, Texas	—	Owned
Palmdale Regional Medical Center	Palmdale, California	184	Owned
South Texas Health System (3)			
Edinburg Regional Medical Center/Children's Hospital	Edinburg, Texas	235	Owned
McAllen Medical Center (2)	McAllen, Texas	441	Leased
McAllen Heart Hospital	McAllen, Texas	60	Owned
South Texas Behavioral Health Center	McAllen, Texas	134	Owned
STHS ER at Alamo	Alamo, Texas	—	Owned
STHS ER at McColl	Edinburg, Texas	—	Owned
STHS ER at Mission (2)	Mission, Texas	—	Leased
STHS ER at Monte Cristo	Edinburg, Texas	—	Owned
STHS ER at Ware Road	McAllen, Texas	—	Owned
STHS ER at Weslaco (2)	Weslaco, Texas	—	Leased
Southwest Healthcare System			
Inland Valley Campus (2)	Wildomar, California	130	Leased
Rancho Springs Campus	Murrieta, California	120	Owned
Spring Valley Hospital Medical Center	Las Vegas, Nevada	364	Owned
St. Mary's Regional Medical Center	Enid, Oklahoma	229	Owned
Summerlin Hospital Medical Center	Las Vegas, Nevada	485	Owned
Temecula Valley Hospital	Temecula, California	140	Owned
Texoma Medical Center	Denison, Texas	266	Owned
TMC Behavioral Health Center	Denison, Texas	60	Owned
Valley Hospital Medical Center	Las Vegas, Nevada	306	Owned

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Wellington Regional Medical Center (2)	West Palm Beach, Florida	233	Leased

Inpatient Behavioral Health Care Facilities

United States:

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Alabama Clinical Schools	Birmingham, Alabama	80	Owned
Alhambra Hospital	Rosemead, California	109	Owned
Alliance Health Center	Meridian, Mississippi	214	Owned
The Arbour Hospital	Boston, Massachusetts	136	Owned
Arbour-Fuller Hospital	South Attleboro, Massachusetts	102	Owned
Arbour-HRI Hospital	Brookline, Massachusetts	62	Owned
Arrowhead Behavioral Health	Maumee, Ohio	48	Owned
Austin Lakes Hospital	Austin, Texas	58	Leased
Austin Oaks Hospitals	Austin, Texas	80	Owned
Behavioral Hospital of Bellaire	Houston, Texas	124	Leased
Belmont Pines Hospital	Youngstown, Ohio	102	Owned
Benchmark Behavioral Health System	Woods Cross, Utah	94	Owned
Black Bear Treatment Center	Sautee, Georgia	115	Owned
Bloomington Meadows Hospital	Bloomington, Indiana	78	Owned
Boulder Creek Academy	Bonners Ferry, Idaho	105	Owned
Brentwood Behavioral Health of Mississippi	Flowood, Mississippi	121	Owned
Brentwood Hospital	Shreveport, Louisiana	200	Owned
The Bridgeway	North Little Rock, Arkansas	127	Owned
Brook Hospital—Dupont	Louisville, Kentucky	88	Owned
Brook Hospital—KMI	Louisville, Kentucky	110	Owned
Brooke Glen Behavioral Hospital	Fort Washington, Pennsylvania	146	Owned
Brynn Marr Hospital	Jacksonville, North Carolina	102	Owned
Calvary Addiction Recovery Center	Phoenix, Arizona	68	Owned
Canyon Ridge Hospital	Chino, California	106	Owned
The Carolina Center for Behavioral Health	Greer, South Carolina	138	Owned
Cedar Creek	St. Johns, Michigan	34	Owned
Cedar Grove Residential Treatment Center	Murfreesboro, Tennessee	40	Owned
Cedar Hills Hospital (8)	Beaverton, Oregon	94	Owned
Cedar Ridge	Oklahoma City, Oklahoma	60	Owned
Cedar Ridge Residential Treatment Center	Oklahoma City, Oklahoma	56	Owned
Cedar Ridge Bethany	Bethany, Oklahoma	56	Owned
Cedar Springs Behavioral Health	Colorado Springs, Colorado	110	Owned
Centennial Peaks	Louisville, Colorado	104	Owned
Center for Change	Orem, Utah	58	Owned
Central Florida Behavioral Hospital	Orlando, Florida	174	Owned
Chicago Children's Center for Behavioral Health	Chicago, Illinois	40	Leased
Chris Kyle Patriots Hospital	Anchorage, Alaska	36	Owned
Clarion Psychiatric Center	Clarion, Pennsylvania	112	Owned
Coastal Behavioral Health	Savannah, Georgia	50	Owned
Coastal Harbor Treatment Center	Savannah, Georgia	147	Owned
Columbus Behavioral Center for Children and Adolescents	Columbus, Indiana	57	Owned
Compass Intervention Center	Memphis, Tennessee	108	Owned
Copper Hills Youth Center	West Jordan, Utah	197	Owned

United States:

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Coral Shores	Stuart, Florida	80	Owned
Cumberland Hall	Hopkinsville, Kentucky	97	Owned
Cumberland Hospital	New Kent, Virginia	110	Owned
Cypress Creek Hospital	Houston, Texas	128	Owned
Del Amo Hospital	Torrance, California	166	Owned
Diamond Grove Center	Louisville, Mississippi	55	Owned
Dover Behavioral Health	Dover, Delaware	104	Owned
El Paso Behavioral Health System	El Paso, Texas	166	Owned
Emerald Coast Behavioral Hospital	Panama City, Florida	86	Owned
Fairmount Behavioral Health System	Philadelphia, Pennsylvania	239	Owned
Fairfax			
Fairfax Hospital	Kirkland, Washington	157	Owned
Fairfax Hospital—Everett	Everett, Washington	30	Leased
Fairfax Hospital—Monroe	Monroe, Washington	34	Leased
Forest View Hospital	Grand Rapids, Michigan	108	Owned
Fort Lauderdale Hospital	Fort Lauderdale, Florida	182	Leased
Foundations Behavioral Health	Doylestown, Pennsylvania	108	Leased
Foundations for Living	Mansfield, Ohio	84	Owned
Fox Run Hospital	St. Clairsville, Ohio	100	Owned
Fremont Hospital	Fremont, California	148	Owned
Friends Hospital	Philadelphia, Pennsylvania	219	Owned
Garfield Park Hospital	Chicago, Illinois	88	Owned
Garland Behavioral Health	Garland, Texas	72	Leased
Glen Oaks Hospital	Greenville, Texas	54	Owned
Gulf Coast Youth Services	Fort Walton Beach, Florida	24	Owned
Gulfport Behavioral Health System	Gulfport, Mississippi	109	Owned
Hampton Behavioral Health Center	Westhampton, New Jersey	120	Owned
Harbour Point (Pines)	Portsmouth, Virginia	186	Owned
Hartgrove Hospital	Chicago, Illinois	160	Owned
Havenwyck Hospital	Auburn Hills, Michigan	243	Owned
Heartland Behavioral Health Services	Nevada, Missouri	151	Owned
Hermitage Hall	Nashville, Tennessee	111	Owned
Heritage Oaks Hospital	Sacramento, California	125	Owned
Hickory Trail Hospital	DeSoto, Texas	86	Owned
Highlands Behavioral Health System	Highlands Ranch, Colorado	86	Owned
Hill Crest Behavioral Health Services	Birmingham, Alabama	219	Owned
Holly Hill Hospital	Raleigh, North Carolina	285	Owned
The Horsham Clinic	Ambler, Pennsylvania	206	Owned
Hughes Center	Danville, Virginia	64	Owned
Inland Northwest Behavioral Health (12)	Spokane, Washington	100	Owned
Intermountain Hospital	Boise, Idaho	155	Owned
Kempsville Center of Behavioral Health	Norfolk, Virginia	82	Owned
KeyStone Center	Wallingford, Pennsylvania	153	Owned
Kingwood Pines Hospital	Kingwood, Texas	116	Owned
La Amistad Behavioral Health Services	Maitland, Florida	85	Owned
Lakeside Behavioral Health System	Memphis, Tennessee	345	Owned
Lancaster Behavioral Health Hospital (11)	Lancaster, Pennsylvania	126	Owned
Laurel Heights Hospital	Atlanta, Georgia	112	Owned
Laurel Oaks Behavioral Health Center	Dothan, Alabama	124	Owned
Laurel Ridge Treatment Center	San Antonio, Texas	250	Owned
Liberty Point Behavioral Health	Stauton, Virginia	56	Owned

United States:

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Lighthouse Care Center of Augusta	Augusta, Georgia	68	Owned
Lighthouse Care Center of Conway	Conway, South Carolina	96	Owned
Lincoln Prairie Behavioral Health Center	Springfield, Illinois	97	Owned
Lincoln Trail Behavioral Health System	Radcliff, Kentucky	140	Owned
Mayhill Hospital	Denton, Texas	59	Leased
McDowell Center for Children	Dyersburg, Tennessee	32	Owned
The Meadows Psychiatric Center	Centre Hall, Pennsylvania	117	Owned
Meridell Achievement Center	Austin, Texas	134	Owned
Mesilla Valley Hospital	Las Cruces, New Mexico	104	Owned
Michael's House	Palm Springs, California	120	Owned
Michiana Behavioral Health Center	Plymouth, Indiana	80	Owned
Midwest Center for Youth and Families	Kouts, Indiana	74	Owned
Millwood Hospital	Arlington, Texas	134	Leased
Mountain Youth Academy	Mountain City, Tennessee	90	Owned
Natchez Trace Youth Academy	Waverly, Tennessee	115	Owned
Newport News Behavioral Health Center	Newport News, Virginia	132	Owned
North Spring Behavioral Healthcare	Leesburg, Virginia	103	Leased
North Star Hospital	Anchorage, Alaska	74	Owned
North Star Bragaw	Anchorage, Alaska	30	Owned
North Star DeBarr Residential Treatment Center	Anchorage, Alaska	30	Owned
North Star Palmer Residential Treatment Center	Palmer, Alaska	30	Owned
Oak Plains Academy	Ashland City, Tennessee	98	Owned
The Oaks Treatment Center	Memphis, Tennessee	71	Owned
Okaloosa Youth Academy	Crestview, Florida	75	Leased
Old Vineyard Behavioral Health	Winston-Salem, North Carolina	164	Owned
Palmetto Lowcountry Behavioral Health	North Charleston, South Carolina	108	Owned
Palmetto Pee Dee Behavioral Health	Florence, South Carolina	59	Leased
Palmetto Summerville	Summerville, South Carolina	64	Leased
Palm Point Behavioral	Titusville, FL	74	Owned
Palm Shores Behavioral Health Center	Bradenton, Florida	64	Owned
Palo Verde Behavioral Health	Tucson, Arizona	84	Leased
Parkwood Behavioral Health System	Olive Branch, Mississippi	148	Owned
The Pavilion	Champaign, Illinois	106	Owned
Peachford Behavioral Health System of Atlanta	Atlanta, Georgia	246	Owned
Pembroke Hospital	Pembroke, Massachusetts	120	Owned
Pinnacle Pointe Hospital	Little Rock, Arkansas	127	Owned
Poplar Springs Hospital	Petersburg, Virginia	208	Owned
Prairie St John's	Fargo, North Dakota	158	Owned
Pride Institute	Eden Prairie, Minnesota	42	Owned
Provo Canyon School	Provo, Utah	274	Owned
Provo Canyon Behavioral Hospital	Orem, Utah	80	Owned
Psychiatric Institute of Washington	Washington, D.C.	130	Owned
Quail Run Behavioral Health	Phoenix, Arizona	102	Owned
The Recovery Center	Wichita Falls, Texas	34	Leased
The Ridge Behavioral Health System	Lexington, Kentucky	110	Owned
Rivendell Behavioral Health Services of Arkansas	Benton, Arkansas	80	Owned
Rivendell Behavioral Health Services of Kentucky	Bowling Green, Kentucky	125	Owned
River Crest Hospital	San Angelo, Texas	80	Owned
Riveredge Hospital	Forest Park, Illinois	210	Owned
River Oaks Hospital	New Orleans, Louisiana	126	Owned
River Park Hospital	Huntington, West Virginia	187	Owned

United States:

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
River Point Behavioral Health	Jacksonville, Florida	84	Owned
Rockford Center	Newark, Delaware	138	Owned
Rolling Hills Hospital	Franklin, Tennessee	130	Owned
Roxbury	Shippensburg, Pennsylvania	112	Owned
Salt Lake Behavioral Health	Salt Lake City, Utah	118	Leased
San Marcos Treatment Center	San Marcos, Texas	265	Owned
Sandy Pines Hospital	Tequesta, Florida	149	Owned
Schick Shadel Hospital	Burien, Washington	60	Owned
Shadow Mountain Behavioral Health System	Tulsa, Oklahoma	249	Owned
Sierra Vista Hospital	Sacramento, California	171	Owned
Southern Crescent Behavioral Health			
Anchor Hospital	Atlanta, Georgia	122	Owned
Crescent Pines	Stockbridge, Georgia	50	Owned
St. Simons by the Sea	St. Simons, Georgia	101	Owned
Skywood Recovery	Augusta, Michigan	100	Owned
Spring Mountain Sahara	Las Vegas, Nevada	30	Owned
Spring Mountain Treatment Center	Las Vegas, Nevada	110	Owned
Springwoods	Fayetteville, Arkansas	80	Owned
Stonington Institute	North Stonington, Connecticut	64	Owned
Streamwood Behavioral Health	Streamwood, Illinois	178	Owned
Summit Oaks Hospital	Summit, New Jersey	126	Owned
SummitRidge	Lawrenceville, Georgia	96	Owned
Suncoast Behavioral Health Center	Bradenton, Florida	60	Owned
Texas NeuroRehab Center	Austin, Texas	151	Owned
Three Rivers Behavioral Health	West Columbia, South Carolina	122	Owned
Three Rivers Residential Treatment-Midlands Campus	West Columbia, South Carolina	64	Owned
Turning Point Hospital	Moultrie, Georgia	69	Owned
University Behavioral Center	Orlando, Florida	112	Owned
University Behavioral Health of Denton	Denton, Texas	104	Owned
Valle Vista Hospital	Greenwood, Indiana	132	Owned
Valley Hospital	Phoenix, Arizona	122	Owned
The Vines Hospital	Ocala, Florida	98	Owned
Virginia Beach Psychiatric Center	Virginia Beach, Virginia	100	Owned
Wekiva Springs	Jacksonville, Florida	120	Owned
Wellstone Regional Hospital	Jeffersonville, Indiana	100	Owned
West Hills Hospital	Reno, Nevada	95	Owned
West Oaks Hospital	Houston, Texas	160	Owned
Willow Springs Center	Reno, Nevada	116	Owned
Windmoor Healthcare	Clearwater, Florida	144	Owned
Windsor—Laurelwood Center	Willoughby, Ohio	159	Leased
Wyoming Behavioral Institute	Casper, Wyoming	146	Owned

United Kingdom:

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Acer Clinic (9)	Chestherfield, UK	14	Owned
Acer Clinic 2 (9)	Chestherfield, UK	14	Owned
Albert Ward (9)	Darlington, UK	8	Owned
Amberwood Lodge (9)	Dorset, UK	9	Owned
Ashfield House (9)	Huddersfield, UK	6	Owned

United Kingdom:

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Aspen House (9)	South Yorkshire, UK	20	Owned
Aspen Lodge (9)	Rotherham, UK	16	Owned
Beacon Lower (9)	Bradford, UK	8	Owned
Beacon Upper (9)	Bradford, UK	8	Owned
Beckly House (9)	Halifax, UK	12	Owned
Bostall House (10)	London, UK	6	Owned
Bury Hospital	Bury, UK	167	Owned
Broughton House (9)	Lincolnshire, UK	34	Owned
Broughton Lodge (9)	Cheshire, UK	20	Owned
Cambian Alders (9)	Gloucester, UK	20	Owned
Cambian Ansel Clinic (9)	Nottingham, UK	24	Owned
Cambian Appletree (9)	Durham, UK	26	Owned
Cambian Beeches (9)	Nottinghamshire, UK	12	Owned
Cambian Birches (9)	Notts, UK	6	Owned
Cambian Cedars (9)	Birmingham, UK	24	Owned
Cambian Churchill (9)	London, UK	57	Owned
Cambian Conifers (9)	Derby, UK	7	Owned
Cambian Elms (9)	Birmingham, UK	10	Owned
Cambian Grange (9)	Nottinghamshire, UK	8	Owned
Cambian Heathers (9)	West Bromwich, UK	20	Owned
Cambian Lodge (9)	Nottinghamshire, UK	8	Owned
Cambian Manor (9)	Central Drive, UK	20	Owned
Cambian Nightingale (9)	Dorset, UK	10	Owned
Cambian Oaks (9)	Barnsley, UK	36	Owned
Cambian Pines (9)	Woodhouse, UK	7	Owned
Cambian Views (9)	Matlock, UK	10	Owned
Cambian Woodside (9)	Bradford, UK	9	Owned
CAS Brunel (9)	Henbury, UK	32	Owned
Cedar Vale (10)	Nottinghamshire, UK	14	Owned
Chaseways	Sawbridgeworth, UK	6	Owned
Chesterholme (10)	Northumberland, UK	16	Owned
Coulby Lodge (10)	North Yorkshire, UK	8	Owned
Coventry	Coventry, UK	56	Owned
Cygnet Hospital—Beckton	Beckton, UK	62	Owned
Cygnet Hospital—Bierley	Bierley, UK	63	Owned
Cygnet Wing—Blackheath	Blackheath, UK	32	Leased
Cygnet Lodge—Brighouse	Brighouse, UK	25	Owned
Cygnet Hospital—Derby	Derby, UK	50	Owned
Cygnet Hospital—Ealing	Ealing, UK	26	Owned
Cygnet Hospital—Godden Green	Godden Green, UK	39	Owned
Cygnet Hospital—Harrogate	Harrogate, UK	36	Owned
Cygnet Hospital—Harrow	Harrow, UK	61	Owned
Cygnet Hospital—Kewstoke	Kewstoke, UK	72	Owned
Cygnet Lodge—Lewisham	Lewisham, UK	17	Owned
Cygnet Hospital—Stevenage	Stevenage, UK	88	Owned
Cygnet Hospital—Taunton	Taunton, UK	49	Owned
Cygnet Lodge – Kenton	Westlands, UK	15	Owned
Cygnet Hospital—Wyke	Wyke, UK	52	Owned
Cygnet Lodge – Woking	Knaphill, UK	31	Owned
Delfryn House (9)	Flintshire, UK	28	Owned
Delfryn Lodge (9)	Flintshire, UK	24	Owned

United Kingdom:

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Dene Brook (9)	Dalton Parva, UK	13	Owned
Devon Lodge (9)	Southampton, UK	12	Owned
Ducks Halt (10)	Essex, UK	5	Owned
Eleni House (9)	Essex, UK	8	Owned
Ellen Mhor (10)	Dundee, UK	12	Owned
Elston House (9)	Nottinghamshire, UK	8	Owned
Fairways (9)	Suffolk, UK	8	Owned
Farm Lodge	Rainham, UK	5	Owned
The Fields (9)	Sheffield, UK	54	Owned
Flower Adams (9)	Colchester, UK	20	Owned
The Fountains (9)	Blackburn, UK	32	Owned
The Gables (9)	Essex, UK	7	Owned
Gledcliffe Road (9)	Huddersfield, UK	6	Owned
Gledholt (9)	Huddersfield, UK	9	Owned
Hawkstone (9)	Utley, UK	10	Owned
Hollyhurst (10)	County Durham, UK	19	Owned
Hope House (10)	County Durham, UK	11	Owned
Kirkside House (9)	Leeds, UK	7	Owned
Kirkside Lodge (9)	Leeds, UK	8	Owned
Langdale House (9)	Huddersfield, UK	8	Owned
Langdale Coach House (9)	Huddersfield, UK	3	Owned
Larch Court (9)	Essex, UK	4	Owned
Limes Houses (9)	Nottinghamshire, UK	6	Owned
Longfield House (9)	Bradford, UK	9	Owned
Lowry House (9)	Hyde, UK	12	Owned
Maidstone	Maidstone, UK	65	Owned
Marion House (9)	Derby, UK	5	Owned
Meadows Mews (9)	Tipton, UK	10	Owned
Newbus Grange (10)	County Durham, UK	17	Owned
Norcott House (9)	Liversedge, UK	11	Owned
Norcott Lodge (9)	Liversedge, UK	9	Owned
Oak Court (9)	Essex, UK	12	Owned
Oakhurst Lodge (9)	Hampshire, UK	8	Owned
Oaklands (10)	Northumberland, UK	19	Owned
Old Leigh House (10)	Essex, UK	7	Leased
The Orchards (10)	Essex, UK	5	Owned
The Outwood (9)	Leeds, UK	10	Owned
Oxley Lodge (9)	Huddersfield, UK	4	Owned
Oxley Woodhouse (9)	Huddersfield, UK	13	Owned
Portland Road 45 (9)	Edgbaston, UK	4	Leased
Raglan House (9)	West Midlands, UK	25	Owned
Ramsey (9)	Colchester, UK	21	Owned
Ranaich House (10)	Stirling, UK	14	Owned
Redlands (10)	County Durham, UK	5	Owned
Rhyd Alyn (9)	Flintshire, UK	6	Owned
Rufford Lodge (9)	Mansfield, UK	2	Owned
Sedgley House (9)	Wolverhampton, UK	20	Owned
Sedgley Lodge (9)	Wolverhampton, UK	14	Owned
Shear Meadow (9)	Hemel Hempstead, UK	4	Owned
Sheffield Hospital	Sheffield, UK	55	Owned
Sherwood House (9)	Mansfield, UK	30	Owned

United Kingdom:

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
Sherwood Lodge (9)	Mansfield, UK	17	Owned
Sherwood Lodge Step Down (9)	Mansfield, UK	9	Owned
The Squirrels (9)	Hampshire, UK	9	Owned
St. Augustine's (9)	Stoke on Trent, UK	32	Owned
St. Teilo House (9)	Gwent, UK	23	Owned
Storthfields (9)	Derby, UK	22	Owned
The Sycamores (9)	Derbyshire, UK	6	Owned
The Sycamores No 4 & 5 (9)	Derbyshire, UK	4	Owned
Tabley Nursing Home—Tabley	Tabley, UK	51	Leased
Thistle Care Home (10)	Dundee, UK	10	Owned
Thornfield Grange (10)	County Durham, UK	9	Owned
Thornfield House (9)	Bradford, UK	7	Owned
Thors Park (10)	Essex, UK	14	Owned
Toller Road (10)	Leicestershire, UK	8	Owned
Trinity House (10)	Galloway, UK	13	Owned
Tupwood Gate Nursing Home	Caterham, UK	32	Owned
Victoria House (10)	County Durham, UK	6	Owned
Vincent Court (9)	Lancashire, UK	5	Owned
Walkern Lodge (9)	Stevenage, UK	4	Owned
Wallace Hospital (10)	Dundee, UK	10	Owned
Wast Hills (10)	West Midlands, UK	26	Owned
Whorlton Hall (10)	County Durham, UK	17	Owned
Willow House (10)	West Midlands, UK	8	Owned
Woking Hospital	Woking, UK	60	Owned
Woodcross Street (9)	Wolverhampton, UK	8	Owned
Yew Trees (10)	Essex, UK	10	Owned

Puerto Rico:

Name of Facility	Location	Number of Beds	Real Property Ownership Interest
First Hospital Panamericano—Cidra	Cidra, Puerto Rico	165	Owned
First Hospital Panamericano—San Juan	San Juan, Puerto Rico	45	Owned
First Hospital Panamericano—Ponce	Ponce, Puerto Rico	30	Owned

Outpatient Behavioral Health Care Facilities

United States:

Name of Facility	Location	Real Property Ownership Interest
Arbour Counseling Services	Rockland, Massachusetts	Owned
Arbour Senior Care	Rockland, Massachusetts	Owned
Behavioral Educational Services	Riverdale, Florida	Leased
The Canyon at Santa Monica	Santa Monica, California	Leased
First Home Care (VA)	Portsmouth, Virginia	Leased
Foundations Atlanta	Atlanta, Georgia	Leased
Foundations Chicago	Chicago, Illinois	Leased
Foundations Detroit	Bingham Farms, Michigan	Leased

United States:

Name of Facility	Location	Real Property Ownership Interest
Foundations Los Angeles	Los Angeles, California	Leased
Foundations Memphis	Memphis, Tennessee	Leased
Foundations Nashville	Nashville, Tennessee	Leased
Foundations Roswell	Roswell, Georgia	Leased
Foundations San Diego	San Diego, California	Leased
Foundations San Francisco	San Francisco, California	Leased
Good Samaritan Counseling Center	Anchorage, Alaska	Owned
Michael's House Outpatient	Palm Springs, California	Leased
The Pointe	Little Rock, Arkansas	Leased
St. Louis Behavioral Medicine Institute	St. Louis, Missouri	Owned
Talbott Recovery	Atlanta, Georgia	Owned

United Kingdom:

Name of Facility	Location	Real Property Ownership Interest
Long Eaton Day Services (9)	Nottingham, UK	Owned
Sheffield Day Services (9)	Sheffield, UK	Owned

Outpatient Centers and Surgical Hospital

Name of Facility	Location	Real Property Ownership Interest
Aiken Surgery Center	Aiken, South Carolina	Owned
Cancer Care Institute of Carolina	Aiken, South Carolina	Owned
Cornerstone Regional Hospital (4)	Edinburg, Texas	Leased
Manatee Diagnostic Center	Bradenton, Florida	Leased
Palms Westside Clinic ASC (6)	Royal Palm Beach, Florida	Leased
Quail Surgical and Pain Management Center (13)	Reno, Nevada	Leased
Temecula Valley Day Surgery and Pain Therapy Center (5)	Murrieta, California	Leased

(1) We hold an 80% ownership interest in this facility through a general partnership interest in a limited partnership. The remaining 20% ownership interest is held by an unaffiliated third party which leases the property to the partnership for nominal rent. The term of the partnership is scheduled to expire in July, 2047, and we have five, five-year extension options. The term of the lease is coterminous with the partnership term with a fair market value rental of the property during the extension term.
(2) Real property leased from Universal Health Realty Income Trust.
(3) Edinburg Regional Medical Center/Children's Hospital, McAllen Medical Center, McAllen Heart Hospital, South Texas Behavioral Health Center, STHS ER at Mission and STHS ER at Weslaco are consolidated under one license operating as the South Texas Health System.
(4) We manage and own a noncontrolling interest of approximately 50% in the entity that operates this facility.
(5) We manage and own a minority interest in an LLC that owns and operates this center.
(6) We own a noncontrolling ownership interest of approximately 50% in the entity that operates this facility that is managed by a third-party.
(7) We hold an 89% ownership interest in this facility through both general and limited partnership interests. The remaining 11% ownership interest is held by unaffiliated third parties.
(8) Land of this facility is leased.
(9) These facilities were acquired in late December, 2016, upon our completion of the acquisition of Cambian Group, PLC's adult services' division (the "Cambian Adult Services").
(10) These facilities were acquired in late July, 2018, upon our completion of the acquisition of The Danshell Group.
(11) We manage and own a noncontrolling interest of 50% in this facility. The remaining 50% ownership interest is held by an unaffiliated third party. Land of this facility is leased from the unaffiliated third party member.

(12) We manage and hold an 80% ownership interest in this facility. The remaining 20% ownership interest is held by an unaffiliated third party.
(13) We hold a 51% ownership interest in this facility. The remaining 49% ownership interest is held by unaffiliated third parties.

We own or lease medical office buildings adjoining some of our hospitals. We believe that the leases on the facilities, medical office buildings and other real estate leased or owned by us do not impose any material limitation on our operations. The aggregate lease payments on facilities leased by us were $81 million in 2018, $80 million in 2017 and $74 million in 2016.

ITEM 3. ***Legal Proceedings***

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

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

Certain legal matters are described below:

Government Investigations:

UHS Behavioral Health

In February, 2013, the Office of Inspector General for the United States Department of Health and Human Services ("OIG") served a subpoena requesting various documents from January, 2008 to the date of the subpoena directed at Universal Health Services, Inc. ("UHS") concerning it and UHS of Delaware, Inc., and certain UHS owned behavioral health facilities including: Keys of Carolina, Old Vineyard Behavioral Health, The Meadows Psychiatric Center, Streamwood Behavioral Health, Hartgrove Hospital, Rock River Academy and Residential Treatment Center, Roxbury Treatment Center, Harbor Point Behavioral Health Center, f/k/a The Pines Residential Treatment Center, including the Crawford, Brighton and Kempsville campuses, Wekiva Springs Center and River Point Behavioral Health. Prior to receipt of this subpoena, some of these facilities had received independent subpoenas from state or federal agencies. Subsequent to the February 2013 subpoenas, some of the facilities above have received additional, specific subpoenas or other document and information requests. In addition to the OIG, the DOJ and various U.S. Attorneys' and state

Attorneys' General Offices are also involved in this matter. Since February 2013, additional facilities have also received subpoenas and/or document and information requests or we have been notified are included in the omnibus investigation. Those facilities include: National Deaf Academy, Arbour-HRI Hospital, Behavioral Hospital of Bellaire, St. Simons By the Sea, Turning Point Care Center, Salt Lake Behavioral Health, Central Florida Behavioral Hospital, University Behavioral Center, Arbour Hospital, Arbour-Fuller Hospital, Pembroke Hospital, Westwood Lodge, Coastal Harbor Health System, Shadow Mountain Behavioral Health, Cedar Hills Hospital, Mayhill Hospital, Southern Crescent Behavioral Health (Anchor Hospital and Crescent Pines campuses), Valley Hospital (AZ), Peachford Behavioral Health System of Atlanta, University Behavioral Health of Denton, El Paso Behavioral Health System, Newport News Behavioral Health Center and The Hughes Center.

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

In April, 2014, the Centers for Medicare and Medicaid Services ("CMS") instituted a Medicare payment suspension at River Point Behavioral Health in accordance with federal regulations regarding suspension of payments during certain investigations. The Florida Agency for Health Care Administration ("AHCA") subsequently issued a Medicaid payment suspension for the facility. River Point Behavioral Health submitted a rebuttal statement disputing the basis of the suspension and requesting revocation of the suspension. Notwithstanding, CMS continued the payment suspension. River Point Behavioral Health provided additional information to CMS in an effort to obtain relief from the payment suspension but the Medicare suspension remains in effect. In June 2017, AHCA advised that while they were maintaining the suspension for dual eligible and cross-over Medicare beneficiaries, the Medicaid payment suspension was lifted effective June 27, 2017. We cannot predict if and/or when the facility's remaining suspended payments will resume in total. From inception through December 31, 2018, the aggregate funds withheld from us in connection with the River Point Behavioral Health payment suspension amounted to approximately $9 million. Although the operating results of River Point Behavioral Health did not have a material impact on our consolidated results of operations during 2018, 2017 or 2016, the payment suspension has had a material adverse effect on the facility's results of operations and financial condition.

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

DOJ investigation of Turning Point Hospital.

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

Litigation:

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

This is a False Claims Act case filed against Universal Health Services, Inc., UHS of Delaware, Inc. and HRI Clinics, Inc. d/b/a Arbour Counseling Services in U.S. District Court for the District of Massachusetts. This qui tam action primarily alleges that Arbour Counseling Services failed to appropriately supervise certain clinical providers in contravention of regulatory requirements and the submission of claims to Medicaid were subsequently improper. Relators make other claims of improper billing to Medicaid associated with alleged failures of Arbour Counseling to comply with state regulations. The U.S. Attorney's Office and the

Massachusetts Attorney General's Office initially declined to intervene. UHS filed a motion to dismiss and the trial court originally granted the motion dismissing the case. The First Circuit Court of Appeals ("First Circuit") reversed the trial court's dismissal of the case. The United States Supreme Court subsequently vacated the First Circuit's opinion and remanded the case for further consideration under the new legal standards established by the Supreme Court for False Claims Act cases. During the 4th quarter of 2016, the First Circuit issued a revised opinion upholding their reversal of the trial court's dismissal. The case was then remanded to the trial court for further proceedings. In January 2017, the U.S. Attorney's Office and Massachusetts Attorney General's Office advised of the potential for intervention in the case. The Massachusetts Attorney General's Office subsequently filed its motion to intervene which was granted and, in April 2017, filed their Complaint in Intervention. We are defending this case vigorously. At this time, we are uncertain as to potential liability or financial exposure, if any, which may be associated with this matter.

Shareholder Class Action

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

Shareholder Derivative Cases

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

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

This is a lawsuit filed in 1999 in state court in Hidalgo County, Texas by a physician and his professional associations alleging tortious interference with contractual relationships and retaliation against McAllen Medical Center in McAllen, Texas as well as Universal Health Services, Inc. The state court had entered a summary judgment order awarding plaintiff $3.85 million in damages. With prejudgment interest, the total amount of the order amounted to approximately $9 million, for which a corresponding reserve had previously been included in our financial statements. The case was removed to federal court. During the first quarter of 2019, the federal court entered an order vacating the state court's summary judgment. The parties have reached a preliminary settlement of this matter, pending finalization of settlement documentation, for an amount that did not have a material impact on our consolidated financial statements.

Disproportionate Share Hospital Payment Matter:

In late September, 2015, many hospitals in Pennsylvania, including seven of our behavioral health care hospitals located in the state, received letters from the Pennsylvania Department of Human Services (the "Department") demanding repayment of allegedly

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

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

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

Department of Justice Investigation of Riveredge Hospital

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. We have recently been notified by the DOJ that there is no longer an investigation pending against Riveredge Hospital that is separate from the UHS Behavioral Health matter referenced above.

Department of Justice Investigation of Friends Hospital

In October, 2010, Friends Hospital in Philadelphia, Pennsylvania, received a subpoena from the DOJ requesting certain documents from the facility. The requested documents were collected and provided to the DOJ for review and examination. Another subpoena was issued to the facility in July, 2011 requesting additional documents, which have also been delivered to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. We have recently been notified by the DOJ that there is no longer an investigation pending against Friends Hospital that is separate from the UHS Behavioral Health matter referenced above.

Other Matters:

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

ITEM 4. ***Mine Safety Disclosures***

Not applicable.

PART II

ITEM 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Our Class B Common Stock is traded on the New York Stock Exchange under the symbol UHS. Shares of our Class A, Class C and Class D Common Stock are not traded in any public market, but are each convertible into shares of our Class B Common Stock on a share-for-share basis.

The table below sets forth, for the quarters indicated, the high and low reported closing sales prices per share reported on the New York Stock Exchange for our Class B Common Stock for the years ended December 31, 2018 and 2017:

	2018	2017
	High-Low Sales Price	High-Low Sales Price
Quarter:		
1st	**$127.27-$110.15**	**$126.65-$106.71**
2nd	**$122.04-$111.44**	**$125.07-$112.33**
3rd	**$130.16-$110.98**	**$125.00-$105.37**
4th	**$137.99-$113.42**	**$115.06-$95.77**

The number of stockholders of record as of January 31, 2019, were as follows:

Class A Common	14
Class B Common	806
Class C Common	1
Class D Common	98

Stock Repurchase Programs

In December of 2018, our Board of Directors authorized a $500 million increase to our stock repurchase program, which increased the aggregate authorization to $1.7 billion from the previous $1.2 billion authorization approved during 2017, 2016 and 2014. Pursuant to this program, we may purchase shares of our Class B Common Stock, from time to time as conditions allow, on the open market or in negotiated private transactions. There is no expiration date for our stock repurchase programs.

As reflected below, during the three-month period ended December 31, 2018, we have repurchased approximately 1.2 million shares at an aggregate cost of approximately $149.3 million pursuant to the terms of our stock repurchase program. In addition, 26,198 shares were repurchased in connection with income tax withholding obligations resulting from the exercise of stock options and the vesting of restricted stock grants.

During the period of October 1, 2018 through December 31, 2018, we repurchased the following shares:

	Additional Dollars Authorized For Repurchase (in thousands)	Total number of shares purchased	Total number of shares cancelled	Average price paid per share for forfeited restricted shares	Total Number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid (in thousands)	Maximum number of dollars that may yet be purchased under the program (in thousands)
October, 2018	—	1,006	795	$ 0.01	—	N/A	—	$ 111,618
November, 2018	—	21,561	796	$ 0.01	—	N/A	—	$ 111,618
December, 2018	$ 500,000	1,224,852	1,458	$ 0.01	1,221,221	$ 122.23	$ 149,274	$ 462,344
Total October through December	$ 500,000	1,247,419	3,049	$ 0.01	1,221,221	$ 122.23	$ 149,274	

Dividends

During the two years ending December 31, 2018, dividends per share were declared and paid as follows:

	2018	2017
First quarter	$ .10	$ .10
Second quarter	$ .10	$ .10
Third quarter	$ .10	$ .10
Fourth quarter	$ .10	$ .10
Total	$ .40	$ .40

Our Credit Agreement contains covenants that include limitations on, among other things, dividends and stock repurchases (see below in *Capital Resources-Credit Facilities and Outstanding Debt Securities*).

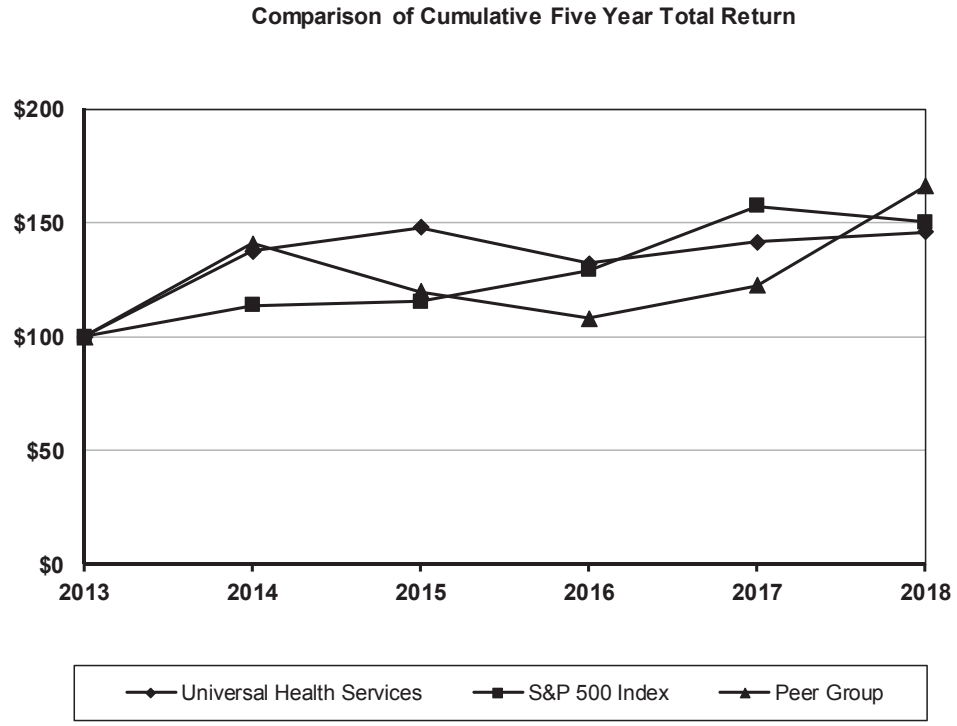
Equity Compensation

Refer to Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, of this report for information regarding securities authorized for issuance under our equity compensation plans.

Stock Price Performance Graph

The following graph compares the cumulative total stockholder return on our common stock with the cumulative total return on the stock included in the Standard & Poor's 500 Index and a Peer Group Index during the five year period ended December 31, 2018. The graph assumes an investment of $100 made in our common stock and each Index as of January 1, 2014 and has been weighted based on market capitalization. Note that our common stock price performance shown below should not be viewed as being indicative of future performance.

Companies in the peer group, which consist of companies in the S&P 500 Index or S&P MidCap 400 Index are as follows: Acadia Healthcare Co., Inc., Community Health Systems, Inc., HCA Healthcare, Inc., Health Management Associates, Inc. (included in January, 2014 when it was acquired by Community Health Systems, Inc.), LifePoint Health, Inc. (included until November, 2018, when it was acquired by Apollo Management) and Tenet Healthcare Corporation.



Company Name / Index	2013 Base	2014	2015	2016	2017	2018
Universal Health Services, Inc.	$ 100.00	$ 137.33	$ 147.96	$ 132.16	$ 141.32	$ 145.79
S&P 500 Index	$ 100.00	$ 113.69	$ 115.26	$ 129.05	$ 157.22	$ 150.33
Peer Group	$ 100.00	$ 140.92	$ 119.66	$ 107.88	$ 122.47	$ 166.09

ITEM 6. Selected Financial Data

The following table contains our selected financial data for, or as of the end of, each of the five years ended December 31, 2018. You should read this table in conjunction with the consolidated financial statements and related notes included elsewhere in this report and in Part II, *Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations.*

	Year Ended December 31,				
	2018	2017	2016	2015	2014
Summary of Operations (in thousands)					
Net revenues	$10,772,278	$10,409,865	$ 9,766,210	$9,043,451	$8,205,088
Income before income taxes	$ 1,034,525	$ 1,135,009	$ 1,156,358	$1,145,901	$ 929,667
Net income attributable to UHS	$ 779,705	$ 752,303	$ 702,409	$ 680,528	$ 545,343
Net margin	7.2%	7.2%	7.2%	7.5%	6.6%
Return on average equity	14.7%	15.5%	16.0%	16.6%	15.3%
Financial Data (in thousands)					
Cash provided by operating activities	$ 1,340,893	$ 1,183,252	$ 1,333,842	$1,068,262	$1,069,788
Capital expenditures, net (1)	$ 664,962	$ 557,506	$ 519,939	$ 379,321	$ 391,150
Total assets	$11,265,480	$10,761,828	$10,317,802	$9,615,444	$8,974,443
Current maturities of long-term debt	$ 63,446	$ 545,619	$ 105,895	$ 62,722	$ 68,319
Long-term debt	$ 3,935,187	$ 3,494,390	$ 4,030,230	$3,368,634	$3,210,215
UHS's common stockholders' equity	$ 5,389,262	$ 4,989,514	$ 4,533,220	$4,249,647	$3,735,946
Percentage of total debt to total capitalization	43%	45%	48%	45%	47%
Operating Data—Acute Care Hospitals (2)					
Average licensed beds	6,232	6,127	5,934	5,832	5,776
Average available beds	6,056	5,954	5,759	5,656	5,571
Inpatient admissions	303,985	297,390	274,074	261,727	251,165
Average length of patient stay	4.5	4.4	4.6	4.7	4.6
Patient days	1,376,988	1,312,265	1,251,511	1,218,969	1,167,726
Occupancy rate for licensed beds	61%	59%	58%	57%	55%
Occupancy rate for available beds	62%	60%	59%	59%	57%
Operating Data—Behavioral Health Facilities (2)					
Average licensed beds	23,509	23,151	21,829	21,202	20,231
Average available beds	23,425	23,068	21,744	21,116	20,131
Inpatient admissions	482,658	467,822	456,052	447,007	426,510
Average length of patient stay	13.3	13.6	13.2	13.1	12.9
Patient days	6,418,334	6,381,756	6,004,066	5,835,134	5,518,660
Occupancy rate for licensed beds	75%	76%	75%	75%	75%
Occupancy rate for available beds	75%	76%	75%	76%	75%
Per Share Data					
Net income attributable to UHS—basic	$ 8.35	$ 7.86	$ 7.22	$ 6.89	$ 5.52
Net income attributable to UHS—diluted	$ 8.31	$ 7.81	$ 7.14	$ 6.76	$ 5.42
Dividends declared	$ 0.40	$ 0.40	$ 0.40	$ 0.40	$ 0.30
Other Information (in thousands)					
Weighted average number of shares outstanding—basic	93,276	95,652	97,208	98,797	98,826
Weighted average number of shares and share equivalents outstanding—diluted	93,750	96,325	98,380	100,694	100,544

(1) Amounts exclude non-cash capital lease obligations, if any.
(2) Excludes statistical information related to divested facilities.

ITEM 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

Overview

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

As of February 27, 2019, we owned and/or operated 350 inpatient facilities and 37 outpatient and other facilities including the following located in 37 states, Washington, D.C., the United Kingdom and Puerto Rico:

Acute care facilities located in the U.S.:

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

Behavioral health care facilities (324 inpatient facilities and 21 outpatient facilities):

Located in the U.S.:

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

Located in the U.K.:

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

Located in Puerto Rico:

- 3 inpatient behavioral health care facilities.

As a percentage of our consolidated net revenues, net revenues from our acute care hospitals, outpatient facilities and commercial health insurer accounted for 53% during each of 2018 and 2017 and 52% during 2016. Net revenues from our behavioral health care facilities and commercial health insurer accounted for 47% of our consolidated net revenues during each of 2018 and 2017 and 48% during 2016.

Our behavioral health care facilities located in the U.K. generated net revenues of approximately $505 million in 2018, $429 million in 2017 and $241 million in 2016. Total assets at our U.K. behavioral health care facilities were approximately $1.224 billion as of December 31, 2018, $1.098 billion as of December 31, 2017 and $965 million as of December 31, 2016.

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

Forward-Looking Statements and Risk Factors

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

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

- our ability to comply with the existing laws and government regulations, and/or changes in laws and government regulations;
- an increasing number of legislative initiatives have been passed into law that may result in major changes in the health care delivery system on a national or state level. Legislation has already been enacted that has eliminated the penalty for failing to maintain health coverage that was part of the original Legislation. President Trump has already taken executive actions: (i) requiring all federal agencies with authorities and responsibilities under the Legislation to "exercise all authority and discretion available to them to waiver, defer, grant exemptions from, or delay" parts of the Legislation that place "unwarranted economic and regulatory burdens" on states, individuals or health care providers; (ii) the issuance of a final rule in June, 2018 by the Department of Labor to enable the formation of association health plans that would be exempt from certain Legislation requirements such as the provision of essential health benefits; (iii) the issuance of a final rule in August, 2018 by the Department of Labor, Treasury, and Health and Human Services to expand the availability of short-term, limited duration health insurance, (iv) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level; (v) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and lead to additional enrollment in short-term, limited duration insurance and association health plans; and (vi) the issuance of a proposed rule by the Department of Labor, Treasury, and Health and Human Services that would be incentivize the use of health reimbursement accounts by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these Executive Branch policies has led to reduced Exchange enrollment in 2018 and 2019 and is expected to further worsen the individual and small group market risk pools in future years. It is also anticipated that these and future policies may create additional cost and reimbursement pressures on hospitals, including ours. In addition, while attempts to repeal the entirety of the Affordable Care Act ("ACA") have not been successful to date, a key provision of the ACA was repealed as part of the Tax Cuts and Jobs Act and on December 14, 2018, a federal U.S. District Court Judge in Texas ruled the entire ACA is unconstitutional. While that ruling is stayed and has been appealed, it has caused greater uncertainty regarding the future status of the ACA. If all or any parts of the ACA are found to be unconstitutional, it could have a material adverse effect on our business, financial condition and results of operations. See below in *Sources of Revenue and Health Care Reform* for additional disclosure;
- possible unfavorable changes in the levels and terms of reimbursement for our charges by third party payers or government based payers, including Medicare or Medicaid in the United States, and government based payers in the United Kingdom;
- our ability to enter into managed care provider agreements on acceptable terms and the ability of our competitors to do the same, including contracts with United/Sierra Healthcare in Las Vegas, Nevada;
- the outcome of known and unknown litigation, government investigations, false claim act allegations, and liabilities and other claims asserted against us and other matters as disclosed in *Item 3. Legal Proceedings,* and the effects of adverse publicity relating to such matters*;*
- the potential unfavorable impact on our business of deterioration in national, regional and local economic and business conditions, including a worsening of unfavorable credit market conditions;
- competition from other healthcare providers (including physician owned facilities) in certain markets;
- technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for healthcare;
- our ability to attract and retain qualified personnel, nurses, physicians and other healthcare professionals and the impact on our labor expenses resulting from a shortage of nurses and other healthcare professionals;
- demographic changes;
- the availability of suitable acquisition and divestiture opportunities and our ability to successfully integrate and improve our acquisitions since failure to achieve expected acquisition benefits from certain of our prior or future acquisitions could result in impairment charges for goodwill and purchased intangibles;
- the impact of severe weather conditions, including the effects of hurricanes;

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

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

Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes.

A summary of our significant accounting policies is outlined in Note 1 to the financial statements. We consider our critical accounting policies to be those that require us to make significant judgments and estimates when we prepare our financial statements, including the following:

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

See *Note 10 to the Consolidated Financial Statements-Revenue Recognition*, for additional disclosure related to our revenues including a disaggregation of our consolidated net revenues by major source for each of the periods presented herein.

We report net patient service revenue at the estimated net realizable amounts from patients and third-party payers and others for services rendered. We have agreements with third-party payers that provide for payments to us at amounts different from our established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Estimates of contractual allowances, which represent explicit price concessions under ASC 606, under managed care plans are based upon the payment terms specified in the related contractual agreements. We closely monitor our historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payers may be different from the amounts we estimate and record.

We estimate our Medicare and Medicaid revenues using the latest available financial information, patient utilization data, government provided data and in accordance with applicable Medicare and Medicaid payment rules and regulations. The laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation and as a result, there is at least a reasonable possibility that recorded estimates will change by material amounts in the near term. Certain types of payments by the Medicare program and state Medicaid programs (e.g. Medicare Disproportionate Share Hospital, Medicare Allowable Bad Debts and Inpatient Psychiatric Services) are subject to retroactive adjustment in future periods as a result of administrative review and audit and our estimates may vary from the final settlements. Such amounts are included in accounts receivable, net, on our Consolidated Balance Sheets. The funding of both federal Medicare and state Medicaid programs are subject to legislative and regulatory changes. As such, we cannot provide any assurance that future legislation and regulations, if enacted, will not have a material impact on our future Medicare and Medicaid reimbursements. Adjustments related to the final settlement of these retrospectively determined amounts did not materially impact our results in 2018, 2017 or 2016. If it were to occur, each 1% adjustment to our estimated net Medicare revenues that are subject to retrospective review and settlement as of December 31, 2018, would change our after-tax net income by approximately $1 million.

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

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

methodologies are considered, these revenue adjustments are considered at the time the services are provided in determination of the transaction price.

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

A portion of the accounts receivable at our acute care facilities are comprised of Medicaid accounts that are pending approval from third-party payers but we also have smaller amounts due from other miscellaneous payers such as county indigent programs in certain states. Our patient registration process includes an interview of the patient or the patient's responsible party at the time of registration. At that time, an insurance eligibility determination is made and an insurance plan code is assigned. There are various pre-established insurance profiles in our patient accounting system which determine the expected insurance reimbursement for each patient based on the insurance plan code assigned and the services rendered. Certain patients may be classified as Medicaid pending at registration based upon a screening evaluation if we are unable to definitively determine if they are currently Medicaid eligible. When a patient is registered as Medicaid eligible or Medicaid pending, our patient accounting system records net revenues for services provided to that patient based upon the established Medicaid reimbursement rates, subject to the ultimate disposition of the patient's Medicaid eligibility. When the patient's ultimate eligibility is determined, reclassifications may occur which impacts net revenues in future periods . Although the patient's ultimate eligibility determination may result in adjustments to net revenues, these adjustments do not have a material impact on our results of operations in 2018, 2017 or 2016 since our facilities make estimates at each financial reporting period to adjust revenue based on historical collections. Under ASC 605, these estimates were reported in the provision for doubtful accounts.

We also provide discounts to uninsured patients (included in "uninsured discounts" amounts below) who do not qualify for Medicaid or charity care. Because we do not pursue collection of amounts classified as uninsured discounts, the transaction price is fully adjusted and there is no impact in our net revenues or in our net accounts receivable. In implementing the discount policy, we first attempt to qualify uninsured patients for governmental programs, charity care or any other discount program. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Uncompensated care (charity care and uninsured discounts):

The following table shows the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the years ended December 31, 2018, 2017 and 2016:

	(dollar amounts in thousands)					
	2018		2017		2016	
	Amount	%	Amount	%	Amount	%
Charity care	$ 761,783	40%	$ 887,136	50%	$ 733,585	50%
Uninsured discounts	1,132,811	60%	881,265	50%	720,205	50%
Total uncompensated care	$1,894,594	100%	$1,768,401	100%	$1,453,790	100%

The estimated cost of providing uncompensated care:

The estimated cost of providing uncompensated care, as reflected below, were based on a calculation which multiplied the percentage of operating expenses for our acute care hospitals to gross charges for those hospitals by the above-mentioned total uncompensated care amounts. The percentage of cost to gross charges is calculated based on the total operating expenses for our acute care facilities divided by gross patient service revenue for those facilities. An increase in the level of uninsured patients to our facilities and the resulting adverse trends in the adjustments to net revenues and uncompensated care provided could have a material unfavorable impact on our future operating results.

	(amounts in thousands)		
	2018	2017	2016
Estimated cost of providing charity care	$ 94,088	$ 120,208	$ 107,887
Estimated cost of providing uninsured discounts related care	139,913	119,412	105,920
Estimated cost of providing uncompensated care	$ 234,001	$ 239,620	$ 213,807

Self-Insured/Other Insurance Risks: We provide for self-insured risks including general and professional liability claims, workers' compensation claims and healthcare and dental claims. Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents,

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

See *Note 8 to the Consolidated Financial Statements-Commitments and Contingencies*, for additional disclosure related to our professional and general liability, workers' compensation liability and property insurance.

Long-Lived Assets: We review our long-lived assets for impairment whenever events or circumstances indicate that the carrying value of these assets may not be recoverable. The assessment of possible impairment is based on our ability to recover the carrying value of our asset based on our estimate of its undiscounted future cash flow. If the analysis indicates that the carrying value is not recoverable from future cash flows, the asset is written down to its estimated fair value and an impairment loss is recognized. Fair values are determined based on estimated future cash flows using appropriate discount rates.

Goodwill and Intangible Assets: Goodwill and indefinite-lived intangible assets are reviewed for impairment at the reporting unit level on an annual basis or sooner if the indicators of impairment arise. Our judgments regarding the existence of impairment indicators are based on market conditions and operational performance of each reporting unit. We have designated October 1st as our annual impairment assessment date for our goodwill and indefinite-lived intangible assets.

We performed an impairment assessment as of October 1, 2018 which indicated no impairment of goodwill. There were also no goodwill impairments during 2017 or 2016.

For our indefinite-lived intangible assets, consisting primarily of a tradename initially valued at $124 million recorded in connection with our 2015 acquisition of Foundation Recovery Network, L.L.C. ("Foundations"), we recorded a pre-tax $49 million provision for asset impairment during the fourth quarter of 2018. See below in *Provision for Intangible Assets Impairment* for additional information.

Future changes in the estimates used to conduct the impairment review, including profitability and market value projections, could indicate impairment in future periods potentially resulting in a write-off of a portion or all of our goodwill or indefinite-lived intangible assets.

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

On December 22, 2017, the President of the United States signed into law comprehensive tax legislation commonly referred to as the Tax Cuts and Jobs Act of 2017 (the "TCJA-17"). The TCJA-17 made broad and complex changes to the U.S. tax code, including, but not limited to, (1) reducing the U.S. federal corporate tax rate from 35 percent to 21 percent; (2) requiring companies to pay a one-time transition tax on certain unrepatriated earnings of foreign subsidiaries; (3) generally eliminating U.S. federal income taxes on dividends from foreign subsidiaries; (4) requiring current inclusion in U.S. federal taxable income of certain earnings of controlled foreign corporations through the implementation of a territorial tax system; (5) creating a new limitation on deductible interest expense, and; (6) limiting certain other deductions. The SEC staff issued Staff Accounting Bulletin No. 118 ("SAB 118") to address the application of U.S. GAAP in situations when a registrant has not obtained, prepared, or analyzed (including computations) all of the information needed in order to complete the accounting for certain income tax effects of the TCJA-17. To the extent that a company's accounting for certain income tax effects of the TCJA-17 is incomplete, a reasonable estimate should be recorded as a provisional amount in the financial statements during a measurement period not to extend beyond one year of the enactment date. We previously provided a provisional estimate of the effects of the TCJA-17 in the fourth quarter of 2017 financial statements. In the fourth quarter of 2018, we completed our analysis to determine the effects of the TCJA-17 as follows:

Reduction of U.S. federal corporate tax rate: The TCJA-17 reduces the corporate tax rate to 21 percent, effective January 1, 2018. Deferred income taxes are based on the estimated future tax effects of differences between the financial statement carrying

amounts and the tax basis of assets and liabilities under the provisions of the enacted laws. For certain of our deferred tax assets and deferred tax liabilities, we have recorded a provisional decrease of $97 million and $127 million, respectively, with a corresponding net adjustment to deferred tax benefit of $30 million for the year ended December 31, 2017. Upon completion of our 2017 U.S. Corporate Income Tax Return, an increase of $1 million attributable to certain deferred tax assets and a decrease of $5 million attributable to certain deferred tax liabilities was recorded resulting in an additional net deferred tax benefit of $6 million.

Deemed Repatriation Transition Tax: The Deemed Repatriation Transition Tax ("Transition Tax") is a tax on previously untaxed accumulated and current earnings and profits ("E&P") of certain of our foreign subsidiaries. The one-time Transition Tax is based upon the amount of post-1986 E&P of the relevant subsidiaries, the amount of non-U.S. income tax paid on such earnings, as well as other factors. We originally estimated and recorded a provisional Transition Tax obligation of $11.3 million. Upon completion of our 2017 U.S. Corporate Income Tax Return, the final Transition Tax increased by $100,000 for a total of $11.4 million.

The decrease in our effective tax rate for the year ended December 31, 2018, as compared to 2017 and 2016, is due to the net favorable impact of the enactment of the TCJA-17 as discussed above, the tax benefit resulting from our January 1, 2017, adoption of ASU 2016-09, and the tax effects of our foreign operations in connection with our acquisition of Danshell Group (acquired in July 2018).

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

See *Provision for Income Taxes and Effective Tax Rates* below for discussion of our effective tax rates during each of the last three years.

Recent Accounting Pronouncements: For a summary of recent accounting pronouncements, please see *Note 1 to the Consolidated Financial Statements-Accounting Standards* as included in this Report on Form 10-K for the year ended December 31, 2018.

Results of Operations

The following table summarizes our results of operations, and is used in the discussion below, for the years ended December 31, 2018, 2017 and 2016 (dollar amounts in thousands):

	Year Ended December 31,					
	2018		2017		2016	
	Amount	% of Net Revenues	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts			$11,278,942		$10,507,788	
Less: Provision for doubtful accounts			869,077		741,578	
Net revenues	$10,772,278	100.0%	10,409,865	100.0%	9,766,210	100.0%
Operating charges:						
Salaries, wages and benefits	5,254,536	48.8%	4,980,637	47.8%	4,585,530	47.0%
Other operating expenses	2,614,687	24.3%	2,493,062	23.9%	2,359,339	24.2%
Supplies expense	1,168,654	10.8%	1,105,096	10.6%	1,031,337	10.6%
Depreciation and amortization	453,045	4.2%	447,765	4.3%	416,608	4.3%
Lease and rental expense	106,094	1.0%	103,127	1.0%	97,324	1.0%
Electronic health records incentive income	0	0.0%	0	0.0%	(5,339)	-0.1%
Subtotal-operating expenses	9,597,016	89.1%	9,129,687	87.7%	8,484,799	86.9%
Income from operations	1,175,262	10.9%	1,280,178	12.3%	1,281,411	13.1%
Interest expense, net	154,956	1.4%	145,169	1.4%	125,053	1.3%
Other (income) expense, net	(14,219)	-0.1%	0	0.0%	0	0.0%
Income before income taxes	1,034,525	9.6%	1,135,009	10.9%	1,156,358	11.8%
Provision for income taxes	236,642	2.2%	363,697	3.5%	409,187	4.2%
Net income	797,883	7.4%	771,312	7.4%	747,171	7.7%
Less: Net income attributable to noncontrolling interests	18,178	0.2%	19,009	0.2%	44,762	0.5%
Net income attributable to UHS	$ 779,705	7.2%	$ 752,303	7.2%	$ 702,409	7.2%

Year Ended December 31, 2018 as compared to the Year Ended December 31, 2017:

Net revenues increased 3.5% or $362 million to $10.77 billion during 2018 as compared to $10.41 billion during 2017. The increase was primarily attributable to:

- a $369 million or 3.6% increase in net revenues generated from our acute care and behavioral health care operations owned during both periods (which we refer to as "same facility"), and;
- $7 million of other combined net revenue decreases.

Income before income taxes (before deduction for income attributable to noncontrolling interests) decreased $100 million to $1.03 billion during 2018 as compared to $1.14 billion during 2017. The net decrease in our income before income taxes during 2018, as compared to 2017, was due to the following:

- an increase of $67 million as discussed below in Acute Care Hospital Services;
- a decrease of $4 million as discussed below in Behavioral Health Services (excluding the $49 million intangible asset impairment charge recorded during 2018 related to Foundations Recovery Network, LLC, as discussed below);
- a decrease of $102 million due to an increase recorded during 2018 to the reserve established in connection with the civil aspects of the government's investigation of certain of our behavioral health care facilities (reserve increased to $123 million as of December 31, 2018; see *Item 3 – Legal Proceedings* for additional disclosure);
- a decrease of $49 million from an intangible asset (tradename) impairment charge recorded during 2018 in connection with Foundations Recovery Network, LLC which was acquired by us during 2015;
- a decrease of $10 million resulting from an increase in interest expense, as discussed below in Other Operating Results, and;
- $2 million of other combined net decreases.

Net income attributable to UHS increased $27 million to $780 million during 2018 as compared to $752 million during 2017.

The increase consisted of:

- a decrease of $100 million in income before income taxes, as discussed above;
- an increase of $1 million due to a decrease in the income attributable to noncontrolling interests, and;
- an increase of $127 million resulting from a net decrease in the provision for income taxes resulting primarily from: (i) a decrease in the provision for income taxes resulting from the $99 million decrease in pre-tax income ($100 million decrease in income before income taxes partially offset by a $1 million increase in pre-tax income due to a decrease in income attributable to noncontrolling interests); (ii) a decrease in the provision for income taxes realized during 2018 resulting from the Tax Cuts and Jobs Act of 2017 which, among other things, reduced the U.S. federal corporate tax rate from 35% to 21%; (iii) a decrease resulting from an $11 million increase in the provision for income taxes recorded during 2017 due to the repatriation tax incurred pursuant to the Tax Cuts and Jobs Act of 2017 (in connection with our behavioral health care facilities located in the U.K), partially offset by; (iv) an increase resulting from a $30 million decrease in the provision for income taxes recorded during 2017 due to a reduction in our net deferred income tax liability resulting from a lower federal income tax rate beginning January 1, 2018 pursuant to the Tax Cuts and Jobs Act of 2017, and; (v) a $21 million increase to our provision for income taxes due to an unfavorable change resulting from our January 1, 2017 adoption of ASU 2016-09, which decreased our provision for income taxes by $1 million during 2018 as compared to $22 million during 2017.

Year Ended December 31, 2017 as compared to the Year Ended December 31, 2016:

Net revenues increased 6.6% or $644 million to $10.41 billion during 2017 as compared to $9.77 billion during 2016. The increase was primarily attributable to:

- a $313 million or 3.3% increase in net revenues generated from our acute care and behavioral health care operations on a same facility basis, and;
- $331 million of other combined revenue consisting primarily of the revenues generated at the facilities acquired in December, 2016 in connection with our acquisition of Cambian Adult Services, and the revenues generated at Henderson Hospital, a newly constructed acute care hospital that was completed and opened during the fourth quarter of 2016.

Income before income taxes (before deduction for income attributable to noncontrolling interests) decreased $21 million to $1.14 billion during 2017 as compared to $1.16 billion during 2016. The net decrease in our income before income taxes during 2017, as compared to 2016, was due to the following:

- an increase of $84 million as discussed below in Acute Care Hospital Services;
- a decrease of $62 million as discussed below in Behavioral Health Services;
- a decrease of $20 million resulting from an increase in interest expense, as discussed below in Other Operating Results, and;
- $23 million of other combined net decreases, including an aggregate of approximately $20 million recording during 2017 in connection certain matters as discussed in *Item 3 – Legal Proceedings*.

Net income attributable to UHS increased $50 million to $752 million during 2017 as compared to $702 million during 2016.

The increase consisted of:

- a decrease of $21 million in income before income taxes, as discussed above;
- an increase of $26 million resulting from a decrease in the income attributable to noncontrolling interests due primarily to the May, 2016, purchase of the minority ownership interests held by a third-party in six acute care hospitals located in Las Vegas, Nevada, and;
- an increase of $45 million resulting from a decrease in the provision for income taxes resulting from:
    - a decrease of $30 million due to a reduction in our net deferred income tax liability resulting from a lower federal income tax rate beginning January 1, 2018 pursuant to the Tax Cuts and Jobs Act of 2017;
    - an increase of $11 million due to the repatriation tax incurred pursuant to the Tax Cuts and Jobs Act of 2017 (in connection with our behavioral health care facilities located in the U.K.);
    - a decrease of $22 million resulting from our January 1, 2017 adoption of ASU 2016-09, as discussed herein;
    - a decrease caused by lower effective rates applicable to the income generated during 2017 in connection with our acquisition of Cambian Group, PLC's adult services division.

Acute Care Hospital Services

Year Ended December 31, 2018 as compared to the Year Ended December 31, 2017:

Acute Care Hospital Services-Same Facility Basis

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

The following table summarizes the results of operations for our acute care hospital services on a same facility basis and is used in the discussions below for the years ended December 31, 2018 and 2017 (dollar amounts in thousands):

	Year Ended December 31, 2018		Year Ended December 31, 2017	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts			$ 6,128,103	
Less: Provision for doubtful accounts			755,615	
Net revenues	$ 5,618,428	100.0%	5,372,488	100.0%
Operating charges:				
Salaries, wages and benefits	2,366,078	42.1%	2,241,127	41.7%
Other operating expenses	1,238,787	22.0%	1,244,186	23.2%
Supplies expense	967,833	17.2%	905,164	16.8%
Depreciation and amortization	278,558	5.0%	262,950	4.9%
Lease and rental expense	57,229	1.0%	57,208	1.1%
Subtotal-operating expenses	4,908,485	87.4%	4,710,635	87.7%
Income from operations	709,943	12.6%	661,853	12.3%
Interest expense, net	1,658	0.0%	2,684	0.0%
Other (income) expense, net	(2,498)	0.0%	0	0.0%
Income before income taxes	$ 710,783	12.7%	$ 659,169	12.3%

On a same facility basis during 2018, as compared to 2017, net revenues from our acute care services increased $246 million or 4.6%. Income before income taxes increased $52 million or 8% to $711 million or 12.7% of net revenues during 2018 as compared to $659 million or 12.3% of net revenues during 2017.

Inpatient admissions to our acute care hospitals owned during both years increased 2.2% during 2018, as compared to 2017, while patient days increased 4.9%. Adjusted admissions (adjusted for outpatient activity) increased 2.1% and adjusted patient days increased 4.8% during 2018, as compared to 2017. The average length of inpatient stay at these facilities was 4.5 days during 2018 and 4.4 days during 2017. The occupancy rate, based on the average available beds at these facilities, was 62% during 2018 and 60% during 2017. On a same facility basis, net revenue per adjusted admission at these facilities increased 4.1% during 2018, as compared to 2017, and net revenue per adjusted patient day increased 1.4% during 2018, as compared to 2017.

All Acute Care Hospital Services

The following table summarizes the results of operations for all our acute care operations during 2018 and 2017. These amounts include: (i) our acute care results on a same facility basis, as indicated above; (ii) the impact of the implementation of EHR applications at our acute care hospitals (beginning in 2018, the EHR impact is included in our same facility results as well as all acute care hospitals); (iii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no

impact on income before income taxes, and; (iv) certain other amounts that were included in our results of operations that relate to prior years, as discussed below. Dollar amounts below are reflected in thousands.

	Year Ended December 31, 2018		Year Ended December 31, 2017	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts			$ 6,240,302	
Less: Provision for doubtful accounts			755,619	
Net revenues	$ 5,719,905	100.0%	5,484,683	100.0%
Operating charges:				
Salaries, wages and benefits	2,367,014	41.4%	2,241,527	40.9%
Other operating expenses	1,341,088	23.4%	1,350,741	24.6%
Supplies expense	968,067	16.9%	905,165	16.5%
Depreciation and amortization	278,661	4.9%	285,501	5.2%
Lease and rental expense	57,235	1.0%	57,208	1.0%
Electronic health records incentive income	0	0.0%	0	0.0%
Subtotal-operating expenses	5,012,065	87.6%	4,840,142	88.2%
Income from operations	707,840	12.4%	644,541	11.8%
Interest expense, net	1,658	0.0%	2,684	0.0%
Other (income) expense, net	(2,498)	0.0%	0	0.0%
Income before income taxes	$ 708,680	12.4%	$ 641,857	11.7%

During 2018, as compared to 2017, net revenues generated from our acute care hospital services increased $235 million or 4.3% to $5.72 billion due primarily to: (i) a $246 million, or 4.6%, increase same facility revenues, as discussed above, and; (ii) other combined net decrease of $11 million due primarily to $15 million of revenues received during 2017 in connection with Medicaid settlements related to prior years.

Income before income taxes increased $67 million to $709 million or 12.4% of net revenues during 2018 as compared to $642 million or 11.7% of net revenues during 2017.

Included in these results are the following:

- the $52 million increase in income before income taxes from our acute care hospital services, on a same facility basis, as discussed above, and;
- other combined net increase of $15 million resulting primarily from: (i) the unfavorable change caused by the income recorded during 2017 in connection with Medicaid settlements relating to prior years ($15 million), offset by the following favorable changes; (ii) the depreciation and amortization expense incurred in connection with the implementation of EHR applications at our acute care hospitals (this expense, which amounted to approximately $22 million during 2017, was excluded from our same facility basis results prior to January 1, 2018, however, the impact is included in our same facility basis results thereafter since the amount no longer materially impacts our results of operations), and; (iii) increased professional and general liability expense relating to prior years that was recorded during 2017, based upon a reserve analysis ($9 million).

Year Ended December 31, 2017 as compared to the Year Ended December 31, 2016:

Acute Care Hospital Services-Same Facility Basis

The following table summarizes the results of operations for our acute care hospital services on a same facility basis and is used in the discussions below for the years ended December 31, 2017 and 2016 (dollar amounts in thousands):

	Year Ended December 31, 2017		Year Ended December 31, 2016	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 5,983,425		$ 5,649,163	
Less: Provision for doubtful accounts	728,438		627,827	
Net revenues	5,254,987	100.0%	5,021,336	100.0%
Operating charges:				
Salaries, wages and benefits	2,187,390	41.6%	2,083,357	41.5%
Other operating expenses	1,225,494	23.3%	1,215,144	24.2%
Supplies expense	886,829	16.9%	836,399	16.7%
Depreciation and amortization	252,365	4.8%	237,658	4.7%
Lease and rental expense	55,915	1.1%	52,582	1.0%
Subtotal-operating expenses	4,607,993	87.7%	4,425,140	88.1%
Income from operations	646,994	12.3%	596,196	11.9%
Interest expense, net	2,683	0.1%	3,277	0.1%
Income before income taxes	$ 644,311	12.3%	$ 592,919	11.8%

On a same facility basis during 2017, as compared to 2016, net revenues from our acute care services increased $234 million or 4.7%. Income before income taxes increased $51 million or 9% to $644 million or 12.3% of net revenues during 2017 as compared to $593 million or 11.8% of net revenues during 2016.

Inpatient admissions to our acute care hospitals owned during both years increased 6.2% during 2017, as compared to 2016, while patient days increased 3.4%. Adjusted admissions increased 5.5% and adjusted patient days increased 2.8% during 2017, as compared to 2016. The average length of inpatient stay at these facilities was 4.4 days during 2017 and 4.6 days during 2016. The occupancy rate, based on the average available beds at these facilities, was 61% during 2017 and 60% during 2016. On a same facility basis, net revenue per adjusted admission at these facilities decreased 0.3% during 2017, as compared to 2016, and net revenue per adjusted patient day increased 2.4% during 2017, as compared to 2016.

All Acute Care Hospital Services

The following table summarizes the results of operations for all our acute care operations during 2017 and 2016. These amounts include: (i) our acute care results on a same facility basis, as indicated above; (ii) the impact of the implementation of EHR applications at our acute care hospitals; (iii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iv) certain other amounts including the results of a 25-bed acute care hospital located in Pahrump, Nevada that was acquired in August, 2016, the results of a newly constructed, 130-bed acute care hospital located in Henderson, Nevada that was completed and opened during the fourth quarter of 2016 and the favorable impact of Medicaid settlements relating to prior years that is included in our results of operations during 2017. Dollar amounts below are reflected in thousands.

	Year Ended December 31, 2017		Year Ended December 31, 2016	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 6,240,302		$ 5,740,777	
Less: Provision for doubtful accounts	755,619		627,827	
Net revenues	5,484,683	100.0%	5,112,950	100.0%
Operating charges:				
Salaries, wages and benefits	2,241,527	40.9%	2,086,986	40.8%
Other operating expenses	1,350,741	24.6%	1,308,293	25.6%
Supplies expense	905,165	16.5%	836,481	16.4%
Depreciation and amortization	285,501	5.2%	273,176	5.3%
Lease and rental expense	57,208	1.0%	52,604	1.0%
Electronic health records incentive income	0	0.0%	(5,339)	-0.1%
Subtotal-operating expenses	4,840,142	88.2%	4,552,201	89.0%
Income from operations	644,541	11.8%	560,749	11.0%
Interest expense, net	2,684	0.0%	3,277	0.1%
Income before income taxes	$ 641,857	11.7%	$ 557,472	10.9%

During 2017, as compared to 2016, net revenues generated from our acute care hospital services increased $372 million or 7.3% to $5.48 billion due primarily to: (i) a $234 million, or 4.7%, increase same facility revenues, as discussed above, and; (ii) other combined net increase of $138 million due primarily to the net revenues generated at the two above-mentioned acute care hospitals located in Nevada that were acquired or opened during 2016.

Income before income taxes increased $84 million to $642 million or 11.7% of net revenues during 2017 as compared to $557 million or 10.9% of net revenues during 2016.

Included in these results are the following:

- the $51 million increase in income before income taxes from our acute care hospital services, on a same facility basis, as discussed above;
- a net increase of $6 million resulting from: (i) the income recorded in connection with Medicaid settlements relating to prior years ($15 million), partially offset by; (ii) increased professional and general liability expense recorded during 2017 related to prior years, based upon a reserve analysis ($9 million), and;
- other combined net increase of $27 million consisting primarily of the income generated at the two above-mentioned acute care hospitals located in Nevada that were acquired or opened during 2016.

Behavioral Health Care Services

Year Ended December 31, 2018 as compared to the Year Ended December 31, 2017

Behavioral Health Care Services-Same Facility Basis

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

The following table summarizes the results of operations for our behavioral health care services, on a same facility basis, and is used in the discussions below for the years ended December 31, 2018 and 2017 (dollar amounts in thousands):

	Year Ended December 31, 2018		Year Ended December 31, 2017	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts			$ 4,878,039	
Less: Provision for doubtful accounts			110,030	
Net revenues	$ 4,891,178	100.0%	4,768,009	100.0%
Operating charges:				
Salaries, wages and benefits	2,558,296	52.3%	2,437,495	51.1%
Other operating expenses	935,562	19.1%	935,750	19.6%
Supplies expense	197,305	4.0%	195,813	4.1%
Depreciation and amortization	153,924	3.1%	145,707	3.1%
Lease and rental expense	46,942	1.0%	43,825	0.9%
Subtotal-operating expenses	3,892,029	79.6%	3,758,590	78.8%
Income from operations	999,149	20.4%	1,009,419	21.2%
Interest expense, net	1,597	0.0%	2,005	0.0%
Other (income) expense, net	0	0.0%	0	0.0%
Income before income taxes	$ 997,552	20.4%	$ 1,007,414	21.1%

On a same facility basis during 2018, as compared to 2017, net revenues generated from our behavioral health care services increased $123 million or 2.6% to $4.89 billion during 2018 as compared to $4.77 billion during 2017. Income before income taxes decreased $10 million or 1% to $998 million or 20.4% of net revenues during 2018 as compared to $1.01 billion or 21.2% of net revenues during 2017.

Inpatient admissions to our behavioral health care facilities owned during both years increased 3.3% during 2018, as compared to 2017, while patient days increased 0.8%. Adjusted admissions increased 3.0% and adjusted patient days increased 0.5% during 2018, as compared to 2017. The average length of inpatient stay at these facilities were 13.2 days and 13.5 days during 2018 and 2017, respectively. The occupancy rate, based on the average available beds at these facilities, were 76% and 77% during 2018 and 2017, respectively. On a same facility basis, net revenue per adjusted admission at these facilities was unchanged during 2018, as compared to 2017, and net revenue per adjusted patient day increased 2.5% during 2018, as compared to 2017.

In certain markets in which we operate, the ability of our behavioral health facilities to fully meet the demand for their services has been unfavorably impacted by a shortage of clinicians which includes psychiatrists, nurses and mental health technicians which has, at times, caused the closure of a portion of available bed capacity. As a result, we have instituted certain initiatives at the impacted facilities designed to enhance recruitment and retention of clinical staff. Additionally, compression of length of stay from managed Medicaid and managed Medicare payers continues to create downward pressure on our revenue growth. We can provide no assurance that these factors will not continue to unfavorably impact our patient volumes.

All Behavioral Health Care Services

The following table summarizes the results of operations for all our behavioral health care services during 2018 and 2017. These amounts include: (i) our behavioral health care results on a same facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes; (iii) an intangible asset impairment charge recorded during 2018 in connection with Foundations Recovery Network, L.L.C., and; (iv) certain other amounts including the results of facilities acquired or opened during the past year as well as the results of certain facilities that were closed or restructured during the past year. Dollar amounts below are reflected in thousands.

	Year Ended December 31, 2018		Year Ended December 31, 2017	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts			$ 5,020,177	
Less: Provision for doubtful accounts			113,458	
Net revenues	$ 5,038,874	100.0%	4,906,719	100.0%
Operating charges:				
Salaries, wages and benefits	2,617,337	51.9%	2,496,236	50.9%
Other operating expenses	1,091,102	21.7%	1,042,056	21.2%
Supplies expense	200,008	4.0%	199,936	4.1%
Depreciation and amortization	163,155	3.2%	152,067	3.1%
Lease and rental expense	48,316	1.0%	45,445	0.9%
Subtotal-operating expenses	4,119,918	81.8%	3,935,740	80.2%
Income from operations	918,956	18.2%	970,979	19.8%
Interest expense, net	1,597	0.0%	2,005	0.0%
Other (income) expense, net	1,842	0.0%	0	0.0%
Income before income taxes	$ 915,517	18.2%	$ 968,974	19.7%

During 2018, as compared to 2017, net revenues generated from our behavioral health care services increased $132 million, or 2.7%, to $5.04 billion during 2018 as compared to $4.91 billion during 2017. The increase in net revenues was attributable to: (i) $123 million or 2.6% increase in same facility revenues, as discussed above, and; (ii) an $9 million other combined net increase consisting primarily of the revenues generated at the 25 behavioral health facilities acquired in the U.K. in connection with our acquisition of The Danshell Group (acquired during the third quarter of 2018) and the revenues generated from the acquisition of a 109-bed behavioral health care facility located in Gulfport, Mississippi (acquired during the first quarter of 2018), partially offset by a decrease to net revenues resulting from the closure or restructuring of certain behavioral health care facilities.

Income before income taxes decreased $53 million or 6% to $916 million or 18.2% of net revenues during 2018 as compared to $969 billion or 19.7% of net revenues during 2017. The decrease in income before income taxes at our behavioral health facilities was attributable to:

- a $10 million decrease at our behavioral health facilities on a same facility basis, as discussed above;
- a decrease of $49 million from an intangible asset (tradename) impairment charge recorded during 2018 in connection with Foundations Recovery Network, LLC which was acquired by us during 2015;
- a $13 million increase due to the following unfavorable amounts recorded during 2017: (i) a prior year Medicaid disproportionate shares hospital revenue adjustment related to a certain state ($7 million), and; (ii) increased professional and general liability expense related to prior years, based upon a reserve analysis ($6 million), and;
- other combined net decrease of $7 million consisting primarily of the losses incurred at certain behavioral health care facilities that have restructured or closed during the past year.

Year Ended December 31, 2017 as compared to the Year Ended December 31, 2016

Behavioral Health Care Services-Same Facility Basis

The following table summarizes the results of operations for our behavioral health care services, on a same facility basis, and is used in the discussions below for the years ended December 31, 2017 and 2016 (dollar amounts in thousands):

	Year Ended December 31, 2017		Year Ended December 31, 2016	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 4,743,340		$ 4,666,633	
Less: Provision for doubtful accounts	111,277		113,455	
Net revenues	4,632,063	100.0%	4,553,178	100.0%
Operating charges:				
Salaries, wages and benefits	2,361,545	51.0%	2,257,512	49.6%
Other operating expenses	921,991	19.9%	885,574	19.4%
Supplies expense	195,291	4.2%	193,901	4.3%
Depreciation and amortization	136,000	2.9%	131,231	2.9%
Lease and rental expense	44,259	1.0%	44,975	1.0%
Subtotal-operating expenses	3,659,086	79.0%	3,513,193	77.2%
Income from operations	972,977	21.0%	1,039,985	22.8%
Interest expense, net	2,006	0.0%	1,728	0.0%
Income before income taxes	$ 970,971	21.0%	$ 1,038,257	22.8%

On a same facility basis during 2017, as compared to 2016, net revenues generated from our behavioral health care services increased $79 million or 1.7% to $4.63 billion during 2017 as compared to $4.55 billion during 2016. Income before income taxes decreased $67 million or 7% to $971 million or 21.0% of net revenues during 2017 as compared to $1.04 billion or 22.8% of net revenues during 2016.

Inpatient admissions to our behavioral health care facilities owned during both years increased 2.5% during 2017, as compared to 2016, while patient days increased 0.3%. Adjusted admissions increased 2.4% and adjusted patient days increased 0.2% during 2017, as compared to 2016. The average length of inpatient stay at these facilities were 12.8 days and 13.1 days during 2017 and 2016, respectively. The occupancy rate, based on the average available beds at these facilities, were 75% and 76% during 2017 and 2016, respectively. On a same facility basis, net revenue per adjusted admission at these facilities decreased 0.4% during 2017, as compared to 2016, and net revenue per adjusted patient day increased 1.9% during 2017, as compared to 2016.

All Behavioral Health Care Services

The following table summarizes the results of operations for all our behavioral health care services during 2017 and 2016. These amounts include: (i) our behavioral health care results on a same facility basis, as indicated above; (ii) the impact of provider tax assessments which increased net revenues and other operating expenses but had no impact on income before income taxes, and; (iii) certain other amounts including the results of facilities acquired or opened during the previous year including the behavioral health care facilities acquired in the U.K. in connection with our acquisition of Cambian Group, PLC's adult services division which was acquired in late December, 2016. Dollar amounts below are reflected in thousands.

	Year Ended December 31, 2017		Year Ended December 31, 2016	
	Amount	% of Net Revenues	Amount	% of Net Revenues
Net revenues before provision for doubtful accounts	$ 5,020,177		$ 4,758,761	
Less: Provision for doubtful accounts	113,458		113,754	
Net revenues	4,906,719	100.0%	4,645,007	100.0%
Operating charges:				
Salaries, wages and benefits	2,496,236	50.9%	2,271,967	48.9%
Other operating expenses	1,042,056	21.2%	965,873	20.8%
Supplies expense	199,936	4.1%	194,872	4.2%
Depreciation and amortization	152,067	3.1%	134,487	2.9%
Lease and rental expense	45,445	0.9%	45,346	1.0%
Subtotal-operating expenses	3,935,740	80.2%	3,612,545	77.8%
Income from operations	970,979	19.8%	1,032,462	22.2%
Interest expense, net	2,005	0.0%	1,728	0.0%
Income before income taxes	$ 968,974	19.7%	$ 1,030,734	22.2%

During 2017, as compared to 2016, net revenues generated from our behavioral health care services increased 5.6% or $262 million to $4.91 billion during 2017 as compared to $4.65 billion during 2016. The increase in net revenues was attributable to: (i) $79 million or 1.7% increase in same facility revenues, as discussed above, and; (ii) $183 million of other combined net increases consisting primarily of the revenues generated at the facilities acquired in the U.K. in late December, 2016 in connection with our acquisition of Cambian Group, PLC's Adult Services division.

Income before income taxes decreased $62 million or 6% to $969 million or 19.7% of net revenues during 2017 as compared to $1.03 billion or 22.2% of net revenues during 2016. The decrease in income before income taxes at our behavioral health facilities was attributable to:

- a $67 million decrease at our behavioral health facilities on a same facility basis, as discussed above;
- a $13 million decrease due to the following which were recorded during 2017: (i) a prior year Medicaid disproportionate shares hospital revenue adjustment related to a certain state ($7 million), and; (ii) increased professional and general liability expense related to prior years, based upon a reserve analysis ($6 million), and;
- other combined net increase of $18 million consisting primarily of the income generated during 2017 at the facilities acquired in the Cambian Group, PLC's adult services division transaction in December, 2016, partially offset by other unfavorable changes.

Sources of Revenue

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

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

Patients are generally not responsible for any difference between customary hospital charges and amounts reimbursed for such services under Medicare, Medicaid, some private insurance plans, and managed care plans, but are responsible for services not covered by such plans, exclusions, deductibles or co-insurance features of their coverage. The amount of such exclusions, deductibles and co-insurance has generally been increasing each year. Indications from recent federal and state legislation are that this trend will

continue. Collection of amounts due from individuals is typically more difficult than from governmental or business payers which unfavorably impacts the collectability of our patient accounts.

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

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

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

A 2012 U.S. Supreme Court ruling limited the federal government's ability to expand health insurance coverage by holding unconstitutional sections of the Legislation that sought to withdraw federal funding for state noncompliance with certain Medicaid coverage requirements. Pursuant to that decision, the federal government may not penalize states that choose not to participate in the Medicaid expansion program by reducing their existing Medicaid funding. Therefore, states can choose to accept or not to participate without risking the loss of federal Medicaid funding. As a result, many states, including Texas, have not expanded their Medicaid programs without the threat of loss of federal funding. CMS has granted, and is expected to grant additional, section 1115 demonstration waivers providing for work and community engagement requirements for certain Medicaid eligible individuals. It is anticipated this will lead to reductions in coverage, and likely increases in uncompensated care, in states where these demonstration waivers are granted.

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

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

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

federal civil False Claims Act. The Legislation also expands the Recovery Audit Contractor program to Medicaid. These amendments also make it easier for severe fines and penalties to be imposed on healthcare providers that violate applicable laws and regulations.

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

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

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

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

For additional disclosure related to our revenues including a disaggregation of our consolidated net revenues by major source for each of the periods presented herein, please see *Note 11 to the Consolidated Financial Statements-Revenue*.

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

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

In August, 2018, CMS published its IPPS 2019 final payment rule which provides for a 2.9% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments ACA-mandated adjustments are considered, without consideration for the decreases related to the required Medicare DSH payment changes and decrease to the Medicare Outlier threshold, the overall increase in IPPS payments is approximately 0.5%. Including the estimated increase to our DSH payments (approximating 2.1%) and certain other adjustments, we estimate our overall increase from the final IPPS 2019 rule (covering the period of October 1, 2018 through September 30, 2019) will approximate 2.7%. This projected impact from the IPPS 2019 final rule includes an increase of approximately 0.5% to partially restore cuts made as a result of the American Taxpayer Relief Act of 2012 ("ATRA"), as required by the 21st Century Cures Act but excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, Bipartisan Budget Act of 2015, and Bipartisan Budget Act of 2018, as discussed below. CMS continued to phase-in the use of uncompensated care data from both the 2014 and 2015 Worksheet S-10 hospital cost reports, two-third weighting as part of the proxy methodology to allocate approximately $8 billion in the DSH Uncompensated Care Pool. This final rule change will continue to result in wide variations among all hospitals nationwide in the distribution of these DSH funds compared to previous years until the full phase-in of worksheet S-10 is completed by CMS.

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

In August, 2016, CMS published its IPPS 2017 final payment rule which provides for a 2.7% market basket increase to the base Medicare MS-DRG blended rate. When statutorily mandated budget neutrality factors, annual geographic wage index updates, documenting and coding adjustments and ACA-mandated adjustments are considered, without consideration for the decreases related to the required DSH payment changes and increase to the Medicare Outlier threshold, the overall increase in IPPS payments would approximate 0.95%. Including the estimated decreases to our DSH payments (approximating -0.8%) and certain other adjustments, we estimate our overall decrease from the final IPPS 2017 rule (covering the period of October 1, 2016 through September 30, 2017) would approximate -0.2%. This projected impact from the IPPS 2017 final rule includes both the impact of ATRA documentation and coding adjustment and the required changes to the DSH payments related to the traditional Medicare fee for service, however, it excludes the impact of the sequestration reductions related to the Budget Control Act of 2011, and Bipartisan Budget Act of 2015, as discussed below.

In August, 2013, CMS published its final IPPS 2014 payment rule which expanded CMS's policy under which it defines inpatient admissions to include the use of an objective time of care standard. Specifically, it would require Medicare's external review contractors to presume that hospital inpatient admissions are reasonable and necessary when beneficiaries receive a physician order for admission and receive medically necessary services for at least two midnights (the "Two Midnight" rule). In October, 2015 as part of the 2016 Medicare Outpatient Prospective Payment System ("OPPS") final rule (additional related disclosure below), CMS will allow payment for one-midnight stays under the Medicare Part A benefit on a case-by case basis for rare and unusual exceptions based

the presence of certain clinical factors. CMS also announced in the final rule that, effective October 1, 2015, Quality Improvement Organizations ("QIOs") will conduct reviews of short inpatient stay reviews rather than Medicare Administrative Contractors. Additionally, CMS also announced that Recovery Audit Contractors ("RACs") resumed patient status reviews for claims with admission dates of January 1, 2016 or later, and the agency indicates that RACs will conduct these reviews focused on providers with high denial rates that are referred by the QIOs. In its IPPS 2017 final payment rule, CMS: (i) reversed the Two-Midnight rule's 0.2% reduction in hospital payments, and; (ii) implemented a temporary one-time increase of 0.8% in FFY 2017 payments to offset cuts in the preceding fiscal years affected by the prior 0.2% reduction.

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

On January 2, 2013 ATRA was enacted which, among other things, includes a requirement for CMS to recoup $11 billion from hospitals from Medicare IPPS rates during federal fiscal years 2014 to 2017. The recoupment relates to IPPS documentation and coding adjustments for the period 2008 to 2013 for which adjustments were not previously applied by CMS. Both the 2014 and 2015 IPPS final rules include a -0.8% recoupment adjustment. CMS has included the same 0.8% recoupment adjustment in fiscal year 2016, a 1.5% recoupment adjustment in federal fiscal year 2017, a 0.45% positive adjustment in fiscal year 2018, and a 0.5% positive adjustment in fiscal year 2019 in order to recover the entire $11 billion. This adjustment is reflected in the IPPS estimated impact amounts noted above. On April 16, 2015, the Medicare Access and CHIP Reauthorization Act of 2015 was enacted and an anticipated 3.2% payment increase in 2018 is scheduled to be phased in at approximately 0.5% per year over 6 years beginning in fiscal year 2018.

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

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

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

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

In December, 2018, the U.S. District Court for the District of Columbia ruled that the U.S. Department of Health and Human Services ("HHS") did not have statutory authority to implement the 2018 Medicare OPPS rate reduction related to hospitals that qualify for drug discounts under the federal 340B Drug Discount Program and granted a permanent injunction against the payment reduction. However, recognizing both the complexity of the OPPS payment system as well as its budget neutral rate setting system, the Court refrained from imposing a remedy. Instead the Judge in the case called for additional briefing from the Plaintiffs and Defendants on the proper scope and implementation for relief. The case is expected to be appealed by HHS. We are unable to predict the ultimate outcome of any appeal and the type of relief that may be ordered by the Courts. We estimate that the CMS 2018 change in the 340B payment policy increased our 2018 Medicare OPPS payments by approximately $8 million, which has been fully reserved in our results of operations for the year, and estimate that a comparable amount was scheduled to be earned during 2019.

In November, 2018, CMS published its OPPS final rule for 2019. The hospital market basket increase is 2.9%. The Medicare statute requires a productivity adjustment reduction of 0.8% and 0.75% reduction to the 2019 OPPS market basket resulting in a 2019

update to OPPS payment rates by 1.35%. When other statutorily required adjustments and hospital patient service mix are considered, we estimate that our overall Medicare OPPS update for 2019 will aggregate to a net increase of 1.1% which includes a 5.7% increase to behavioral health division partial hospitalization rates. When the behavioral health division's partial hospitalization rate impact is excluded, we estimate that our Medicare 2019 OPPS payments will result in a 0.4% increase in payment levels for our acute care division, as compared to 2018.

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

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

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

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

The ACA substantially increases the federally and state-funded Medicaid insurance program, and authorizes states to establish federally subsidized non-Medicaid health plans for low-income residents not eligible for Medicaid starting in 2014. However, the Supreme Court has struck down portions of the ACA requiring states to expand their Medicaid programs in exchange for increased federal funding. Accordingly, many states in which we operate have not expanded Medicaid coverage to individuals at 133% of the federal poverty level. Facilities in states not opting to expand Medicaid coverage under the ACA may be additionally penalized by corresponding reductions to Medicaid disproportionate share hospital payments beginning in 2020, as discussed below. We can provide no assurance that further reductions to Medicaid revenues, particularly in the above-mentioned states, will not have a material adverse effect on our future results of operations.

Various State Medicaid Supplemental Payment Programs:

We incur health-care related taxes ("Provider Taxes") imposed by states in the form of a licensing fee, assessment or other mandatory payment which are related to: (i) healthcare items or services; (ii) the provision of, or the authority to provide, the health care items or services, or; (iii) the payment for the health care items or services. Such Provider Taxes are subject to various federal regulations that limit the scope and amount of the taxes that can be levied by states in order to secure federal matching funds as part of

their respective state Medicaid programs. As outlined below, we derive a related Medicaid reimbursement benefit from assessed Provider Taxes in the form of Medicaid claims based payment increases and/or lump sum Medicaid supplemental payments.

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

Texas Uncompensated Care/Upper Payment Limit Payments:

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

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

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

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

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

Texas Delivery System Reform Incentive Payments:

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

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

The following table summarizes the revenues, Provider Taxes and net benefit related to each of the above-mentioned Medicaid supplemental programs for the years ended December 31, 2018, 2017 and 2016. The Provider Taxes are recorded in other operating expenses on the Condensed Consolidated Statements of Income as included herein.

	(amounts in millions)		
	2018	2017	2016
Texas UC/UPL:			
Revenues	$ 135	$ 88	$ 56
Provider Taxes	(51)	(25)	(10)
Net benefit	$ 84	$ 63	$ 46
Texas DSRIP:			
Revenues	$ 29	$ 46	$ 47
Provider Taxes	(9)	(19)	(20)
Net benefit	$ 20	$ 27	$ 27
Various other state programs:			
Revenues	$ 223	$ 223	$ 224
Provider Taxes	(119)	(127)	(136)
Net benefit	$ 104	$ 96	$ 88
Total all Provider Tax programs:			
Revenues	$ 387	$ 357	$ 327
Provider Taxes	(179)	(171)	(166)
Net benefit	$ 208	$ 186	$ 161

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

Texas and South Carolina Medicaid Disproportionate Share Hospital Payments:

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

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

In connection with these DSH programs, included in our financial results was an aggregate of approximately $38 million during 2018, $34 million during 2017 and $39 million during 2016. We expect the aggregate reimbursements to our hospitals pursuant to the Texas and South Carolina 2019 fiscal year programs to be approximately $33 million.

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

Nevada SPA:

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

In connection with this program, included in our financial results was approximately $26 million during 2018, $21 million during 2017 and $14 million during 2016. We estimate that our reimbursements pursuant to this program will approximate $26 million during the year ended December 31, 2019.

California SPA:

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

Risk Factors Related To State Supplemental Medicaid Payments:

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

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

but allows for a transition of the pass-through payments into value-based payment structures, delivery system reform initiatives or payments tied to services under a MCO contract. Since we are unable to determine the financial impact of this aspect of the final rule, we can provide no assurance that the final rule will not have a material adverse effect on our future results of operations.

Massachusetts Health Safety Net Care Pool ("SNCP")

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

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

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

The pre-tax charges incurred in connection with the implementation of EHR applications at our acute care hospitals did not have a material impact on our consolidated results of operations during the year ended December 31, 2018. Our consolidated result of operations during 2017 and 2016 include net pre-tax charges of $22 million and $28 million (net of $5 million of EHR incentive income), respectively, consisting of depreciation and amortization expense related to the costs incurred for the purchase and development of the EHR applications.

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

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

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

Commercial Insurance: Our hospitals also provide services to individuals covered by private health care insurance. Private insurance carriers typically make direct payments to hospitals or, in some cases, reimburse their policy holders, based upon the

particular hospital's established charges and the particular coverage provided in the insurance policy. Private insurance reimbursement varies among payers and states and is generally based on contracts negotiated between the hospital and the payer.

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

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

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

Implemented Medicare Reductions and Reforms:

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

Medicaid Revisions:

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

Health Insurance Revisions:

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

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

Value-Based Purchasing:

There is a trend in the healthcare industry toward value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care

provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events. Many large commercial payers currently require hospitals to report quality data, and several commercial payers do not reimburse hospitals for certain preventable adverse events.

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

Hospital Acquired Conditions:

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

Readmission Reduction Program:

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

Accountable Care Organizations:

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

Bundled Payments for Care Improvement Advanced:

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

As of October 1, 2018, the CMMI implemented a new, second generation voluntary episode payment model, Bundled Payments for Care Improvement Advanced (BPCI-Advanced or the Program). BPCI-Advanced is designed to test a new iteration of bundled payments for 32 Clinical Episodes (29 inpatient and 3 outpatient) with an aim to align incentives among participating health care providers to reduce expenditures and improve quality of care for traditional Medicare beneficiaries. The first cohort of participants entered BPCI-Advanced on October 1, 2018, and agreed to an initial performance period that will run through December 31, 2023. We have elected to participate in BPCI-Advanced at seventeen (17) of our acute care hospitals across almost two hundred (200) clinical episodes in collaboration with a third-party convener which has extensive experience and success in BPCI. The ultimate

success and financial impact of the BPCI-Advanced program is contingent on multiple variables so we are unable to estimate the impact. However, given the breadth and scope of participation of our acute care hospitals in BPCI-Advanced, the impact could be significant (either favorably or unfavorably) depending on actual program results.

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

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

Other Operating Results

Interest Expense

Reflected below are the components of our interest expense which amounted to $155 million during 2018, $145 million during 2017 and $125 million during 2016 (amounts in thousands):

	2018	2017	2016
Revolving credit & demand notes (a.)	$ 12,240	$ 10,933	$ 4,577
$400 million, 7.125% Senior Notes due 2016 (c.)	—	—	12,031
$300 million, 3.75% Senior Notes due 2019 (d.)	10,156	11,250	11,250
$700 million, 4.75% Senior Notes due 2022 (e.)	32,280	32,280	24,628
$400 million, 5.00% Senior Notes due 2026 (f.)	20,000	20,000	11,556
Term loan facility A (a.)	63,021	47,745	36,578
Term loan facility B (a.)(b.)	3,511	—	—
Accounts receivable securitization program (g.)	11,785	7,987	4,739
Subtotal-revolving credit, demand notes, Senior Notes, term loan facility and accounts receivable securitization program	152,993	130,195	105,359
Interest rate swap expense, net	(6,726)	2,403	8,488
Amortization of financing fees	9,143	8,932	8,208
Other combined interest expense	3,343	4,740	5,064
Capitalized interest on major projects	(2,266)	(1,020)	(1,916)
Interest income	(1,531)	(81)	(150)
Interest expense, net	$ 154,956	$ 145,169	$ 125,053

(a.) In October, 2018, we entered into a sixth amendment to our credit agreement dated November 15, 2010 to, among other things: (i.) increase the aggregate amount of the revolving commitments by $200 million to $1 billion; (ii) increase the aggregate amount of the term loan facility A by approximately $290 million to $2 billion, and; (iii) extend the maturity date of the credit agreement from August 7, 2019 to October 23, 2023. The credit agreement, as amended in October, 2018, consists of: (i) an $1 billion revolving credit facility (there are no outstanding borrowings under the revolving credit facility as of December 31, 2018); (ii) a $2 billion term loan A facility (with $2.0 billion outstanding as of December 31, 2018), and; (iii) a $500 million term loan B facility (with $500 million outstanding as of December 31, 2018).

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

(c.) The $400 million, 7.125% Senior Notes matured and were repaid in June, 2016.

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

(e.) In June, 2016, we completed the offering of an additional $400 million aggregate principal amount of 4.75% Senior Notes due in 2022 (issued at a yield of 4.35%), the terms of which were identical to the terms of our $300 million aggregate

principal amount of 4.75% Senior Notes due in 2022, issued in August, 2014. These Senior Notes, combined, are referred to as $700 million, 4.75% Senior Notes due in 2022.

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

(g.) In April, 2018, we amended our accounts receivable securitization program, which was scheduled to expire in December, 2018. Pursuant to the amendment, the term has been extended through April 26, 2021, and the borrowing limit has been increased to $450 million from $440 million ($390 million outstanding as of December 31, 2018).

Interest expense increased $10 million during 2018 to $155 million as compared to $145 million during 2017. The increase was due primarily to: (i) a net increase of $23 million in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan A and B facilities and accounts receivable securitization program resulting from an increase in our aggregate average cost of borrowings pursuant to these facilities (3.8% during 2018, as compared to 3.2% during 2017), partially offset by a decrease in the aggregate average outstanding borrowings ($4.00 billion during 2018 as compared to $4.02 billion during 2017), partially offset by; (ii) a $9 million decrease in the interest rate swap expense; (iii) a $3 million combined increase in capitalized interest and interest income, and; (iv) $1 million of other combined net decreases.

Interest expense increased $20 million during 2017 to $145 million as compared to $125 million during 2016. The increase was due primarily to: (i) a $25 million increase in aggregate interest expense on our revolving credit, demand notes, senior notes, term loan facility and accounts receivable securitization program resulting from an increase in the average outstanding borrowings ($4.02 billion during 2017, as compared to $3.54 billion during 2016), as well as an increase in our aggregate average cost of borrowings pursuant to these facilities (3.2% during 2017, as compared to 3.0% during 2016); (ii) a $1 million decrease in capitalized interest, partially offset by; (iii) a $6 million decrease in our interest rate swap expense.

The aggregate average outstanding borrowings under our revolving credit, demand notes, senior notes, term loan A and B facilities and accounts receivable securitization program were approximately $4.00 billion during 2018, $4.02 billion during 2017 and $3.54 billion during 2016. The average effective interest rate on these facilities, including amortization of deferred financing costs and original issue discounts and designated interest rate swap expense was 3.8% during 2018, 3.5% during 2017 and 3.4% during 2016.

Costs Related to Early Extinguishment of Debt

In connection with various financing transaction completed during the year, as discussed below in *Capital Resources-Credit Agreements and Outstanding Debt Securities*, our 2018 results of operations include a $4 million pre-tax charge incurred for the costs related to the extinguishment of debt. This charge, which was included in other operating expenses, consisted of the write-off of deferred charges ($3 million) as well as the make-whole premium paid ($1 million) on the early redemption of the $300 million, 3.75% senior notes scheduled to mature in 2019.

Provision for Intangible Assets Impairment

During 2018, we recorded a pre-tax $49 million provision for asset impairment to reduce the carrying value of a tradename intangible asset to approximately $75 million from approximately $124 million as previously recorded in connection with our 2015 acquisition of Foundation Recovery Network, L.L.C. (“Foundations”). The intangible asset impairment charge, which is included in other operating expenses in our 2018 consolidated statements of income, was recorded after evaluation of the estimated fair value of the Foundations’ tradename for its existing facilities, consisting of 4 inpatient and 12 outpatient facilities as of December 31, 2018, as well as estimated planned de novos. This asset impairment charge was impacted by the following: (i) the lost future revenue and cash flows resulting from the permanent closure of a Foundations’ inpatient facility located in Malibu, California that was severely damaged in the California wildfires during the fourth quarter of 2018; (ii) reduction in growth rates of projected future patient volumes, revenues and operating cash flows based upon pressures on reimbursement rates experienced from certain payers and competitive pressures experienced in certain markets, and; (iii) revisions made to the number and timing of planned de novo facilities.

Provision for Income Taxes and Effective Tax Rates

The effective tax rates, as calculated by dividing the provision for income taxes by income before income taxes, were as follows for each of the years ended December 31, 2018, 2017 and 2016 (dollar amounts in thousands):

	2018	2017	2016
Provision for income taxes	$ 236,642	$ 363,697	$ 409,187
Income before income taxes	1,034,525	1,135,009	1,156,358
Effective tax rate	22.9%	32.0%	35.4%

The decrease in the effective tax rate during 2018, as compared to 2017, was due primarily to the following:

- a decrease in the provision for income taxes during 2018 resulting from the Tax Cuts and Jobs Act of 2017 ("TCJA-17") which, among other things, reduced the U.S. federal corporate tax rate from 35% to 21% effective January 1, 2018, partially offset by;
- a net increase of $13 million in the provision for income taxes during 2018, as compared to 2017, due to the following that decreased or increased our provision for income taxes during 2018 and/or 2017: (i) decreases of $6 million and $30 million recorded during 2018 and 2017, respectively, resulting from a reduction in our net deferred income tax liability recorded in connection with the TCJA-17 which reduced the U.S. federal corporate tax rate to 21% from 35%, effective January 1, 2018, partially offset by; (ii) an increase of $11 million recorded during 2017 due to a one-time repatriation tax incurred pursuant to the TCJA-17 (in connection with our behavioral health care facilities located in the U.K. and Puerto Rico), and;
- a $21 million increase in our provision for income taxes during 2018, as compared to 2017, due to an unfavorable change resulting from our January 1, 2017 adoption of ASU 2016-09, which decreased our provision for income taxes by $1 million during 2018 as compared to $22 million during 2017.

The decrease in the effective tax rate during 2017, as compared to 2016, was due primarily to the following that increased or decreased our provision for income taxes in 2017:

- a decrease of $30 million recorded during 2017 resulting from a reduction in our net deferred income tax liability recorded in connection with the TCJA-17 which reduced the U.S. federal corporate tax rate to 21% from 35%, effective January 1, 2018;
- an increase of $11 million recorded during 2017 due to a one-time repatriation tax incurred pursuant to the TCJA-17 (in connection with our behavioral health care facilities located in the U.K. and Puerto Rico);
- a decrease of $22 million recorded during 2017 resulting from our January 1, 2017 adoption of ASU 2016-09, as discussed herein, and;
- a decrease caused by lower effective rates applicable to the income generated during 2017 in connection with our acquisition of Cambian Group, PLC's adult services division (acquired in late December, 2016).

The impact of discrete tax items did not have a material impact on our provision for income taxes during 2016.

Previously, in 2016, we had provided no deferred taxes related to unremitted earnings from foreign subsidiaries. As a result of the mandatory repatriation tax provisions in the TCJA-17, we recorded an accrued tax provision of $11 million as of December 31, 2017. Going forward, we anticipate repatriating only previously taxed foreign income and any future earnings that would qualify for a full dividend received deduction permitted under the TCJA-17 for distributions after December 31, 2017. At this time, there are no material tax effects related to future cash repatriation of our previously taxed foreign income. As such, we have not recognized a deferred tax liability related to existing undistributed earnings.

Effects of Inflation and Seasonality

Seasonality —Our acute care services business is typically seasonal, with higher patient volumes and net patient service revenue in the first and fourth quarters of the year. This seasonality occurs because, generally, more people become ill during the winter months, which results in significant increases in the number of patients treated in our hospitals during those months.

Inflation —Inflation has not had a material impact on our results of operations over the last three years. However, since the healthcare industry is very labor intensive and salaries and benefits are subject to inflationary pressures, as are supply and other costs, we cannot predict the impact that future economic conditions may have on our ability to contain future expense increases. Our ability to pass on increased costs associated with providing healthcare to Medicare and Medicaid patients is limited due to various federal, state and local laws which have been enacted that, in certain cases, limit our ability to increase prices. We believe, however, that through adherence to cost containment policies, labor management and reasonable price increases, the effects of inflation on future operating margins should be manageable.

Liquidity

Year ended December 31, 2018 as compared to December 31, 2017:

Net cash provided by operating activities

Net cash provided by operating activities was $1.341 billion during 2018 as compared to $1.183 billion during 2017. The net increase of $158 million was primarily attributable to the following:

- a favorable change of $130 million in cash flows from forward exchange contracts related to our investments in the United Kingdom;
- a favorable change of $91 million due to an increase in net income plus/minus depreciation and amortization expense, stock-based compensation, a net gain on sales of assets, and provision for intangible asset impairment;
- an unfavorable change of $48 million in accrued and deferred income taxes;
- a favorable change of $40 million in other working capital accounts resulting primarily from changes in accrued expenses and due to timing of disbursements;
- an unfavorable change of $18 million in accounts receivable;
- an unfavorable change of $7 million in accrued insurance expense, net of commercial premiums paid, and;
- $30 million of other combined net unfavorable changes.

Days sales outstanding ("DSO"): Our DSO are calculated by dividing our net revenue by the number of days in the year. The result is divided into the accounts receivable balance the end of the year. Our DSO were 51 days at December 31, 2018 and 53 days at each of December 31, 2017 and 2016.

Our accounts receivable as of December 31, 2018 and December 31, 2017 include amounts due from Illinois of approximately $32 million and $25 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $18 million as of December 31, 2018 and $8 million as of December 31, 2017, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. Although the accounts receivable due from Illinois could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois. Failure to ultimately collect all outstanding amounts due to us from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

Net cash used in investing activities

Net cash used in investing activities was $813 million during 2018 and $620 million during 2017

2018:

The $813 million of net cash used in investing activities during 2018 consisted of:

- $665 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $110 million spent to acquire businesses and property consisting primarily of the acquisition of: (i) The Danshell Group, consisting of 25 behavioral health facilities located in the U.K. (acquired during the third quarter of 2018), and; (ii) a 109-bed behavioral health care facility located in Gulfport, Mississippi (acquired during the first quarter of 2018);
- $36 million spent on the purchase and implementation of information technology applications;
- $15 million spent to fund construction costs of a new behavioral health care facility, that is jointly owned by us and a third-party, that was completed and opened during the third quarter of 2018, and;
- $13 million received in connection with the sale of a business and property including The Limes, an 18-bed facility located in the U.K.

2017:

The $620 million of net cash used in investing activities during 2017 consisted of:

- $557 million spent on capital expenditures including capital expenditures for equipment, renovations and new projects at various existing facilities;
- $29 million spent on the purchase and implementation of information technology applications;
- $23 million spent to acquire businesses and property;
- $8 million spent to fund construction costs of a new, jointly owned behavioral health care facility, and;
- $3 million spent to increase the statutorily required capital reserves of our commercial insurance subsidiary.

Net cash used in financing activities

Net cash used in financing activities was $492 million during 2018 and $519 million during 2017.

2018:

The $492 million of net cash used in financing activities during 2018 consisted of the following:

- spent $830 million on net repayment of debt as follows: (i) $67 million related to our term loan A facility; (ii) $403 million related to our revolving credit facility; (iii) $300 million related to the early redemption of our 3.75% bonds that were scheduled to mature in 2019; (iv) $29 million related to our accounts receivable securitization program; (v) $29 million related to our short-term, on-demand credit facility, and; (vi) $2 million related to other debt facilities;
- generated $791 million of proceeds related to new borrowings pursuant to our term loan A facility ($291 million) and our term loan B facility ($500 million);
- spent $397 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our $1.7 billion stock repurchase program ($384 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($13 million);
- spent $37 million to pay dividends (paid quarterly at $.10 per share);
- spent $14 million in financing costs;
- spent $15 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $10 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

2017:

The $519 million of net cash used in financing activities during 2017 consisted of the following:

- spent $143 million on net repayment of debt as follows: (i) $89 million related to our term loan A facility; (ii) $52 million related to our revolving credit facility, and; (iii) $2 million related to other debt facilities;
- generated $41 million of proceeds related to new borrowings pursuant to our accounts receivable securitization program ($21 million) and short-term, on-demand credit facility ($20 million);
- spent $364 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our $1.7 billion stock repurchase program ($330 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($34 million);
- spent $38 million to pay dividends (paid quarterly at $.10 per share);
- spent $25 million to pay profit distributions related to noncontrolling interests in majority owned businesses, and;
- generated $10 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans.

Year ended December 31, 2017 as compared to December 31, 2016:

Net cash provided by operating activities

Net cash provided by operating activities was $1.183 billion during 2017 as compared to $1.334 billion during 2016. The net decrease of $151 million was primarily attributable to the following:

- an unfavorable change of $144 million in cash flows from forward exchange contracts related to our investments in the United Kingdom;
- an unfavorable change of $90 million in other working capital accounts resulting primarily from changes in accounts payable and accrued expenses due to timing of disbursements;
- a favorable change of $64 million due to an increase in net income plus depreciation and amortization and stock-based compensation expense;
- a favorable change of $63 million in accounts receivable;
- an unfavorable change of $28 million in accrued and deferred income taxes, and;
- $16 million of other combined net unfavorable changes.

Net cash used in investing activities

Net cash used in investing activities was $620 million during 2017 and $1.155 billion during 2016. The factors contributing to the $620 million of net cash used in investing activities during 2017 are detailed above.

2016:

The $1.155 billion of net cash used in investing activities during 2016 consisted of:

- $614 million spent related to the acquisition of businesses and property including the acquisition of the adult services division of Cambian Group, PLC consisting of 79 inpatient and 2 outpatient behavioral health facilities located in the U.K., the acquisition of Desert View Hospital, a 25-bed acute care facility located in Pahrump, Nevada, and the acquisition of various other businesses and real property assets;
- $520 million spent on capital expenditures, and;
- $21 million spent on the purchase and implementation of an information technology application.

Net cash used in financing activities

Net cash used in financing activities was $519 million during 2017 and $171 million during 2016. The factors contributing to the $519 million of net cash used in financing activities during 2017 are detailed above.

2016:

The $171 million of net cash used in financing activities during 2016 consisted of the following:

- spent $459 million on net repayment of debt as follows: (i) $400 million related to the 7.125% senior secured notes that matured in June, 2016; (ii) $55 million related to our term loan A facility; (iii) $1 million related to our accounts receivable securitization program, and; (iv) $3 million related to other debt facilities;
- generated $1.171 billion of proceeds related to new borrowings as follows: (i) $406 million received in connection with the issuance of additional 4.75% senior secured notes due in 2022; (ii) $400 million received from the issuance of 5.0% senior secured notes due in 2026; (iii) $200 million of additional borrowings pursuant to our term loan A facility; (iv) $155 million of additional borrowings pursuant to our revolving credit facility, and; (v) $10 million of proceeds from new borrowings pursuant to a short-term, on-demand credit facility;
- spent $418 million to purchase third-party minority ownership interests in our six acute care hospitals located in Las Vegas, Nevada;
- spent $353 million to repurchase shares of our Class B Common Stock in connection with: (i) open market purchases pursuant to our stock repurchase program ($296 million), and; (ii) income tax withholding obligations related to stock-based compensation programs ($57 million);

- spent $70 million to pay profit distributions related to noncontrolling interests in majority owned businesses
- spent $39 million to pay dividends (paid quarterly at $.10 per share);
- generated $10 million from the issuance of shares of our Class B Common Stock pursuant to the terms of employee stock purchase plans, and;
- spent $12 million in financing costs.

2019 Expected Capital Expenditures:

During 2019, we expect to spend approximately $675 million to $725 million on capital expenditures which includes expenditures for capital equipment, renovations and new projects at existing hospitals. Approximately $250 million of our 2019 expected capital expenditures relates to completion of projects that are in progress as of December 31, 2018. We believe that our capital expenditure program is adequate to expand, improve and equip our existing hospitals. We expect to finance all capital expenditures and acquisitions with internally generated funds and/or additional funds, as discussed below.

Capital Resources

Credit Facilities and Outstanding Debt Securities

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

The Sixth Amendment amended the Senior Credit Facility to, among other things: (i) increase the aggregate amount of the revolving credit facility to $1 billion (increase of $200 million over the $800 million previous commitment); (ii) increase the aggregate amount of the tranche A term loan commitments to $2 billion, which represents the outstanding borrowings as of December 31, 2018 (increase of approximately $290 million over the $1.71 billion of outstanding borrowings prior to the amendment), and; (iii) extended the maturity date of the revolving credit and tranche A term loan facilities to October 23, 2023 from August 7, 2019.

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

As of December 31, 2018, we had no borrowings outstanding pursuant to our $1 billion revolving credit facility and we had $960 million of available borrowing capacity net of $34 million of outstanding letters of credit and $6 million of outstanding borrowings pursuant to a short-term credit facility.

Pursuant to the terms of the Sixth Amendment, the tranche A term loan provides for eight installment payments of $12.5 million per quarter commencing on March 31, 2019 followed by payments of $25 million per quarter until maturity when all outstanding amounts will be due. The tranche B term loan provides for installment payments of $1.25 million per quarter commencing March 31, 2019 through maturity.

Borrowings under the Senior Credit Agreement bear interest at our election at either (1) the ABR rate which is defined as the rate per annum equal to the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.375% to 0.625% for revolving credit and term loan A borrowings and 0.75% for tranche B borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.375% to 1.625% for revolving credit and term loan A borrowings and 1.75% for the tranche B term loan. As of December 31, 2018, the applicable margins were 0.50% for ABR-based loans and 1.50% for LIBOR-based loans under the revolving credit and term loan A facilities. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Senior Credit Agreement is secured by certain assets of the Company and our material subsidiaries (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

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

In late April, 2018, we entered into the sixth amendment to our accounts receivable securitization program ("Securitization") dated as of October 27, 2010 with a group of conduit lenders, liquidity banks, and PNC Bank, National Association, as administrative agent, which provides for borrowings outstanding from time to time by certain of our subsidiaries in exchange for undivided security interests in their respective accounts receivable. The sixth amendment, among other things, extended the term of the Securitization program through April 26, 2021 and increased the borrowing capacity to $450 million (from $440 million previously). Although the program fee and certain other fees were adjusted in connection with the sixth amendment, substantially all other provisions of the Securitization program remained unchanged. Pursuant to the terms of our Securitization program, substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At December 31, 2018, we had $390 million of outstanding borrowings pursuant to the terms of the Securitization and $60 million of available borrowing capacity.

As of December 31, 2018, we had combined aggregate principal of $1.1 billion from the following senior secured notes:

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

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

Interest is payable on the 2019 Notes and the 2022 Notes on February 1 and August 1 of each year until the maturity date of August 1, 2019 for the 2019 Notes and August 1, 2022 for the 2022 Notes. Interest on the 2026 Notes is payable on June 1 and December 1 until the maturity date of June 1, 2026. The 2019 Notes, 2022 Notes and 2026 Notes were offered only to qualified institutional buyers under Rule 144A and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act of 1933, as amended (the "Securities Act"). The 2019 Notes, 2022 Notes and 2026 Notes have not been registered under the Securities Act and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements.

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

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

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

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

Contractual Obligations and Off-Balance Sheet Arrangements

As of December 31, 2018 we were party to certain off balance sheet arrangements consisting of standby letters of credit and surety bonds which totaled $113 million consisting of: (i) $107 million related to our self-insurance programs, and; (ii) $6 million of other debt and public utility guarantees.

Obligations under operating leases for real property, real property master leases and equipment amount to $368 million as of December 31, 2018. The real property master leases are leases for buildings on or near hospital property for which we guarantee a certain level of rental income. We sublease space in these buildings and any amounts received from these subleases are offset against the expense. In addition, we lease three hospital facilities from Universal Health Realty Trust (the "Trust") with two hospital terms expiring in 2021 and the third in 2026. These leases contain up to two 5-year renewal options. We also lease two free-standing emergency departments and space in certain medical office buildings which are owned by the Trust. In addition, we lease the real property of certain other facilities from non-related parties as indicated in *Item 2. Properties,* as included herein.

The following represents the scheduled maturities of our contractual obligations as of December 31, 2018:

	Payments Due by Period (dollars in thousands)				
	Total	Less than 1 year	2-3 years	4-5 years	After 5 years
Long-term debt obligations (a)	$ 3,998,637	$ 63,446	$ 552,746	$ 2,507,105	$ 875,340
Estimated future interest payments on debt outstanding as of December 31, 2018 (b)	846,565	182,808	324,333	245,393	94,031
Construction commitments (c)	54,750	11,370	43,380	0	0
Purchase and other obligations (d)	253,594	60,794	101,700	91,100	0
Operating leases (e)	367,847	72,353	108,383	64,072	123,039
Estimated future payments for defined benefit pension plan, and other retirement plan (f)	200,989	16,398	15,705	17,584	151,302
Health and dental unpaid claims (g)	78,288	78,288	0	0	0
Total contractual cash obligations	$ 5,800,670	$ 485,457	$ 1,146,247	$ 2,925,254	$ 1,243,712

(a) Reflects borrowings outstanding as of December 31, 2018 as discussed in *Note 4 to the Consolidated Financial Statements*.

(b) Assumes that all debt outstanding as of December 31, 2018, including borrowings under our Credit Agreement, demand note and accounts receivable securitization program, remain outstanding until the final maturity of the debt agreements at the same interest rates (some of which are floating) which were in effect as of December 31, 2018. We have the right to repay borrowings upon short notice and without penalty, pursuant to the terms of the Credit Agreement, demand note and accounts receivable securitization program. Also includes the impact of various interest rate swap and cap agreements in effect as of December 31, 2018, as calculated to maturity dates utilizing the applicable floating interest rates in effect as of December 31, 2018.

(c) Our share of the remaining estimated construction cost of two newly constructed behavioral health care facilities located in Washington and Arizona that are scheduled to be completed and opened 2020. We are required to build these facilities pursuant to joint-venture agreements with third parties. In addition, we had various other projects under construction as of December 31, 2018. Because we can terminate substantially all of the construction contracts related to the various other projects at any time without paying a termination fee, these costs are excluded from the table above.

(d) Consists of: (i) $57 million related to long-term contracts with third-parties consisting primarily of certain revenue cycle data processing services for our acute care facilities; (ii) $194 million related to the future expected costs to be paid to a third-party vendor in connection with the ongoing operation of an electronic health records application and purchase and implementation of a revenue cycle and other applications for our acute care facilities, and; (iii) a $2 million liability for physician commitments expected to be paid in the future.

(e) Reflects our future minimum operating lease payment obligations related to our operating lease agreements outstanding as of December 31, 2018 as discussed in *Note 7 to the Consolidated Financial Statements*. Some of the lease agreements provide us with the option to renew the lease and our future lease obligations would change if we exercised these renewal options.

(f) Consists of $180 million of estimated future payments related to our non-contributory, defined benefit pension plan (estimated through 2088), as disclosed in *Note 8 to the Consolidated Financial Statements*, and $21 million of estimated future payments related to other retirement plan liabilities ($18 million of liabilities recorded in other non-current liabilities as of December 31, 2018 in connection with these retirement plans).

(g) Consists of accrued and unpaid estimated claims expense incurred in connection with our commercial health insurers and self-insured employee benefit plans.

As of December 31, 2018, the total accrual for our professional and general liability claims was $243 million, of which $42 million is included in other current liabilities and $201 million is included in other non-current liabilities. We exclude the $243 million

for professional and general liability claims from the contractual obligations table because there are no significant contractual obligations associated with these liabilities and because of the uncertainty of the dollar amounts to be ultimately paid as well as the timing of such payments. Please see *Self-Insured/Other Insurance Risks* above for additional disclosure related to our professional and general liability claims and reserves.

ITEM 7A. Quantitative and Qualitative Disclosures About Market Risk

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

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

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

The fair value of interest rate swap agreements approximates the amount at which they could be settled, based on estimates obtained from the counterparties. We assess the effectiveness of our hedge instruments on a quarterly basis. We performed periodic assessments of the cash flow hedge instruments during 2018 and 2017 and determined the hedges to be highly effective. We also determined that any portion of the hedges deemed to be ineffective was de minimis and therefore there was no material effect on our consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose us to credit risk in the event of nonperformance. We do not anticipate nonperformance by our counterparties. We do not hold or issue derivative financial instruments for trading purposes.

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

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

On or before the April 15, 2019 expiration of the $1.0 billion of interest rate swaps, as outlined above, we intend to enter into new interest rate swap agreements on a similar total notional amount.

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

The table below presents information about our long-term financial instruments that are sensitive to changes in interest rates as of December 31, 2018. For debt obligations, the table presents principal cash flows and related weighted-average interest rates by contractual maturity dates.

Maturity Date, Fiscal Year Ending December 31

(dollars in thousands)

	2019	2020	2021	2022	2023	Thereafter	Total
Long-term debt:							
Fixed rate:							
Debt	$ 2,146	$ 1,650	$ 1,696	$699,550	$ 2,476	$ 405,613	$1,113,131
Average interest rates	5.0%	5.0%	4.9%	4.9%	5.2%	3.7%	4.8%
Variable rate:							
Debt	$ 61,300	$ 55,000	494,400	105,000	1,700,079	469,727	$2,885,506
Average interest rates	3.9%	3.9%	3.9%	4.0%	4.0%	2.7%	3.7%
Interest rate swaps:							
Notional amount	$1,000,000						$1,000,000
Average interest rates	1.3%						1.3%

As calculated based upon our variable rate debt outstanding as of December 31, 2018 that is subject to interest rate fluctuations, each 1% change in interest rates would impact our pre-tax income by approximately $19 million.

ITEM 8. *Financial Statements and Supplementary Data*

Our Consolidated Balance Sheets, Consolidated Statements of Income, Consolidated Statements of Changes in Equity, Consolidated Statements of Cash Flows and Consolidated Statements of Comprehensive Income, together with the reports of PricewaterhouseCoopers LLP, independent registered public accounting firm, are included elsewhere herein. Reference is made to the "Index to Financial Statements and Financial Statement Schedule."

ITEM 9. *Changes in and Disagreements with Accountants on Accounting and Financial Disclosure*

None.

ITEM 9A. *Controls and Procedures.*

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

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting or in other factors during the fourth quarter of 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Management's Report on Internal Control Over Financial Reporting

Management is responsible for establishing and maintaining an adequate system of internal control over our financial reporting. In order to evaluate the effectiveness of internal control over financial reporting, as required by Section 404 of the Sarbanes-Oxley Act, management has conducted an assessment, including testing, using the criteria on *Internal Control—Integrated Framework*

(2013), issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Our system of internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation and fair presentation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness of internal control over financial reporting to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Based on its assessment, management has concluded that we maintained effective internal control over financial reporting as of December 31, 2018, based on criteria in *Internal Control—Integrated Framework (2013)*, issued by the COSO. The effectiveness of the Company's internal control over financial reporting as of December 31, 2018 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm as stated in its report which appears herein.

ITEM 9B ***Other Information***

None.

PART III

ITEM 10. ***Directors, Executive Officers and Corporate Governance***

There is hereby incorporated by reference the information to appear under the captions "Election of Directors", "Section 16(a) Beneficial Ownership Reporting Compliance" and "Corporate Governance" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2018. See also "Executive Officers of the Registrant" appearing in Item 1 hereof.

ITEM 11. ***Executive Compensation***

There is hereby incorporated by reference the information to appear under the caption "Executive Compensation" in our Proxy Statement to be filed with the Securities and Exchange Commission within 120 days after December 31, 2018.

ITEM 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

There is hereby incorporated by reference the information to appear under the caption "Security Ownership of Certain Beneficial Owners and Management" and "Executive Compensation" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2018.

ITEM 13. ***Certain Relationships and Related Transactions, and Director Independence***

There is hereby incorporated by reference the information to appear under the captions "Certain Relationships and Related Transactions" and "Corporate Governance" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2018.

ITEM 14. ***Principal Accountant Fees and Services.***

There is hereby incorporated by reference the information to appear under the caption "Relationship with Independent Auditors" in our Proxy Statement, to be filed with the Securities and Exchange Commission within 120 days after December 31, 2018.

PART IV

ITEM 15. ***Exhibits and Financial Statement Schedules***

(a) Documents filed as part of this report:

(1) Financial Statements:

See "Index to Financial Statements and Financial Statement Schedule."

(2) Financial Statement Schedules:

See "Index to Financial Statements and Financial Statement Schedule."

(3) Exhibits:

No.	Description
3.1	Registrant's Restated Certificate of Incorporation, and Amendments thereto, previously filed as Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, are incorporated herein by reference (P).
3.2	Bylaws of Registrant, as amended, previously filed as Exhibit 3.2 to the Company's Annual Report on Form 10-K for the year ended December 31, 1987, is incorporated herein by reference (P).
3.3	Amendment to the Registrant's Restated Certificate of Incorporation previously filed as Exhibit 3.1 to the Company's Current Report on Form 8-K dated July 3, 2001 is incorporated herein by reference.
4.1	Indenture, dated as of August 7, 2014, among Universal Health Services, Inc., its subsidiaries specified therein, MUFG Union Bank, N.A., as Trustee, JPMorgan Chase Bank, N.A., as Collateral Agent (including forms of the 3.750% Senior Secured Notes due 2019 and the 4.750% Senior Secured Notes due 2022), previously filed as Exhibit 4.1 to the Company's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.
4.2	Supplemental Indenture, dated as of June 3, 2016, to Indenture, dated as of August 7, 2014, by and among the Company, the subsidiary guarantors party thereto, MUFG Union Bank, N.A., as trustee, and JPMorgan Chase Bank, N.A., as collateral agent, previously filed as Exhibit 4.1 to the Company's Current Report on Form 8-K dated June 8, 2016, is incorporated herein by reference.
4.3	Indenture, dated as of June 3, 2016, between the Company, the subsidiary guarantors party thereto, MUFG Union Bank, N.A., as trustee, and JPMorgan Chase Bank, N.A., as collateral agent, previously filed as Exhibit 4.2 to the Company's Current Report on Form 8-K dated June 8, 2016, is incorporated herein by reference.
4.4	Additional Authorized Representative Joinder Agreement, dated as of June 3, 2016, among the Company, the subsidiary guarantors party thereto and JPMorgan Chase Bank, N.A., as collateral agent, previously filed as Exhibit 4.3 to the Company's Current Report on Form 8-K dated June 8, 2016, is incorporated herein by reference.
10.1*	Employment Agreement, dated as of July 24, 2013, by and between Universal Health Services, Inc. and Alan B. Miller, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated July 26, 2013, is incorporated herein by reference.
10.2*	Amendment dated as of November 5, 2018 to the Employment Agreement, dated as July 24, 2013, by and between Universal Health Services, Inc. and Alan B. Miller, previously filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2018, is incorporated herein by reference.
10.3	Advisory Agreement dated as of December 24, 1986, and amended and restated effective as of January 1, 2019 between Universal Health Realty Income Trust and UHS of Delaware, Inc.
10.4	Form of Leases, including Form of Master Lease Document for Leases, between certain subsidiaries of the Company and Universal Health Realty Income Trust, filed as Exhibit 10.3 to Amendment No. 3 of the Registration Statement on Form S-11 and Form S-2 of Registrant and Universal Health Realty Income Trust (Registration No. 33-7872), is incorporated herein by reference (P).

No.	Description
10.5	Corporate Guaranty of Obligations of Subsidiaries Pursuant to Leases and Contract of Acquisition, dated December 24, 1986, issued by the Company in favor of Universal Health Realty Income Trust, previously filed as Exhibit 10.5 to the Company's Current Report on Form 8-K dated December 24, 1986, is incorporated herein by reference (P).
10.6	Universal Health Services, Inc. Executive Retirement Income Plan dated January 1, 1993, previously filed as Exhibit 10.7 to the Company's Annual Report on Form 10-K for the year ended December 31, 2002, is incorporated herein by reference.
10.7	Asset Purchase Agreement dated as of February 6, 1996, among Amarillo Hospital District, UHS of Amarillo, Inc. and Universal Health Services, Inc., previously filed as Exhibit 10.28 to the Company's Annual Report on Form 10-K for the year ended December 31, 1995, is incorporated herein by reference (P).
10.8	Agreement of Limited Partnership of District Hospital Partners, L.P. (a District of Columbia limited partnership) by and among UHS of D.C., Inc. and The George Washington University, previously filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarters ended March 30, 1997, and June 30, 1997, is incorporated herein by reference (P).
10.9	Contribution Agreement between The George Washington University (a congressionally chartered institution in the District of Columbia) and District Hospital Partners, L.P. (a District of Columbia limited partnership), previously filed as Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, is incorporated herein by reference (P).
10.10	Amended and Restated Universal Health Services, Inc. Supplemental Deferred Compensation Plan dated as of January 1, 2002, previously filed as Exhibit 10.29 to the Company's Annual Report on Form 10-K for the year ended December 31, 2002, is incorporated herein by reference.
10.11*	Universal Health Services, Inc. Employee Stock Purchase Plan, previously filed as Exhibit 4.1 to the Company's Registration Statement on Form S-8 (File No. 333-122188), dated January 21, 2005 is incorporated herein by reference.
10.12*	Universal Health Services, Inc. Third Amended and Restated 2005 Stock Incentive Plan as Amended, previously filed as Exhibit 99.1 to the Company's Registration Statement on Form S-8 (File No.333-218359), dated May 31, 2017, is incorporated herein by reference.
10.13*	Form of Stock Option Agreement, previously filed as Exhibit 10.4 to the Company's Current Report on Form 8-K, dated June 8, 2005, is incorporated herein by reference.
10.14*	Form of Stock Option Agreement for Non-Employee Directors, previously filed as Exhibit 10.2 to the Company's Current Report on Form 8-K, dated October 3, 2005, is incorporated herein by reference.
10.15	Amendment No. 1 to the Master Lease Document, between certain subsidiaries of Universal Health Services, Inc. and Universal Health Realty Income Trust, dated April 24, 2006, previously filed as Exhibit 10.29 to the Company's Annual Report on Form 10-K for the year ended December 31, 2006, is incorporated herein by reference.
10.16*	Amended and Restated Universal Health Services, Inc. 2010 Employees' Restricted Stock Purchase Plan, previously filed as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q filed on August 7, 2015, is incorporated herein by reference.
10.17*	Universal Health Services, Inc. 2010 Executive Incentive Plan, previously filed as Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q filed on August 7, 2015, is incorporated herein by reference.
10.18	Omnibus Amendment to Receivables Sale Agreements, dated as of October 27, 2010, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 2, 2010, is incorporated herein by reference.
10.19	Amended and Restated Credit and Security Agreement, dated as of October 27, 2010, previously filed as Exhibit 10.2 to the Company's Current Report on Form 8-K dated November 2, 2010, is incorporated herein by reference.
10.20	Second Amendment to Amended and Restated Credit and Security Agreement, dated as of October 25, 2013, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated October 30, 2013, is incorporated herein by reference.

No.	Description
10.21	Third Amendment to Amended and Restated Credit and Security Agreement, dated as of August 1, 2014, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated August 4, 2014, is incorporated herein by reference.
10.22	Fourth Amendment to Amended and Restated Credit and Security Agreement, dated as of December 22, 2015, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated December 22, 2015, is incorporated herein by reference.
10.23	Fifth Amendment to Amended and Restated Credit and Security Agreement, dated as of July 7, 2017, previously filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q filed on August 7, 2017, is incorporated herein by reference.
10.24	Sixth Amendment to Amended and Restated Credit and Security Agreement, dated as of April 26, 2018, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated April 27, 2018, is incorporated herein by reference.
10.25	Assignment and Assumption Agreement, dated as of October 27, 2010, previously filed as Exhibit 10.3 to the Company's Current Report on Form 8-K dated November 2, 2010, is incorporated herein by reference.
10.26	Credit Agreement, dated as of November 15, 2010, by and among Universal Health Services, Inc., JPMorgan Chase Bank, N.A. and the various financial institutions as are or may become parties thereto, as Lenders, SunTrust Bank, The Royal Bank of Scotland, Plc, Bank of Tokyo-Mitsubishi UFJ Trust Company and Credit Agricole Corporate and Investment Bank, as co-documentation agents, Deutsche Bank Securities Inc. and Bank of America N.A. as co-syndication agents, and JPMorgan Chase Bank, N.A., as administrative agent for the Lenders and as collateral agent for the secured parties, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 17, 2010, is incorporated herein by reference.
10.27	First Amendment, dated as of March 15, 2011, to the Credit Agreement, dated as of November 15, 2010, by and among Universal Health Services, Inc., JPMorgan Chase Bank, N.A. and the various financial institutions as are or may become parties thereto, as Lenders, certain banks as co-documentation agents, and as co-syndication agents, and JPMorgan Chase Bank, N.A., as administrative agent for the Lenders and as collateral agent for the secured parties, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated March 15, 2011, is incorporated herein by reference.
10.28	Credit Agreement, dated as of November 15, 2010 and amended and restated as of September 21, 2012, by and among Universal Health Services, Inc. (the borrower), the several lenders from time to time parties thereto, Credit Agricole Corporate and Investment Bank, Mizuho Corporate Bank LTD., Royal Bank of Canada and The Royal Bank of Scotland PLC (as co-documentation agents), Bank of Tokyo-Mitsubishi UFJ Trust Company, Bank of America N.A. and SunTrust Bank (as co-syndication agents), and JPMorgan Chase Bank, N.A. (as administrative agent), previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated September 26, 2012, is incorporated herein by reference.
10.29	Second Amendment, dated as of September 21, 2012, to the Credit Agreement, dated as of November 15, 2010 (as amended from time to time), among Universal Health Services, Inc., a Delaware corporation, the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.2 to the Company's Current Report on Form 8-K dated September 26, 2012, is incorporated herein by reference.
10.30	Third Amendment, dated as of May 16, 2013, to the Credit Agreement, dated as of November 15, 2010, as amended from time to time, among Universal Health Services, Inc., a Delaware corporation, the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated May 17, 2013, is incorporated herein by reference.
10.31	Fourth Amendment, dated as of August 7, 2014, to the Credit Agreement, dated as of November 15, 2010, as previously amended from time to time, by and among Universal Health Services, Inc., the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.

No.	Description
10.32	Fifth Amendment to the Credit Agreement, dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012, May 16, 2013 and August 7, 2014, among the Company, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders, JPMorgan Chase Bank, N.A., as administrative agent, and the other agents party thereto, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated June 8, 2016, is incorporated herein by reference.
10.33	Sixth Amendment, dated as of October 23, 2018, to the Credit Agreement, dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012, May 16, 2013, August 7, 2014 and June 7, 2016, among the Company, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders, JPMorgan Chase Bank, N.A., as administrative agent, and the other agents party thereto, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated October 24, 2018, is incorporated herein by reference.
10.34	Increased Facility Activation Notice – Incremental Term Loans, dated as of October 31, 2018, to the Credit Agreement, dated as of November 15, 2010, as amended on March 15, 2011, September 21, 2012, May 16, 2013, August 7, 2014, June 7, 2016 and October 23, 2018, among the Company, as borrower, the several banks and other financial institutions from time to time parties thereto, as lenders, JPMorgan Chase Bank, N.A., as administrative agent, and the other agents party thereto, previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 2, 2018, is incorporated herein by reference.
10.35	Credit Agreement, dated as of November 15, 2010 and amended and restated as of August 7, 2014, by and among Universal Health Services, Inc., the several banks and other financial institutions from time to time parties thereto, JPMorgan Chase Bank, N.A., as administrative agent and the other agents party thereto, previously filed as Exhibit 10.2 to the Company's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.
10.36*	Form of Supplemental Life Insurance Plan and Agreement Part A: Alan B. Miller 1998 Dual Life Insurance Trust (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), and Anthony Pantaleoni as Trustee), previously filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.
10.37*	Form of Supplemental Life Insurance Plan and Agreement Part B: Alan B. Miller 2002 Trust (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), and Anthony Pantaleoni as Trustee), previously filed as Exhibit 10.2 to the Company's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.
10.38*	Universal Health Services, Inc. Termination, Assignment and Release Agreement (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), Anthony Pantaleoni as Trustee of the Alan B. Miller 1998 Dual Life Insurance Trust, and Alan B. Miller, Executive), previously filed as Exhibit 10.3 to the Company's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.
10.39*	Universal Health Services, Inc. Termination, Assignment and Release Agreement (effective December 9, 2010, by and between Universal Health Services, Inc., a Delaware corporation (the "Company"), Anthony Pantaleoni as Trustee of the Alan B. Miller 2002 Trust, and Alan B. Miller, Executive), previously filed as Exhibit 10.4 to the Company's Current Report on Form 8-K dated December 10, 2010, is incorporated herein by reference.
10.40	Collateral Agreement, dated as of August 7, 2014, among Universal Health Services, Inc., the subsidiary guarantors party thereto, MUFG Union Bank, N.A., as 2014 Trustee, The Bank of New York Mellon Trust Company, N.A., as 2006 Trustee, and JPMorgan Chase Bank, N.A., as collateral agent, previously filed as Exhibit 10.4 to the Company's Current Report on Form 8-K dated August 12, 2014, is incorporated herein by reference.
11	Statement regarding computation of per share earnings is set forth in Note 1 of the Notes to the Consolidated Financial Statements.
21	Subsidiaries of Registrant.
23.1	Consent of Independent Registered Public Accounting Firm-PricewaterhouseCoopers LLP.
31.1	Certification from the Company's Chief Executive Officer Pursuant to Rule 13a-14(a)/15(d)-14(a) of the Securities Exchange Act of 1934.

No.	Description
31.2	Certification from the Company's Chief Financial Officer Pursuant to Rule 13a-14(a)/15(d)-14(a) of the Securities Exchange Act of 1934.
32.1	Certification from the Company's Chief Executive Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification from the Company's Chief Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	INS XBRL Instance Document
101	SCH XBRL Taxonomy Extension Schema Document
101	CAL XBRL Taxonomy Extension Calculation Linkbase Document
101	DEF XBRL Taxonomy Extension Definition Linkbase Document
101	LAB XBRL Taxonomy Extension Label Linkbase Document
101	PRE XBRL Taxonomy Extension Presentation Linkbase Document

* Management contract or compensatory plan or arrangement.

Exhibits, other than those incorporated by reference, have been included in copies of this Annual Report filed with the Securities and Exchange Commission. Stockholders of the Company will be provided with copies of those exhibits upon written request to the Company.

ITEM 16. ***Form 10-K Summary***

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

UNIVERSAL HEALTH SERVICES, INC.

By: /s/ ALAN B. MILLER
Alan B. Miller
Chairman of the Board
and Chief Executive Officer

February 27, 2019

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Signatures	Title	Date
/s/ ALAN B. MILLER **Alan B. Miller**	Chairman of the Board and Chief Executive Officer (Principal Executive Officer)	February 27, 2019
/s/ MARC D. MILLER **Marc D. Miller**	Director and President	February 27, 2019
/s/ LAWRENCE S. GIBBS **Lawrence S. Gibbs**	Director	February 27, 2019
/s/ ROBERT H. HOTZ **Robert H. Hotz**	Director	February 27, 2019
/s/ EILEEN C. MCDONNELL **Eileen C. McDonnell**	Director	February 27, 2019
/s/ WARREN J. NIMETZ **Warren J. Nimetz**	Director	February 27, 2019
/s/ ELLIOTT J. SUSSMAN M.D. **Elliot J. Sussman M.D.**	Director	February 27, 2019
/s/ STEVE FILTON **Steve Filton**	Executive Vice President, Chief Financial Officer and Secretary (Principal Financial and Accounting Officer)	February 27, 2019

UNIVERSAL HEALTH SERVICES, INC.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of Universal Health Services, Inc.:

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the consolidated financial statements, including the related notes and financial statement schedule, of Universal Health Services, Inc. and its subsidiaries (the "Company") as listed in the accompanying index (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
Philadelphia, Pennsylvania
February 27, 2019

We have served as the Company's auditor since 2007.

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2018	**2017**	**2016**
	(in thousands, except per share data)		
Net revenues before provision for doubtful accounts		$ 11,278,942	$ 10,507,788
Less: Provision for doubtful accounts		869,077	741,578
Net revenues	10,772,278	10,409,865	9,766,210
Operating charges:			
Salaries, wages and benefits	5,254,536	4,980,637	4,585,530
Other operating expenses	2,614,687	2,493,062	2,359,339
Supplies expense	1,168,654	1,105,096	1,031,337
Depreciation and amortization	453,045	447,765	416,608
Lease and rental expense	106,094	103,127	97,324
Electronic health records incentive income	0	0	(5,339)
	9,597,016	9,129,687	8,484,799
Income from operations	1,175,262	1,280,178	1,281,411
Interest expense, net	154,956	145,169	125,053
Other (income) expense, net	(14,219)	0	0
Income before income taxes	1,034,525	1,135,009	1,156,358
Provision for income taxes	236,642	363,697	409,187
Net income	797,883	771,312	747,171
Less: Net income attributable to noncontrolling interests	18,178	19,009	44,762
Net income attributable to UHS	$ 779,705	$ 752,303	$ 702,409
Basic earnings per share attributable to UHS	$ 8.35	$ 7.86	$ 7.22
Diluted earnings per share attributable to UHS	$ 8.31	$ 7.81	$ 7.14
Weighted average number of common shares—basic	93,276	95,652	97,208
Add: Other share equivalents	474	673	1,172
Weighted average number of common shares and equivalents—diluted	93,750	96,325	98,380

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2018	2017	2016
Net income	$ 797,883	$ 771,312	$ 747,171
Other comprehensive income (loss):			
Unrealized derivative gains on cash flow hedges	(2,805)	6,679	1,438
Amortization of terminated hedge	0	0	(167)
Minimum pension liability	(6,892)	4,070	13,356
Foreign currency translation adjustment	9,718	(2,169)	(2,229)
Other	4,398	26,678	(10,038)
Other comprehensive income before tax	4,419	35,258	2,360
Income tax expense related to items of other comprehensive income	8,905	2,664	4,648
Total other comprehensive income (loss), net of tax	(4,486)	32,594	(2,288)
Comprehensive income	793,397	803,906	744,883
Less: Comprehensive income attributable to noncontrolling interests	18,178	19,009	44,762
Comprehensive income attributable to UHS	$ 775,219	$ 784,897	$ 700,121

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS

	December 31, 2018	December 31, 2017
	(Dollar amounts in thousands)	
Assets		
Current assets:		
Cash and cash equivalents	$ 105,220	$ 74,423
Accounts receivable, net	1,509,909	1,500,898
Supplies	148,206	136,177
Other current assets	174,467	86,504
Total current assets	1,937,802	1,798,002
Property and Equipment		
Land	565,607	520,447
Buildings and improvements	5,387,646	4,952,856
Equipment	2,251,822	2,000,305
Property under capital lease	44,020	44,740
	8,249,095	7,518,348
Accumulated depreciation	(3,715,515)	(3,349,289)
	4,533,580	4,169,059
Construction-in-progress	314,360	402,778
	4,847,940	4,571,837
Other assets:		
Goodwill	3,844,628	3,825,157
Deferred income taxes	5,280	3,007
Deferred charges	8,772	9,787
Other	621,058	554,038
	4,479,738	4,391,989
Total Assets	$ 11,265,480	$ 10,761,828
Liabilities and Stockholders' Equity		
Current liabilities:		
Current maturities of long-term debt	$ 63,446	$ 545,619
Accounts payable	445,652	441,984
Accrued liabilities		
Compensation and related benefits	343,384	304,668
Interest	19,277	23,755
Taxes other than income	56,218	85,800
Legal reserves	129,150	38,555
Other	389,183	389,319
Current federal and state income taxes	2,428	18,334
Total current liabilities	1,448,738	1,848,034
Other noncurrent liabilities	361,809	306,304
Long-term debt	3,935,187	3,494,390
Deferred income taxes	49,661	54,962
Commitments and contingencies (Note 8)		
Redeemable noncontrolling interest	4,292	6,702
Equity:		
Class A Common Stock, voting, $.01 par value; authorized 12,000,000 shares: issued and outstanding 6,577,100 shares in 2018 and 6,595,308 shares in 2017	66	66
Class B Common Stock, limited voting, $.01 par value; authorized 150,000,000 shares: issued and outstanding 84,092,304 shares in 2018 and 86,947,407 shares in 2017	841	869
Class C Common Stock, voting, $.01 par value; authorized 1,200,000 shares: issued and outstanding 661,688 shares in 2018 and 663,940 shares in 2017	7	7
Class D Common Stock, limited voting, $.01 par value; authorized 5,000,000 shares: issued and outstanding 18,653 shares in 2018 and 20,868 shares in 2017	0	0
Cumulative dividends	(409,156)	(371,814)
Retained earnings	5,793,262	5,353,209
Accumulated other comprehensive income	4,242	7,177
Universal Health Services, Inc. common stockholders' equity	5,389,262	4,989,514
Noncontrolling interest	76,531	61,922
Total Equity	5,465,793	5,051,436
Total Liabilities and Stockholders' Equity	$ 11,265,480	$ 10,761,828

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
For the Years Ended December 31, 2018, 2017 and 2016
(in thousands)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Balance, January 1, 2016	$ 242,509	$ 66	$ 910	$ 7	$ 0	$ (294,728)	$4,566,521	$ (23,129)	$ 4,249,647	$ 59,514	$4,309,161
Common Stock											
Issued/(converted) including tax benefits from exercise of stock options	—	—	13	—	—	—	54,840	—	54,853	—	54,853
Repurchased	—	—	(30)	—	—	—	(346,860)	—	(346,890)	—	(346,890)
Restricted share-based compensation expense	—	—	—	—	—	—	1,439	—	1,439	—	1,439
Dividends paid	—	—	—	—	—	(38,875)	—	—	(38,875)	—	(38,875)
Stock option expense	—	—	—	—	—	—	45,777	—	45,777	—	45,777
Distributions to noncontrolling interests	(51,847)	—	—	—	—	—	—	—	—	(17,735)	(17,735)
Acquisition of noncontrolling interests in majority owned businesses	(206,200)	—	—	—	—	—	(132,852)	—	(132,852)	—	(132,852)
Other	—	—	—	—	—	—	—	—	—	2,690	2,690
Comprehensive income:											
Net income to UHS / noncontrolling interests	24,857	—	—	—	—	—	702,409	—	702,409	19,905	722,314
Foreign currency translation adjustments	—	—	—	—	—	—	—	(10,038)	(10,038)	—	(10,038)
Amortization of terminated hedge (net of income tax effect of $60)	—	—	—	—	—	—	—	(107)	(107)	—	(107)
Unrealized loss on marketable security (net of income tax effect of $831)	—	—	—	—	—	—	—	(1,398)	(1,398)	—	(1,398)
Unrealized derivative gains on cash flow hedges (net of income tax effect of $536)	—	—	—	—	—	—	—	902	902	—	902
Minimum pension liability (net of income tax effect of $5,003)	—	—	—	—	—	—	—	8,353	8,353	—	8,353
Subtotal - comprehensive income	24,857	—	—	—	—	—	702,409	(2,288)	700,121	19,905	720,026
Balance, December 31, 2016	$ 9,319	$ 66	$ 893	$ 7	$ —	$ (333,603)	$4,891,274	$ (25,417)	$ 4,533,220	$ 64,374	$4,597,594

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY—(Continued)
For the Years Ended December 31, 2018, 2017 and 2016
(in thousands)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Common Stock											
Issued/(converted) including tax benefits from exercise of stock options	—	—	9	—	—	—	10,370	—	10,379	—	10,379
Repurchased	—	—	(33)	—	—	—	(356,380)	—	(356,413)	—	(356,413)
Restricted share-based compensation expense	—	—	—	—	—	—	1,377	—	1,377	—	1,377
Dividends paid	—	—	—	—	—	(38,211)	—	—	(38,211)	—	(38,211)
Stock option expense	—	—	—	—	—	—	54,265	—	54,265	—	54,265
Distributions to noncontrolling interests	(1,781)	—	—	—	—	—	—	—	—	(22,932)	(22,932)
Other	—	—	—	—	—	—	—	—	—	635	635
Comprehensive income:											
Net income to UHS / noncontrolling interests	(836)	—	—	—	—	—	752,303	—	752,303	19,845	772,148
Foreign currency translation adjustments	—	—	—	—	—	—	—	26,678	26,678	—	26,678
Unrealized loss on marketable security (net of income tax effect of $809)	—	—	—	—	—	—	—	(1,360)	(1,360)	—	(1,360)
Unrealized derivative gains on cash flow hedges (net of income tax effect of $2,490)	—	—	—	—	—	—	—	4,189	4,189	—	4,189
Minimum pension liability (net of income tax effect of $983)	—	—	—	—	—	—	—	3,087	3,087	—	3,087
Subtotal - comprehensive income	(836)	—	—	—	—	—	752,303	32,594	784,897	19,845	804,742
Balance, December 31, 2017	$ 6,702	$ 66	$ 869	$ 7	$ —	$ (371,814)	$5,353,209	$ 7,177	$ 4,989,514	$ 61,922	$5,051,436

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY—(Continued)
For the Years Ended December 31, 2018, 2017 and 2016
(in thousands)

	Redeemable Noncontrolling Interest	Class A Common	Class B Common	Class C Common	Class D Common	Cumulative Dividends	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	UHS Common Stockholders' Equity	Noncontrolling Interest	Total
Cumulative-effect adjustment due to adoption of ASU 2016-01 (net of income tax effect of $1,045)							(3,353)	3,353	—		—
Common Stock											
Issued/(converted) including tax benefits from exercise of stock options	—	—	6	—	—	—	11,882	—	11,888	—	11,888
Repurchased	—	—	(34)	—	—	—	(413,968)	—	(414,002)	—	(414,002)
Restricted share-based compensation expense	—	—	—	—	—	—	2,924	—	2,924	—	2,924
Dividends paid	—	—	—	—	—	(37,342)	—	—	(37,342)	—	(37,342)
Stock option expense	—	—	—	—	—	—	61,061	—	61,061	—	61,061
Distributions to noncontrolling interests	(2,500)	—	—	—	—	—	—	—	—	(12,095)	(12,095)
Other	—	—	—	—	—	—	—	—	—	8,616	8,616
Comprehensive income:											
Net income to UHS / noncontrolling interests	90	—	—	—	—	—	779,705	—	779,705	18,088	797,793
Reclassification due to adoption of ASU 2018-02	—	—	—	—	—	—	1,802	(1,802)	—		
Foreign currency translation adjustments (net of income tax effect of $6,824)	—	—	—	—	—	—	—	2,894	2,894	—	2,894
Unrealized derivative gains on cash flow hedges (net of income tax effect of $667)	—	—	—	—	—	—	—	(2,138)	(2,138)	—	(2,138)
Minimum pension liability (net of income tax effect of $1,650)	—	—	—	—	—	—	—	(5,242)	(5,242)	—	(5,242)
Subtotal - comprehensive income	90	—	—	—	—	—	778,154	(2,935)	775,219	18,088	793,307
Balance, December 31, 2018	$ 4,292	$ 66	$ 841	$ 7	$ 0	$ (409,156)	$ 5,793,262	$ 4,242	$ 5,389,262	$ 76,531	$ 5,465,793

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

UNIVERSAL HEALTH SERVICES, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2018	2017	2016
	(Amounts in thousands)		
Cash Flows from Operating Activities:			
Net income	$ 797,883	$ 771,312	$ 747,171
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation & amortization	453,076	447,883	416,608
Gains on sales of assets and businesses, net of losses	(2,513)	0	0
Stock-based compensation expense	66,581	56,738	48,109
Costs related to extinguishment of debt	2,727	0	0
Provision for intangible asset impairment	49,310	0	0
Changes in assets & liabilities, net of effects from acquisitions and dispositions:			
Accounts receivable	(42,239)	(24,719)	(87,881)
Accrued interest	(4,478)	705	9,766
Accrued and deferred income taxes	(54,052)	(6,405)	22,068
Other working capital accounts	24,696	(15,165)	74,489
Other assets and deferred charges	(31,429)	(27,936)	(25,522)
Other	64,615	(42,564)	81,139
Excess income tax benefits related to stock-based compensation	0	0	45,219
Accrued insurance expense, net of commercial premiums paid	92,863	102,595	84,638
Payments made in settlement of self-insurance claims	(76,147)	(79,192)	(81,962)
Net cash provided by operating activities	1,340,893	1,183,252	1,333,842
Cash Flows from Investing Activities:			
Property and equipment additions, net of disposals	(664,962)	(557,506)	(519,939)
Acquisition of property and businesses	(110,464)	(22,878)	(613,803)
Proceeds received from sales of assets and businesses	13,502	108	0
Costs incurred for purchase and implementation of information technology applications	(36,243)	(29,047)	(21,475)
Decrease (Increase) in capital reserves of commercial insurance subsidiary	100	(3,100)	0
Investment in and advances to joint venture	(15,331)	(7,976)	0
Net cash used in investing activities	(813,398)	(620,399)	(1,155,217)
Cash Flows from Financing Activities:			
Reduction of long-term debt	(830,496)	(143,106)	(459,183)
Additional borrowings	791,247	41,100	1,170,800
Acquisition of noncontrolling interests in majority owned businesses	0	0	(418,000)
Financing costs	(13,787)	(76)	(12,449)
Repurchase of common shares	(397,425)	(364,401)	(353,380)
Dividends paid	(37,342)	(38,211)	(38,875)
Issuance of common stock	10,196	10,254	9,503
Profit distributions to noncontrolling interests	(14,595)	(24,713)	(69,583)
Net cash used in financing activities	(492,202)	(519,153)	(171,167)
Effect of exchange rate changes on cash and cash equivalents	(2,905)	1,647	(2,790)
Increase in cash and cash equivalents	32,388	45,347	4,668
Cash, cash equivalents and restricted cash, beginning of period	167,297	121,950	117,282
Cash, cash equivalents and restricted cash, end of period	$ 199,685	$ 167,297	$ 121,950
Supplemental Disclosures of Cash Flow Information:			
Interest paid	$ 150,293	$ 135,533	$ 107,079
Income taxes paid, net of refunds	$ 293,837	$ 370,855	$ 344,611
Noncash purchases of property and equipment	$ 77,674	$ 82,496	$ 65,702

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

1) BUSINESS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

The more significant accounting policies follow:

A) Principles of Consolidation: The consolidated financial statements include the accounts of our majority-owned subsidiaries and partnerships controlled by us or our subsidiaries as the managing general partner. All intercompany accounts and transactions have been eliminated.

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

See Note 10-*Revenue Recognition*, for additional disclosure related to our revenues including a disaggregation of our consolidated net revenues by major source for each of the periods presented herein.

We report net patient service revenue at the estimated net realizable amounts from patients and third-party payers and others for services rendered. We have agreements with third-party payers that provide for payments to us at amounts different from our established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Estimates of contractual allowances, which represent explicit price concessions under ASC 606, under managed care plans are based upon the payment terms specified in the related contractual agreements. We closely monitor our historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payers may be different from the amounts we estimate and record..

We estimate our Medicare and Medicaid revenues using the latest available financial information, patient utilization data, government provided data and in accordance with applicable Medicare and Medicaid payment rules and regulations. The laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation and as a result, there is at least a reasonable possibility that recorded estimates will change by material amounts in the near term. Certain types of payments by the Medicare program and state Medicaid programs (e.g. Medicare Disproportionate Share Hospital, Medicare Allowable Bad Debts and Inpatient Psychiatric Services) are subject to retroactive adjustment in future periods as a result of administrative review and audit and our estimates may vary from the final settlements. Such amounts are included in accounts receivable, net, on our Consolidated Balance Sheets. The funding of both federal Medicare and state Medicaid programs are subject to legislative and regulatory changes. As such, we cannot provide any assurance that future legislation and regulations, if enacted, will not have a material impact on our future Medicare and Medicaid reimbursements. Adjustments related to the final settlement of these retrospectively determined amounts did not materially impact our results in 2018, 2017 or 2016. If it were to occur, each 1% adjustment to our estimated net Medicare revenues that are subject to retrospective review and settlement as of December 31, 2018, would change our after-tax net income by approximately $1 million.

C) Charity Care, Uninsured Discounts and Other Adjustments to Revenue: Collection of receivables from third-party payers and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. We estimate

our revenue adjustments for implicit price concessions based on general factors such as payer mix, the agings of the receivables and historical collection experience, consistent with our estimates for provision for doubtful accounts under ASC 605. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts and make adjustments to our allowances as warranted. At our acute care hospitals, third party liability accounts are pursued until all payment and adjustments are posted to the patient account. For those accounts with a patient balance after third party liability is finalized or accounts for uninsured patients, the patient receives statements and collection letters.

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

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

A portion of the accounts receivable at our acute care facilities are comprised of Medicaid accounts that are pending approval from third-party payers but we also have smaller amounts due from other miscellaneous payers such as county indigent programs in certain states. Our patient registration process includes an interview of the patient or the patient's responsible party at the time of registration. At that time, an insurance eligibility determination is made and an insurance plan code is assigned. There are various pre-established insurance profiles in our patient accounting system which determine the expected insurance reimbursement for each patient based on the insurance plan code assigned and the services rendered. Certain patients may be classified as Medicaid pending at registration based upon a screening evaluation if we are unable to definitively determine if they are currently Medicaid eligible. When a patient is registered as Medicaid eligible or Medicaid pending, our patient accounting system records net revenues for services provided to that patient based upon the established Medicaid reimbursement rates, subject to the ultimate disposition of the patient's Medicaid eligibility. When the patient's ultimate eligibility is determined, reclassifications may occur which impacts net revenues in future periods. Although the patient's ultimate eligibility determination may result in adjustments to net revenues, these adjustments do not have a material impact on our results of operations in 2018, 2017 or 2016 since our facilities make estimates at each financial reporting period to adjust revenue based on historical collections. Under ASC 605, these estimates were reported in the provision for doubtful accounts.

We also provide discounts to uninsured patients (included in "uninsured discounts" amounts below) who do not qualify for Medicaid or charity care. Because we do not pursue collection of amounts classified as uninsured discounts, the transaction price is fully adjusted and there is no impact in our net revenues or in our net accounts receivable. In implementing the discount policy, we first attempt to qualify uninsured patients for governmental programs, charity care or any other discount program. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Uncompensated care (charity care and uninsured discounts):

The following table shows the amounts recorded at our acute care hospitals for charity care and uninsured discounts, based on charges at established rates, for the years ended December 31, 2018, 2017 and 2016:

	(dollar amounts in thousands)					
	2018		2017		2016	
	Amount	%	Amount	%	Amount	%
Charity care	$ 761,783	40%	$ 887,136	50%	$ 733,585	50%
Uninsured discounts	1,132,811	60%	881,265	50%	720,205	50%
Total uncompensated care	$1,894,594	100%	$1,768,401	100%	$1,453,790	100%

The estimated cost of providing uncompensated care:

The estimated cost of providing uncompensated care, as reflected below, were based on a calculation which multiplied the percentage of operating expenses for our acute care hospitals to gross charges for those hospitals by the above-mentioned total uncompensated care amounts. The percentage of cost to gross charges is calculated based on the total operating expenses for our acute care facilities divided by gross patient service revenue for those facilities. An increase in the level of uninsured patients to our facilities and the resulting adverse trends in the adjustments to net revenues and uncompensated care provided could have a material unfavorable impact on our future operating results.

	(amounts in thousands)		
	2018	**2017**	**2016**
Estimated cost of providing charity care	$ 94,088	$ 120,208	$ 107,887
Estimated cost of providing uninsured discounts related care	139,913	119,412	105,920
Estimated cost of providing uncompensated care	$ 234,001	$ 239,620	$ 213,807

Our accounts receivable as of December 31, 2018 and December 31, 2017 include amounts due from Illinois of approximately $32 million and $25 million, respectively. Collection of the outstanding receivables continues to be delayed due to state budgetary and funding pressures. Approximately $18 million as of December 31, 2018 and $8 million as of December 31, 2017, of the receivables due from Illinois were outstanding in excess of 60 days, as of each respective date. Although the accounts receivable due from Illinois could remain outstanding for the foreseeable future, since we expect to eventually collect all amounts due to us, no related reserves have been established in our consolidated financial statements. However, we can provide no assurance that we will eventually collect all amounts due to us from Illinois. Failure to ultimately collect all outstanding amounts due to us from Illinois would have an adverse impact on our future consolidated results of operations and cash flows.

D) Concentration of Revenues: Our six acute care hospitals in the Las Vegas, Nevada market contributed, on a combined basis, 15% in 2018, 15% in 2017 and 14% in 2016 of our consolidated net revenues.

E) Cash, Cash Equivalents and Restricted Cash: We consider all highly liquid investments purchased with maturities of three months or less to be cash equivalents.

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

	(amounts in thousands)		
	2018	**2017**	**2016**
Cash and cash equivalents	$ 105,220	$ 74,423	$ 33,747
Restricted cash (a)	94,465	92,874	88,203
Total cash, cash equivalents and restricted cash	$ 199,685	$ 167,297	$ 121,950

(a) Restricted cash is included in other assets on the accompanying consolidated balance sheet and consists of statutorily required capital reserves related to our commercial insurance subsidiary.

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

F) Property and Equipment: Property and equipment are stated at cost. Expenditures for renewals and improvements are charged to the property accounts. Replacements, maintenance and repairs which do not improve or extend the life of the respective asset are expensed as incurred. We remove the cost and the related accumulated depreciation from the accounts for assets sold or retired and the resulting gains or losses are included in the results of operations. Construction-in-progress includes both construction projects and equipment not yet placed into service.

While in progress, we capitalized interest on major construction projects and the development and implementation of information technology applications amounting to $2.3 million during 2018, $1.0 million during 2017 and $1.9 million during 2016.

Depreciation is provided on the straight-line method over the estimated useful lives of buildings and improvements (twenty to forty years) and equipment (three to fifteen years). Depreciation expense was $410.0 million during 2018, $388.4 million during 2017 and $350.8 million during 2016.

G) Long-Lived Assets: We review our long-lived assets, including intangible assets, for impairment whenever events or circumstances indicate that the carrying value of these assets may not be recoverable. The assessment of possible impairment is based on our ability to recover the carrying value of our asset based on our estimate of its undiscounted future cash flow. If the analysis indicates that the carrying value is not recoverable from future cash flows, the asset is written down to its estimated fair value and an impairment loss is recognized. Fair values are determined based on estimated future cash flows using appropriate discount rates.

H) Goodwill: Goodwill is reviewed for impairment at the reporting unit level on an annual basis or sooner if the indicators of impairment arise. Our judgments regarding the existence of impairment indicators are based on market conditions and operational performance of each reporting unit. We have designated October 1st as our annual impairment assessment date and performed quantitative impairment assessments as of October 1, 2018 which indicated no impairment of goodwill. There were also no goodwill impairments during 2017 or 2016. Future changes in the estimates used to conduct the impairment reviews, including profitability and market value projections, could indicate impairment in future periods potentially resulting in a write-off of a portion or all of our goodwill.

Changes in the carrying amount of goodwill for the two years ended December 31, 2018 were as follows (in thousands):

	Acute Care Services	Behavioral Health Services	Total Consolidated
Balance, January 1, 2017	$ 440,294	$ 3,343,812	$ 3,784,106
Goodwill acquired during the period	80	0	80
Adjustments to goodwill (a)	1,137	39,834	40,971
Balance, December 31, 2017	441,511	3,383,646	3,825,157
Goodwill acquired during the period	917	44,173	45,090
Goodwill divested during the period	0	(2,135)	(2,135)
Adjustments to goodwill (a)	34	(23,518)	(23,484)
Balance, December 31, 2018	$ 442,462	$ 3,402,166	$ 3,844,628

(a) The increase/(decrease) in the Behavioral Health Services' goodwill consists primarily of foreign currency translation adjustments.

I) Other Assets and Intangible Assets: Other assets consist primarily of amounts related to: (i) intangible assets acquired in connection with our acquisitions of Cambian Group, PLC's adult services' division, Foundations Recovery Network, L.L.C. ("Foundations") during 2015, Ascend Health Corporation during 2012 and Psychiatric Solutions, Inc. during 2010; (ii) prepaid fees for various software and other applications used by our hospitals; (iii) costs incurred in connection with the purchase and implementation of an electronic health records application for each of our acute care facilities; (iv) statutorily required capital reserves related to our commercial insurance subsidiary ($112 million as of December 31, 2018); (v) deposits; (vi) investments in various businesses, including Universal Health Realty Income Trust ($8 million as of December 31, 2018) and Premier, Inc. ($56 million as of December 31, 2018); (vii) the invested assets related to a deferred compensation plan that is held by an independent trustee in a rabbi-trust and that has a related payable included in other noncurrent liabilities; (viii) the estimated future payments related to physician-related contractual commitments, as discussed below, and; (ix) other miscellaneous assets.

Intangible assets are reviewed for impairment on an annual basis or sooner if the indicators of impairment arise. Our judgments regarding the existence of impairment indicators are based on market conditions and operational performance of each asset. We have designated October 1st as our annual impairment assessment date and performed impairment assessments as of October 1, 2018 which indicated an impairment to the Foundations tradename intangible asset, as discussed below. There were no impairments during 2017 or 2016.

During 2018, we recorded a pre-tax $49 million provision for asset impairment to reduce the carrying value of a tradename intangible asset to approximately $75 million from approximately $124 million as previously recorded in connection with our 2015 acquisition of Foundations. The intangible asset impairment charge, which is included in other operating expenses in our 2018 consolidated statements of income, was recorded after evaluation of the estimated fair value of the Foundations' tradename for its existing facilities, consisting of 4 inpatient and 12 outpatient facilities as of December 31, 2018, as well as estimated planned de novos. This asset impairment charge was impacted by the following: (i) the lost future revenue and cash flows resulting from the permanent closure of a Foundations' inpatient facility located in Malibu, California that was severely damaged in the California wildfires during the fourth quarter of 2018; (ii) reduction in growth rates of projected future patient volumes, revenues and operating cash flows based upon pressures on reimbursement rates experienced from certain payers and competitive pressures experienced in certain markets, and; (iii) revisions made to the number and timing of planned de novo facilities.

The following table shows the amounts recorded as net intangible assets for the years ended December 31, 2018 and 2017:

	(amounts in millions)	
	2018	**2017**
Foundations tradename	$ 75	$ 124
Medicare licenses	57	57
Certificates of need	21	12
Contract relationships and other (net of $49 and $44 of accumulated amortization for 2018 and 2017, respectively)	20	27
Net Intangible Assets	$ 173	$ 220

J) Physician Guarantees and Commitments: Our accrued liabilities-other, and our other assets included approximately $2 million of estimated future payments related to physician-related contractual commitments as of each of December 31, 2018 and 2017. Substantially all of the $2 million of potential future financial obligations outstanding as of December 31, 2018 are potential 2019 obligations.

K) Self-Insured/Other Insurance Risks: We provide for self-insured risks, primarily general and professional liability claims and workers' compensation claims. Our estimated liability for self-insured professional and general liability claims is based on a number of factors including, among other things, the number of asserted claims and reported incidents, estimates of losses for these claims based on recent and historical settlement amounts, estimate of incurred but not reported claims based on historical experience, and estimates of amounts recoverable under our commercial insurance policies. All relevant information, including our own historical experience is used in estimating the expected amount of claims. While we continuously monitor these factors, our ultimate liability for professional and general liability claims could change materially from our current estimates due to inherent uncertainties involved in making this estimate. Our estimated self-insured reserves are reviewed and changed, if necessary, at each reporting date and changes are recognized currently as additional expense or as a reduction of expense. See Note 8 - *Commitments and Contingencies* for discussion of adjustments to our prior year reserves for claims related to our self-insured general and professional liability and workers' compensation liability.

In addition, we also: (i) own commercial health insurers headquartered in Nevada and Puerto Rico, and; (ii) maintain self-insured employee benefits programs for employee healthcare and dental claims. The ultimate costs related to these programs/operations include expenses for claims incurred and paid in addition to an accrual for the estimated expenses incurred in connection with claims incurred but not yet reported. Given our significant insurance-related exposure, there can be no assurance that a sharp increase in the number and/or severity of claims asserted against us will not have a material adverse effect on our future results of operations.

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

We operate in multiple jurisdictions with varying tax laws. We are subject to audits by any of these taxing authorities. Our tax returns have been examined by the Internal Revenue Service ("IRS") through the year ended December 31, 2006. We believe that adequate accruals have been provided for federal, foreign and state taxes. See Note 6 - *Income Taxes,* for additional disclosure.

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

N) Redeemable Noncontrolling Interests and Noncontrolling Interest: As of December 31, 2018, outside owners held noncontrolling, minority ownership interests of: (i) 20% in an acute care facility located in Washington, D.C.; (ii) approximately 11% in an acute care facility located in Texas; (iii) 20% and 30% in two behavioral health care facilities located in Pennsylvania and Ohio, respectively; (iv) approximately 5% in an acute care facility located in Nevada and; (v) approximately 20% in a newly constructed behavioral health care facility located in Spokane, Washington which was completed and opened in October, 2018. The noncontrolling interest and redeemable noncontrolling interest balances of $77 million and $4 million, respectively, as of December 31, 2018, consist primarily of the third-party ownership interests in these hospitals.

In May, 2016, we purchased the minority ownership interests held by a third-party in our six acute care hospitals located in Las Vegas, Nevada, for an aggregate cash payment of $445 million which included both the purchase price ($418 million) and the return of reserve capital ($27 million). The ownership interests purchased ranged from 26.1% to 27.5%.

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

O) Accumulated Other Comprehensive Income: The accumulated other comprehensive income ("AOCI") component of stockholders' equity includes: net unrealized gains and losses on effective cash flow hedges, foreign currency translation adjustments and the net minimum pension liability of a non-contributory defined benefit pension plan which covers employees at one of our subsidiaries. See Note 11 - *Pension Plan* for additional disclosure regarding the defined benefit pension plan.

The amounts recognized in AOCI for the two years ended December 31, 2018 were as follows (in thousands):

	Net Unrealized Gains (Losses) on Effective Cash Flow Hedges	Foreign Currency Translation Adjustment	Unrealized loss on marketable security	Minimum Pension Liability	Total AOCI
Balance, January 1, 2017, net of income tax	$ 19	$ (14,197)	$ (1,398)	$ (9,841)	$ (25,417)
2017 activity:					
Pretax amount	6,679	26,678	(2,169)	4,070	35,258
Income tax effect	(2,490)	—	809	(983)	(2,664)
Change, net of income tax	4,189	26,678	(1,360)	3,087	32,594
Balance, January 1, 2018, net of income tax	4,208	12,481	(2,758)	(6,754)	7,177
2018 activity:					
Pretax amount	(2,805)	9,718	4,398	(6,892)	4,419
Income tax effect, net of adoption of ASU 2018-02	1,577	(6,824)	(1,640)	(467)	(7,354)
Change, net of income tax	(1,228)	2,894	2,758	(7,359)	(2,935)
Balance, December 31, 2018, net of income tax	$ 2,980	$ 15,375	$ —	$ (14,113)	$ 4,242

P) Accounting for Derivative Financial Investments and Hedging Activities and Foreign Currency Forward Exchange Contracts: We manage our ratio of fixed to floating rate debt with the objective of achieving a mix that management believes is appropriate. To manage this risk in a cost-effective manner, we, from time to time, enter into interest rate swap agreements in which we agree to exchange various combinations of fixed and/or variable interest rates based on agreed upon notional amounts.

We account for our derivative and hedging activities using the Financial Accounting Standard Board's ("FASB") guidance which requires all derivative instruments, including certain derivative instruments embedded in other contracts, to be carried at fair value on the balance sheet. For derivative transactions designated as hedges, we formally document all relationships between the hedging instrument and the related hedged item, as well as its risk-management objective and strategy for undertaking each hedge transaction.

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

We use interest rate derivatives in our cash flow hedge transactions. Such derivatives are designed to be highly effective in offsetting changes in the cash flows related to the hedged liability. For derivative instruments designated as cash flow hedges, the ineffective portion of the change in expected cash flows of the hedged item are recognized currently in the income statement.

Derivative instruments designated in a hedge relationship to mitigate exposure to changes in the fair value of an asset, liability, or firm commitment attributable to a particular risk, such as interest rate risk, are considered fair value hedges. Fair value hedges are accounted for by recording the changes in the fair value of both the derivative instrument and the hedged item in the income statement.

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

We use forward exchange contracts to hedge our net investment in foreign operations against movements in exchange rates. The effective portion of the unrealized gains or losses on these contracts is recorded in foreign currency translation adjustment within accumulated other comprehensive income and remains there until either the sale or liquidation of the subsidiary. The cash flows from these contracts are reported as operating activities in the Consolidated Statements of Cash Flows.

Q) Stock-Based Compensation: At December 31, 2018, we have a number of stock-based employee compensation plans. Pursuant to the FASB's guidance, we expense the grant-date fair value of stock options and other equity-based compensation pursuant to the straight-line method over the stated vesting period of the award using the Black-Scholes option-pricing model.
The expense associated with share-based compensation arrangements is a non-cash charge. In the Consolidated Statements of Cash Flows, share-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities.

R) Earnings per Share: Basic earnings per share are based on the weighted average number of common shares outstanding during the year. Diluted earnings per share are based on the weighted average number of common shares outstanding during the year adjusted to give effect to common stock equivalents.

The following table sets forth the computation of basic and diluted earnings per share, for the periods indicated:

	Twelve Months Ended December 31,		
	2018	2017	2016
Basic and diluted:			
Net Income	$ 797,883	$ 771,312	$ 747,171
Less: Net income attributable to noncontrolling interest	(18,178)	(19,009)	(44,762)
Less: Net income attributable to unvested restricted share grants	(1,091)	(362)	(314)
Net income attributable to UHS—basic and diluted	$ 778,614	$ 751,941	$ 702,095
Basic earnings per share attributable to UHS:			
Weighted average number of common shares—basic	93,276	95,652	97,208
Total basic earnings per share	$ 8.35	$ 7.86	$ 7.22
Diluted earnings per share attributable to UHS:			
Weighted average number of common shares	93,276	95,652	97,208
Net effect of dilutive stock options and grants based on the treasury stock method	474	673	1,172
Weighted average number of common shares and equivalents—diluted	93,750	96,325	98,380
Total diluted earnings per share	$ 8.31	$ 7.81	$ 7.14

The "Net effect of dilutive stock options and grants based on the treasury stock method", for all years presented above, excludes certain outstanding stock options applicable to each year since the effect would have been anti-dilutive. The excluded weighted-average stock options totaled approximately 7.9 million during 2018, 6.2 million during 2017 and 2.2 million during 2016.

S) Fair Value of Financial Instruments: The fair values of our debt and investments are based on quoted market prices. The fair values of other long-term debt, including capital lease obligations, are estimated by discounting cash flows using period-end interest rates and market conditions for instruments with similar maturities and credit quality. The carrying amounts reported in the balance sheet for cash, accounts receivable, accounts payable, and short-term borrowings approximates their fair values due to the short-term nature of these instruments. Accordingly, these items have been excluded from the fair value disclosures included elsewhere in these notes to consolidated financial statements.

T) Use of Estimates: The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires us to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

U) Mergers and Acquisitions: The acquisition method of accounting for business combinations requires that the assets acquired and liabilities assumed be recorded at the date of acquisition at their respective fair values with limited exceptions. Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. Any excess of the purchase price (consideration transferred) over the estimated fair values of net assets acquired is recorded as goodwill. Transaction costs and costs to restructure the acquired company are expensed as incurred. The fair value of intangible assets, including

Medicare licenses, certificates of need, tradenames and certain contracts, is based on significant judgments made by our management, and accordingly, for significant items we typically obtain assistance from third party valuation specialists.

V) GPO Agreement/Minority Ownership Interest: During 2013, we entered into a new group purchasing organization agreement ("GPO") with Premier, Inc. ("Premier), a healthcare performance improvement alliance, and acquired a minority interest in the GPO for a nominal amount. During the fourth quarter of 2013, in connection with the completion of an initial public offering of the stock of Premier, we received cash proceeds for the sale of a portion of our ownership interest in the GPO, which were recorded as deferred income, on a pro rata basis, as a reduction to our supplies expense over the initial expected life of the GPO agreement. Also in connection with this GPO agreement, we received shares of restricted stock in Premier which vest ratably over a seven-year period (2014 through 2020), contingent upon our continued participation and minority ownership interest in the GPO. We recognize the fair value of this restricted stock, as a reduction to our supplies expense, in our consolidated statements of income, on a pro rata basis, over the vesting period. We have elected to retain a portion of the previously vested shares of Premier, the value of which is included in other assets on our consolidated balance sheet. Based upon the closing price of Premier's stock on each respective date, the market value of our shares of Premier on which the restrictions have lapsed was $56 million and $33 million as of December 31, 2018 and 2017, respectively. The $23 million increase in market value at December 31, 2018, as compared to December 31, 2017, consists of $17 million of additional vested shares and $6 million of increased market value. In connection with our 2018 adoption of ASU 2016-01, "Recognition and Measurement of Financial Assets and Financial Liabilities", since our vested shares of Premier are held for investment and classified as available for sale, the $6 million increase in market value of these shares since December 31,2017 was recorded as an unrealized gain and included in "Other (income) expense, net" on our consolidated statements of income for the twelve-month period ended December 31, 2018. Prior to 2018, changes in the market value of our vested Premier stock were recorded to other comprehensive income/loss on our consolidated balance sheet.

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

Under these programs, including the impact of the Texas Uncompensated Care and Upper Payment Limit program, the Texas Delivery System Reform Incentive program, and various other state programs, we earned revenues (before Provider Taxes) of approximately $387 million during 2018, $357 million during 2017 and $327 million during 2016. These revenues were offset by Provider Taxes of approximately $179 million during 2018, $171 million during 2017, $166 million during 2016, which are recorded in other operating expenses on the Consolidated Statements of Income as included herein. The aggregate net benefit from these programs was $208 million during 2018, $186 million during 2017 and $161 million during 2016. The aggregate net benefit pursuant to these programs is earned from multiple states and therefore no particular state's portion is individually material to our consolidated financial statements. In addition, under various disproportionate share hospital payment programs and the Nevada state plan amendment program, we earned revenues of $64 million in 2018, $55 million in 2017 and $53 million in 2016.

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

In February, 2016, the FASB issued ASU 2016-02, "Leases (Topic 842): Amendments to the FASB Accounting Standards Codification ("Update 2016-02"), which requires an entity to recognize lease assets and lease liabilities on the balance sheet and to disclose key qualitative and quantitative information about the entity's leasing arrangements. In July 2018, the FASB issued ASU 2018-11, "Leases (Topic 842) - Targeted Improvements ("ASU 2018-11"), which provides an additional transition method allowing entities to initially apply the new lease standard at the adoption date and recognize a cumulative-effect adjustment to the opening balance of retained earnings in the period of adoption. This update is effective for annual reporting periods beginning after December 15, 2018 with early adoption permitted.

While we continue to evaluate other practical expedients available under the guidance, we expect to elect the package of practical expedients permitted under the transition guidance within ASU 2016-02 to not reassess prior conclusions related to contracts containing leases, lease classification and initial direct costs and, therefore, do not anticipate a material impact on our consolidated statements of income. While we are continuing to assess the effects of adoption, we currently believe the most significant changes relate to the recognition of significant right-of-use assets and lease liabilities on our consolidated balance sheet as a result of our operating lease obligations, as well as the impact of new disclosure requirements. Operating lease expense will still be recognized on a straight-line basis over the remaining life of the lease within lease and rental expense in the consolidated statements of income. We

plan to adopt ASU 2016-02 on January 1, 2019 and anticipate using the optional transition method in ASU 2018-11. Under this method, we would not adjust our comparative period financial statements for the effects of the new standard or make the new required lease disclosures for periods prior to the effective date.

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

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

In February, 2018, the FASB issued ASU 2018-02, "Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income", which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the Tax Cuts and Jobs Act of 2017. We early adopted this ASU effective January 1, 2018, which required a cumulative-effect reclass from accumulated other comprehensive income to retained earnings.

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

Y) Foreign Currency Translation: Assets and liabilities of our U.K. subsidiaries are denominated in pound sterling and translated into U.S. dollars at: (i) the rates of exchange at the balance sheet date, and; (ii) average rates of exchange prevailing during the year for revenues and expenses. The currency translation adjustments are reported as a component of accumulated other comprehensive income. See Note 3 - *Financial Instruments*, *Foreign Currency Forward Exchange Contracts* for additional disclosure.

Z) Supplies: Supplies, which consist primarily of medical supplies, are stated at the lower of cost (first-in, first-out basis) or market.

2) ACQUISITIONS AND DIVESTITURES

Year ended December 31, 2018:

2018 Acquisitions of Assets and Businesses:

During 2018 we spent $110 million primarily to:

- acquire The Danshell Group, consisting of 25 behavioral health facilities located in the U.K. (acquired during the third quarter of 2018), and;
- acquire a 109-bed behavioral health care facility located in Gulfport, Mississippi (acquired during the first quarter of 2018).

The aggregate net purchase price of the facilities, which were acquired to enhance and expand our existing operations in the U.S. and the U.K., was allocated to assets and liabilities based on their preliminary estimated fair values as follows:

	Amount (000s)
Working capital, net	$ (3,988)
Property & equipment	59,520
Goodwill	45,090
Other assets	8,409
Income tax assets, net of deferred tax liabilities	1,749
Other	(316)
Cash paid in 2018 for acquisitions	$ 110,464

Goodwill of the facilities acquired during each of the last 3 years is computed, pursuant to the residual method, by deducting the fair value of the acquired assets and liabilities from the total purchase price. The factors that contribute to the recognition of goodwill, which may also influence the purchase price, include the following for each of the acquired facilities: (i) the historical cash flows and income levels; (ii) the reputations in their respective markets; (iii) the nature of the respective operations, and; (iv) the future cash flows and income growth projections. The vast majority of the goodwill resulting from these transactions is not deductible for federal income tax purposes (see Note 6 - *Income Taxes*).

2018 Divestiture of Assets and Businesses:

During 2018, we received $13 million in connection with the sale of a business and property including The Limes, an 18-bed facility located in the UK.

Year ended December 31, 2017:

2017 Acquisitions of Assets and Businesses:

During 2017 we spent $23 million to acquire businesses and property.

2017 Divestiture of Assets and Businesses:

There were no significant divestitures during 2017.

Year ended December 31, 2016:

2016 Acquisitions of Assets and Businesses:

During 2016 we spent $614 million to:

- acquire the adult services division of Cambian Group, PLC consisting of 79 inpatient and 2 outpatient behavioral health facilities located in the U.K. (acquired late in the fourth quarter);
- acquire Desert View Hospital, a 25-bed acute care facility located in Pahrump, Nevada (acquired during the third quarter), and;
- acquire various other businesses and real property assets.

The aggregate net purchase price of the facilities, which were acquired to enhance and expand our existing operations in the U.S. and the U.K., was allocated to assets and liabilities based on their preliminary estimated fair values as follows:

	Amount (000s)
Working capital, net	$ 6,680
Property & equipment	343,846
Goodwill	234,658
Other assets (includes $18 million of contract-based relationships intangible assets)	19,910
Income tax assets, net of deferred tax liabilities	11,551
Debt	(152)
Noncontrolling interest	(2,690)
Cash paid in 2016 for acquisitions	$ 613,803

On December 28, 2016, we completed the acquisition of Cambian Group, PLC's adult services' division (the "Cambian Adult Services") for a total purchase price of approximately $473 million. At the time of acquisition, the Cambian Adult Services consisted of 79 inpatient and 2 outpatient behavioral health facilities located in the U.K. The Competition and Markets Authority ("CMA") in the U.K. reviewed our acquisition of the Cambian Adult Services. In April, 2017, the CMA notified us that they identified potential competition concerns in certain markets and announced its decision to refer our acquisition of Cambian Group, PLC's Adult Services division for a Phase 2 investigation. In October, 2017, the CMA provided the final ruling regarding the Phase 2 investigation requiring us to divest a facility which was subsequently designated to be The Limes, an 18-bed facility. The operating results for The Limes are reflected as discontinued operations during 2017. Since the aggregate income from discontinued operations before income tax expense for this facility is not material to our 2017 consolidated financial statements, it is included as a reduction to our operating expenses. For the twelve-month period ended December 31, 2017, The Limes generated approximately $3 million of net revenues, $953,000 of income before income taxes and $770,000 of after-tax income.

Our consolidated statement of income for the year ended December 31, 2016 was not impacted by our acquisition of the Cambian Adult Services business since the acquisition occurred in late December, 2016. Our consolidated net revenues for the year ended December 31, 2016 included approximately $12 million of net revenues generated at the above-mentioned Desert View Hospital representing the facility's net revenues from the date of acquisition through December 31, 2016. The earnings generated by the hospital since its date of acquisition was not material to our 2016 consolidated net income attributable to UHS and net income attributable to UHS per diluted share.

Assuming the acquisition of the Cambian Adult Services business and Desert View Hospital occurred on January 1, 2016, our 2016 unaudited pro forma net revenues would have been approximately $9.98 billion and our unaudited pro forma net income attributable to UHS would have been approximately $730 million, or $7.25 per diluted share.

2016 Divestiture of Assets and Businesses:

There were no divestitures during 2016.

3) FINANCIAL INSTRUMENTS

Fair Value Hedges:

During 2018, 2017 and 2016, we had no fair value hedges outstanding.

Cash Flow Hedges:

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

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

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

The fair value of interest rate swap agreements approximates the amount at which they could be settled, based on estimates obtained from the counterparties. We assess the effectiveness of our hedge instruments on a quarterly basis. We performed periodic assessments of the cash flow hedge instruments during 2018 and 2017 and determined the hedges to be highly effective. We also determined that any portion of the hedges deemed to be ineffective was de minimis and therefore there was no material effect on our consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose us to credit risk in the event of nonperformance. We do not anticipate nonperformance by our counterparties. We do not hold or issue derivative financial instruments for trading purposes.

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

- Four forward starting interest rate swaps, entered into during the second quarter of 2015, whereby we pay a fixed rate on a total notional amount of $500 million and receive one-month LIBOR. Each of the four swaps became

effective on July 15, 2015 and are scheduled to mature on April 15, 2019. The average fixed rate payable on these swaps is 1.40%;

- Four forward starting interest rate swaps, entered into during the third quarter of 2015, whereby we pay a fixed rate on a total notional amount of $400 million and receive one-month LIBOR. One swap on a notional amount of $100 million became effective on July 15, 2015, two swaps on a total notional amount of $200 million became effective on September 15, 2015 and another swap on a notional amount of $100 million became effective on December 15, 2015. All of these swaps are scheduled to mature on April 15, 2019. The average fixed rate payable on these four swaps is 1.23%, and;
- One interest rate swap, entered into during the fourth quarter of 2015, whereby we pay a fixed rate on a total notional amount of $100 million and receive one-month LIBOR. The swap became effective on December 15, 2015 and is scheduled to mature on April 15, 2019. The fixed rate payable on this swap is 1.21%.

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

Foreign Currency Forward Exchange Contracts:

We use forward exchange contracts to hedge our net investment in foreign operations against movements in exchange rates. The effective portion of the gains or losses on these contracts is recorded in foreign currency translation adjustment within accumulated other comprehensive income and remains there until either the sale or liquidation of the subsidiary. The cash flows from these contracts are reported as operating activities in the consolidated statements of cash flows. In connection with these forward exchange contracts, we recorded net cash inflows of $66 million during 2018, net cash outflows of $64 million during 2017 and net cash inflows of $79 million during 2016.

Our open foreign exchange forward contracts are recorded at fair value with the corresponding gain or loss recorded in foreign currency translation adjustment within accumulated other comprehensive income. We consider inputs to determine fair value to be "level 2" in the fair value hierarchy as outlined in the authoritative guidance for disclosures in connection with derivative instruments and hedging activities.

4) LONG-TERM DEBT

A summary of long-term debt follows:

	December 31,	
	2018	2017
	(amounts in thousands)	
Long-term debt:		
Notes payable and Mortgages payable (including obligations under capitalized leases of $19,941 in 2018 and $21,780 in 2017) and term loans with varying maturities through 2027; weighted average interest rates of 9.5% in 2018 and 9.1% in 2017 (see Note 7 regarding capitalized leases)	$ 20,159	$ 22,794
Revolving credit and on-demand credit facility	6,300	438,100
Term Loan A, net of unamortized discount of $708 in 2017	2,000,000	1,774,607
Term Loan B	500,000	—
Accounts receivable securitization program	390,000	419,500
3.75% Senior Secured Notes due 2019, net of unamortized discount of $69 in 2017	—	299,931
4.75% Senior Secured Notes due 2022, including unamortized premium of $3,460 in 2018 and $4,430 in 2017 and net of unamortized discount of $97 in 2018 and $124 in 2017	703,363	704,306
5.00% Senior Secured Notes due 2026	400,000	400,000
Total debt before unamortized financing costs	4,019,822	4,059,238
Less-Unamortized financing costs	(21,189)	(19,229)
Total debt after unamortized financing costs	3,998,633	4,040,009
Less-Amounts due within one year (net of unamortized financing costs)	(63,446)	(545,619)
Long-term debt	$ 3,935,187	$ 3,494,390

Credit Facilities and Outstanding Debt Securities

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

The Sixth Amendment amended the Senior Credit Facility to, among other things: (i) increase the aggregate amount of the revolving credit facility to $1 billion (increase of $200 million over the $800 million previous commitment); (ii) increase the aggregate amount of the tranche A term loan commitments to $2 billion, which represents the outstanding borrowings as of December 31, 2018 (increase of approximately $290 million over the $1.71 billion of outstanding borrowings prior to the amendment), and; (iii) extended the maturity date of the revolving credit and tranche A term loan facilities to October 23, 2023 from August 7, 2019.

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

As of December 31, 2018, we had no borrowings outstanding pursuant to our $1 billion revolving credit facility and we had $960 million of available borrowing capacity net of $34 million of outstanding letters of credit and $6 million of outstanding borrowings pursuant to a short-term credit facility.

Pursuant to the terms of the Sixth Amendment, the tranche A term loan provides for eight installment payments of $12.5 million per quarter commencing on March 31, 2019 followed by payments of $25 million per quarter until maturity when all outstanding amounts will be due. The tranche B term loan provides for installment payments of $1.25 million per quarter commencing March 31, 2019 through maturity.

Borrowings under the Senior Credit Agreement bear interest at our election at either (1) the ABR rate which is defined as the rate per annum equal to the greatest of (a) the lender's prime rate, (b) the weighted average of the federal funds rate, plus 0.5% and (c) one month LIBOR rate plus 1%, in each case, plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 0.375% to 0.625% for revolving credit and term loan A borrowings and 0.75% for tranche B borrowings, or (2) the one, two, three or six month LIBOR rate (at our election), plus an applicable margin based upon our consolidated leverage ratio at the end of each quarter ranging from 1.375% to 1.625% for revolving credit and term loan A borrowings and 1.75% for the tranche B term loan. As of December 31, 2018, the applicable margins were 0.375% for ABR-based loans and 1.375% for LIBOR-based loans under the revolving credit and term loan A facilities. The revolving credit facility includes a $125 million sub-limit for letters of credit. The Senior Credit Agreement is secured by certain assets of the Company and our material subsidiaries (which generally excludes asset classes such as substantially all of the patient-related accounts receivable of our acute care hospitals, and certain real estate assets and assets held in joint-ventures with third parties) and is guaranteed by our material subsidiaries.

The Senior Credit Agreement includes a material adverse change clause that must be represented at each draw. The Senior Credit Agreement contains covenants that include a limitation on sales of assets, mergers, change of ownership, liens and indebtedness, transactions with affiliates, dividends and stock repurchases; and requires compliance with financial covenants including maximum leverage. We are compliant with all required covenants as of December 31, 2018 and 2017.

In late April, 2018, we entered into the sixth amendment to our accounts receivable securitization program ("Securitization") dated as of October 27, 2010 with a group of conduit lenders, liquidity banks, and PNC Bank, National Association, as administrative agent, which provides for borrowings outstanding from time to time by certain of our subsidiaries in exchange for undivided security interests in their respective accounts receivable. The sixth amendment, among other things, extended the term of the Securitization program through April 26, 2021 and increased the borrowing capacity to $450 million (from $440 million previously). Although the program fee and certain other fees were adjusted in connection with the sixth amendment, substantially all other provisions of the Securitization program remained unchanged. Pursuant to the terms of our Securitization program, substantially all of the patient-related accounts receivable of our acute care hospitals ("Receivables") serve as collateral for the outstanding borrowings. We have accounted for this Securitization as borrowings. We maintain effective control over the Receivables since, pursuant to the terms of the Securitization, the Receivables are sold from certain of our subsidiaries to special purpose entities that are wholly-owned by us. The Receivables, however, are owned by the special purpose entities, can be used only to satisfy the debts of the wholly-owned special purpose entities, and thus are not available to us except through our ownership interest in the special purpose entities. The wholly-owned special purpose entities use the Receivables to collateralize the loans obtained from the group of third-party conduit lenders and liquidity banks. The group of third-party conduit lenders and liquidity banks do not have recourse to us beyond the assets of the wholly-owned special purpose entities that securitize the loans. At December 31, 2018, we had $390 million of outstanding borrowings pursuant to the terms of the Securitization and $60 million of available borrowing capacity.

As of December 31, 2018, we had combined aggregate principal of $1.1 billion from the following senior secured notes:

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

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

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

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

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

The aggregate scheduled maturities of our total debt outstanding as of December 31, 2018 are as follows:

	(000s)
2019	$ 63,446
2020	56,650
2021	496,696
2022	810,526
2023	1,707,476
Later	885,028
Total maturities before unamortized financing costs	4,019,822
Less-Unamortized financing costs	(21,189)
Total	$ 3,998,633

5) COMMON STOCK

Dividends

Cash dividends of $0.40 per share ($37.3 million in the aggregate) were declared and paid during 2018, $0.40 per share ($38.2 million in the aggregate) were declared and paid during 2017 and $0.40 per share ($38.9 million in the aggregate) were declared and paid during 2016. All classes of our common stock have similar economic rights.

Stock Repurchase Programs

In December of 2018, our Board of Directors authorized a $500 million increase to our stock repurchase program, which increased the aggregate authorization to $1.7 billion from the previous $1.2 billion authorization approved during 2017, 2016 and 2014. Pursuant to this program, we may purchase shares of our Class B Common Stock, from time to time as conditions allow, on the open market or in negotiated private transactions. There is no expiration date for our stock repurchase programs.

The following schedule provides information related to our stock repurchase program for each of the three years ended December 31, 2018. During 2018, 3,321,968 shares ($401.3 million) were repurchased pursuant to the terms of our stock repurchase program, 102,800 shares ($12.7 million in the aggregate) were repurchased in connection with the income tax withholding obligations

resulting from the exercise of stock options and the vesting of restricted stock grants, and 11,224 shares were repurchased as a result of forfeited restricted shares. During 2017, 2,960,843 shares ($322.2 million) were repurchased pursuant to the terms of our stock repurchase program, 305,278 shares ($34.2 million in the aggregate) were repurchased in connection with the income tax withholding obligations resulting from the exercise of stock options and the vesting of restricted stock grants and 10,791 shares were repurchased as a result of forfeited restricted shares. During 2016, 2,512,592 shares ($289.9 million) were repurchased pursuant to the terms of our stock repurchase program, 468,228 shares ($57.0 million in the aggregate) were repurchased in connection with the income tax withholding obligations resulting from the exercise of stock options and the vesting of restricted stock grants and 2,500 shares were repurchased as a result of forfeited restricted shares.

	Additional dollars authorized for repurchase (in thousands)	Total number of shares purchased (a.)	Total number of shares cancelled	Average price paid per share for forfeited restricted shares	Total number of shares purchased as part of publicly announced programs	Average price paid per share for shares purchased as part of publicly announced program	Aggregate purchase price paid (in thousands)	Aggregate purchase price paid for shares purchased as part of publicly announced program	Maximum number of dollars that may yet be purchased under the program (in thousands)
Balance as of January 1, 2016									$ 175,828
2016	$ 400,000	2,983,320	2,500	$ 0.01	2,512,592	$ 115.39	$ 346,890	$ 289,937	$ 285,891
2017	$ 400,000	3,266,121	10,791	$ 0.01	2,960,843	$ 108.83	$ 356,413	$ 322,231	$ 363,660
2018	$ 500,000	3,435,992	11,224	$ 0.01	3,321,968	$ 120.81	$ 414,002	$ 401,316	$ 462,344
Total for three year period ended December 31, 2018	$1,300,000	9,685,433	24,515	$ 0.01	8,795,403	$ 115.23	$1,117,305	$1,013,484	

(a.) Includes 11,224, 10,791 and 2,500 of restricted shares that were forfeited by former employees pursuant to the terms of our restricted stock purchase plan during 2018, 2017 and 2016, respectively.

Stock-based Compensation Plans

At December 31, 2018, we have a number of stock-based employee compensation plans. Pursuant to the FASB's guidance, we expense the grant-date fair value of stock options and other equity-based compensation pursuant to the straight-line method over the stated vesting period of the award using the Black-Scholes option-pricing model.

Pre-tax compensation costs of $61.1 million during 2018, $54.3 million during 2017 and $45.8 million during 2016 were recognized related to outstanding stock options. In addition, pre-tax compensation costs of $5.5 million during 2018, $2.5 million during 2017 and $2.3 million during 2016 were recognized related to amortization of restricted stock and discounts provided in connection with shares purchased pursuant to our 2005 Employee Stock Purchase Plan. As of December 31, 2018, there was approximately $110.8 million of unrecognized compensation cost related to unvested stock options and restricted stock which is expected to be recognized over the remaining average vesting period of 2.6 years.

The expense associated with stock-based compensation arrangements is a non-cash charge. In the Consolidated Statements of Cash Flows, stock-based compensation expense is an adjustment to reconcile net income to cash provided by operating activities and aggregated to $66.6 million in 2018, $56.7 million in 2017 and $48.1 million in 2016.

Effective January 1, 2017, we adopted ASU 2016-09, "Compensation – Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting", which amends the accounting for employee share-based payment transactions to require recognition of the tax effects resulting from the settlement of stock-based awards as income tax expense or benefit in the income statement in the reporting period in which they occur. For the year ended December 31, 2018 and 2017, our provision for income taxes and our net income attributable to UHS were each favorably impacted by $1.2 million and $22.1 million, respectively, resulting from our adoption of ASU 2016-09. Additionally, effective with our modified retrospective adoption of ASU 2016-09 on January 1, 2017, excess income tax benefits related to stock based compensation amounting to $45.2 million during 2016 are reflected as cash inflows from operating activities in our Consolidated Statement of Cash Flows. Prior to the adoption of ASU 2016-09, excess income tax benefits related to stock based compensation were reflected as cash inflows from financings activities in our Consolidated Statement of Cash Flows.

In 2005, we adopted the 2005 Stock Incentive Plan which was amended in 2008, 2010, 2015 and 2017 (the "Stock Incentive Plan"). An aggregate of 35.6 million shares of Class B Common Stock has been reserved under the Stock Incentive Plan. During

2018, 2017 and 2016, stock options, net of cancellations, of approximately 2.4 million, 2.9 million and 2.7 million, respectively, were granted. Stock options to purchase Class B Common Stock have been granted to our officers, key employees and members of our Board of Directors. Commencing in 2018, our key employees and non-executive officers began receiving a portion of their stock-based compensation in the form of restricted stock (as discussed below) in addition to receiving options to purchase Class B Common Stock.

The per option weighted-average grant-date fair value of options granted during 2018, 2017 and 2016 was $28.19, $27.05 and, $23.80, respectively. All stock options were granted with an exercise price equal to the fair market value on the date of the grant. Options are exercisable ratably over a four-year period beginning one year after the date of the grant. All outstanding options expire five years after the date of the grant. As of December 31, 2018, approximately 6.2 million shares of Class B Common Stock remain available for issuance pursuant to the Stock Incentive Plan.

The fair value of each option grant was estimated on the date of grant using the Black-Scholes option-pricing model. The following weighted average assumptions were derived from averaging the number of options granted during the most recent five-year period. The weighted-average assumptions reflected below were based upon twenty-seven option grants for the five-year period ending December 31, 2018, twenty-seven option grants for the five-year period ending December 31, 2017 and twenty-seven option grants for the five-year period ending December 31, 2016.

Year Ended December 31,	2018	2017	2016
Volatility	27%	28%	31%
Interest rate	1%	1%	1%
Expected life (years)	3.4	3.4	3.4
Forfeiture rate	13%	10%	10%
Dividend yield	0.3%	0.4%	0.4%

The risk-free rate is based on the U.S. Treasury zero coupon four year yield in effect at the time of grant. The expected life of the stock options granted was estimated using the historical behavior of employees. Expected volatility was based on historical volatility for a period equal to the stock option's expected life. Expected dividend yield is based on our dividend yield at the time of grant. The forfeiture rate is based upon the actual historical forfeitures utilizing the 5-year term of the option.

The table below summarizes our stock option activity during each of the last three years:

Outstanding Options	Number of Shares	Average Option Price	Range (High-Low)
Balance, January 1, 2016	8,400,183	$ 80.50	$142.43-$36.95
Granted	2,945,550	$ 118.72	$138.00-$107.39
Exercised	(2,162,850)	$ 53.02	$117.29-$36.95
Cancelled	(412,750)	$ 103.01	$130.32-$36.95
Balance, January 1, 2017	8,770,133	$ 99.06	$142.43-$36.95
Granted	3,061,725	$ 124.38	$124.56-$110.15
Exercised	(1,734,409)	$ 64.41	$118.62-$36.95
Cancelled	(457,500)	$ 118.65	$142.43-$53.38
Balance, January 1, 2018	9,639,949	$ 112.40	$138.00-$53.38
Granted	2,567,653	$ 119.73	$127.29-$112.68
Exercised	(1,591,859)	$ 100.95	$124.56-$53.38
Cancelled	(940,952)	$ 121.07	$136.00-$78.17
Balance, December 31, 2018	9,674,791	$ 115.39	$138.00-$78.17
Outstanding options vested and exercisable as of December 31, 2018	3,724,179	$ 106.77	$138.00-$78.17

The following table provides information about unvested options for the year ending December 31, 2018:

	Shares	Weighted Average Grant Date Fair Value
Unvested options as of January 1, 2018	6,770,603	$ 24.16
Granted	2,567,653	$ 28.19
Vested	(2,568,379)	$ 22.60
Cancelled	(819,265)	$ 25.87
Unvested options as of December 31, 2018	5,950,612	$ 26.34

The following table provides information regarding all options outstanding at December 31, 2018:

	Options Outstanding	Options Exercisable
Number of options outstanding	9,674,791	3,724,179
Weighted average exercise price	$ 115.39	$ 106.77
Aggregate intrinsic value as of December 31, 2018	$ 43,806,400	$ 43,594,160
Weighted average remaining contractual life	2.6	1.4

The total in-the-money value of all stock options exercised during the years ended December 31, 2018, 2017 and 2016 were $39.9 million, $85.5 million and $149.4 million, respectively.

The weighted average remaining contractual life for options outstanding and weighted average exercise price per share for exercisable options at December 31, 2018 were as follows:

Exercise Price	Options Outstanding Shares	Weighted Average Exercise Price Per Share	Weighted Average Remaining Contractual Life (in Years)	Exercisable Options Shares	Weighted Average Exercise Price Per Share	Expected to Vest Options (a) Shares	Weighted Average Exercise Price Per Share
$78.17 – $96.98	1,134,475	$ 78.17	0.2	1,134,475	$ 78.17	N/A	$ 78.17
$102.21 – $118.60	1,788,801	117.14	1.3	1,183,150	117.25	572,521	117.14
$118.62 – $124.22	4,288,690	119.19	3.3	854,088	118.64	2,265,877	119.19
$124.44 – $138.00	2,462,825	124.65	3.2	552,466	124.68	1,575,926	124.65
Total	9,674,791	$ 115.39	2.6	3,724,179	$ 106.77	4,414,324	$ 120.82

(a) Assumes a weighted average forfeiture rate of 13.06%.

Under our Amended and Restated 2010 Employees' Restricted Stock Purchase Plan (the "Restricted Stock Plan"), which allows eligible participants to purchase shares of Class B Common Stock at par value, subject to certain restrictions, 600,000 shares of Class B Common Stock have been reserved. During 2018, 2017 and 2016, restricted shares, net of cancellations, of approximately 136,571, 23,557, and 13,021, respectively, were granted and issued, with various ratable vesting periods ranging up to five years from the date of grant. The weighted-average grant-date fair value of the restricted shares granted during 2018, 2017 and 2016 was $119.51, $118.14 and $120.26, respectively. The fair value of each restricted stock grant was determined as the closing UHS market price on the date of grant. Restricted shares of Class B Common Stock have been granted to our officers and key employees.

In addition to the Stock Incentive Plan and the Restricted Stock Plan, we have our 2005 Employee Stock Purchase Plan (the "Employee Stock Plan") which allows eligible employees to purchase shares of Class B Common Stock at a ten percent discount. There were 87,051, 86,693 and 75,792 and shares issued pursuant to the Employee Stock Purchase Plan during 2018, 2017 and 2016, respectively.

In connection with the Restricted Stock Plan and the Employee Stock Plan, we have reserved 2.6 million shares of Class B Common Stock for issuance and have issued approximately 1.6 million shares, net of cancellations, as of December 31, 2018. As of December 31, 2018, approximately 1.0 million shares of Class B Common Stock remain available for issuance pursuant to these plans.

At December 31, 2018, 24,230,875 shares of Class B Common Stock were reserved for issuance upon conversion of shares of Class A, C and D Common Stock outstanding, for issuance upon exercise of options to purchase Class B Common Stock and for

issuance of stock under other incentive plans. Class A, C and D Common Stock are convertible on a share for share basis into Class B Common Stock.

6) INCOME TAXES

Components of income tax expense/(benefit) are as follows (amounts in thousands):

	Year Ended December 31,		
	2018	2017	2016
Current			
Federal	$ 195,862	$ 352,433	$ 368,957
Foreign	13,699	10,625	8,513
State	37,555	37,421	42,166
	247,116	400,479	419,636
Deferred			
Federal	(6,216)	(36,998)	(12,092)
Foreign	(666)	24	2,463
State	(3,592)	192	(820)
	(10,474)	(36,782)	(10,449)
Total	$ 236,642	$ 363,697	$ 409,187

On December 22, 2017, the President of the United States signed into law comprehensive tax legislation commonly referred to as the Tax Cuts and Jobs Act of 2017 (the "TCJA-17"). The TCJA-17 made broad and complex changes to the U.S. tax code, including, but not limited to, (1) reducing the U.S. federal corporate tax rate from 35 percent to 21 percent; (2) requiring companies to pay a one-time transition tax on certain unrepatriated earnings of foreign subsidiaries; (3) generally eliminating U.S. federal income taxes on dividends from foreign subsidiaries; (4) requiring a current inclusion in U.S. federal taxable income of certain earnings of controlled foreign corporations through the implementation of a territorial tax system; (5) creating a new limitation on deductible interest expense; and (6) limiting certain other deductions. The SEC staff issued Staff Accounting Bulletin No. 118 ("SAB 118") to address the application of U.S. GAAP in situations when a registrant has not obtained, prepared, or analyzed (including computations) all of the information needed in order to complete the accounting for certain income tax effects of the TCJA-17. To the extent that a company's accounting for certain income tax effects of the TCJA-17 is incomplete, a reasonable estimate should be recorded as a provisional amount in the financial statements during a measurement period not to extend beyond one year of the enactment date. We previously provided a provisional estimate of the effects of the TCJA-17 in the fourth quarter of 2017 financial statements. In the fourth quarter of 2018, we completed our analysis to determine the effects of the TCJA-17 as follows:

Reduction of U.S. federal corporate tax rate: The TCJA-17 reduces the corporate tax rate to 21 percent, effective January 1, 2018. Deferred income taxes are based on the estimated future tax effects of differences between the financial statement carrying amounts and the tax bases of assets and liabilities under the provisions of the enacted tax laws. For certain of our deferred tax assets and deferred tax liabilities, we have recorded a provisional decrease of $97 million and $127 million, respectively, with a corresponding net adjustment to deferred tax benefit of $30 million for the year ended December 31, 2017. Upon completion of our 2017 U.S. Corporate Income Tax Return in the fourth quarter, an increase of $1 million attributable to certain deferred tax assets and a decrease of $5 million attributable to certain deferred tax liabilities was recorded resulting in an additional net deferred tax benefit of $6 million.

Deemed Repatriation Transition Tax: The Deemed Repatriation Transition Tax ("Transition Tax") is a tax on previously untaxed accumulated and current earnings and profits ("E&P") of certain of our foreign subsidiaries. The one-time Transition Tax is based upon the amount of post-1986 E&P of the relevant subsidiaries, the amount of non-U.S. income tax paid on such earnings, as well as other factors. We originally estimated and recorded a provisional Transition Tax obligation of $11.3 million. Upon completion of our 2017 U.S. Corporate Income Tax Return, the final Transition Tax increased by $100,000 for a total of $11.4 million.

The TCJA-17 contains two new anti-base erosion tax provisions, (1) the global intangible low-taxed income ("GILTI") provisions and (2) the base erosion and anti-abuse tax ("BEAT") provisions:

GILTI: The GILTI provisions require the inclusion of the earnings of certain foreign subsidiaries in excess of an acceptable rate of return on certain assets of the respective subsidiaries in our U.S. tax return for tax years beginning after December 31, 2017. An

accounting policy election was made during 2018 to treat taxes related to GILTI as a period cost when the tax is incurred. We recorded a GILTI tax provision of less than $1 million for the year ended December 31, 2018.

BEAT: The BEAT provisions limit the deduction for U.S. tax base erosion related payments made by U.S. operations to related foreign affiliates. We do not have any tax expense related to BEAT included in our consolidated financial statements.

The foreign provision for income taxes is based on foreign pre-tax earnings of $84 million in 2018, $70 million in 2017 and $58 million in 2016. Prior to the TCJA-17, no deferred taxes were provided related to unremitted earnings from foreign subsidiaries. As a result of the mandatory repatriation tax provisions of the Transition Tax included in the TCJA-17, all undistributed earnings from foreign subsidiaries as of December 31, 2017, were subject to tax. Going forward, we anticipate repatriating only previously taxed foreign earnings subjected to the mandatory repatriation tax as well as any future earnings that would qualify for a full dividend received deduction permitted under the TCJA-17 for distributions post-December 31, 2017. As of December 31, 2018, the amount of previously taxed earnings and earnings that would qualify for a full dividend received deduction total $148 million. At this time, there are no material tax effects related to future cash repatriation of undistributed foreign earnings. As such, we have not recognized a deferred tax liability related to existing undistributed earnings.

Our provision for income taxes for the year ended December 31, 2018 and 2017 included tax benefits of $1 million and $22 million, respectively, related to the adoption of ASU 2016-09, which changes how companies account for certain aspects of share-based payments to employees. Under ASU 2016-09, excess tax benefits (when the deductible amount related to the settlement of employee equity awards for tax purposes exceeds the cumulative compensation cost recognized for financial reporting purposes) are no longer recorded in equity. Instead, we recognize these tax benefits (and deficiencies, if applicable) as a component of our tax provision. This reporting change is applied prospectively and prior period amounts are not restated (the excess tax benefit for the year ending December 31, 2016, related to the settlement of employee equity awards, was $45 million, and was recorded in equity). ASU 2016-09 requires companies to present excess tax benefits as an operating activity on the Consolidated Statement of Cash Flows rather than as a financing activity, as previously required. We have elected to apply the change to the Consolidated Statement of Cash Flows on a modified retrospective basis resulting in a reclassification of the excess income tax benefits related to stock-based compensation from financing activities to operating activities.

A reconciliation between the federal statutory rate and the effective tax rate is as follows:

	Year Ended December 31,		
	2018	2017	2016
Federal statutory rate	21.0%	35.0%	35.0%
State taxes, net of federal income tax benefit	2.6%	2.2%	2.4%
Tax effects of foreign operations	-0.5%	-1.2%	-0.8%
Tax benefit from settlement of employee equity awards	-0.1%	-1.9%	0.0%
Enactment of the TCJA-17	-0.6%	-1.7%	0.0%
Other items	0.9%	0.2%	0.2%
Impact of income attributable to noncontrolling interests	-0.4%	-0.6%	-1.4%
Effective tax rate	22.9%	32.0%	35.4%

Our effective tax rates were 22.9%, 32.0% and 35.4% for the years ended December 31, 2018, 2017 and 2016, respectively. The decrease in our effective tax rate for the year ended December 31, 2018 as compared to 2017 is due primarily to the net favorable impact of the enactment of the TCJA-17, as discussed above, partially offset by a $21 million unfavorable change in the tax benefit resulting from our January 1, 2017 adoption of ASU 2016-09, as discussed above. The decrease in our effective tax rate for the year ended December 31, 2017, as compared to 2016, is due primarily to the $22 million tax benefit recorded in 2017 resulting from our January 1, 2017 adoption of ASU 2016-09, the $19 million net favorable impact of the enactment of the TCJA-17 ($30 million favorable impact recorded during 2017 resulting from a reduction in our net deferred income tax liability, partially offset by an $11 million unfavorable impact recorded during 2017 resulting from a one-time repatriation tax, as discussed above), and the tax effects of our foreign operations in connection with our acquisition of Cambian Group, PLC's adult services division (acquired in late December, 2016).

Included in "Other current assets" on our Consolidated Balance Sheet are prepaid federal and state income taxes amounting to approximately $24 million and $5 million as of December 31, 2018 and 2017, respectively.

As a result of the reduction in the U.S. corporate income tax rate from 35% to 21% effective January 1, 2018 under the TCJA-17, the deferred tax assets and liabilities were revalued with a provisional net deferred tax benefit of $30 million recorded in the consolidated statement of income for the year ended December 31, 2017. Upon completion of our 2017 U.S. Corporate Income Tax Return, an increase of $1 million attributable to certain deferred tax assets and a decrease of $5 million attributable to certain deferred tax liabilities was recorded resulting in an additional net deferred tax benefit of $6 million. The components of deferred taxes are as follows (amounts in thousands):

	Year Ended December 31,			
	2018		2017	
	Assets	Liabilities	Assets	Liabilities
Self-insurance reserves	$ 68,402	$	$ 64,181	$
Compensation accruals	74,124		63,021	
Doubtful accounts and other reserves	27,184		20,809	
Other currently non-deductible accrued liabilities	35,253		19,759	
Depreciable and amortizable assets		257,896		226,389
State and foreign net operating loss carryforwards and other state and foreign deferred tax assets	86,315		76,439	
Net pension liabilities – OCI only	4,475		2,825	
Other combined items – OCI only		929		550
Other liabilities		2,045		1,824
	$ 295,753	$ 260,870	$ 247,034	$ 228,763
Valuation Allowance	(79,264)	0	(70,227)	0
Total deferred income taxes	$ 216,489	$ 260,870	$ 176,807	$ 228,763

At December 31, 2018, state net operating loss carryforwards (expiring in years 2019 through 2038), and credit carryforwards available to offset future taxable income approximated $1.12 billion representing approximately $75 million in deferred state tax benefit (net of the federal benefit); and state related interest expense carryforwards approximated $78 million representing approximately $4 million in deferred state tax benefit (net of the federal benefit). At December 31, 2018, there were foreign net operating losses and credit carryforwards of approximately $30 million, most of which are carried forward indefinitely, representing approximately $7 million in deferred foreign tax benefit.

A valuation allowance is required when it is more likely than not that some portion of the deferred tax assets will not be realized. Based on available evidence, it is more likely than not that certain of our state tax benefits will not be realized. Therefore, valuation allowances of approximately $75 million and $66 million have been reflected as of December 31, 2018 and 2017, respectively. During 2018, the valuation allowance on these state tax benefits increased by $9 million due to additional net operating losses incurred and state related interest expense carryforwards. In addition, valuation allowances of approximately $4 million have been reflected as of December 31, 2018 and 2017 related to foreign net operating losses and credit carryforwards.

During 2018 and 2017, the estimated liabilities for uncertain tax positions (including accrued interest and penalties) were increased less than $1 million due to tax positions taken in the current and prior years. The balance at each of December 31, 2018 and 2017, if subsequently recognized, that would favorably affect the effective tax rate and the provision for income taxes is approximately $1 million as of each date.

We recognize accrued interest and penalties associated with uncertain tax positions as part of the tax provision. As of December 31, 2018 and 2017, we have accrued interest and penalties of less than $1 million as of each date. The U.S. federal statute of limitations remains open for the 2015 and subsequent years. Foreign and U.S. state and local jurisdictions have statutes of limitations generally ranging for 3 to 4 years. The statute of limitations on certain jurisdictions could expire within the next twelve

months. It is reasonably possible that the amount of unrecognized tax benefits will change during the next 12 months, however, it is anticipated that any such change, if it were to occur, would not have a material impact on our results of operations.

The tabular reconciliation of unrecognized tax benefits for the years ended December 31, 2018, 2017 and 2016 is as follows (amounts in thousands):

	As of December 31,		
	2018	2017	2016
Balance at January 1,	$ 1,096	$ 1,259	$ 1,982
Additions based on tax positions related to the current year	500	500	50
Additions for tax positions of prior years	62	47	74
Reductions for tax positions of prior years	0	0	(94)
Settlements	(105)	(710)	(753)
Balance at December 31,	$ 1,553	$ 1,096	$ 1,259

7) LEASE COMMITMENTS

Three of our hospital facilities are held under operating leases with Universal Health Realty Income Trust with two hospital terms expiring in 2021 and the third expiring in 2026 (see Note 9 for additional disclosure). We also lease the real property of certain facilities (see Item 2. Properties for additional disclosure).

A summary of property under capital lease follows (amounts in thousands):

	As of December 31,	
	2018	2017
Land, buildings and equipment	$ 44,020	$ 44,740
Less: accumulated amortization	(30,646)	(29,628)
	$ 13,374	$ 15,112

Future minimum rental payments under lease commitments with a term of more than one year as of December 31, 2018, are as follows (amounts in thousands):

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

We assumed no capital lease obligations in 2018 or 2017 and assumed capital lease obligations of approximately $152,000 in 2016 in connection with the leases on certain real estate assets. In the ordinary course of business, our facilities routinely lease equipment pursuant to new lease arrangements that will likely result in future lease and rental expense in excess of amounts indicated above.

8) COMMITMENTS AND CONTINGENCIES

Professional and General Liability, Workers' Compensation Liability

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

As of December 31, 2018, the total the total accrual for our professional and general liability claims was $243 million, of which $42 million was included in current liabilities. As of December 31, 2017, the total accrual for our professional and general liability claims was $229 million, of which $54 million was included in current liabilities. During 2017, based upon a reserve analysis of our estimated future claims payments, we recorded an increase to our professional and general liability self-insurance reserves (relating to prior years) of $15 million. Our consolidated results of operations during 2018 and 2016 were not materially impacted by adjustments to our prior year reserves for professional and general liability claims.

As of December 31, 2018, the total accrual for our workers' compensation liability claims was $72 million, of which $40 million was included in current liabilities. As of December 31, 2017, the total accrual for our workers' compensation liability claims was $70 million, of which $35 million was included in current liabilities. Our consolidated results of operations during 2018, 2017 and 2016 were not materially impacted by adjustments to our prior year reserves for workers' compensation claims.

Below is a schedule showing the changes in our general and professional liability and workers' compensation reserves during the three years ended December 31, 2018 (amount in thousands):

	General and Professional Liability	Workers' Compensation	Total
Balance at January 1, 2016	$ 203,973	$ 67,503	$ 271,476
Liabilities assumed in acquisition	0	661	661
Plus: Accrued insurance expense, net of commercial premiums paid	54,671	29,967	84,638
Less: Payments made in settlement of self-insured claims	(51,185)	(30,775)	(81,960)
Balance at January 1, 2017	207,459	67,356	274,815
Plus: Accrued insurance expense, net of commercial premiums paid	65,049	37,546	102,595
Less: Payments made in settlement of self-insured claims	(43,817)	(35,371)	(79,188)
Balance at January 1, 2018	228,691	69,531	298,222
Plus: Accrued insurance expense, net of commercial premiums paid	54,387	38,476	92,863
Less: Payments made in settlement of self-insured claims	(40,027)	(36,117)	(76,144)
Balance at December 31, 2018	$ 243,051	$ 71,890	$ 314,941

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

Property Insurance:

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

Other Contractual Commitments:

In addition to our long-term debt obligations as discussed in Note 4 - *Long-Term Debt* and our operating lease obligations as discussed in Note 7 - *Lease Commitments*, we have various other contractual commitments outstanding as of December 31, 2018 as follows: (i) other combined estimated future purchase obligations of $254 million related to a long-term contract with third-parties consisting primarily of certain revenue cycle data processing services for our acute care facilities ($57 million), expected future costs to be paid to a third-party vendor in connection with the ongoing operation of an electronic health records application and purchase implementation of a revenue cycle and other applications for our acute care facilities ($194 million) and estimated minimum liabilities for physician commitments expected to be paid in the future ($2 million); (ii) estimated construction commitment of $55million representing our share of the construction costs of two newly constructed behavioral health care facilities located in Washington and Arizona that we are required to build pursuant to joint-venture agreements with third-parties; (iii) combined estimated future payments of $201 million related to our non-contributory, defined benefit pension plan ($180 million consisting of estimated payments through 2088) and other retirement plan liabilities ($21 million), and; (iv) accrued and unpaid estimated claims expense incurred in connection with our commercial health insurers and self-insured employee benefit plans ($78 million).

Legal Proceedings

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

The laws and regulations governing the healthcare industry are complex covering, among other things, government healthcare participation requirements, licensure, certification and accreditation, privacy of patient information, reimbursement for patient services as well as fraud and abuse compliance. These laws and regulations are constantly evolving and expanding. Further, the Affordable

Care Act has added additional obligations on healthcare providers to report and refund overpayments by government healthcare programs and authorizes the suspension of Medicare and Medicaid payments "pending an investigation of a credible allegation of fraud." We monitor our business and have developed an ethics and compliance program with respect to these complex laws, rules and regulations. Although we believe our policies, procedures and practices comply with government regulations, there is no assurance that we will not be faced with the sanctions referenced above which include fines, penalties and/or substantial damages, repayment obligations, payment suspensions, licensure revocation, and expulsion from government healthcare programs. Even if we were to ultimately prevail in any action brought against us or our facilities or in responding to any inquiry, such action or inquiry could have a material adverse effect on us.

Certain legal matters are described below:

Government Investigations:

UHS Behavioral Health

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

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

In April, 2014, the Centers for Medicare and Medicaid Services ("CMS") instituted a Medicare payment suspension at River Point Behavioral Health in accordance with federal regulations regarding suspension of payments during certain investigations. The Florida Agency for Health Care Administration ("AHCA") subsequently issued a Medicaid payment suspension for the facility. River Point Behavioral Health submitted a rebuttal statement disputing the basis of the suspension and requesting revocation of the suspension. Notwithstanding, CMS continued the payment suspension. River Point Behavioral Health provided additional information to CMS in an effort to obtain relief from the payment suspension but the Medicare suspension remains in effect. In June 2017, AHCA advised that while they were maintaining the suspension for dual eligible and cross-over Medicare beneficiaries, the Medicaid payment suspension was lifted effective June 27, 2017. We cannot predict if and/or when the facility's remaining suspended payments will resume in total. From inception through December 31, 2018, the aggregate funds withheld from us in connection with the River Point Behavioral Health payment suspension amounted to approximately $9 million. Although the operating results of River Point Behavioral Health did not have a material impact on our consolidated results of operations during 2018, 2017 or 2016, the payment suspension has had a material adverse effect on the facility's results of operations and financial condition.

The DOJ has advised us that the civil aspect of the coordinated investigation referenced above is a False Claims Act investigation focused on billings submitted to government payers in relation to services provided at those facilities. While there have been various matters raised by DOJ during the pendency of this investigation, DOJ Civil has advised that the focus of their investigation is on medical necessity issues and billing for services not eligible for payment due to non-compliance with regulatory requirements relating to, among other things, admission eligibility, discharge decisions, length of stay and patient care issues. It is our understanding that the DOJ Criminal Fraud Section is investigating issues similar to those focused on by the DOJ Civil Division and the other related agencies involved in this matter. UHS denies any fraudulent billings were submitted to government payers; however, we are involved in settlement discussions with the DOJ Civil Division in an attempt to resolve this matter. During 2018, we recorded pre-tax increases to the reserve established in connection with the civil aspects of these matters amounting to $102 million increasing the aggregate pre-tax reserve to $123 million as of December 31, 2018 from $22 million as of December 31, 2017. Changes in the

reserve may be required in future periods as discussions with the DOJ continue and additional information becomes available. We cannot predict the ultimate resolution of these matters and therefore can provide no assurance that final amounts paid in settlement or otherwise, if any, or associated costs, as well as the income tax deductibility of payments, will not differ materially from our established reserve and assumptions related to income tax deductibility.

DOJ investigation of Turning Point Hospital.

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

Litigation:

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

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

Shareholder Class Action

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

Shareholder Derivative Cases

In March 2017, a shareholder derivative suit was filed by plaintiff David Heed in the Court of Common Pleas of Philadelphia County. A notice of removal to the United States District Court for the Eastern District of Pennsylvania was filed (Case No. 2:17-cv-01476-LS). Plaintiff filed a motion to remand. In December 2017, the Court denied plaintiff's motion to remand and has retained the case in federal court. In May, June and July 2017, additional shareholder derivative suits were filed in the United States District Court for the Eastern District of Pennsylvania. The plaintiffs in those cases are: Central Laborers' Pension Fund (Case No. 17-cv-02187-LS); Firemen's Retirement System of St. Louis (Case No. 17—cv-02317-LS); Waterford Township Police & Fire Retirement System (Case No. 17-cv-02595-LS); and Amalgamated Bank Longview Funds (Case No. 17-cv-03404-LS). The Fireman's Retirement System case has since been voluntarily dismissed. The federal court has consolidated all of the cases pending in the Eastern District of Pennsylvania and has appointed co-lead plaintiffs and co-lead counsel. Lead Plaintiffs have filed a consolidated, amended complaint. We have filed a motion to dismiss the amended complaint. In addition, a shareholder derivative case was filed in Chancery Court in Delaware by the Delaware County Employees' Retirement Fund (Case No. 2017-0475-JTL). In December 2017, the Chancery Court stayed this case pending resolution of other contemporaneous matters. Each of these cases have named certain current and former members of the Board of Directors individually and certain officers of Universal Health Services, Inc. as defendants. UHS has also been named as a nominal

defendant in these cases. The derivative cases make substantially similar allegations and claims as the shareholder class action relating to practices at our behavioral health facilities and board and corporate oversight of these facilities as well as claims relating to the stock trading by the individual defendants and company repurchase of shares during the relevant time period. The cases make claims of breaches of fiduciary duties by the named board members and officers; alleged violations of federal securities laws; and common law causes of action against the individual defendants including unjust enrichment, corporate waste, abuse of control, constructive fraud and gross mismanagement. The cases seek monetary damages allegedly incurred by the company; restitution and disgorgement of profits, benefits and other compensation from the individual defendants and various forms of equitable relief relating to corporate governance matters. The defendants deny liability and intend to defend these cases vigorously. At this time, we are uncertain as to potential liability or financial exposure, if any, which may be associated with these matters.

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

This is a lawsuit filed in 1999 in state court in Hidalgo County, Texas by a physician and his professional associations alleging tortious interference with contractual relationships and retaliation against McAllen Medical Center in McAllen, Texas as well as Universal Health Services, Inc. The state court had entered a summary judgment order awarding plaintiff $3.85 million in damages. With prejudgment interest, the total amount of the order amounted to approximately $9 million, for which a corresponding reserve had previously been included in our financial statements. The case was removed to federal court. During the first quarter of 2019, the federal court entered an order vacating the state court's summary judgment. The parties have reached a preliminary settlement of this matter, pending finalization of settlement documentation, for an amount that did not have a material impact on our consolidated financial statements.

Disproportionate Share Hospital Payment Matter:

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

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

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

Department of Justice Investigation of Riveredge Hospital

In 2008, Riveredge Hospital in Chicago, Illinois received a subpoena from the DOJ requesting certain information from the facility. Additional requests for documents were also received from the DOJ in 2009 and 2010. The requested documents have been provided to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. We have recently been notified by the DOJ that there is no longer an investigation pending against Riveredge Hospital that is separate from the UHS Behavioral Health matter referenced above.

Department of Justice Investigation of Friends Hospital

In October, 2010, Friends Hospital in Philadelphia, Pennsylvania, received a subpoena from the DOJ requesting certain documents from the facility. The requested documents were collected and provided to the DOJ for review and examination. Another subpoena was issued to the facility in July, 2011 requesting additional documents, which have also been delivered to the DOJ. All documents requested and produced pertained to the operations of the facility while under PSI's ownership prior to our acquisition. We have recently been notified by the DOJ that there is no longer an investigation pending against Friends Hospital that is separate from the UHS Behavioral Health matter referenced above.

Other Matters:

Various other suits, claims and investigations, including government subpoenas, arising against, or issued to, us are pending and additional such matters may arise in the future. Management will consider additional disclosure from time to time to the extent it

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

9) RELATIONSHIP WITH UNIVERSAL HEALTH REALTY INCOME TRUST AND OTHER RELATED PARTY TRANSACTIONS

Relationship with Universal Health Realty Income Trust:

At December 31, 2018, we held approximately 5.7% of the outstanding shares of Universal Health Realty Income Trust (the "Trust"). We serve as Advisor to the Trust under an annually renewable advisory agreement, which is scheduled to expire on December 31st of each year, pursuant to the terms of which we conduct the Trust's day-to-day affairs, provide administrative services and present investment opportunities. The advisory agreement was Amended and Restated effective January 1, 2019. Among other things, the Amended and Restated Advisory Agreement (the "Agreement") eliminated the 20% annual incentive fee clause which we were previously entitled to under certain conditions (the incentive fee requirements have never been achieved). In addition, certain of our officers and directors are also officers and/or directors of the Trust. Management believes that it has the ability to exercise significant influence over the Trust, therefore we account for our investment in the Trust using the equity method of accounting. The advisory agreement was renewed by the Trust for 2019 at the same rate as the prior three years. During 2018, 2017 and 2016, the advisory fee was computed at 0.70% of the Trust's average invested real estate assets. We earned an advisory fee from the Trust, which is included in net revenues in the accompanying consolidated statements of income, of approximately $3.8 million during 2018, $3.6 million during 2017 and $3.3 million during 2016.

Our pre-tax share of income from the Trust was $1.4 million during 2018 which is included in other income, net, on the accompanying consolidated statements of income. Our pre-tax share of income from the Trust was $2.6 million during 2017 and $1.0 million during 2016, which are included in net revenues in the accompanying consolidated statements of income for each year. Included in our share of the Trust's income for 2018, is income realized by the Trust in connection with hurricane-related insurance proceeds received in connection with the damage sustained from Hurricane Harvey in August, 2017. Included in our share of the Trust's income for 2017 was a gain realized by the Trust in connection with a divestiture of property that was completed during the first quarter of 2017, as well as insurance proceeds in excess of damaged Trust property. We received dividends from the Trust amounting to $2.1 million during each of 2018 and 2017 and $2.0 million during 2016.

The carrying value of our investment in the Trust was $7.5 million and $8.2 million at December 31, 2018 and 2017, respectively, and is included in other assets in the accompanying consolidated balance sheets. The market value of our investment in the Trust was $48.3 million at December 31, 2018 and $59.2 million at December 31, 2017, based on the closing price of the Trust's stock on the respective dates.

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

Total rent expense under the operating leases on the three hospital facilities with the Trust was $16.0 million during each of 2018 and 2017 and $15.9 million in 2016. Pursuant to the terms of the three hospital leases with the Trust, we have the option to renew the leases at the lease terms described above by providing notice to the Trust at least 90 days prior to the termination of the then current term. We also have the right to purchase the respective leased hospitals at the end of the lease terms or any renewal terms at their appraised fair market value as well as purchase any or all of the three leased hospital properties at the appraised fair market value upon one month's notice should a change of control of the Trust occur. In addition, we have rights of first refusal to: (i) purchase the respective leased facilities during and for 180 days after the lease terms at the same price, terms and conditions of any third-party offer, or; (ii) renew the lease on the respective leased facility at the end of, and for 180 days after, the lease term at the same terms and conditions pursuant to any third-party offer. During the second quarter of 2018, we exercised our 5-year renewal option on McAllen Medical Center which extended the lease term on this facility, at the existing lease rate, through December, 2026.

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

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

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

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

Other Related Party Transactions:

In December, 2010, our Board of Directors approved the Company's entering into supplemental life insurance plans and agreements on the lives of our chief executive officer ("CEO") and his wife. As a result of these agreements, as amended in October, 2016, based on actuarial tables and other assumptions, during the life expectancies of the insureds, we would pay approximately $28 million in premiums, and certain trusts owned by our CEO, would pay approximately $9 million in premiums. Based on the projected premiums mentioned above, and assuming the policies remain in effect until the death of the insureds, we will be entitled to receive death benefit proceeds of no less than approximately $37 million representing the $28 million of aggregate premiums paid by us as well as the $9 million of aggregate premiums paid by the trusts. In connection with these policies, we paid approximately $1.1 million, net, and $1.2 million, net, in premium payments during 2018 and 2017, respectively.

In August, 2015, Marc D. Miller, our President and member of our Board of Directors, was appointed to the Board of Directors of Premier, Inc. ("Premier"), a healthcare performance improvement alliance. During 2013, we entered into a new group purchasing organization agreement ("GPO") with Premier. In conjunction with the GPO agreement, we acquired a minority interest in Premier for a nominal amount. During the fourth quarter of 2013, in connection with the completion of an initial public offering of the stock of Premier, we received cash proceeds for the sale of a portion of our ownership interest in the GPO. Also in connection with this GPO agreement, we received shares of restricted stock of Premier which vest ratably over a seven-year period (2014 through 2020), contingent upon our continued participation and minority ownership interest in the GPO. We have elected to retain a portion of the previously vested shares of Premier, the market value of which is included in other assets on our consolidated balance sheet. Based upon the closing price of Premier's stock on each respective date, the market value of our shares of Premier on which the restrictions have lapsed was $56 million as of December 31, 2018 and $33 million as of December 31, 2017. The $23 million increase in market value at December 31, 2018, as compared to December 31, 2017, consists of $17 million of additional vested shares and $6 million of increased market value. In connection with our 2018 adoption of ASU 2016-01, "Recognition and Measurement of Financial Assets and Financial Liabilities", since our vested shares of Premier are held for investment and classified as available for sale, the $6 million increase in market value of these shares since December 31, 2017 was recorded as an unrealized gain and included in "Other (income) expense, net" on our condensed consolidated statements of income for the twelve-month period ended December 31, 2018. Prior to 2018, changes in the market value of our vested Premier stock were recorded to other comprehensive income/loss on our consolidated balance sheet.

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

10) REVENUE RECOGNITION

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

The performance obligation is separately identifiable from other promises in the customer contract. As the performance obligations are met (i.e.: room, board, ancillary services, level of care), revenue is recognized based upon allocated transaction price. The transaction

price is allocated to separate performance obligations based upon the relative standalone selling price. In instances where we determine there are multiple performance obligations across multiple months, the transaction price will be allocated by applying an estimated implicit and explicit rate to gross charges based on the separate performance obligations.

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

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

	As Reported	Balances Without Adoption ASC 606	Effect of Change
For the twelve months ended December 31, 2018:			
Net Revenue before provision for doubtful accounts		$ 11,846,088	
Less: Provision for doubtful accounts		1,088,267	
Net Revenues	$ 10,772,278	$ 10,757,821	$ 14,457
Other operating expenses	$ 2,614,687	$ 2,600,230	$ 14,457

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

The following table disaggregates our revenue by major source for the years ended December 31, 2018, 2017 and 2016 (in thousands):

	For the year ended December 31, 2018					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 1,296,152	23%	$ 579,723	12%		$ 1,875,875	17%
Managed Medicare	730,387	13%	199,003	4%		929,390	9%
Medicaid	487,197	9%	696,421	14%		1,183,618	11%
Managed Medicaid	554,438	10%	975,567	19%		1,530,005	14%
Managed Care (HMO and PPOs)	2,093,890	37%	1,395,980	28%		3,489,870	32%
UK Revenue	0	0%	504,721	10%		504,721	5%
Other patient revenue and adjustments, net	167,570	3%	483,417	10%		650,987	6%
Other non-patient revenue	390,271	7%	204,042	4%	13,499	607,812	6%
Total Net Revenue	$ 5,719,905	100%	$ 5,038,874	100%	$ 13,499	10,772,278	100%

	For the year ended December 31, 2017					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 1,223,150	22%	$ 593,690	12%		$ 1,816,840	17%
Managed Medicare	630,083	11%	161,320	3%		791,403	8%
Medicaid	482,820	9%	723,544	15%		1,206,364	12%
Managed Medicaid	511,844	9%	876,907	18%		1,388,751	13%
Managed Care (HMO and PPOs)	1,949,435	36%	1,412,086	29%		3,361,521	32%
UK Revenue	0	0%	426,575	9%		426,575	4%
Other patient revenue and adjustments, net	219,056	4%	498,915	10%		717,971	7%
Other non-patient revenue	468,295	9%	213,682	4%	18,463	700,440	7%
Total Net Revenue	$ 5,484,683	100%	$ 4,906,719	100%	$ 18,463	10,409,865	100%

	For the year ended December 31, 2016					
	Acute Care		Behavioral Health		Other	Total	
Medicare	$ 1,114,911	22%	$ 614,182	13%		$ 1,729,093	18%
Managed Medicare	536,224	10%	143,554	3%		679,778	7%
Medicaid	424,934	8%	755,226	16%		1,180,160	12%
Managed Medicaid	444,164	9%	793,234	17%		1,237,398	13%
Managed Care (HMO and PPOs)	1,845,571	36%	1,407,458	30%		3,253,029	33%
UK Revenue	0	0%	241,098	5%		241,098	2%
Other patient revenue and adjustments, net	284,872	6%	456,350	10%		741,222	8%
Other non-patient revenue	462,274	9%	233,905	5%	8,253	704,432	7%
Total Net Revenue	$ 5,112,950	100%	$ 4,645,007	100%	$ 8,253	9,766,210	100%

11) PENSION PLAN

We maintain contributory and non-contributory retirement plans for eligible employees. Our contributions to the contributory plan amounted to $56.6 million, $50.1 million and $45.7 million in 2018, 2017 and 2016, respectively. The non-contributory plan is a defined benefit pension plan which covers employees of one of our subsidiaries. The benefits are based on years of service and the employee's highest compensation for any five years of employment. Our funding policy is to contribute annually at least the minimum amount that should be funded in accordance with the provisions of ERISA.

For defined benefit pension plans, the benefit obligation is the "projected benefit obligation", the actuarial present value, as of December 31 measurement date, of all benefits attributed by the pension benefit formula to employee service rendered to that date. The amount of benefit to be paid depends on a number of future events incorporated into the pension benefit formula, including estimates of the average life of employees/survivors and average years of service rendered. It is measured based on assumptions

concerning future interest rates and future compensation levels. The following table shows the reconciliation of the defined benefit pension plan as of December 31, 2018 and 2017:

	2018	2017
	(000s)	
Change in plan assets:		
Fair value of plan assets at beginning of year	$ 118,667	$ 109,677
Actual return (loss) on plan assets	(7,522)	15,533
Benefits paid	(6,031)	(5,846)
Administrative expenses	(523)	(697)
Fair value of plan assets at end of year	$ 104,591	$ 118,667
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 116,056	$ 110,949
Service cost	689	721
Interest cost	4,063	4,465
Benefits paid	(6,031)	(5,846)
Actuarial (gain) loss	(6,350)	5,767
Benefit obligation at end of year	$ 108,427	$ 116,056
Amounts recognized in the Consolidated Balance Sheet:		
Other non-current assets		2,611
Other non-current liabilities	3,836	
Total amounts recognized at end of year	$ 3,836	$ 2,611

	2018	2017	2016
		(000s)	
Components of net periodic cost (benefit)			
Service cost	$ 689	$ 721	$ 926
Interest cost	4,063	4,465	4,997
Expected return on plan assets	(5,197)	(5,862)	(5,708)
Amortization of actuarial loss	—	863	3,072
Net periodic cost	$ (445)	$ 187	$ 3,287

	2018	2017
Measurement Dates		
Benefit obligations	12/31/2018	12/31/2017
Fair value of plan assets	12/31/2018	12/31/2017

	2018	2017
Weighted average assumptions as of December 31		
Discount rate	4.03%	3.60%
Rate of compensation increase	4.00%	4.00%

	2018	2017	2016
Weighted-average assumptions for net periodic benefit cost calculations			
Discount rate	3.60%	4.14%	4.34%
Expected long-term rate of return on plan assets	4.50%	5.50%	5.50%
Rate of compensation increase	4.00%	4.00%	4.00%

The accumulated benefit obligation for our pension plan represents the actuarial present value of benefits based on employee service and compensation as of a certain date and does not include an assumption about future compensation levels. The accumulated benefit obligation for our plan was $108.3 million and $115.9 million as of December 31, 2018 and 2017, respectively. As of December 31, 2018, the accumulated benefit obligation exceeded the fair value of plan assets by $3.7 million. As of December 31, 2017, the fair value of plan assets exceeded the accumulated benefit obligation by $2.7 million.

We estimate that there will be no net loss or prior service cost amortized from accumulated other comprehensive income during 2019.

In May, 2015, the FASB issued ASU No. 2015-07, "Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or its Equivalent)," which is effective for annual reporting periods beginning after December 15, 2015. The standard removes the requirement to categorize investments for which fair value is measured using the net asset value (NAV) per share practical expedient within the fair value hierarchy. We have adopted this standard effective January 1, 2016, and applied the guidance retrospectively. This standard impacts financial statement disclosure only. In previous reporting periods, we disclosed the full fair value hierarchy and disclosed our pension assets as level 2 within the hierarchy. Going forward, we will disclose our pension assets by asset category reported using NAV as a practical expedient for comparative years.

The market values of our pension plan assets at December 31, 2018 and December 31, 2017, reported using net asset value as a practical expedient, by asset category are as follows:

	2018	2017
Equities:		
U.S. Large Cap	$ 7,711	$ 9,393
U.S. Mid Cap	2,309	2,937
U.S. Small Cap	2,094	3,005
International Developed	5,710	7,213
Emerging Markets	4,137	4,792
Fixed income:		
Core Fixed Income	24,617	25,915
Long Duration Fixed Income	55,318	62,522
Real Estate:		
REIT Fund	2,037	2,370
Cash/Currency:		
Cash Equivalents	658	520
Total market value	$ 104,591	$ 118,667

To develop the expected long-term rate of return on plan assets assumption, we considered the historical returns and the future expectations for returns for each asset class, as well as the target asset allocation of the pension portfolio.

The following table shows expected benefit payments for the years ended December 31, 2019 through 2028 for our defined pension plan. There will be benefit payments under this plan beyond 2028.

Estimated Future Benefit Payments (000s)	
2019	$ 6,595
2020	6,744
2021	6,834
2022	6,891
2023	6,921
2024-2028	34,270
Total	$ 68,255

	2018	2017
Plan Assets		
Asset Category		
Equity securities	21%	23%
Fixed income securities	76%	75%
Other	3%	2%
Total	100%	100%

Investment Policy, Guidelines and Objectives have been established for the defined benefit pension plan. The investment policy is in keeping with the fiduciary requirements under existing federal laws and managed in accordance with the Prudent Investor Rule. Total portfolio risk is regularly evaluated and compared to that of the plan’s policy target allocation and judged on a relative basis over

a market cycle. The following asset allocation policy and ranges have been established in accordance with the overall risk and return objectives of the portfolio:

	As of 12/31/2018	Permitted Range
Total Equity	21%	10-30%
Total Fixed Income	76%	70-90%
Other	3%	0-10%

In accordance with the investment policy, the portfolio will invest in high quality, large and small capitalization companies traded on national exchanges, and investment grade securities. The investment managers will not write or buy options for speculative purposes; securities may not be margined or sold short. The manager may employ futures or options for the purpose of hedging exposure, and will not purchase unregistered sectors, private placements, partnerships or commodities.

12) SEGMENT REPORTING

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

2018	Acute Care Hospital Services	Behavioral Health Services (a.)	Other	Total Consolidated
		(Dollar amounts in thousands)		
Gross inpatient revenues	$ 24,814,959	$ 9,735,521	$ —	$34,550,480
Gross outpatient revenues	$ 14,967,313	$ 1,025,721	$ —	$15,993,034
Total net revenues	$ 5,719,905	$ 5,038,874	$ 13,499	$10,772,278
Income (loss) before allocation of corporate overhead and income taxes	$ 708,680	$ 915,517	$ (589,672)	$ 1,034,525
Allocation of corporate overhead	$ (199,823)	$ (161,282)	$ 361,105	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 508,857	$ 754,235	$ (228,567)	$ 1,034,525
Total assets	$ 4,094,537	$ 6,786,369	$ 384,574	$11,265,480

2017	Acute Care Hospital Services	Behavioral Health Services (a.)	Other	Total Consolidated
		(Dollar amounts in thousands)		
Gross inpatient revenues	$21,888,207	$ 8,949,984	$ —	$30,838,191
Gross outpatient revenues	$13,115,881	$ 993,409	$ —	$14,109,290
Total net revenues	$ 5,484,683	$ 4,906,719	$ 18,463	$10,409,865
Income (loss) before allocation of corporate overhead and income taxes	$ 641,857	$ 968,974	$ (475,822)	$ 1,135,009
Allocation of corporate overhead	$ (182,713)	$ (158,735)	$ 341,448	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 459,144	$ 810,239	$ (134,374)	$ 1,135,009
Total assets	$ 3,849,214	$ 6,648,818	$ 263,796	$10,761,828

2016	Acute Care Hospital Services	Behavioral Health Services (a.)	Other	Total Consolidated
		(Dollar amounts in thousands)		
Gross inpatient revenues	$19,042,627	$ 8,017,585	$ —	$27,060,212
Gross outpatient revenues	$11,374,098	$ 902,102	$ —	$12,276,200
Total net revenues	$ 5,112,950	$ 4,645,007	$ 8,253	$ 9,766,210
Income (loss) before allocation of corporate overhead and income taxes	$ 557,472	$ 1,030,734	$ (431,848)	$ 1,156,358
Allocation of corporate overhead	$ (170,767)	$ (154,843)	$ 325,610	$ 0
Income (loss) after allocation of corporate overhead and before income taxes	$ 386,705	$ 875,891	$ (106,238)	$ 1,156,358
Total assets	$ 3,723,075	$ 6,440,195	$ 154,532	$10,317,802

(a.) Includes net revenues generated from our behavioral health care facilities located in the U.K. amounting to approximately $505 million in 2018, $429 million in 2017 and $241 million in 2016. Total assets at our U.K. behavioral health care facilities were approximately $1.224 billion as of December 31, 2018, $1.098 billion as of December 31, 2017 and $965 million as of December 31, 2016. In addition, included in our 2018 Behavioral Health Services operating segment Income (loss) before allocation of corporate overhead and income taxes is a pre-tax $49 million provision for asset impairment to reduce the carrying value of a tradename intangible asset.

13) QUARTERLY RESULTS (unaudited)

The quarterly financial data is prepared on the same basis as the audited annual financial statements, and include all adjustments, which include only normal recurring adjustments, necessary for the fair statement of our results of operations for these periods. The following tables summarize the quarterly financial data for the two years ended December 31, 2018 and 2017:

2018	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total
	(amounts in thousands, except per share amounts)				
Net revenues	$ 2,687,516	$ 2,681,353	$ 2,648,913	$ 2,754,496	$10,772,278
Net income	$ 228,669	$ 230,711	$ 174,881	$ 163,622	$ 797,883
Less: Net income attributable to noncontrolling interests	$ 4,837	$ 4,659	$ 3,135	$ 5,547	$ 18,178
Net income attributable to UHS	$ 223,832	$ 226,052	$ 171,746	$ 158,075	$ 779,705
Earnings per share attributable to UHS-Basic:					
Total basic earnings per share	$ 2.37	$ 2.40	$ 1.85	$ 1.71	$ 8.35
Earnings per share attributable to UHS-Diluted:					
Total diluted earnings per share	$ 2.36	$ 2.39	$ 1.84	$ 1.70	$ 8.31

The 2018 quarterly financial data presented above includes the following:

First Quarter:

- an unfavorable $13.0 million pre-tax impact ($9.9 million, or $.11 per diluted share, net of taxes) increase in the reserve established in connection with the discussions with the Department of Justice related to the civil aspects of the government's investigation of certain of our behavioral health care facilities (" DOJ Reserve");
- a favorable after-tax impact of $1.6 million, or $.02 per diluted share, resulting from our January 1, 2017 adoption of ASU 2016-09, "Compensation – Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting" ("ASU 2016-09").

Second Quarter:

- an unfavorable $9.5 million pre-tax impact ($7.2 million, or $.08 per diluted share, net of taxes) increase in the DOJ Reserve.

Third Quarter:

- an unfavorable $48.0 million pre-tax impact ($36.6 million, or $.39 per diluted share, net of taxes) increase in the DOJ Reserve.

Fourth Quarter:

- an unfavorable $31.9 million pre-tax impact ($24.5 million, or $.26 per diluted share, net of taxes) increase in the DOJ Reserve;
- an unfavorable $49.3 million pre-tax impact ($37.7 million, or $.41 per diluted share, net of taxes) recorded in connection with provision for intangible asset impairment .

2017	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Total
	(amounts in thousands, except per share amounts)				
Net revenues	$ 2,612,858	$ 2,612,356	$ 2,541,864	$ 2,642,787	$10,409,865
Net income	$ 210,527	$ 190,388	$ 145,362	$ 225,035	$ 771,312
Less: Net income attributable to noncontrolling interests	$ 4,472	$ 4,994	$ 4,117	$ 5,426	$ 19,009
Net income attributable to UHS	$ 206,055	$ 185,394	$ 141,245	$ 219,609	$ 752,303
Earnings per share attributable to UHS-Basic:					
Total basic earnings per share	$ 2.13	$ 1.93	$ 1.48	$ 2.32	$ 7.86
Earnings per share attributable to UHS-Diluted:					
Total diluted earnings per share	$ 2.12	$ 1.91	$ 1.47	$ 2.31	$ 7.81

The 2017 quarterly financial data presented above includes the following:

First Quarter:

- an unfavorable $8.1 million pre-tax impact ($5.1 million, or $.05 per diluted share, net of taxes) recorded in connection with the implementation of electronic health records ("EHR") applications;
- a favorable after-tax impact of $6.8 million, or $.07 per diluted share, resulting from our January 1, 2017 adoption of ASU 2016-09.

Second Quarter:

- an unfavorable $6.4 million pre-tax impact ($4.0 million, or $.04 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- a favorable after-tax impact of $1.4 million, or $.01 per diluted share, resulting from our January 1, 2017 adoption of ASU 2016-09.

Third Quarter:

- an unfavorable $4.2 million pre-tax impact ($2.6 million, or $.03 per diluted share, net of taxes) recorded in connection with the implementation of EHR application;
- a favorable after-tax impact of $487,000, or $.01 per diluted share, resulting from our January 1, 2017 adoption of ASU 2016-09.

Fourth Quarter:

- an unfavorable $3.6 million pre-tax impact ($2.3 million, or $.03 per diluted share, net of taxes) recorded in connection with the implementation of EHR applications;
- a favorable after-tax impact of $13.5 million, or $.14 per diluted share, resulting from our January 1, 2017 adoption of ASU 2016-09;
- a favorable after-tax impact of $30.0 million, or $.32 per diluted share, resulting from a reduction in our net deferred income tax liability resulting from lower federal income tax rates beginning January 1, 2018 pursuant to the Tax Cuts and Jobs Act of 2017 ("TCJA-17");
- an unfavorable after-tax impact of $11.3 million, or $.12 per diluted share, resulting from the one-time repatriation tax incurred pursuant to the TCJA-17 (in connection with our behavioral health care facilities located in the U.K. and Puerto Rico).

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
(amounts in thousands)

Valuation Allowance for Deferred Tax Assets:	Balance at beginning of period	Charges to costs and expenses	Acquisitions of business	Write-off of uncollectible accounts	Balance at end of period
Year ended December 31, 2018	$ 70,227	$ 9,037	$ -	$ -	$ 79,264
Year ended December 31, 2017	$ 56,333	$ 13,894	$ -	$ -	$ 70,227
Year ended December 31, 2016	$ 52,567	$ 3,766	$ -	$ -	$ 56,333

Allowance for Doubtful Accounts Receivable:	Balance at beginning of period	Charges to costs and expenses	Acquisitions of business	Write-offs	Balance at end of period
Year ended December 31, 2017 (a)	$ 410,374	$ 869,077	$ -	$ (799,162)	$ 480,289
Year ended December 31, 2016	$ 398,797	$ 741,578	$ -	$ (730,001)	$ 410,374

(a) Effective January 1, 2018, the Company adopted ASC 606 using a modified retrospective approach. This schedule discloses allowance for doubtful accounts receivable for periods reported under ASC 605 only.

CORPORATE INFORMATION

EXECUTIVE OFFICES

Universal Corporate Center
367 South Gulph Road
King of Prussia, PA 19406
(610) 768-3300

ANNUAL MEETING

May 15, 2019, 10:00 a.m.
Universal Corporate Center
367 South Gulph Road
King of Prussia, PA 19406

COMPANY COUNSEL

Norton Rose Fulbright
New York, New York

AUDITORS

PricewaterhouseCoopers LLP
Philadelphia, Pennsylvania

TRANSFER AGENT AND REGISTRAR

Computershare
250 Royall Street
Canton, MA 02021
1-800-851-9677

Shareholder website:
www.computershare.com/investor

Shareholder online inquiries:

https://www-us.computershare.com/investor/Contact

TDD: Hearing Impaired # 1-800-231-5469

Please contact Computershare for prompt assistance on address changes, lost certificates, consolidation of duplicate accounts or related matters.

INTERNET ADDRESS

The Company can be accessed online at www.uhsinc.com.

LISTING

Class B Common Stock: New York Stock Exchange under the symbol UHS

PUBLICATIONS

For copies of the Company's annual report, Form 10-K, Form 10-Q, quarterly earnings releases, and proxy statements, please call 1-800-874-5819, or write

Investor Relations
Universal Health Services, Inc.
Universal Corporate Center
367 South Gulph Road
King of Prussia, PA 19406

FINANCIAL COMMUNITY INQUIRIES

The Company welcomes inquiries from members of the financial community seeking information on the Company. These should be directed to Steve Filton, Chief Financial Officer.

DISCLOSURE UNDER 303A.12(a)

In accordance with Section 303A.12(a) of The New York Stock Exchange Listed Company Manual, we submitted our CEO's Certification to the New York Stock Exchange in 2018. Additionally, contained in Exhibits 31.1 and 31.2 of our Annual Report on Form 10-K filed with the Securities and Exchange Commission on February 27, 2019, are our CEO's and CFO's Certifications regarding the quality of our public disclosure under Section 302 of the Sarbanes-Oxley Act of 2002.

UHS of Delaware, Inc. is the management company for, and a wholly owned subsidiary of Universal Health Services, Inc. All of our "Corporate Officers" listed above are employees of UHS of Delaware, Inc. The Staff Vice Presidents and officers of the Acute and Behavioral Divisions listed above are solely officers and employees of UHS of Delaware, Inc.

FACILITY LOCATIONS

UNITED STATES
Alabama | Alaska | Arizona
Arkansas | California | Colorado | Connecticut
Delaware | District of Columbia
Florida | Georgia | Idaho | Illinois
Indiana | Kentucky | Louisiana
Massachusetts | Michigan | Minnesota
Mississippi | Missouri
Nevada | New Jersey | New Mexico
North Carolina | North Dakota | Ohio
Oklahoma | Oregon | Pennsylvania
South Carolina | Tennessee | Texas
Utah | Virginia | Washington
West Virginia | Wyoming

UNITED KINGDOM

PUERTO RICO



UNIVERSAL HEALTH SERVICES, INC.

Corporate Center
367 South Gulph Road
King of Prussia, PA 19406
www.uhsinc.com

Cygnet Health Care
Third Floor - 4 Millbank
SW1P 3JA London
United Kingdom

Appendix 10.

CN-Forms.

Form CN-1

(OAR 333-580-0080)

STATE OF OREGON

FOR HEALTH DIVISION USE ONLY	
APPN. NO.	
DATE RECEIVED	
DATE COMPLETE	
FEE	

Facility Name: NEWCO Oregon, Inc.

Street Address: 9470 SW Day Road City/Zip: Wilsonville OR

Applicant/ Licensee: NEWCO Oregon, Inc., a Delaware Corporation

Licensee Address (if different):

Facility Administrator: To be determined Phone:

Medicare Provider No.: Medicaid Provider No.:

PERSON AUTHORIZED TO ANSWER QUESTIONS, ACT AND RECEIVE SERVICE ON BEHALF OF THE APPLICANT (if other than the facility administrator)

Name: Mr. Ron Escarda and Frank Fox, PhD. Phone: Mr. Escarda-(425) 821-2000; Dr. Fox (206) 366-1550

Title: Mr. Escarda-UHS Group Director of the Pacific Northwest; DR. Fox-Consultant

Firm: UHS of Delaware, Inc.

Address: 367 South Gulph Road City/Zip: King of Prussia PA 19406-0958

Have you previously submitted an application for this or a similar project? YES ☒ NO ☐

If yes, date submitted: January 5, 2016 Application ID No. CN #675

CERTIFICATION BY APPLICANT

I hereby attest that I reviewed the application and have knowledge of the content of information contained in this application. I therefore declare under penalty of perjury, that the project described and each statement, amount and supporting documents included are true and correct to the best of my knowledge and belief.

Name: Ron Escarda Title: UHS Group Director, Pacific Northwest

Signature: [signature] Date: 7/2/19

CERTIFICATE OF NEED APPLICATION FORM

Signature: _____ Date: _____

ARCHITECTURAL SECTION

PROJECT SUMMARY

(1.) PROJECT DESCRIPTION

(a) Project Type(s): New Structure: **X** Addition: ☐ Remodel: ☐

(b) Number of Floors: Basement: **None** No. of floors above grade: **2**

(c) Shelled-in areas (identify location of any unfinished spaces with description of future intended use):

None

(d) Renovation Considerations (for projects involving remodel): **None**

Will the renovations involved be done to conform to the new construction/major alteration standards of the Senior and Disables Services or Health Division (as applicable) and NFPA 101 codes?

YES ☐ NO ☐

If no, explain in detail which of these standards will not be complied with and explain why:

(e) Building Structural System (in accord with Uniform Building Code):

☐ Type I - Noncombustible **X** Type II - Noncombustible

☐ Type III - HR or N ☐ Type IV - 1 hr. ☐ Type V - 1 hr.

(2.) MAJOR DIAGNOSTIC AND TREATMENT EQUIPMENT

(List all diagnostic and treatment equipment items in excess of $1,000,000 purchase cost.) **None**

Identify Item	Department	Cost of Each Item	Number of Purchased Items

(3.) PROJECT DEPARTMENT BREAKDOWN

(Complete department breakdown required for hospital applications only; nursing home applications require completion of totals column only)

DEPARTMENT AREA SCHEDULE					DEPARTMENT COST SCHEDULE			
Ancillary Dept. or Patient Care Unit	Departmental Areas in Gross Square Feet[1]				Departmental Remodel Cost	Departmental New Constr. Cost	Remodel Cost Per Sq. Ft.	New Constr. Cost Per Sq. Ft.
	Existing	Remodel Area	New	Total at Completion				
Admin. Support	0	0	9,000	9,000		$650		$5,850,000
Outpatient Svcs.			1,760	1,760		$700		$1,232,000
Pharmacy			400	400		$850		$340,000
Dietary			4,660	4,660		$800		$3,728,000
Bldg. Support.			4,600	4,600		$600		$2,760,000
Gymnasium			3,000	3,000		$600		$1,800,000
Clinical Support			7,190	7,190		$850		$6,111,500
Activity Areas			10,220	10,220		$800		$8,176,000
Patient Rooms			16,750	16,750		$850		$14,237,500
Remaining unassignable spaces:	0	0	5,080	5,080		$553		$2,809,127
TOTALS	**0**	**0**	**62,660**	**62,660**		**$751**		**$47,044,127**

REMARKS: Departmental cost per Sq. Ft. schedule uses total project cost of $47,044,127. Remaining unassignable spaces includes stairwells, corridors and mechanical areas.

[1] Gross square feet is calculated including interior partitions and related outside walls. Do not include stairwells, corridors or mechanical areas serving more than a single department.

CAPITAL EXPENDITURE ESTIMATE

a. Planning:			
(A)	Consultant Fees	$1,420,187	
(B)	Surveys and Studies ...	$30,000	
(C)	Other	$0	
(D)	TOTAL PLANNING		**$1,450,187**
b. Administrative:			
(A)	Legal.....	$0	
(B)	Other.....	$0	
(C)	TOTAL ADMINISTRATIVE.....		**$0**
c. Site:			
(A)	Purchase Price of Property (if within previous year or yet to be purchased)	$3,248,740	
(B)	Appraisals.....	$0	
(C)	Site Surveys.....	$0	
(D)	Soil Investigations.....	$0	
(E)	Site Preparation (not paid for under construction contract).....	$4,524,415	
(F)	Other.....	$306,301	
(G)	TOTAL SITE.....		**$8,079,456**
d. Equipment:			
(A)	Diagnostic or Therapeutic Purchase.....	$0	
(B)	Diagnostic or Therapeutic Equipment Lease Value[1].....	$0	
(C)	Other Equipment Purchase.....	$2,934,000	
(D)	Other Equipment Value or Lease[1].....	$0	
(E)	Contingency Fund for Equipment.....	$0	
(F)	TOTAL EQUIPMENT.....		**$2,934,000**
e. Architectural/Engineering Services and Related Costs:			
(A)	Architectural Master Planning Prior to Project.....		
(B)	Project Architectural/Engineering Fees	$2,276,292	
(C)	Plan Check Fees (not paid for under construction).....		
(D)	Project Inspection Fees (owner's Clerk of the Works and inspections not included in (B)).....	$905,500	
(E)	Other Costs.....		
(F)	TOTAL ARCHITECTURAL/ENGINEERING SERVICES.....		**$3,181,792**

[1] Use this space to describe the basis for estimate of value of leased equipment and space. Explain other items as may be necessary. Use additional sheets if more space is needed.

f. Construction:

(A)	General Construction - New.....	$26,491,407	
(B)	General Construction - Remodel		
(C)	Demolition (not included under f(A) and f(B) or c(E).....		
(D)	Other.....	$115,000	
(E)	TOTAL CONSTRUCTION.....		**$26,606,407**

g. Landscaping:

(A)	Owner's Costs (not paid for under construction contract)		
(B)	TOTAL LANDSCAPING.....		**$0**

h. Miscellaneous:

(A)	Owner's Fire and Liability Insurance During Construction.....		
(B)	Performance Bonds or Other Bonds (not paid for under construction contract).....		
(C)	Other (list).....		
	General Risk Mitigation	$1,566,106	
	Cost Escalation	$3,226,179	
(D)	TOTAL MISCELLANEOUS.....		**$4,792,285**

i. TOTAL PROJECT COST (items a through h)

$47,044,127

j. CONSTRUCTION COST PER BED (if applicable)

f(E) / # beds added = $26,606

k. PROJECT COST PER BED (if applicable)

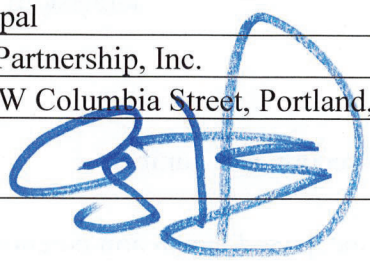
total project cost / # beds added = $47,044

l. CONSTRUCTION INFLATION ASSUMPTION

5.9% % per year

VERIFICATION BY LICENSED ARCHITECT OR ENGINEER OF PROBABLE CONSTRUCTION COSTS

I hereby submit and declare that the amounts listed Sections e., f., g., and h., above, are true and correct to the best of my knowledge and belief.

Name:	Craig Tompkins, AIA	Phone:	(503) 222-1917
Title:	Principal	License:	OR 2699
Firm Name:	SRG Partnership, Inc.		
Address:	621 SW Columbia Street, Portland, Oregon 97201		
Signature:		Date:	June 27, 2019

PROJECT DEVELOPMENT SCHEDULE

a. Estimated completion date of final drawing and specifications: April 2020

b. Estimated construction start date: ..... July 2020

c. Estimated project completion date: ..... September 2021(first patient admission)

SUPPORTING INFORMATION

Provide the following as attachments, referenced by subsection and number.

a. Architectural master plan indicating long-range concept and expansion potential.

b. A short statement regarding accessibility of the proposed facility to each of the following:

(A) Patients;
(B) Medical staff;
(C) Facility personnel;
(D) Supplies delivery;
(E) Visitors;
(F) Public transportation;
(G) Highway systems; and
(H) Emergency vehicles (including air)

c. Schematic architectural plans, prepared by a licensed architect or engineer as follows:[1]

(A) Scale site plan, indicating property dimensions, location of existing and new structures, parking, access roads, and location of planned additions.

(B) Floor plans for all proposed construction and remodel areas, indicating the intended use of each room, location and number of beds, plumbing fixtures and major built-in equipment. Plans must be drawn at 1/16" = 1'0" minimum scale. A single line drawing is acceptable.

(C) Small scale floor plan of existing building if the project involves remodel, addition to an existing building, or replacement of existing departmental areas.

[1] Only one copy of larger scale plans is required with submission to the Health Division. All other application copies may include small reductions only.

MEMORANDUM

MEMO DATE: June 27, 2019
REVISION DATE: July 2, 2019

PROJECT NAME:UHS Wilsonville Behavioral Health

SRG PROJECT #: 219015

TO: Pamela Brink, Senior Project Manager
UHS of Delaware, Inc.

FROM:Craig Tompkins, AIA, Principal

SUBJECT: Certificate of Need Application Form CN-3 – Supporting information, Item b. Accessibility Narrative

DISTRIBUTION: file

ATTACHMENTS: none

SRG

SRG PARTNERSHIP, INC

621 SW COLUMBIA STREET
PORTLAND, OREGON 97201
503 222 1917

110 UNION STREET, SUITE 300
SEATTLE, WASHINGTON 98101
206 973 1700

SRGPARTNERSHIP.COM

UHS is proposing to construct a 100-bed, behavioral health hospital to be located at the southeast corner of Boones Ferry Road and Day Road in Wilsonville, Oregon. The project will be comprised of a one and two-story structure including 62,660 GSF of enclosed space for administration, registration, inpatient care, outpatient services, dietary services, indoor recreation and plant operations. In summary, the proposed facility will provide access to each of the following:

(A) Patients:
Patients that will be served by this facility will include adolescents, adults and older adults, from 4 separate inpatient units, or as outpatients in separate therapy spaces to treat a variety of clinical psychiatric conditions. Patients will enter the facility at the main entrance and public lobby. A separate entrance is included for patients that arrive (or depart) by ambulance transport.

(B) Medical Staff and (C) Facility Personnel:
By the fifth full year of operations, the clinical and non-clinical staff will include 201 FTE's, not including MD's. Staff and MD's will be scheduled in 3 shifts, with the peak shift occurring during the day.

(C) Supplies Delivery:
The delivery of supplies and food products will be scheduled daily. A separate entry for deliveries is provided inside a secured service yard.

(D) Visitors:
Visitor parking will be provided near the main entrance and visiting hours will be scheduled during day-time hours and no overnight visitor accommodations.

(E) Public Transportation:
UHS encourages its staff to use alternative modes of transportation, when available, to reduce vehicular traffic in the communities they serve.

(F) Highway Systems:
The project site is located approximately 1,500-feet from the North Wilsonville Exit of I-5 and SW Boones Ferry Road, making vehicular access to and from the Interstate Highway System simple and convenient.

(G) Emergency Vehicles (including air):
The proposed facility has planned for the transportation of patients by ambulance and included a separate, dedicated entrance for that function. No on-site emergency air transportation facilities will be provided.

END OF MEMORANDUM

MEMORANDUM

MEMO DATE: June 27, 2019
REVISION DATE: Date

PROJECT NAME:UHS Wilsonville Behavioral Health Hospital

SRG PROJECT #: 219015

TO: Pamela Brink, Project Manager
UHS of Delaware

FROM:Craig Tompkins, AIA

SUBJECT: New OHA CON Application

DISTRIBUTION:

ATTACHMENTS: Floor Plans, Site Plan, OHA CN Forms CN-2, CN-3 and CN-4 and Patient Access Narrative

SRG

SRG PARTNERSHIP, INC

621 SW COLUMBIA STREET
PORTLAND, OREGON 97201
503 222 1917

110 UNION STREET, SUITE 300
SEATTLE, WASHINGTON 98101
206 973 1700

SRGPARTNERSHIP.COM

Regarding the new CON Application submittal for the Wilsonville Behavioral Health Hospital, we offer the following project update information:

Patient Unit Bed Quantities and Patient Types:

The project has been redesigned for the following patient types and bed quantities:
Unit 1A – 28 Beds for Adult Patients
Unit 1B – 32 Beds for Adult Patients
Unit 2A – 16 Beds for Adolescent Patients
Unit 2 B – 24 Beds for Older Adult Patients
Children and Alzheimer/Dementia Patients will not be admitted to this Hospital.

Compliance with the 2018 FGI

We have reviewed the plans for compliance with the 2018 FGI Guidelines, due to their anticipated adoption by the State of Oregon in January 2020. The plan submitted complies with the 2018 FGI with the following clarification:

The combined area of the Social Spaces serving Adult Unit 1B (32 Beds) includes 30 SF per bed which exceeds the minimum requirement of 25 SF per bed (FGI 2.5-2.2.10.2(2)(a)). The combined area of the Social Spaces serving Adult Unit 1A (28 Beds) and Older Adult Unit 2B (24 Beds) exceeds the 40 SF per bed requirement for inclusion of dining activity (FGI 2.5-2.2.10.2). The combined area of Social Spaces serving the Adolescent Unit 2A (16 Beds) exceeds the 50 SF per bed requirement for inclusion of dining activity (FGI 2.5-2.3.3.1).

The operational protocol for patient dining in the facility will be to encourage all patients to dine in the main Dining Room as scheduled. The sole exception will be newly admitted patients that have yet to be interviewed by the Hospital Psychologist. This interview is typically completed within the first 24-hours of a patient's stay. If necessary, meals for these patients will be served in the Quiet Activity Room or Patient Room.

END OF MEMORANDUM

FINANCIAL SECTION
PROJECT COST ESTIMATE

1.	TOTAL PROJECT COST (from Form CN-3, item i.): **$47,044,127**		
2.	AMOUNTS TO BE FINANCED: **None**		
	a. Tax-Exempt Bonds:		
	(A) Principle Amount ……		
	(B) Interest Amount ……...		
	(C) Rate _____% Term _____Years		
	(D) Will a hospital authority be sponsoring project related bonds? ☐YES ☐NO		
	b. Conventional Loan:		
	(A) Principle Amount …….		
	(B) Interest Amount ……..		
	(C) Rate _____% Term _____Years		
	c. Federal Loan:		
	(A) Principle Amount …….		
	(B) Interest Amount ……..		
	(C) Rate _____% Term _____Years		
	d. Interim Financing:		
	(A) Principle Amount …….		
	(B) Interest Amount ……..		
	(C) Rate _____% Term _____Years		
	e. Other:		
	(A) Principle Amount …….		
	(B) Interest Amount ……..		
	(C) Rate _____% Term _____Years		
	f. TOTAL PRINCIPLE ……...		
	g. TOTAL INTEREST ……		
	h. TOTAL PRINCIPLE & INTEREST …….		
	i. ANNUAL DEBT SERVICE REQUIREMENT ……..		
3.	INTERIM FINANCING: **None**		
	a. Principle Amount …….		
	b. Interest Amount ……		
	c. Rate _____% Term _____Years		
	d. TOTAL INTERIM FINANCING ……...		
	e. Interest earned during the period principal is invested ……		
	f. NET GAIN OR LOSS DURING INTERIM FINANCING ……..		
4.	AMOUNT OF PROJECT COSTS TO BE PAID FROM NON-INTEREST BEARING SOURCES		
	a. Cash on Hand ……...		
	b. Community Contributions ……	None	
	c. District or County Tax Levy:		
	(A) Amount …….	None	
	(B) Rate per $1,000 Assessed Value ……..		
	(C) Pay-Back Period _____Years		
	d. Federal Grant (identify source) ……	None	
	e. Other: (UHS Reserves)…….	$47,044,127	
	f. TOTAL NON-INTEREST BEARING SOURCES …….....		**$47,044,127**
5.	TOTAL PROJECT COST INCLUDING INTEREST: **$47,044,127**		

INCOME STATEMENT ($)

YEAR	PROJECTED				
	September-December 31, 2021	**Year 1-2022**	**Year 2-2023**	**Year 3-2024**	**Year 4-2025**
OPERATING REVENUE:					
Inpatient Revenue	2,225,120	22,114,004	49,756,510	57,219,986	63,114,429
Inpatient Physician Revenue	145,206	1,443,104	3,246,983	3,734,031	4,118,687
Outpatient Revenue	732,308	2,432,621	5,473,397	6,294,407	6,923,847
Patient Service Revenue	3,102,633	25,989,729	58,476,890	67,248,424	74,156,963
School Revenue	18,000	36,000	54,000	72,000	72,000
Total Revenue	**3,120,633**	**26,025,729**	**58,530,890**	**67,320,424**	**74,228,963**
DEDUCTIONS FROM OPERATING REVENUE					
Medicare Impact Pending Survey	1,011,892				
Provision for Medicare, Welfare & Other Contractual Adjustments -Inpatient	1,118,612	6,448,722	25,013,584	28,765,622	31,728,875
Physician	85,416	848,889	1,910,001	2,196,501	2,422,770
Provision for Medicare, Welfare & Other Contractual Adjustments -Outpatient	444,062	1,475,109	3,318,996	3,816,845	4,198,530
Charity Care	44,502	442,280	995,130	1,144,400	1,262,289
Denials	5,563	55,285	124,391	143,050	157,786
Bad Debt	16,688	165,855	373,174	429,150	473,358
Total Deductions	**2,726,735**	**9,436,140**	**31,735,275**	**36,495,567**	**40,243,607**
NET OPERATING REVENUE	**393,898**	**16,589,588**	**26,795,615**	**30,824,857**	**33,985,356**
OPERATING EXPENSES:					
Salaries &Wages	1,680,200	6,589,121	10,914,739	12,627,873	13,770,605
Employee benefits	304,281	1,222,269	2,019,159	2,336,079	2,547,477
Professional Fees	241,194	1,453,488	2,760,415	3,113,263	3,391,953
Supplies	43,585	433,166	974,624	1,120,818	1,236,277
Travel/Education	38,000	114,000	114,000	114,000	114,000

Maintenance	4,220	116,675	267,956	308,249	339,854
Purchased Services	133,178	550,352	820,392	894,129	951,950
Other Expenses	202,769	608,306	608,306	608,306	608,306
Insurance	8,537	71,196	160,555	184,161	202,505
Non-Allocated	52,565	157,694	157,694	157,694	157,694
Lease Expense	32,000	96,000	96,000	96,000	96,000
TOTAL OPERATING EXPENSE	**2,740,530**	**11,412,267**	**18,893,841**	**21,560,571**	**23,416,621**
OPERATING INCOME	**(2,346,632)**	**5,177,321**	**7,901,773**	**9,264,286**	**10,568,734**
NON-OPERATING EXPENSE					
Depreciation	819,345	2,458,034	2,458,034	2,458,034	2,458,034
Allocated Costs	11,817	497,688	803,868	924,746	1,019,561
TOTAL NON-OPERATING EXPENSES	**831,161**	**2,955,721**	**3,261,902**	**3,382,779**	**3,477,594**
EXCESS REVENUE OVER EXPENSES (Pre-Tax)	**(3,177,793)**	**2,221,600**	**4,639,871**	**5,881,506**	**7,091,140**

DEBT SERVICE COVERAGE ($)

YEAR	PROJECTED ($)				
	September-December 31, 2021	**Year 1-2022**	**Year 2-2023**	**Year 3-2024**	**Year 4-2025**
INCOME FOR DEBT SERVICE COVERAGE:[1] Excess of Revenue Over Expense, or Net Income	(3,177,793)	2,221,600	4,639,871	5,881,506	7,091,140
Depreciation and Amortization	819,345	2,458,034	2,458,034	2,458,034	2,458,034
Interest Expense	0	0	0	0	0
TOTAL DEBT SERVICE COVERAGE	**(2,358,448)**	**4,679,634**	**7,097,905**	**8,339,540**	**9,459,174**
DEBT SERVICE REQUIRMENTS: Interest Expense	0	0	0	0	0
Principle Payments	0	0	0	0	0
TOTAL DEBT SERVICE REQUIREMENTS	**0**	**0**	**0**	**0**	**0**
RATIO:[2] Income for Debt Service Coverage to Debt Service Requirements	NA	NA	NA	NA	NA

[1] Forecast debt service coverage on accrual basis.
[2] Ratio calculation = (net income + depreciation + interest) ÷ (principle + interest).

RATIO ANALYSES[1]

YEAR	PROJECTED				
	September-December 31, 2021	**Year 1-2022**	**Year2-2023**	**Year 3-2024**	**Year4-2025**
PROFITABILITY RATIOS: Operating Margin	-595.7%	31.2%	29.5%	30.1%	31.1%
Operating Ratio	6.96	0.69	0.71	0.70	0.69
Deductibles Ratio	087	0.36	0.54	0.54	0.54
Bottom Line Ratio	(8.1)	0.13	0.17	0.19	0.21
Return on Total Assets - A	NA	NA	NA	NA	NA
- B	NA	NA	NA	NA	NA
Return on Equity - A	NA	NA	NA	NA	NA
- B	NA	NA	NA	NA	NA
DEBTS RATIOS: Equity Financing - A	NA	NA	NA	NA	NA
- B	NA	NA	NA	NA	NA
Debt Service as a Percentage of Gross Patient Revenue	NA	NA	NA	NA	NA
Cash Flow to Total Debt	NA	NA	NA	NA	NA
Total Debt to Total Assets	NA	NA	NA	NA	NA
Peak Debt Service Coverage by Historical Net Revenue	NA	NA	NA	NA	NA

[1]Calculate ratios using formulas in Table 1 of OAR 333-580-0100(4)

YEAR	PROJECTED				
	September-December 31, 2021	**Year 1-2022**	**Year2-2023**	**Year 3-2024**	**Year4-2025**
Debt Service Safety Margin	NA	NA	NA	NA	NA
Debt to Plant	NA	NA	NA	NA	NA
LIQUIDITY RATIOS: Current Ratio	NA	NA	NA	NA	NA
Days Revenue in Accounts Receivable	NA	NA	NA	NA	NA
Average Payment Period	NA	NA	NA	NA	NA
Days Cash on Hand	NA	NA	NA	NA	NA
Quick Ratio	NA	NA	NA	NA	NA
OTHER RATIOS: Adjusted Patient Days	1,359	11,381	25,608	29,449	32,474
Adjusted Admissions	137	1,147	2,581	2,968	3,273

VOLUME-ADJUSTED EXPENSES AND REVENUES

YEAR	PROJECTED				
	September-December 31, 2021	Year 1-2022	Year 2-2023	Year 3-2024	Year 4-2025
Number of Patient Days	1,038	10,316	23,211	26,693	29.442
Operating Expense per Patient Day	$2,640.20	$1,106.27	$814.00	$807.73	$795.34
Amount Attributable to Proposal	All	All	All	All	All
Gross Revenue per Patient Day	$3,006.39	$2,522.85	$2,521.69	$2,522.06	$2,521.16
Amount Attributable to Proposal	All	All	All	All	All
Number of Adjusted Patient Days	1,447	12,124	27,279	31,371	34,594
Operating Expense per Adjusted Patient Day	$1,893.48	$941.30	$692.62	$687.28	$676.91
Amount Attributable to Proposal	All	All	All	All	All
Gross Revenue per Adjusted Patient Day	$2,156.10	$2,146.63	$2,145.64	$2,145.96	$2,145..46
Amount Attributable to Proposal	All	All	All	All	All
Number of Admissions	98	976	2,196	2,525	2,786
Operating Expense per Admission	$27,906.38	$11,693.03	$8,603.85	$8.537.58	$8,406.55
Amount Attributable to Proposal	All	All	All	All	All
Gross Revenue per Admission	$31,776.91	$6,666.00	$26,653.70	$26,657.62	$26,6548.15
Amount Attributable to Proposal	All	All	All	All	All
Number of Adjusted Admissions	137	1,147	2,581	2,968	2,786
Operating Expense per Adjusted Admission	$20,013.66	$9,949.30	$7,320.80	$7,264.41	$7,154.75
Amount Attributable to Proposal	All	All	All	All	All
Gross Revenue per Adjusted Admission	$22,658.04	$22,658.04	$22,658.04	$22,658.04	$22,658.04
Amount Attributable to Proposal	All	All	All	All	All

SOURCES AND USES OF FUNDS FOR THE PROPOSED PROJECT

Sources of Funds:	
Bond Issue	
Applicant Contribution	
Interest Earned on Assets Held by Trustee During Construction	
Other Sources ……UHS Reserves……..……	$47,044,127
Total Sources of Funds ……...	$47,044,127
Uses of Funds:	
Construction Costs…… …47,044,127	
Interest During Construction	
Debt Service Reserve Fund	
Bond Discount to Underwriters	
Legal, Accounting and Printing Costs	
Other Sources ……	
Total Uses of Funds ……	$47,044,127

Appendix 11.

Acute Care Bed Need Methodology

(OAR 333-590-0050 - OAR 333-590-0060)

Division 590
Demonstration of Need for Acute Inpatient Beds and Facilities
OAR 333-590-0050
Bed Need Methodology for Proposed New Hospitals

Data Sources

Category	Subcategory	Source
Historical Utilization	Cedar Hills Hospital	Hospital Discharge Data summary tables provided by OHA's Hospital Reporting Program.
	Non-CHH Hospitals	Hospital Discharge Data (CY2008-CY2017) summary tables provided by OHA's Hospital Reporting Program
Population	Historical	Portland State University – Population Research Center (PRC). Annual Population Reports - Table 9, 2008-2017
	Projections	Oregon State Office of Economic Affairs (OEA). Oregon's long-term county population forecast, 2010-2050 (2013 Release)
Bed Supply		*Hospital Bed Count Data (Excel file) provided by OHA – CON program staff Matt Gillman, MPPA.*

Bed Supply

Table A. Service Area (Washington County) Inpatient Acute Care Bed Supply by Provider

Hospital Name	Licensed Beds
Kaiser Foundation Hospital	122
Legacy Meridian Park	150
Providence St. Vincent Medical Center	523
Cedar Hills Hospital	94
Tuality Community Hospital	215
Total	**1,104**

Step 1.

(1) Determine the Service Area of the applicant facility.

OAR 333-590-0050(1) instructs applicants to "Determine the Service Area of the applicant facility as those zip codes from which either ten percent or more of the hospital's discharges are reasonably expected to originate, or in which the hospital would have at least a 20 percent market share." As a freestanding psychiatric hospital, Cedar Hills Hospital is the closest approximation

to the proposed project in regard to service mix and patient population served. Internal data from UHS' Cedar Hills Hospital facility was used to analyze patient origin and market share distribution.

Cedar Hills' CY2018 discharge data by Washington County zip codes where it had one or more discharges is provided in Table B below. The zip code total discharges at all Oregon hospitals is also presented to calculate Cedar Hills' market share percentage by Washington County zip code.

Table B. Cedar Hills Hospital Patient Origin Analysis, by Zip Code, CY2018.

Patient Zip Code	Cedar Hills - Discharges	% of Total CHH Discharges	Zip Code Total Discharges	Cedar Hills Market Share %
97005	38	1.2%	1,923	2.0%
97123	38	1.2%	3,440	1.1%
97229	37	1.2%	3,155	1.2%
97223	35	1.1%	3,249	1.1%
97007	35	1.1%	3,034	1.2%
97225	34	1.1%	1,610	2.1%
97124	25	0.8%	3,131	0.8%
97006	24	0.8%	3,299	0.7%
97062	23	0.7%	1,953	1.2%
97008	21	0.7%	2,042	1.0%
97224	19	0.6%	2,795	0.7%
97140	17	0.5%	1,394	1.2%
97116	17	0.5%	2,052	0.8%
97113	12	0.4%	1,103	1.1%
97119	4	0.1%	323	1.2%
97133	2	0.1%	361	0.6%
97117	1	0.0%	45	2.2%

*Only displays Washington County zip code that Cedar Hills had 1 or more discharges in 2018

As Table B illustrates, based on patient origin data, there is no single zip code area that constitutes a region with ten percent or more of Cedar Hills' patient discharges or that garners 20 percent market share for acute services. As a result of this, and for reasons discussed in our application, UHS defines its proposed Service Area for the acute care bed need models as the county in which the proposed facility will be located, Washington County (Service Area).

Step 2

(2) Determine the estimated population for the hospital Service Area identified in section (1).

Population counts by gender and age cohort for each of the three counties and the Service Area as a whole are provided below in Table C for the years 2008 – 2017. This data is obtained from the Population Research Center ("PRC") at Portland State University ("PSU").

The OAR rules request population data for 1970, 1980 and 1985 which, in the year 2015, equates to nearly 45 years of historical population counts. However, it is very unlikely that population

counts twenty or thirty years ago have a significant impact on current and future population trends. the population analysis focuses on the years 2008 – 2017 using data published by the PRC.

Table C. Service Area Historical Resident Population, by Gender and Age Cohort, 2008-2017.

SEX	Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Male	0-14 Years Old	59,854	60,375	60,687	58,548	58,770	59,117	59,518	59,886	60,420	60,657
	15-44 Years Old	118,369	118,973	119,233	116,240	116,851	117,687	118,869	120,362	122,514	124,817
	45-64 Years Old	61,998	63,432	64,730	65,132	65,805	66,609	67,634	68,869	70,516	72,127
	65+ Years Old	19,756	20,722	21,522	23,437	24,698	26,254	27,838	29,235	30,851	32,502
Female	0-14 Years Old	56,899	57,367	57,635	55,534	55,767	56,118	56,521	56,893	57,422	57,647
	15-44 Years Old	110,866	111,243	111,297	115,881	117,013	118,375	120,096	122,147	124,885	127,241
	45-64 Years Old	64,191	65,651	66,986	69,520	70,236	71,095	72,189	73,510	75,271	77,014
	65+ Years Old	27,992	29,379	30,531	32,077	33,705	35,735	37,799	39,609	41,716	43,854
Total	**0-14 Years Old**	**116,752**	**117,742**	**118,323**	**114,083**	**114,538**	**115,235**	**116,040**	**116,779**	**117,842**	**118,305**
	15-44 Years Old	**229,235**	**230,215**	**230,529**	**232,121**	**233,864**	**236,062**	**238,965**	**242,508**	**247,399**	**252,058**
	45-64 Years Old	**126,189**	**129,082**	**131,715**	**134,652**	**136,041**	**137,704**	**139,823**	**142,379**	**145,787**	**149,142**
	65+ Years Old	**47,749**	**50,100**	**52,053**	**55,515**	**58,403**	**61,989**	**65,637**	**68,844**	**72,567**	**76,356**

As indicated in Table C, the Service Area has had consistent population growth in the past ten years, with an average growth rate of about 1.5% for the total Service Area population. While the 0 – 14, 15 – 44, and 45 - 64 age cohort population has remained relatively constant over the past ten years, the 65 and older age cohort, however, has experienced by far the most substantial average annual growth rates of 5.7% and 5.1% for men and women, respectively.

The total Service Area population is expected to grow at a rate of approximately 1.7% per year from 2018 – 2030. The 65 and older age cohort is expected to continue growing at the highest average annual rates. However, the 0 – 14, 15 – 44, and 45 – 65 age cohorts are projected to grow moderately. A forecast of Service Area resident population is provided below in Table D.

Table D. Service Area Forecast Resident Population, by Gender and Age Cohort, 2018 – 2030 (Table Continued on Next Page).

SEX	Age Group	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
			Application Submission	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Male	0-14 Years Old	62,237	62,871	63,512	64,358	65,216	66,085	66,965	67,857	68,866	69,889	70,927	71,981
	15-44 Years Old	126,385	128,078	129,794	131,576	133,382	135,213	137,069	138,951	140,509	142,084	143,677	145,288
	45-64 Years Old	73,061	74,152	75,259	76,073	76,896	77,728	78,569	79,419	80,362	81,315	82,280	83,256
	65+ Years Old	35,623	37,712	39,923	41,797	43,759	45,813	47,964	50,216	52,015	53,880	55,811	57,811
Female	0-14 Years Old	58,913	59,444	59,979	60,697	61,424	62,159	62,903	63,656	64,575	65,508	66,454	67,413
	15-44 Years Old	124,097	125,760	127,445	129,174	130,927	132,703	134,504	136,329	137,716	139,118	140,534	141,964
	45-64 Years Old	74,676	75,401	76,134	76,673	77,216	77,763	78,314	78,868	79,653	80,445	81,245	82,053
	65+ Years Old	45,825	48,020	50,320	52,418	54,603	56,880	59,251	61,722	63,717	65,778	67,904	70,100
Total	**0-14 Years Old**	**121,150**	**122,315**	**123,492**	**125,056**	**126,640**	**128,244**	**129,868**	**131,513**	**133,441**	**135,396**	**137,381**	**139,394**
	15-44 Years Old	**250,482**	**253,838**	**257,239**	**260,750**	**264,309**	**267,916**	**271,573**	**275,279**	**278,225**	**281,202**	**284,211**	**287,253**
	45-64 Years Old	**147,737**	**149,553**	**151,393**	**152,746**	**154,112**	**155,491**	**156,883**	**158,288**	**160,014**	**161,760**	**163,525**	**165,309**
	65+ Years Old	**81,448**	**85,731**	**90,243**	**94,215**	**98,363**	**102,693**	**107,215**	**111,937**	**115,733**	**119,657**	**123,715**	**127,911**

Source: OEA Long Term County Forecast (2013 Release)

Step 3

(3) ***Determine current year hospital Service Area and historical Service Area population-based discharge and patient day use-rates from statewide patient origin studies.***

a. Determine current year and historical utilization, by the Service Area population of existing facilities, using available patient origin data from the Annual Reports for hospitals for each of the prior ten years…List, chronologically, factors which may have affected these statistics.

Current statewide patient origin studies are available from OHA's Hospital Reporting Program. Data from patient origin studies were used, in addition to internal Cedar Hills Hospital utilization data for CY2013-2017, as the Annual Reports for hospitals do not exist anymore.

Below, Tables E and F display historical discharge and patient day utilization and associated use-rates for the period 2008-2017, ten years of data, for selected gender and age cohorts, for Washington Count resident populations in the Service Area. Table G includes population, patient days, and use rates for Oregon State as-a-whole, as required by OAR 590-0050 methodology.

Table E. Service Area Discharge Statistics, by Gender and Age Cohort, 2008 – 2017.

Metric	SEX	Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total Discharges	Male	0-14 Years Old	2,013	2,093	2,002	1,925	1,961	1,793	1,953	2,097	2,295	2,315
		15-44 Years Old	2,835	2,775	2,675	2,821	2,457	2,569	2,627	2,647	2,569	2,502
		45-64 Years Old	4,041	4,177	4,131	4,215	4,353	4,251	4,511	4,372	4,177	4,202
		65+ Years Old	4,854	4,711	4,991	5,104	5,157	5,189	5,505	5,907	5,825	5,860
	Female	0-14 Years Old	1,596	1,552	1,532	1,526	1,604	1,555	1,609	1,685	1,888	1,863
		15-44 Years Old	11,741	11,793	10,810	10,593	10,623	10,083	10,378	10,300	9,914	9,562
		45-64 Years Old	4,533	4,590	4,638	4,556	4,514	4,574	4,618	4,425	4,359	4,122
		65+ Years Old	6,270	6,281	6,457	6,634	6,314	6,631	7,078	7,280	7,056	7,363
	Total	**0-14 Years Old**	**3,609**	**3,645**	**3,534**	**3,451**	**3,565**	**3,348**	**3,562**	**3,782**	**4,183**	**4,178**
		15-44 Years Old	**14,576**	**14,568**	**13,485**	**13,414**	**13,080**	**12,652**	**13,005**	**12,947**	**12,483**	**12,064**
		45-64 Years Old	**8,574**	**8,767**	**8,769**	**8,771**	**8,867**	**8,825**	**9,129**	**8,797**	**8,536**	**8,324**
		65+ Years Old	**11,124**	**10,992**	**11,448**	**11,738**	**11,471**	**11,820**	**12,583**	**13,187**	**12,881**	**13,223**
Discharges Per 1,000 Residents	Male	0-14 Years Old	33.6	34.7	33.0	32.9	33.4	30.3	32.8	35.0	38.0	38.2
		15-44 Years Old	24.0	23.3	22.4	24.3	21.0	21.8	22.1	22.0	21.0	20.0
		45-64 Years Old	65.2	65.9	63.8	64.7	66.2	63.8	66.7	63.5	59.2	58.3
		65+ Years Old	245.7	227.3	231.9	217.8	208.8	197.6	197.7	202.1	188.8	180.3
	Female	0-14 Years Old	28.0	27.1	26.6	27.5	28.8	27.7	28.5	29.6	32.9	32.3
		15-44 Years Old	105.9	106.0	97.1	91.4	90.8	85.2	86.4	84.3	79.4	75.1
		45-64 Years Old	70.6	69.9	69.2	65.5	64.3	64.3	64.0	60.2	57.9	53.5
		65+ Years Old	224.0	213.8	211.5	206.8	187.3	185.6	187.3	183.8	169.1	167.9
	Total	**0-14 Years Old**	**30.9**	**31.0**	**29.9**	**30.3**	**31.1**	**29.1**	**30.7**	**32.4**	**35.5**	**35.3**
		15-44 Years Old	**63.6**	**63.3**	**58.5**	**57.8**	**55.9**	**53.6**	**54.4**	**53.4**	**50.5**	**47.9**
		45-64 Years Old	**67.9**	**67.9**	**66.6**	**65.1**	**65.2**	**64.1**	**65.3**	**61.8**	**58.6**	**55.8**
		65+ Years Old	**233.0**	**219.4**	**219.9**	**211.4**	**196.4**	**190.7**	**191.7**	**191.5**	**177.5**	**173.2**

*Excludes MS-DRG 795

Table F. Service Area Resident Patient Day Statistics, by Gender and Age Cohort, 2008 – 2017.

Metric	SEX	Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total Patient Days	Male	0-14 Years Old	10,236	10,376	10,413	9,658	9,819	9,023	9,187	9,881	10,024	10,200
		15-44 Years Old	12,961	12,466	12,262	12,903	10,226	12,032	12,419	13,077	12,779	12,908
		45-64 Years Old	18,061	19,058	18,369	19,205	19,935	19,777	20,170	20,283	19,621	18,669
		65+ Years Old	23,724	22,043	23,436	23,103	22,895	22,518	24,565	26,270	25,284	26,242
	Female	0-14 Years Old	8,147	7,984	7,400	7,332	8,122	7,642	7,782	8,551	8,121	8,126
		15-44 Years Old	36,813	37,380	33,726	32,749	31,767	30,632	32,110	32,044	31,459	31,948
		45-64 Years Old	20,338	19,916	19,962	19,654	19,392	19,115	19,329	18,272	18,610	17,206
		65+ Years Old	28,582	28,705	28,227	28,126	26,316	28,439	29,989	31,651	29,790	32,661
	Total	**0-14 Years Old**	**18,383**	**18,360**	**17,813**	**16,990**	**17,941**	**16,665**	**16,969**	**18,432**	**18,145**	**18,326**
		15-44 Years Old	**49,774**	**49,846**	**45,988**	**45,652**	**41,993**	**42,664**	**44,529**	**45,121**	**44,238**	**44,856**
		45-64 Years Old	**38,399**	**38,974**	**38,331**	**38,859**	**39,327**	**38,892**	**39,499**	**38,555**	**38,231**	**35,875**
		65+ Years Old	**52,306**	**50,748**	**51,663**	**51,229**	**49,211**	**50,957**	**54,554**	**57,921**	**55,074**	**58,903**
Patient Days Per 1,000 Residents	Male	0-14 Years Old	171	172	172	165	167	153	154	165	166	168
		15-44 Years Old	109	105	103	111	88	102	104	109	104	103
		45-64 Years Old	291	300	284	295	303	297	298	295	278	259
		65+ Years Old	1,201	1,064	1,089	986	927	858	882	899	820	807
	Female	0-14 Years Old	143	139	128	132	146	136	138	150	141	141
		15-44 Years Old	332	336	303	283	271	259	267	262	252	251
		45-64 Years Old	317	303	298	283	276	269	268	249	247	223
		65+ Years Old	1,021	977	925	877	781	796	793	799	714	745
	Total	**0-14 Years Old**	**157**	**156**	**151**	**149**	**157**	**145**	**146**	**158**	**154**	**155**
		15-44 Years Old	**217**	**217**	**199**	**197**	**180**	**181**	**186**	**186**	**179**	**178**
		45-64 Years Old	**304**	**302**	**291**	**289**	**289**	**282**	**282**	**271**	**262**	**241**
		65+ Years Old	**1,095**	**1,013**	**993**	**923**	**843**	**822**	**831**	**841**	**759**	**771**

*Excludes MS-DRG 795

b. Estimate future utilization rates by the hospital Service Area population, based on CPRC projected age/sex breakdowns, according to consideration of each of a range of age/sex use-rates based on the most recent available statewide patient origin study for:

1. The state as a whole.

Table G below includes population, patient days, and use rates for Oregon State as-a-whole, as required by OAR 590-0050 methodology.

Table G. Oregon Resident Patient Days and Use Rates per 1,000 Residents, by Gender and Age Cohort, 2008 – 2017.

Metric	SEX	Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total Patient Days	Male	0-14 Years Old	64,851	64,911	68,634	65,639	62,205	58,126	62,171	68,213	69,043	71,267
		15-44 Years Old	97,456	96,248	93,522	94,661	91,001	93,719	103,804	109,489	111,860	112,990
		45-64 Years Old	180,712	185,484	182,992	185,748	179,912	183,664	196,772	204,033	209,727	210,121
		65+ Years Old	243,703	231,758	237,224	235,581	231,170	239,365	254,604	275,513	281,532	295,471
	Female	0-14 Years Old	50,291	53,857	53,680	51,146	51,338	49,944	51,094	58,360	62,099	61,408
		15-44 Years Old	230,768	225,502	215,080	211,806	202,993	199,210	204,480	213,176	213,173	212,579
		45-64 Years Old	182,726	185,163	180,373	173,792	166,423	168,680	174,731	179,081	181,822	176,440
		65+ Years Old	294,688	280,288	279,967	274,336	264,983	273,773	281,913	300,508	298,928	319,925
	Total	**0-14 Years Old**	**115,142**	**118,768**	**122,314**	**116,785**	**113,543**	**108,070**	**113,265**	**126,573**	**131,142**	**132,675**
		15-44 Years Old	**328,224**	**321,750**	**308,602**	**306,467**	**293,994**	**292,929**	**308,284**	**322,665**	**325,033**	**325,569**
		45-64 Years Old	**363,438**	**370,647**	**363,365**	**359,540**	**346,335**	**352,344**	**371,503**	**383,114**	**391,549**	**386,561**
		65+ Years Old	**538,391**	**512,046**	**517,191**	**509,917**	**496,153**	**513,138**	**536,517**	**576,021**	**580,460**	**615,396**
Population	Male	0-14 Years Old	373,842	374,076	373,219	366,610	366,532	366,908	367,605	368,577	369,725	369,753
		15-44 Years Old	799,034	800,478	800,134	781,582	783,735	786,961	792,201	800,581	811,359	823,691
		45-64 Years Old	501,361	507,726	513,312	513,212	512,010	511,088	511,948	515,031	519,806	525,174
		65+ Years Old	215,953	224,743	231,672	246,906	257,853	271,292	284,798	296,571	309,578	323,084
	Female	0-14 Years Old	356,518	356,915	356,264	349,774	349,718	350,089	350,759	351,688	352,774	352,777
		15-44 Years Old	758,505	759,104	757,950	760,012	763,722	768,551	775,375	785,323	797,708	809,971
		45-64 Years Old	513,273	519,343	524,529	534,245	532,660	531,412	532,066	535,059	539,858	545,538
		65+ Years Old	272,590	281,080	287,114	305,285	317,504	332,720	347,958	361,015	375,542	391,112
	Total	**0-14 Years Old**	**730,360**	**730,990**	**729,484**	**716,384**	**716,250**	**716,996**	**718,363**	**720,264**	**722,499**	**722,530**
		15-44 Years Old	**1,557,538**	**1,559,582**	**1,558,084**	**1,541,593**	**1,547,458**	**1,555,513**	**1,567,577**	**1,585,904**	**1,609,067**	**1,633,662**
		45-64 Years Old	**1,014,634**	**1,027,069**	**1,037,841**	**1,047,457**	**1,044,670**	**1,042,499**	**1,044,015**	**1,050,090**	**1,059,664**	**1,070,712**
		65+ Years Old	**488,542**	**505,824**	**518,786**	**552,191**	**575,357**	**604,011**	**632,755**	**657,586**	**685,119**	**714,196**
Patient Days Per 1,000 Residents	Male	0-14 Years Old	173	174	184	179	170	158	169	185	187	193
		15-44 Years Old	122	120	117	121	116	119	131	137	138	137
		45-64 Years Old	360	365	356	362	351	359	384	396	403	400
		65+ Years Old	1,129	1,031	1,024	954	897	882	894	929	909	915
	Female	0-14 Years Old	141	151	151	146	147	143	146	166	176	174
		15-44 Years Old	304	297	284	279	266	259	264	271	267	262
		45-64 Years Old	356	357	344	325	312	317	328	335	337	323
		65+ Years Old	1,081	997	975	899	835	823	810	832	796	818
	Total	**0-14 Years Old**	**158**	**162**	**168**	**163**	**159**	**151**	**158**	**176**	**182**	**184**
		15-44 Years Old	**211**	**206**	**198**	**199**	**190**	**188**	**197**	**203**	**202**	**199**
		45-64 Years Old	**358**	**361**	**350**	**343**	**332**	**338**	**356**	**365**	**370**	**361**
		65+ Years Old	**1,102**	**1,012**	**997**	**923**	**862**	**850**	**848**	**876**	**847**	**862**

*Excludes MS-DRG 795

2. The Health Service Area.

Patient day use rates for Health Service Area 1, which includes Clatsop-Columbia-Tillamook-Multnomah-Washington-Clackamas Counties, are included in Table H below.

Table H. Health Service Area 1 Resident Patient Days and Use Rates per 1,000 Residents, by Gender and Age Cohort, 2008 – 2017.

Metric	SEX	Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total Patient Days	Male	0-14 Years Old	31,295	32,330	33,855	30,912	30,270	28,110	29,238	33,062	33,350	32,109
		15-44 Years Old	51,783	49,841	49,568	51,370	48,880	49,802	54,723	56,312	56,774	57,111
		45-64 Years Old	83,336	85,090	83,875	87,085	84,576	85,442	90,300	93,128	94,280	94,923
		65+ Years Old	93,677	89,196	90,277	89,745	88,681	90,333	96,136	103,940	103,196	109,715
	Female	0-14 Years Old	25,997	26,810	26,372	24,042	25,292	24,241	25,117	28,164	28,163	27,827
		15-44 Years Old	119,145	117,488	111,247	110,184	107,396	103,429	105,554	108,298	106,611	106,444
		45-64 Years Old	83,130	84,447	82,150	79,110	76,280	74,954	78,264	80,027	80,119	75,996
		65+ Years Old	116,114	113,144	112,432	109,535	106,575	110,405	114,016	119,661	115,046	124,449
	Total	**0-14 Years Old**	**57,292**	**59,140**	**60,227**	**54,954**	**55,562**	**52,351**	**54,355**	**61,226**	**61,513**	**59,936**
		15-44 Years Old	**170,928**	**167,329**	**160,815**	**161,554**	**156,276**	**153,231**	**160,277**	**164,610**	**163,385**	**163,555**
		45-64 Years Old	**166,466**	**169,537**	**166,025**	**166,195**	**160,856**	**160,396**	**168,564**	**173,155**	**174,399**	**170,919**
		65+ Years Old	**209,791**	**202,340**	**202,709**	**199,280**	**195,256**	**200,738**	**210,152**	**223,601**	**218,242**	**234,164**
Population	Male	0-14 Years Old	176,453	177,220	177,502	170,776	171,050	171,617	172,286	173,033	173,971	174,166
		15-44 Years Old	379,602	380,351	380,317	380,251	381,987	384,550	387,912	392,757	399,023	405,847
		45-64 Years Old	226,600	230,517	234,139	231,461	232,246	233,104	234,820	237,501	241,128	244,772
		65+ Years Old	77,650	80,978	83,704	89,708	94,184	99,607	105,143	110,065	115,590	121,235
	Female	0-14 Years Old	168,014	168,767	169,055	162,536	162,791	163,326	163,956	164,664	165,551	165,738
		15-44 Years Old	362,615	363,390	363,385	376,268	379,147	382,911	387,476	393,563	401,127	408,009
		45-64 Years Old	229,307	232,739	235,873	239,620	240,317	241,105	242,784	245,458	249,125	252,954
		65+ Years Old	106,072	110,083	113,211	118,180	123,423	129,874	136,438	142,175	148,670	155,480
	Total	**0-14 Years Old**	**344,467**	**345,987**	**346,557**	**333,312**	**333,841**	**334,944**	**336,242**	**337,697**	**339,521**	**339,904**
		15-44 Years Old	**742,218**	**743,741**	**743,702**	**756,519**	**761,134**	**767,461**	**775,388**	**786,319**	**800,150**	**813,856**
		45-64 Years Old	**455,908**	**463,256**	**470,012**	**471,081**	**472,563**	**474,209**	**477,603**	**482,959**	**490,253**	**497,726**
		65+ Years Old	**183,723**	**191,061**	**196,914**	**207,888**	**217,606**	**229,481**	**241,581**	**252,239**	**264,260**	**276,715**
Patient Days Per 1,000 Residents	Male	0-14 Years Old	177	182	191	181	177	164	170	191	192	184
		15-44 Years Old	136	131	130	135	128	130	141	143	142	141
		45-64 Years Old	368	369	358	376	364	367	385	392	391	388
		65+ Years Old	1,206	1,101	1,079	1,000	942	907	914	944	893	905
	Female	0-14 Years Old	155	159	156	148	155	148	153	171	170	168
		15-44 Years Old	329	323	306	293	283	270	272	275	266	261
		45-64 Years Old	363	363	348	330	317	311	322	326	322	300
		65+ Years Old	1,095	1,028	993	927	863	850	836	842	774	800
	Total	**0-14 Years Old**	**166**	**171**	**174**	**165**	**166**	**156**	**162**	**181**	**181**	**176**
		15-44 Years Old	**230**	**225**	**216**	**214**	**205**	**200**	**207**	**209**	**204**	**201**
		45-64 Years Old	**365**	**366**	**353**	**353**	**340**	**338**	**353**	**359**	**356**	**343**
		65+ Years Old	**1,142**	**1,059**	**1,029**	**959**	**897**	**875**	**870**	**886**	**826**	**846**

*Excludes MS-DRG 795

3. The nearest facilities with service mixes most comparable to the proposed facility.

The nearest facility with service mixes comparable to the proposed facility is Cedar Hills Hospital. Internal Cedar Hills Hospital data for CY2013-2017 is provided in Table I.

Table I. Historical Cedar Hills Hospital Patient Day Utilization, 2013-2017

SEX	Age Group	2013	2014	2015	2016	2017
Male	0-14 Years Old					
	15-44 Years Old	9,223	9,003	8,933	8,728	9,638
	45-64 Years Old	5,831	5,793	6,313	6,413	6,874
	65+ Years Old	1,744	2,163	2,277	2,273	1,967
Female	0-14 Years Old					
	15-44 Years Old	4,619	5,448	5,685	4,800	5,648
	45-64 Years Old	4,420	4,561	5,020	5,592	4,315
	65+ Years Old	1,748	1,718	1,735	1,556	1,044
Total	**0-14 Years Old**	**0**	**0**	**0**	**0**	**0**
	15-44 Years Old	**13,842**	**14,451**	**14,618**	**13,528**	**15,286**
	45-64 Years Old	**10,251**	**10,354**	**11,333**	**12,005**	**11,189**
	65+ Years Old	**3,492**	**3,881**	**4,012**	**3,829**	**3,011**

4. The nearest facilities with comprehensive service mixes.

Rather than selecting a single provider, we chose to use all Service Area acute care providers' 2008 – 2017 historical utilization for all inpatient DRGs. This data is provided in Table J below, broken down by gender and age cohorts.

Table J. Service Area Provider Patient Days, By Gender and Age Cohort, 2008 – 2017.

SEX	Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Male	0-14 Years Old	9,117	10,182	10,306	10,704	9,099	7,890	9,723	7,314	6,384	6,185
	15-44 Years Old	10,978	10,434	9,851	9,596	8,645	18,014	18,776	19,333	17,850	19,809
	45-64 Years Old	23,769	21,449	20,245	21,292	19,955	24,487	27,821	28,335	27,960	28,483
	65+ Years Old	36,865	34,345	34,326	33,117	31,039	32,613	37,497	41,656	40,391	41,131
Female	0-14 Years Old	7,921	8,763	7,577	7,426	7,706	7,412	7,296	7,070	5,235	5,110
	15-44 Years Old	40,431	40,036	36,141	35,288	34,655	36,214	38,412	37,048	34,288	35,654
	45-64 Years Old	25,203	23,586	22,828	21,192	20,288	24,772	26,810	27,278	26,969	24,618
	65+ Years Old	45,001	41,087	39,398	39,748	38,230	41,156	45,859	47,364	45,562	47,806
Total	**0-14 Years Old**	**17,038**	**18,945**	**17,883**	**18,130**	**16,805**	**15,302**	**17,019**	**14,384**	**11,619**	**11,295**
	15-44 Years Old	**51,409**	**50,470**	**45,992**	**44,884**	**43,300**	**54,228**	**57,188**	**56,381**	**52,138**	**55,463**
	45-64 Years Old	**48,972**	**45,035**	**43,073**	**42,484**	**40,243**	**49,259**	**54,631**	**55,613**	**54,929**	**53,101**
	65+ Years Old	**81,866**	**75,432**	**73,724**	**72,865**	**69,269**	**73,769**	**83,356**	**89,020**	**85,953**	**88,937**

*Excludes MS-DRG 795

5. Available HMO/age/sex use-rate data for California, Oregon and Washington

This data is unavailable and not applicable to our proposed project.

Step 4

(4) ***Develop a consistent and reasonable set of well-documented assumptions regarding the appropriate use-rates reviewed in section (3) of this rule, and***

regarding the extent to which utilization at the proposed hospital will be "new" utilization and the extent to which it will replace utilization at existing hospitals.

The proposed new facility will primarily help reduce the number of mental health patients in inappropriate care settings, including hospital ERs. This has been discussed in our application and question responses. We do not anticipate replacing acute care utilization at existing hospitals, as there are numerous patients needing care that are currently not receiving it. The only extent to which our facility may affect utilization rates at existing facilities is by reduction or elimination of overcrowded facilities. Further, as the psychiatric bed need model provided in our application and question responses demonstrated, there is clear **net need for more psychiatric beds, given it assumes all current providers' beds are utilized—that is how the model is constructed as a "net need" forecast. Thus, there should be no net impact on other providers.**

A flat-trend, or constant rate, of 2017 levels was used rather than the general assumption of declining use-rates proscribed in 333-590-0030(3). A flat trend corresponds to the Department's ruling regarding Cedar Hills Hospital's Certificate of Need application in 2008. On Page 6, the Department stated:

> "As the outdated standard of declining utilization cannot with any accuracy be applied at this time, the department instead is assuming, that without strong evidence to the contrary, that usage rates within age categories are flat." [1]

Furthermore, the acute care bed methodology focuses on all inpatients while we are requesting approval to establish a licensed, psychiatric hospital, not a medical-surgical facility.

Step 5

(5) ***Analyze the advantages and disadvantages of both "new" and "replacement" components of utilization, with respect to both the population to be served and existing facilities, considering the legislative findings cited in ORS 442.025 with respect to reasonable access to quality health care at a reasonable cost.***

Prior to submitting this application, we examined other alternatives to meet the overwhelming inpatient psychiatric patient need. As we currently operate an inpatient psychiatric hospital in the Service Area, we are acutely aware of insufficient psychiatric inpatient beds and the overflow of patients into hospital EDs. While other mental health services are also much needed to best meet the needs of a large, diverse population, the simple fact is that all available data demonstrate more inpatient psychiatric beds are needed in this densely populated area.

As an existing provider in the Service Area, we are uniquely positioned to offer necessary new services because we have already developed relationships with other healthcare and related service and providers. Our proposed facility in Washington County is able to share staff and other resources, and can facilitate relationships with other existing healthcare providers, relationships Cedar Hills has already established, as discussed above.

[1] Page 6 of May 5th, 2008 Decision on CN# 654; Public Health Division of The Department of Human Services of the State of Oregon.

Step 6

(6) Given all information from the preceding steps, and the five- and ten-year population estimates, compute the range of possible future patient days in five years and in ten years at the facility, allowing appropriate adjustments for out-of-area utilization and other special factors or considerations indicated in OAR 333-590-0030(3). The division will assume that the health Service Area use-rates will decline for the next ten years at the rate indicated in section (3) of this rule. The burden of proof for any different assumption will be on the applicant.

As indicated above, we believe that the department was correct in their 2008 review of Cedar Hills Hospital's Certificate of Need application that a flat trend should be applied. [2]

In accordance with Step 6, we have calculated a 10-year projection of future patient days for the proposed project. The steps taken to calculate these projections include the following:

1. A base Service Area resident patient day forecast, based on patient day use rates featured in Table F and population projections provided in Table D above, serves as the basis for this analysis.

2. Out-migration was determined with the most recent year of statewide patient origin data (2017), including internal Cedar Hills Hospital data for CY2017. Out-migration was calculated by subtracting the number of patient days by Service Area residents at Service Area providers from the total number of patient days by Service Area residents, and dividing this figure by the total number of patient days of Service Area residents. This analysis was done at the County/gender/age cohort level. Out-migration statistics by these Service Area cohorts are provided in Table K.

3. In-migration was determined with the most recent year (2017) of statewide patient origin and internal Cedar Hills Hospital data to determine in-migration. In-migration was calculated by dividing the out-of-area resident days at service area providers by the total service area resident patient days. In-migration statistics by these Service Area cohorts are provided in Table L.

4. Out-migration and in-migration statistics were simultaneously applied to the base Service Area patient day forecast data. Out-migration percentages, by County/Gender/Age cohort, were applied and subtracted from the base Service Area patient day forecast while in-migration percentages were added. The result, provided in Table M, is the projected number of patient days in Service Area facilities.

5. Modest market share projections were applied to the Service Area provider patient day totals presented in Table N, including other statistics to be described in Steps 7-9. It is important to note that patient days increase significantly at Willamette Valley Behavioral Health from 2022 (the projected full first year of operation) to 2026 to simulate an

[2] Page 6, of May 5th, 2008 Decision on CN# 654; Public Health Division of The Department of Human Services of the State of Oregon.

appropriate ramp in growth typically experienced by new facilities. For simplicity, patient day growth at Willamette Valley Behavioral Health is assumed to remain constant by 2026 as the facility will reach well above 80% occupancy at that point, given the assumption that 100 beds will be approved and operational (Table N).

Table K. Service Area Resident Out-Migration, by Gender and Age Cohort, 2017

SEX	Age Group	Service Area Residents at All Providers	Service Area Residents at Service Area Providers	% Out-Migration
Male	0-14 Years Old	10,200	4,055	60.2%
	15-44 Years Old	12,908	6,947	46.2%
	45-64 Years Old	18,669	11,213	39.9%
	65+ Years Old	26,242	18,874	28.1%
Female	0-14 Years Old	8,126	3,410	58.0%
	15-44 Years Old	31,948	21,132	33.9%
	45-64 Years Old	17,206	11,375	33.9%
	65+ Years Old	32,661	24,897	23.8%

*Excludes MS-DRG 795

Table L. Service Area In-Migration, by Gender and Age Cohort, 2017.

SEX	Age Group	Out-of-Area Residents at Service Area Providers	Out-of-Area as % of Service Residents
Male	0-14 Years Old	2,130	21%
	15-44 Years Old	12,862	100%
	45-64 Years Old	17,270	93%
	65+ Years Old	22,257	85%
Female	0-14 Years Old	1,700	21%
	15-44 Years Old	14,522	45%
	45-64 Years Old	13,243	77%
	65+ Years Old	22,909	70%

*Excludes MS-DRG 795

Table M. Service Area Patient Day Forecast (Assuming Flat Trend of 2017 Service Area Use-Rate and In-/Out-Migration), by Gender and Age Cohort, 2018 – 2030 (Continues on Next Page).

Metric	SEX	Age Group	2018	2019	2020	2021	2022	2023	2024
				Application Submission	Year 1	Year 2	Year 3	Year 4	Year 5
Total Patient Days (Service Area Residents)	Male	0-14 Years Old	10,680	10,822	10,967	11,113	11,261	11,411	11,580
		15-44 Years Old	13,423	13,607	13,794	13,983	14,175	14,370	14,531
		45-64 Years Old	19,480	19,690	19,903	20,119	20,336	20,556	20,800
		65+ Years Old	32,233	33,747	35,331	36,989	38,726	40,544	41,997
	Female	0-14 Years Old	8,455	8,556	8,658	8,762	8,867	8,973	9,103
		15-44 Years Old	31,999	32,433	32,873	33,319	33,772	34,230	34,578
		45-64 Years Old	17,009	17,130	17,251	17,373	17,496	17,620	17,795
		65+ Years Old	37,477	39,040	40,667	42,363	44,129	45,969	47,455
	Total	**0-14 Years Old**	**19,135**	**19,378**	**19,625**	**19,875**	**20,128**	**20,384**	**20,683**
		15-44 Years Old	**45,422**	**46,040**	**46,667**	**47,303**	**47,947**	**48,599**	**49,109**
		45-64 Years Old	**36,489**	**36,820**	**37,154**	**37,492**	**37,833**	**38,177**	**38,596**
		65+ Years Old	**69,711**	**72,786**	**75,998**	**79,352**	**82,855**	**86,513**	**89,452**
Out-Migration (Patient Days)	Male	0-14 Years Old	6,434	6,520	6,607	6,695	6,784	6,874	6,977
		15-44 Years Old	6,199	6,284	6,370	6,457	6,546	6,636	6,710
		45-64 Years Old	7,780	7,864	7,949	8,035	8,122	8,210	8,307
		65+ Years Old	9,050	9,475	9,920	10,386	10,873	11,384	11,792
	Female	0-14 Years Old	4,907	4,966	5,025	5,085	5,146	5,208	5,283
		15-44 Years Old	10,833	10,980	11,129	11,280	11,433	11,588	11,706
		45-64 Years Old	5,764	5,805	5,846	5,888	5,929	5,971	6,031
		65+ Years Old	8,909	9,280	9,667	10,070	10,490	10,927	11,281
	Total	**0-14 Years Old**	**11,341**	**11,485**	**11,632**	**11,780**	**11,930**	**12,082**	**12,259**
		15-44 Years Old	**17,032**	**17,264**	**17,499**	**17,738**	**17,979**	**18,224**	**18,417**
		45-64 Years Old	**13,544**	**13,669**	**13,795**	**13,923**	**14,051**	**14,181**	**14,338**
		65+ Years Old	**17,959**	**18,755**	**19,587**	**20,456**	**21,363**	**22,311**	**23,072**
In-Migration (Patient Days)	Male	0-14 Years Old	2,230	2,260	2,290	2,321	2,352	2,383	2,418
		15-44 Years Old	13,375	13,558	13,745	13,933	14,125	14,318	14,479
		45-64 Years Old	18,020	18,215	18,412	18,611	18,812	19,016	19,242
		65+ Years Old	27,339	28,622	29,966	31,372	32,845	34,387	35,620
	Female	0-14 Years Old	1,769	1,790	1,811	1,833	1,855	1,877	1,904
		15-44 Years Old	14,545	14,743	14,943	15,145	15,351	15,559	15,718
		45-64 Years Old	13,092	13,184	13,278	13,372	13,466	13,562	13,697
		65+ Years Old	26,287	27,383	28,525	29,714	30,953	32,243	33,286
	Total	**0-14 Years Old**	**3,999**	**4,050**	**4,101**	**4,154**	**4,206**	**4,260**	**4,323**
		15-44 Years Old	**27,920**	**28,301**	**28,687**	**29,079**	**29,475**	**29,878**	**30,197**
		45-64 Years Old	**31,111**	**31,399**	**31,690**	**31,983**	**32,279**	**32,578**	**32,938**
		65+ Years Old	**53,626**	**56,005**	**58,490**	**61,086**	**63,798**	**66,630**	**68,905**
Total Patient Days (Service Area Providers)	Male	0-14 Years Old	6,476	6,562	6,650	6,738	6,828	6,919	7,022
		15-44 Years Old	20,599	20,882	21,168	21,459	21,753	22,052	22,299
		45-64 Years Old	29,720	30,041	30,366	30,695	31,027	31,363	31,735
		65+ Years Old	50,522	52,894	55,377	57,976	60,698	63,547	65,825
	Female	0-14 Years Old	5,317	5,380	5,445	5,510	5,576	5,643	5,724
		15-44 Years Old	35,711	36,196	36,687	37,185	37,689	38,200	38,589
		45-64 Years Old	24,337	24,509	24,683	24,857	25,033	25,211	25,461
		65+ Years Old	54,855	57,142	59,525	62,006	64,592	67,285	69,460
	Total	**0-14 Years Old**	**11,793**	**11,943**	**12,095**	**12,248**	**12,404**	**12,562**	**12,746**
		15-44 Years Old	**56,310**	**57,077**	**57,855**	**58,643**	**59,443**	**60,252**	**60,889**
		45-64 Years Old	**54,056**	**54,550**	**55,049**	**55,552**	**56,060**	**56,573**	**57,196**
		65+ Years Old	**105,377**	**110,036**	**114,901**	**119,983**	**125,290**	**130,832**	**135,285**

*Excludes MS-DRG 795

Table M. Service Area Patient Day Forecast (Assuming Flat Trend of 2017 Service Area Use-Rate and In-/Out-Migration), by Gender and Age Cohort, 2018 – 2030 (Continued).

Metric	SEX	Age Group	2025	2026	2027	2028	2029
			Year 6	Year 7	Year 8	Year 9	Year 10
Total Patient Days (Service Area Residents)	Male	0-14 Years Old	11,752	11,927	12,104	12,284	12,458
		15-44 Years Old	14,694	14,858	15,025	15,194	15,331
		45-64 Years Old	21,047	21,297	21,549	21,805	22,048
		65+ Years Old	43,502	45,061	46,677	48,349	49,705
	Female	0-14 Years Old	9,234	9,367	9,503	9,640	9,791
		15-44 Years Old	34,930	35,286	35,645	36,008	36,307
		45-64 Years Old	17,972	18,151	18,332	18,514	18,740
		65+ Years Old	48,989	50,573	52,208	53,896	55,124
	Total	**0-14 Years Old**	**20,986**	**21,294**	**21,607**	**21,924**	**22,249**
		15-44 Years Old	**49,624**	**50,144**	**50,670**	**51,201**	**51,638**
		45-64 Years Old	**39,020**	**39,448**	**39,881**	**40,319**	**40,788**
		65+ Years Old	**92,492**	**95,635**	**98,885**	**102,246**	**104,829**
Out-Migration (Patient Days)	Male	0-14 Years Old	7,080	7,185	7,292	7,400	7,505
		15-44 Years Old	6,786	6,862	6,939	7,016	7,080
		45-64 Years Old	8,406	8,505	8,606	8,708	8,805
		65+ Years Old	12,214	12,652	13,105	13,575	13,956
	Female	0-14 Years Old	5,359	5,436	5,515	5,595	5,682
		15-44 Years Old	11,826	11,946	12,068	12,190	12,292
		45-64 Years Old	6,091	6,151	6,213	6,274	6,351
		65+ Years Old	11,645	12,022	12,411	12,812	13,104
	Total	**0-14 Years Old**	**12,439**	**12,622**	**12,807**	**12,995**	**13,188**
		15-44 Years Old	**18,611**	**18,808**	**19,006**	**19,207**	**19,372**
		45-64 Years Old	**14,496**	**14,657**	**14,819**	**14,983**	**15,156**
		65+ Years Old	**23,860**	**24,674**	**25,516**	**26,387**	**27,060**
In-Migration (Patient Days)	Male	0-14 Years Old	2,454	2,491	2,528	2,565	2,602
		15-44 Years Old	14,641	14,805	14,972	15,139	15,277
		45-64 Years Old	19,470	19,701	19,934	20,171	20,396
		65+ Years Old	36,896	38,219	39,588	41,007	42,157
	Female	0-14 Years Old	1,932	1,960	1,988	2,017	2,048
		15-44 Years Old	15,878	16,039	16,202	16,367	16,503
		45-64 Years Old	13,833	13,971	14,110	14,250	14,424
		65+ Years Old	34,362	35,473	36,620	37,804	38,665
	Total	**0-14 Years Old**	**4,386**	**4,450**	**4,516**	**4,582**	**4,650**
		15-44 Years Old	**30,519**	**30,845**	**31,174**	**31,507**	**31,780**
		45-64 Years Old	**33,303**	**33,671**	**34,044**	**34,421**	**34,819**
		65+ Years Old	**71,258**	**73,692**	**76,208**	**78,811**	**80,822**
Total Patient Days (Service Area Providers)	Male	0-14 Years Old	7,126	7,232	7,340	7,449	7,554
		15-44 Years Old	22,549	22,802	23,058	23,316	23,528
		45-64 Years Old	32,111	32,492	32,877	33,268	33,638
		65+ Years Old	68,184	70,628	73,159	75,782	77,906
	Female	0-14 Years Old	5,807	5,891	5,976	6,062	6,157
		15-44 Years Old	38,982	39,379	39,780	40,184	40,519
		45-64 Years Old	25,715	25,970	26,229	26,490	26,813
		65+ Years Old	71,706	74,024	76,418	78,888	80,686
	Total	**0-14 Years Old**	**12,933**	**13,123**	**13,315**	**13,511**	**13,711**
		15-44 Years Old	**61,531**	**62,181**	**62,837**	**63,501**	**64,046**
		45-64 Years Old	**57,826**	**58,462**	**59,106**	**59,757**	**60,451**
		65+ Years Old	**139,890**	**144,652**	**149,577**	**154,670**	**158,591**

*Excludes MS-DRG 795

Table N. Willamette Valley Behavioral Health Patient Day and Census Forecast, 2018 – 2030.

Step	Metric	2018	2019	2020	2021	2022	2023
			Application Submission	Year 1	Year 2	Year 3	Year 4
From Step 6	Total Patient Days	0	0	0	1,038	10,316	23,211
Step 7	ADC				3	28	64
Step 8	Standard Deviation				5	7	9
Step 9	Peak Daily Census				15	44	85

(continued)

Step	Metric	2024	2025	2026	2027	2028	2029
		Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
From Step 6	Total Patient Days	26,693	29,442	29,949	29,949	29,949	29,949
Step 7	ADC	73	81	82	82	82	82
Step 8	Standard Deviation	10	10	10	10	10	10
Step 9	Peak Daily Census	96	105	106	106	106	106

Step 7-9

Willamette Valley Behavioral Health statistics for steps 7-9 are presented above in Table N.

Please see Table O below for statistics for 7-9 pertaining to the Service Area.

Table O. Service Area Patient Day and Census Forecast, 2018 – 2030.

Step	Metric	Age Group	2018	2019	2020	2021	2022	2023
				Application Submission	Year 1	Year 2	Year 3	Year 4
From Step 6	Total Patient Days	All Ages	227,536	233,606	239,900	246,427	253,197	260,220
Step 7	ADC	All Ages	623	640	657	675	694	713
Step 8	Standard Deviation	All Ages	45	46	47	48	49	51
Step 9	Peak Daily Census	All Ages	728	747	767	788	809	831

(continued)

Step	Metric	Age Group	2024	2025	2026	2027	2028	2029
			Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
From Step 6	Total Patient Days	All Ages	266,116	272,180	278,419	284,836	291,439	296,800
Step 7	ADC	All Ages	729	746	763	780	798	813
Step 8	Standard Deviation	All Ages	52	53	54	55	56	57
Step 9	Peak Daily Census	All Ages	850	869	888	909	929	946

*Excludes MS-DRG 795

(7) Convert each computed value of forecasted patient days based on preceding sections of this rule to average daily census (ADC).

Please see Tables O and N above for average daily census forecasts regarding Service Area and Willamette Valley Behavioral Health patient days for the 2018 – 2030 period. These forecasts account for in- and out-migration and assume a flat-trend of 2017 gender/age cohort use-rates.

(8) For each of the values computed under section (7) of this rule, estimate the statistical variability, or standard deviation, of the average daily census.

Please see Tables O and N above for the estimated standard deviations of the average daily census forecasts regarding Service Area and Willamette Valley Behavioral Health patient days for the 2018 – 2030 period. These forecasts account for in- and out-migration and assume a flat-trend of 2017 gender/age cohort use-rates.

Standard deviations were calculated by applying the methodology presented in Section (7) of this rule to the total ADC.

(9) Estimate the statistically expected daily census at the facility by applying an appropriate multiplier to the results of section (8) of this rule, and adding that product to the results of section (7) of this rule.

Please see Tables N and O above. In both tables, a multiplier of 2.33 was applied to the standard deviations calculated in Step 8. The resulting values were then added to the previously calculated ADC figures from Step 7.

Step 10

(10) Using a ten-year projection from the calendar year of submission of the application, and the analysis in sections (4) and (5) of this rule, select from the results of section (7) of this rule the most likely average daily census, noting the assumption in section (6) of this rule. Include consideration of the following factors

Please see Table P in Step 11 for a 10-year forecast of projected demand, supply, and net need for acute care services within the Service Area.

a. Whether it is planned that area health services will be changed.

As described throughout this application, current Service Area healthcare facilities are not expected to change their service offering to meet the substantial need for inpatient psychiatric beds in the region.

b. Whether any new or expanded services will be involved.

The proposed facility will be a new inpatient psychiatric provider.

c. Adding physicians up to, but not beyond minimum physician to population ratios.

The proposed facility will add physicians and mental health professionals to a level needed to be able to care for the demands of the Service Area and other out-of-area residents who rely on Service Area providers for psychiatric care. To our knowledge, there are no commonly accepted physician-to-population ratios.

d. Adding physicians beyond such ratios.

Please read 10(c) above.

e. Utilization generated as a result of adding physicians up to the limits set in (b) may be considered in addition to utilization projected using the use-rate assumption in section (3) of this rule.

This question is not applicable.

Step 11

(11) Select from the results of section (9) of this rule, the peak daily census associated with the result of section (10) of this rule. If this number of beds exceeds the present number of acute inpatient beds within 50 miles by road of the population to be served, the applicant must evaluate the extent to which admissions scheduling by the applicant or by existing institutions could alleviate the need for new beds.

Please see Table P in Step 11 for a 10-year forecast of projected demand, supply, and net need for acute care services within the Service Area. Please see Table A for a list of acute care providers in the Service Area and their respective bed counts.[3]

Table P. Service Area, Net Acute Care, Inpatient Bed Need, 5-Year (2024) and 10-Year (2029) Projections.

	2019	2024	2029
	Application Submission	Year 5	Year 10
Service Area Peak ADC	747	850	946
Total Service Area Bed Supply	1,104	1,104	1,104
Net Bed Need (Surplus) - Before Project	**-357**	**-254**	**-158**

Step 12

(12) If the result of section (11) of this rule indicates that added beds may be needed in the proposed hospital Service Area, an applicant for a new facility shall weight its

[3] To the extent that other inpatient beds within a 50 mile radius of the proposed location would be included in the bed supply, this would further exacerbate the surplus of general acute care beds. However, please see our comments in Step 12, as well as a description of unusual circumstances in other sections of this application, that warrants approval of the proposed project.

proposal against the availability of beds at other facilities within 50 miles by road of the proposed facility's location and against the feasibility of alternative health care services under OAR 333-590-0060.

This step is not applicable as the findings presented in Table P does not show need for additional acute care beds.

However, this acute care model broadly analyzes general inpatient care, where all DRGs are evaluated across all ages in Service Area hospitals, rather than specifically to inpatient psychiatric services. We have followed OAR 333-590-0050, but *in our opinion, the better methodology is one that focuses on demand and supply of inpatient psychiatric care, not all DRGs, and recognizes the unusual circumstances in the community.*

Division 590 Continued
Demonstration of Need for Acute Inpatient Beds and Facilities

OAR 333-590-0060

Relationship of Proposed New Hospitals to Existing Health Care System.

Step 1

(1) Identify as other significant providers, those hospitals located within the Service Area of the applicant facility.

A complete listing of current acute care inpatient facilities providing acute care services is provided in Table A.

Step 2

(2) For the applicant and for each other significant provider, estimate the anticipated commitment ratio, considering the ratio of each facility's patient days originating from the Service Area of the applicant facility, to the total patient days originating from that Service Area, using the most recent statewide patient origin data.

Please see Table Q below. Commitment ratios, titled '% of Days for SA Residents', was calculated by dividing the number of Service Area ("SA") resident days at the individual facility by the total number of days at the facility regardless of patient origin. Due to the lack of historical data to examine for the proposed Willamette Valley Behavioral Health facility, we determined that Cedar Hills Hospital's 2017 percent of discharges should be used as a proxy for Willamette Valley Behavioral Health's commitment ratio.

Table Q. Service Area Hospital Providers' Commitment Ratios, 2017.

	2017				
Provider	Total Provider Patient Days	Market Share	Market Share	Patient Days from SA Residents	% of Days for SA Residents*
Kaiser Westside Medical Center	21,545	10%	10%	12,100	56%
Legacy Meridian Park Medical Center	32,220	15%	15%	11,032	34%
Providence St Vincent Medical Center	104,591	50%	50%	61,744	59%
Tuality Healthcare	20,960	10%	10%	14,410	69%
Cedar Hills Hospital	29,486	14%	14%	2,617	9%
Current Service Area Providers	208,802			101,903	

*Willamette Valley Behavioral Health's commitment ratio of days for SA residents is taken from the percent of Cedar Hills Hospital discharges from Service Area residents.
*Excludes MS-DRG 795

Steps 3-5

Table R. Projected Patient Days and Average Daily Census at Current Service Area Providers and Willamette Valley Behavioral Health, 2022.

	2022					
Provider	Projected Patient Days at SA Providers	Total Projected Provider ADC	Estimated Standard Deviation	Peak ADC	% of Days for SA Residents*	Peak ADC Commitment to SA Residents
Kaiser Westside Medical Center	25,061	69	9.5	90.7	56%	51
Legacy Meridian Park Medical Center	37,479	103	11.7	129.8	34%	44
Providence St Vincent Medical Center	121,661	333	26.4	394.9	59%	233
Tuality Healthcare	24,381	67	9.4	88.6	69%	61
Cedar Hills Hospital	34,298	94	11.1	119.8	9%	11
Current Service Area Providers	242,881	665		823.8		400
Projected WVBH Patient Days	10,316	28.3	6.7	43.9	9%	4
Projected Overall Service Area Providers (Current Providers Plus WVBH)	**253,197**	**694**	**75**	**867.7**		**404**

(3) Calculate expected first year average daily census at the applicant facility, based on OAR 333-590-0050(7), and for each other significant provider for that year.

The first full year of operation at Willamette Valley Behavioral Health is projected to be 2022. This is reflected in the results of Step 3 of this rule, provided above in Table R.

Overall forecasts, including in-/out-migration, for all Service Area providers is provided in Table O above. For the purposes of this rule, the projected number of days in 2022 (253,197) has been used to determine the expected number of patient days and average daily census for Service Area facilities. As listed in Table N above, the projected number of patient days at Willamette Valley Behavioral Health in its first year of operation is 10,316 days.

Once Willamette Valley Behavioral Health's first-year 10,316 patient days are subtracted from the overall projected patient days for all Service Area providers (253,197), the remainder (242,881) is used to represent the number of days to be provided at currently operating facilities. Market share rates supplied in Table Q were applied to calculate each facility's projected number of patient days. All patient day figures were then converted to average daily census by dividing by 365. Please see Table R above.

(4) Calculate peak daily census for that year at each facility by applying the methodology in OAR 333-590-0050(6) through (9) to the Service Area and utilization statistics for these facilities, using a multiplier of 2.33 in order to adjust for the low probability that all facilities will simultaneously be full.

Peak census was calculated for each Service Area facility by applying the same methodology used to complete sections OAR 333-590-0050 (6) through (9) in this application.

(5) Estimate the commitment of beds by each facility to the hospital Service Area at peak occupancy as defined in section (4) of this rule, by multiplying the results of section (4) of this rule by the commitment ratios calculated in section (2) of this rule.

Commitment of beds by each facility to the Service Area at peak occupancy was calculated by multiplying each facility's commitment ratio (tiled '% of Days for SA Residents') by their respective peak census. Please see Table R above.

Steps 6-7

Table S. Projected Net Need (Surplus) at Current Service Area Providers and Willamette Valley Behavioral Health, 2022.

	2022				
Provider	Peak ADC Commitment to SA Residents	Bed Capacity	Net Need (Surplus)	% of Days for SA Residents	Net Need (Surplus) Available for SA Residents
Kaiser Westside Medical Center	51	122	(31.3)	56%	(17.6)
Legacy Meridian Park Medical Center	44	150	(20.2)	34%	(6.9)
Providence St Vincent Medical Center	233	523	(128.1)	59%	(75.6)
Tuality Healthcare	61	215	(126.4)	69%	(86.9)
Cedar Hills Hospital	11	94	25.8	9%	2.3
Current Service Area Providers	400	1,104	(280.2)		(184.7)
Projected WVBH Patient Days	4	100	(56.1)	34%	(19.2)
Projected Overall Service Area Providers (Current Providers Plus WVBH)	**404**	**1,204**	**(336.3)**		**(203.9)**

(6) To estimate available beds at each facility, subtract the peak occupancy of each, as defined in section (4) of this rule, from:

(a) The capacity defined in OAR 333-590-0010(3)

(b) The measure in subsection (a) of this section, plus "shelled space," that is, convertible space which requires construction rather than merely changing furniture.

Please see Table S above for a list of the number of surplus beds at each facility in 2018. These figures were calculated by subtracting the number of beds at each facility from the facility's peak census calculated in Table R.

(7) Estimate the number of beds in excess of peak occupancy which could readily be committed to the Service Area of the applicant, by multiplying the results from section (6) of this rule by the commitment ratios developed in section (2) of this rule.

Please see Table S above for a list of the number of surplus beds at each facility in 2022 committed to Service Area residents. These figures were calculated by multiplying each facility's number of surplus beds, by the facility's individual commitment ratios.

Step 8

(8) Evaluate the feasibility and costs of meeting the estimated future need at the applicant facility, as determined in OAR 333-590-0050, from the inventory of available beds identified in (6) of this rule.

While the results presented in Step 6 of this rule appear to show more than sufficient numbers of acute care inpatient beds available in the Service Area, it does not demonstrate that the inventory of available beds can meet the estimated future need at the applicant facility, given the analysis above focuses on all acute care and our request is for 100 inpatient psychiatric beds. These two types of facilities are not the same. ***This is an integral point for demonstration of need in that general acute care and psychiatric care require fundamentally different resources and care delivery models; general medical/surgical beds and inpatient psychiatric beds are not interchangeable.***

Current acute care service providers either do not have psychiatric services or have very high occupancy rates within their psychiatric units. Available data, including the Unity Center, demonstrates there has been no adult inpatient psychiatric bed increase in recent years, with the exception of Cedar Hills. This points to the fact that the current inventory of acute care beds in the Service Area is unable to serve as a reasonable alternative to the proposed facility.

While current Service Area providers may theoretically have space to convert some of their surplus beds to psychiatric use, this has not happened on any practical level. Instead, the Service Area has experienced growing demand for mental healthcare services without accompanied expansions in capacity. This has resulted in tremendous gaps in patient care, and forced facilities to board patients in emergency departments. Contrary to the apparent results of this specific rule, the proposed facility will meet a serious existing and growing need for inpatient psychiatric beds in the Service Area, alleviating alternative services such as emergency departments so that these facilities best serve the entire community. In summary, general acute care and psychiatric care require fundamentally different resources and care delivery models; they are not interchangeable.

Step 9

(9) If need for acute beds is not demonstrated, or if need is demonstrated but, under this rule, it is found the need can be met by utilization of existing facilities which are within 50 miles by road of the proposed facility's location, the applicant must consider whether an alternative health facility would be the least costly way to solve the applicant's problem of meeting health care needs of the population.

Please see the discussion in Step 8. The proposed facility will not only meet health care needs of the population, but also allow for alternative health facilities to optimize the level of care they provide to their patients rather than act as substandard substitutes.

Step 10

(10) HMO and other health care plans as defined in OAR 333-545-0020 (14) will be considered.

This does not apply to the current application.

(11) Based on subsection (9)(a) and (b) of this rule, the decision may consider proposed findings of need and feasibility, taking into account such factors as:

a. At least 70% of the population is more than 50 road miles from the nearest hospital with 45,000 patient days;

This is not applicable.

b. Population base sufficient to sustain the new facility or service;

As detailed above, the population of the Washington County Service Area is currently 611,000, and is expected to increase to nearly 720,000 in the next ten years. There is ample evidence illustrating the substantial need for inpatient psychiatric beds in the Service Area, including

overcrowded existing facilities, boarding of psychiatric patients at general care hospitals, and incarceration of the mentally ill in jails. High levels of future population growth rate will only exacerbate the current shortage.

c. Community effectively isolated from reasonable access to acute care services;

The community is not isolated from reasonable access to acute care service. However, as demonstrated in our application and question responses, there is a significant gap between current supply of inpatient psychiatric beds and current and projected demand of psychiatric services by the Service Area population.

d. Financial condition of applicant adequate to handle consequences of failure of facility or service…

The financial profile of UHS has been discussed above. Please see Appendix 9 of our application for documentation of its strong financial position.

e. Whether the proposed service(s) and bed capacity (ies) represent the least costly approach, in relation to capital and operating expenses to meet acute care needs;

As discussed previously, while we recognize that a new, freestanding facility is an expensive investment, there is substantial need in the Service Area specifically for inpatient psychiatric beds. There is a fundamental need for these services that cannot be met through any other less costly alternative.

By proposing a medium-sized freestanding facility, we optimize capital and operating expenses. This allows us to provide lower priced services, preserving and strengthening competition within the Service Area.

f. Whether the facility, sized as required under subsection (e) of this section, is designed so that future expansion would be feasible;

The proposed facility costs include one hundred (100) licensed beds. These costs do not include shelled space. Future expansion, however, is feasible as the proposed site is sufficiently large to allow such expansion.

g. Restrictive admission policies;

UHS' proposed facility will accept all patients over the age of twelve in need of inpatient and/or outpatient psychiatric care. Please see Appendix 2 of our application for a copy of all Cedar Hills' admissions policies for inpatients and outpatients.[4] Its admitting criteria are based on medical need, applied uniformly to all prospective patients, based on well-defined guidelines.

Additionally, as discussed previously, and stated in the Cedar Hills' "Involuntary Admissions, IP" Policy, Cedar Hills treats involuntary inpatients, as would Willamette Valley Behavioral Health.

[4] For purposes of completeness, we have included the following policies used to admit patients to Cedar Hills: Admission Criteria, IP; Admission Process, IP; Involuntary Admissions, IP; Medical Exclusionary Policy; Wait listing Patients, IP; Declaration for Mental health Treatment; Admission, IP Divert; and Clinical Services Plan, IP.

Willamette Valley Behavioral Health will also provide voluntary and involuntary care and its policies will follow the same form and include the same content.

It should also be noted that Willamette Valley Behavioral Health will voluntarily apply for and maintain Joint Commission (JCAHO) accreditation as well as CMS and state accreditation, also important for measuring standardized care delivery and quality of care.

h. Access to care-for public patients;

Please see discussion included in 333-580-0050(3)(b).

i. Restrictive staff privileges

Not applicable--UHS has no restrictive staff privilege policies.

Appendix 12.

Cedar Hills Hospital Transfer Agreement with Providence St. Vincent Medical Center

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement") is entered into this 3rd day of December, 2018 (the "Effective Date"), between Providence **St. Vincent Medical Center** ("Hospital"), and **Cedar Hills Hospital** ("Transferring Facility").

To facilitate continuity of patient care and the timely transfer of patients and records from Transferring Facility to Hospital, the parties agree as follows:

1. If a determination is made by the attending physician that a patient requires transfer from the Transferring Facility to the Hospital, Hospital agrees to admit the patient as promptly as possible, as long as it has the available space, qualified personnel and appropriate services for the treatment of the patient, and the requirements of (i) Hospital's applicable polices/protocols, and (ii) applicable federal and state laws and regulation are met.

2. Transferring Facility has the responsibility for transferring the patient to the Hospital and agrees to use qualified personnel and necessary equipment, including medically appropriate life support measures, during the transfer.

3. Transferring Facility agrees to provide the Hospital with appropriate documentation as necessary to ensure continuity of patient care. This information should include, as a minimum, the patient's medical record (i.e., summary of physician findings, nursing notes, flow sheets, lab and radiological findings, including films or underlying studies, copy of EKG, relevant transfer forms, signed consent for transfer, etc.). This documentation will be sent to the Hospital at the time of transfer unless doing so would jeopardize the patient; in which case, the documentation will be sent as promptly as possible after the transfer.

4. To the extent possible, patients will be stabilized prior to transfer to ensure the transfer will not, within reasonable medical probability, result in harm to the patient or jeopardize their survival.

5. All transfers will be done in accordance with (i) Hospital's applicable polices/protocols, (ii) applicable federal and state laws and regulations and (iii) in accordance with the standards of The Joint Commission.

6. Transferring Facility will be responsible for the transfer or other appropriate disposition of the patient's personal effects, particularly money and valuables.

7. Charges for services performed by either party shall be collected by the party rendering the service from the patient, third party payor, or other sources normally billed by the

party. Neither party shall have any liability to the other for such charges, except to the extent such liability would exist separate from this Agreement. The parties shall cooperate with each other in exchanging information about financial responsibility for services rendered by them to patients transferred to the Hospital.

8. Transferring Facility shall indemnify, hold harmless and defend the Hospital, its agents and employees from and against any claim, loss damage, cost, expense or liability, including reasonable attorney's fees, arising out of or related to the performance or nonperformance by the Transferring Facility, its agents and employees of any duty or obligation of the Transferring Facility under this Agreement.

9. Hospital shall indemnify, hold harmless and defend the Transferring Facility, its agents and employees from and against any claim, loss damage, cost, expense or liability, including reasonable attorney's fees, arising out of or related to the performance or nonperformance by the Hospital, its agents and employees of any duty or obligation of the Hospital under this Agreement.

10. The parties shall maintain at their own expense comprehensive general and professional liability insurance and property damage insurance adequate to insure them against risks arising out of this Agreement, with limits no less than those customarily carried by similar facilities. Upon request, each party shall furnish the other party with evidence of such insurance. During the term of this Agreement, each party shall immediately notify the other of any material change in such insurance.

11. Nothing in this Agreement shall be construed as limiting the rights of either party to contract with any other facility or entity on a limited or general basis.

12. Transferring Facility represents and warrants that neither Transferring Facility nor Transferring Facility's shareholders, owners, principals, partners or members (if applicable) are presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from participation in any federally funded health care program, including Medicare and Medicaid. Transferring Facility agrees to immediately notify Hospital of any threatened, proposed, or actual debarment, suspension, or exclusion from any federally funded health care program, including Medicare and Medicaid.

13. This Agreement shall be in effect on the date it is signed by both parties and shall continue until terminated as follows: (i) either party may terminate this Agreement immediately upon a breach of its terms by the other party, or (ii) either party may terminate this Agreement without cause by giving the other party not less than ninety (90) days written notice.

14. This Agreement may be signed in counterparts each of which will be considered an original.

15. This Agreement shall be interpreted and construed in accordance with laws of the state in which Hospital is located. Venue for any action to enforce its terms shall be in the county in which Hospital is located. This Agreement embodies the entire agreement of the parties relating to transfer of patients from Transferring Facility to Hospital, and supercedes all prior agreements, representations and understandings of the parties. This Agreement may only be modified or amended in writing. Amendments and modifications must be signed by both parties to be effective.

SIGNATURES APPEAR ON NEXT PAGE.

HOSPITAL:
PROVIDENCE St. Vincent Medical Center

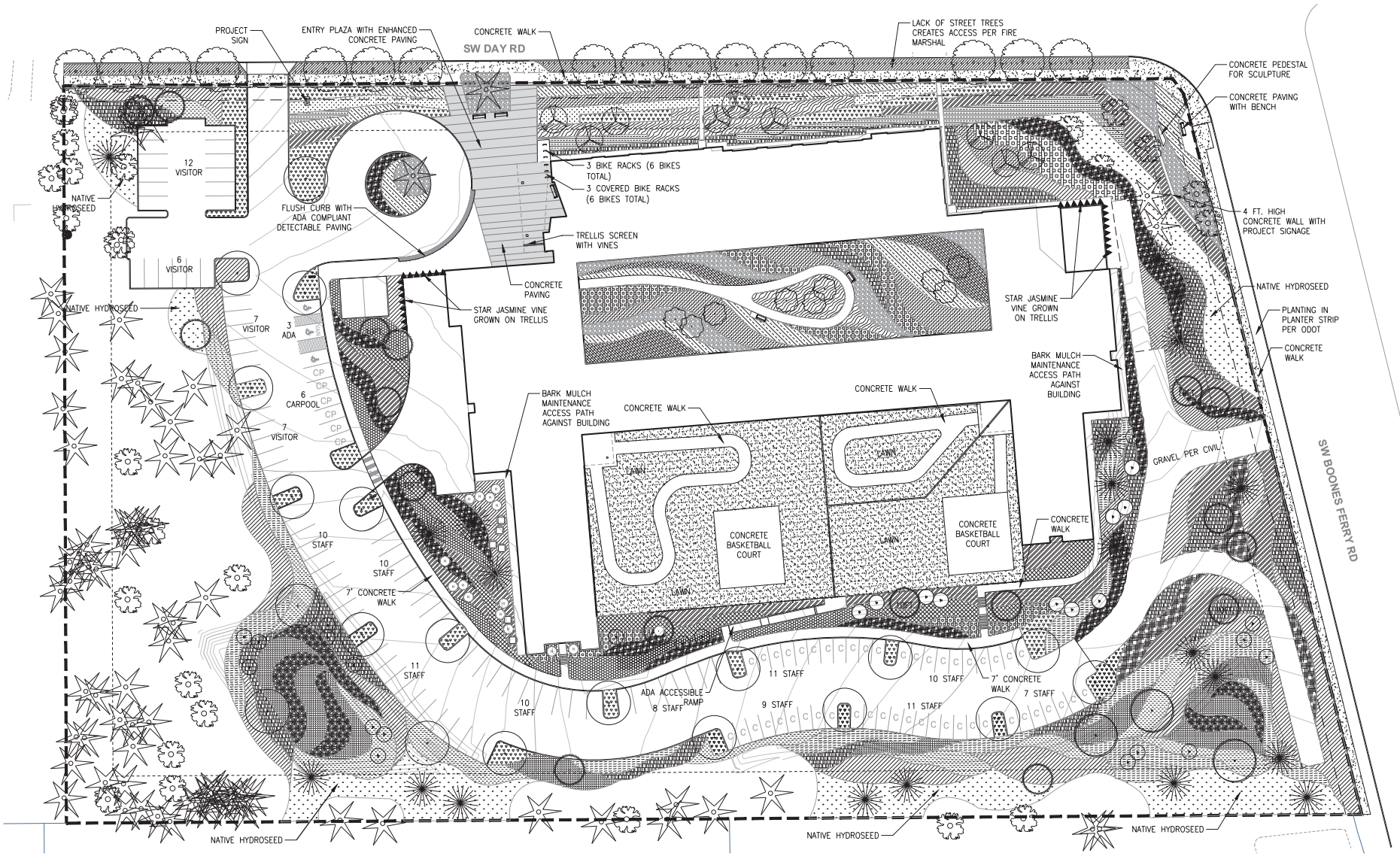
By: _____
Name: Janice Burger
Title: Chief Executive, Providence St. Vincent Medical Center

TRANSFERRING FACILITY:
Cedar Hills Hospital

By: _____
Name: Elizabeth Hutter
Title: Chief Executive Officer, Cedar Hills Hospital

Appendix 13.

Single Line Drawings

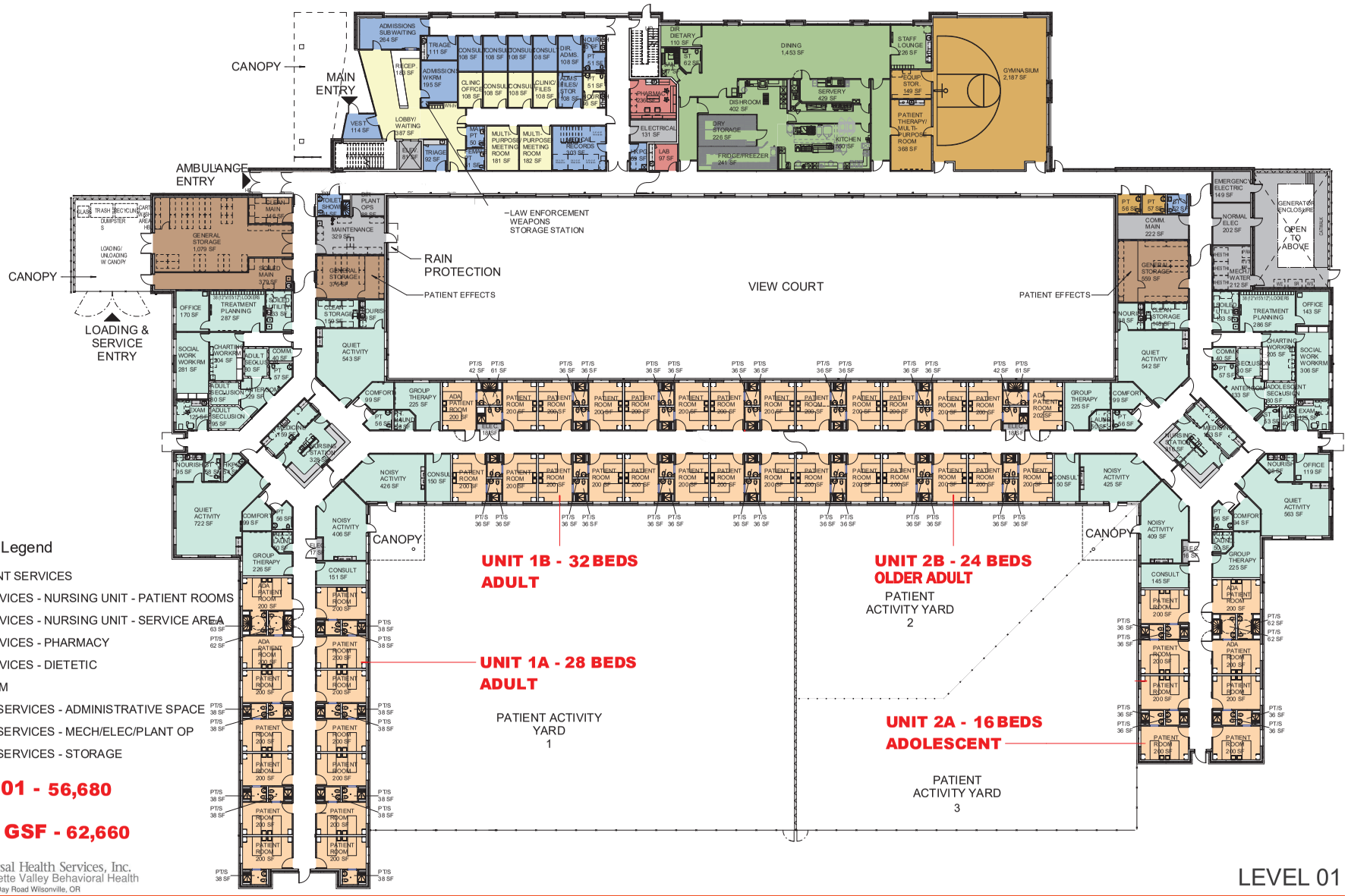


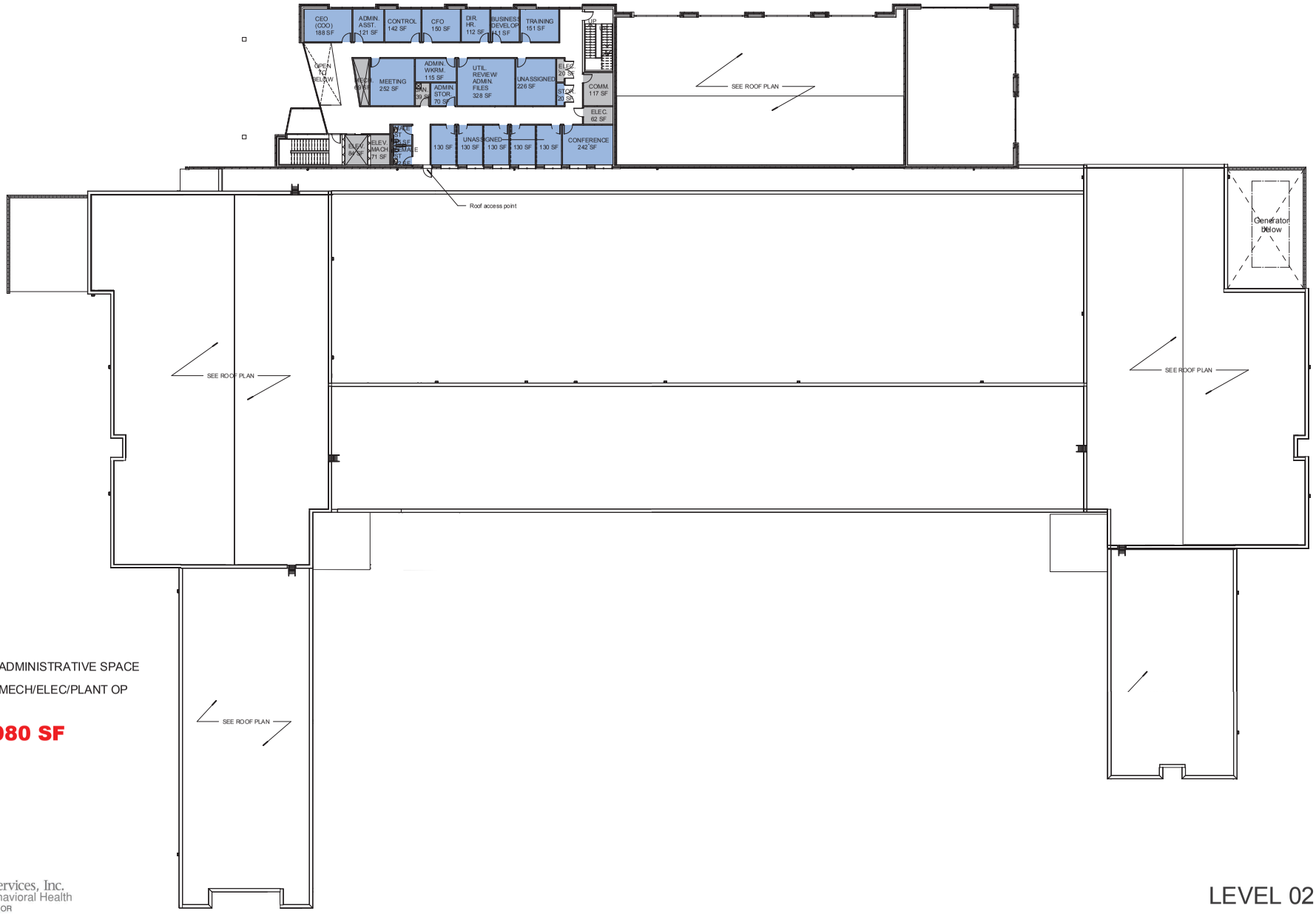
LANDSCAPE PLAN
L-100

Universal Health Services, Inc.
Willamette Valley Behavioral Health
9470 SW Day Road Wilsonville, OR

CERTIFICATE OF NEED APPLICATION - JUNE 27, 2019

WALKER MACY
SRG


CANOPY
MAIN ENTRY
AMBULANCE ENTRY
LOADING & SERVICE ENTRY
LAW ENFORCEMENT WEAPONS STORAGE STATION
RAIN PROTECTION
PATIENT EFFECTS
VIEW COURT
UNIT 1B - 32 BEDS ADULT
UNIT 1A - 28 BEDS ADULT
UNIT 2B - 24 BEDS OLDER ADULT
UNIT 2A - 16 BEDS ADOLESCENT
PATIENT ACTIVITY YARD 1
PATIENT ACTIVITY YARD 2
PATIENT ACTIVITY YARD 3
Department Legend
OUTPATIENT SERVICES
BASIC SERVICES - NURSING UNIT - PATIENT ROOMS
BASIC SERVICES - NURSING UNIT - SERVICE AREA
BASIC SERVICES - PHARMACY
BASIC SERVICES - DIETETIC
GYMNASIUM
SUPPORT SERVICES - ADMINISTRATIVE SPACE
SUPPORT SERVICES - MECH/ELEC/PLANT OP
SUPPORT SERVICES - STORAGE
LEVEL 01 - 56,680
TOTAL GSF - 62,660
Universal Health Services, Inc.
Willamette Valley Behavioral Health
9500 SW Day Road Wilsonville, OR
LEVEL 01
CERTIFICATE OF NEED APPLICATION - JUNE 27, 2019
0' 8' 16' 32' 64'
SRG
A-101



Department Legend

- SUPPORT SERVICES - ADMINISTRATIVE SPACE
- SUPPORT SERVICES - MECH/ELEC/PLANT OP

LEVEL 02 - 5,980 SF

Universal Health Services, Inc.
Willamette Valley Behavioral Health
9500 SW Day Road Wilsonville, OR

LEVEL 02

CON APPLICATION - JUNE 27, 2019

0' 8 16' 32' 64'

SRG
A-102