CtW Investment Group

March 28, 2017

John H. Herrell
Presiding Director and Chairman of the Audit Committee
Universal Health Services, Inc.
367 South Gulph Road
King Of Prussia, PA 19406

Dear Mr. Herrell,

In light of the ongoing criminal investigation of UHS led by the Department of Justice's Criminal Fraud Section, and the unwillingness of the board to respond constructively to shareholder efforts to improve governance, accountability, and compliance, we are again urging you to begin the long overdue process of modernizing UHS's board of directors and governance policies. In particular, we urge the board to promptly:

- Reclassify all shares to ensure that voting power is proportional to economic exposure, and that all shares have equal voting power with respect to all director elections and other matters.
- Declassify the board of directors so that all directors are subject to annual re-election.
- Create a new Compliance Committee comprised of newly appointed, independent directors with extensive professional experience in health care regulation and enforcement.

While we and other shareholders have repeatedly urged you to modernize the entrenched and unaccountable character of UHS's governance practices, while also constructively addressing UHS mounting legal woes, these efforts appear to have fallen on deaf ears. Consequently, unless the board publicly commits to the governance changes we and other shareholders have urged upon you, we will not support the re-election of Lawrence Gibbs as a director at UHS's 2017 annual meeting.

The CtW Investment Group works with pension funds sponsored by affiliates of Change to Win -- a federation of unions representing over six million members -- to enhance long-term shareholder value through active ownership. These funds invest over $250 billion in the global capital markets and are substantial investors in UHS.

Our Previous Communications and the Burgeoning Federal Investigation

We first wrote to you three years ago to express concern over the coordinated federal investigation being undertaken by the Office of the Inspector General for the Department Health and Human Services and the Department of Justice's Criminal Fraud Section. This investigation prompted the issuance of series of subpoenas from February 2013 through July 2013, including at least 10 separate UHS facilities, as disclosed by UHS in November 2013. We noted in our April 2014 letter that UHS's admissions practices – in particular the frequency with which patients were admitted with a suicidal ideation diagnosis - diverged from its competitors, and that such admissions rose sharply in former Psychiatric Services ("PSI") facilities following UHS's acquisition of that company in 2010. We urged the board to address the risk of an adverse enforcement action by creating a new board level committee charged with overseeing legal and regulatory compliance.

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The following year, after UHS disclosed that the Federally led criminal investigation was expanded to an additional 11 facilities, that one of its facilities subject to this investigation had Medicare and Medicaid payments suspended, and most importantly that the corporation as a whole is now subject to this criminal investigation, we wrote to you again, this time noting that over the prior two years, UHS's reserve for professional and general liabilities had been falling sharply relative to its overall assets. We expressed the concern that reducing this reserve seemed imprudent in light of the scrutiny focused on the company, while also noting the implausibility of the company's explanation for the methodological changes through which it explained this reduction. Moreover, we pointed out that in a then recent settlement, UHS had incurred costs well in excess of its expectations, and had to report a $44 million charge to reflect the lack of adequate provisioning for this liability. We again urged the board to create a new committee charged with overseeing legal and regulatory compliance.

In March 2016, we again wrote to you, reiterating our concerns with the board's structure, while also noting additional concerns with the high rate of transfers from UHS acute care hospitals to Inpatient Rehabilitation Facilities ("IRFs"), including facilities owned by UHS itself. We noted that UHS's acute care hospitals, especially those serving the Las Vegas, NV market, exhibited frequencies of IRF transfers much higher than the industry average, even taking into account their patient acuity and age mix. Again, we urged the board to undertake a thorough restructuring, including the creation of a new compliance committee.

Throughout this engagement, we have urged the board to proactively address what appeared to us to be significant signs of vulnerability to regulatory enforcement actions and related liabilities. Unfortunately, to date the board had taken no action, and now the company is mired in an apparently serious, corporation-wide criminal investigation. Its admissions practices have been the subject of investigative reports that have drawn additional public scrutiny, and it continues to maintain a level of professional and general liability reserves well below that of its competitors. In the following sections we update the analysis of inpatient psychiatric admissions, inpatient rehabilitation facility transfers from acute care hospitals, and UHS's professional and general liability reserves.

UHS Psychiatric Facilities Inpatient Admissions Diverge Sharply From Competitors

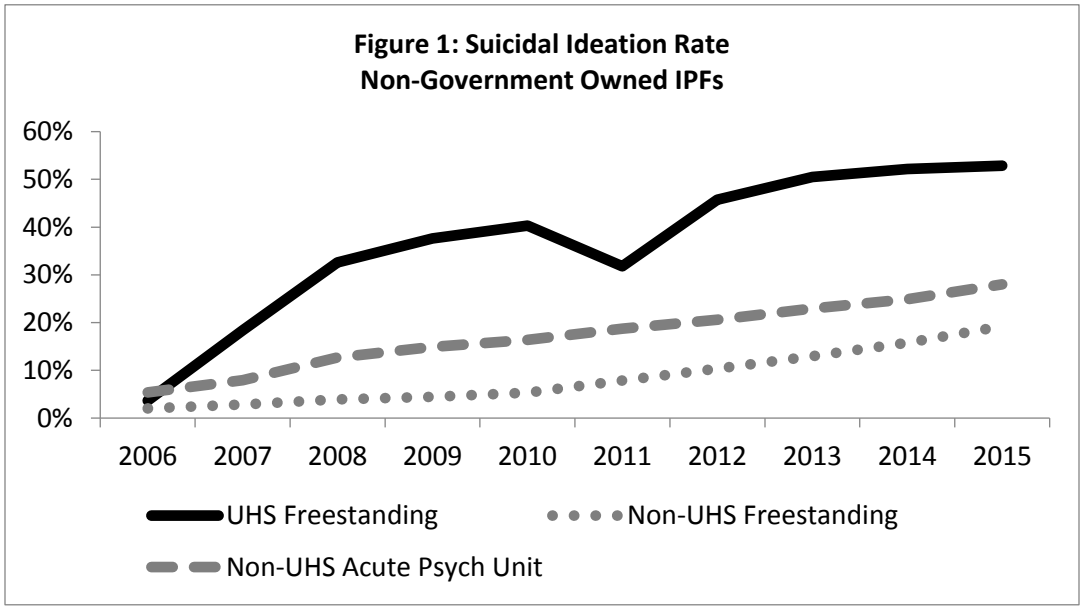
As we noted in our April 2014 letter, a former UHS psychiatrist alleged that UHS manipulates patient diagnosis and treatment decisions in order to increase admissions and maintain a high occupancy level. This psychiatrist specifically identified excessive use of the suicidal ideation diagnosis, and the prescription of unnecessarily expensive pharmaceuticals – which many patients would be unable to afford, causing them to become non-compliant with discharge instructions and establishing an acceptable basis for future readmission. In your response to this letter, you noted that the suicidal ideation diagnosis does not increase payment rates from payers such as Medicare. However, UHS executives have identified maintaining a high occupancy level as beneficial to the company's profitability; for example, CFO Steve Filton told a J.P. Morgan investor conference in 2014 that "We operate this business at fairly high occupancy rates and operating margins. I think those two things are tied together."[1]

Our letter also provided a summary of Medicare data that in fact UHS free-standing inpatient psychiatric facilities do utilize the suicidal ideation code much more frequently that comparable facilities owned

[1] UHS at JP Morgan Conference. January 15, 2014. p.4.

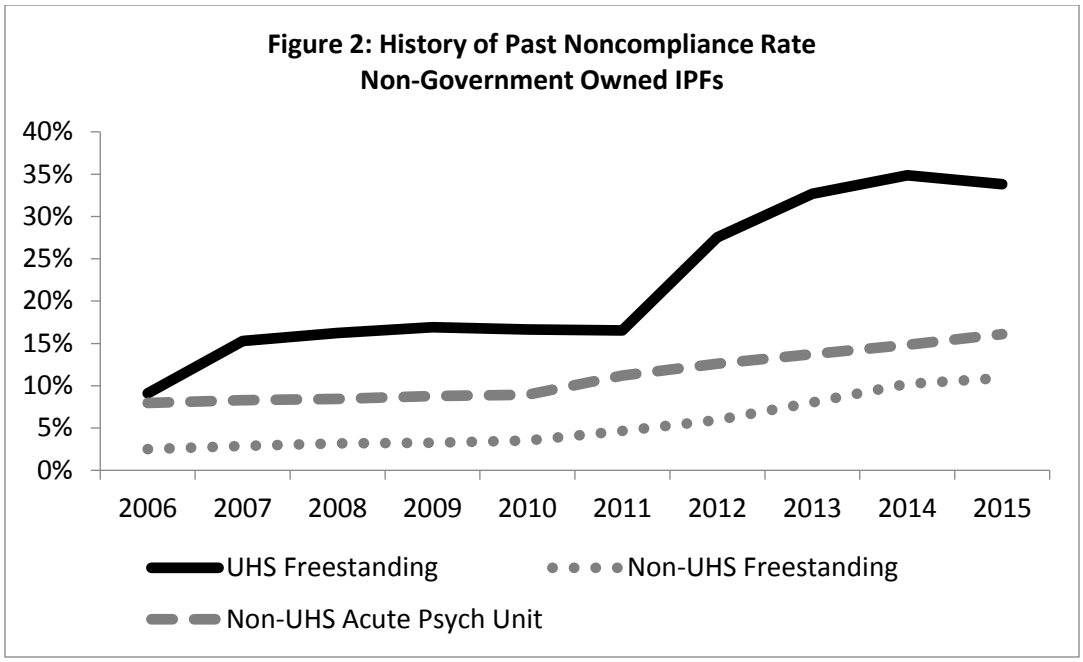
and operated by competitors. In addition, we noted that following the acquisition of PSI in 2010, the suicidal ideation utilization rate at PSI facilities increased dramatically, from below the average for non-UHS facilities, to many times that average. We also noted that between 2010 and 2012, the percentage of PSI facilities that utilized the suicidal ideation code at a frequency placing them in the 80th percentile nationally or higher, increased from 13.4% to 71%.

With three years' worth of additional data available, we can see that the trends we observed in 2014 have continued unabated. As we can see in Figure 1, UHS freestanding psychiatric facilities have continued to admit patients under a suicidal ideation diagnosis much more frequently than its competitors.[2]

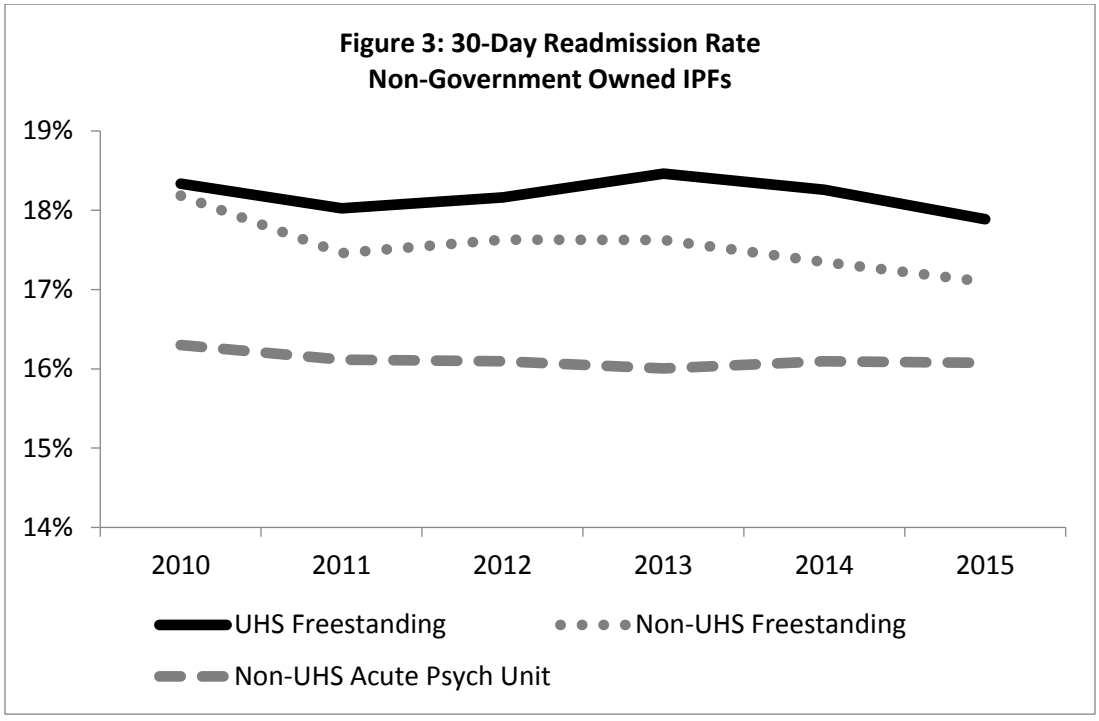


In addition to our concerns about UHS's excessive suicidal ideation rates, we have also identified additional coding and utilization patterns that potentially lead to higher admission and occupancy rates. Figure 2 demonstrates that, especially since 2011, UHS freestanding psychiatric facilities admit patients with a history of past non-compliance with post-discharge instructions at a dramatically higher rate than non-UHS psychiatric facilities. This data appears to be consistent with the allegation that post-discharge instructions from UHS facilities may be objectively more difficult for patients to comply with, resulting in a higher rate of future readmissions.

[2] Based upon SEIU analysis performed of claims data from the Medicare Inpatient Standard Analytical File Limited Data Set, as well as upon data obtained from Medicare Cost Reports. Further methodology is available upon request.



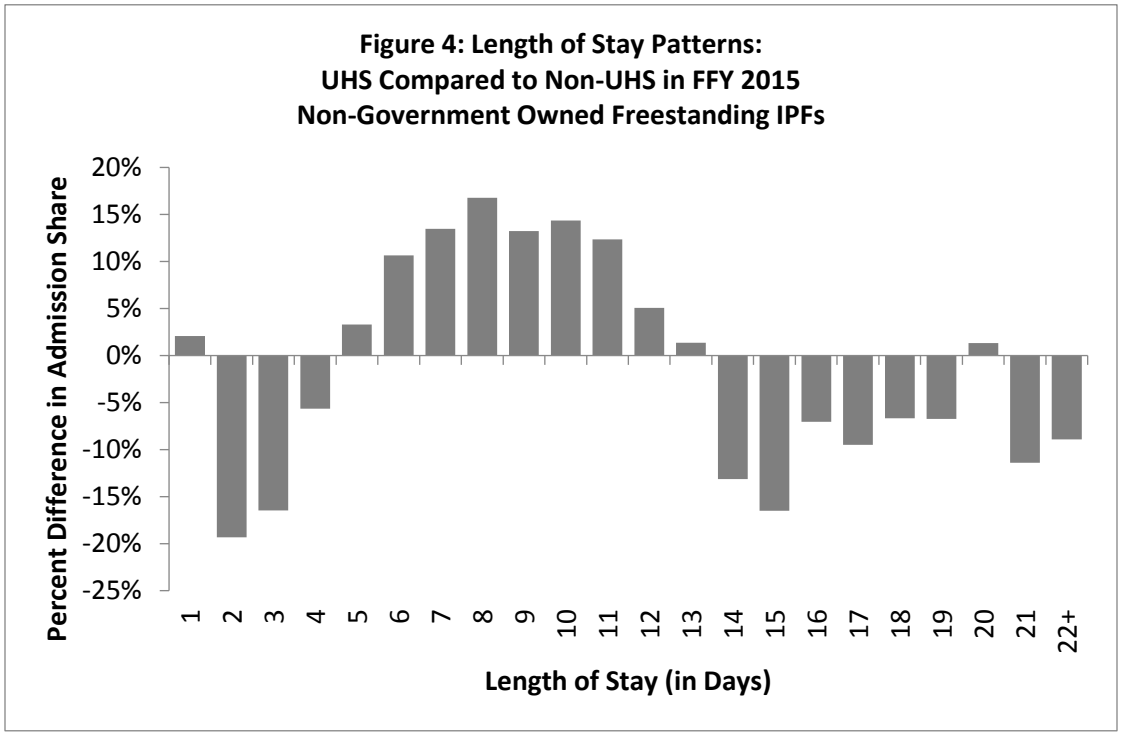
And Figure 3 shows that, in fact, UHS does exhibit a much higher rate of readmission within 30 days of discharge than other facilities.



While Medicare reimbursement penalties are not currently assessed on psychiatric facilities with high readmission rates, we nevertheless believe that such a high readmission rate strongly suggests that there are reasonable grounds to be concerned that quality of care issues could pose risks for the company and for shareholders. When combined with the ongoing high utilization of the suicidal ideation diagnosis and the high non-compliance rate, and the associated whistleblower allegations, this data

suggests that UHS's high overall occupancy levels may be a source of investor risk, rather than an unambiguous positive for the company.

Furthermore, CFO Filton has in the past noted that additional days for current stays may be just as good – if not preferable – to a new admission for UHS, saying "If you can get paid for an increased days [sic], it's easier and cheaper than generating another admission."[3] In fact, the per diem rates paid by Medicare include a multiplicative factor that gradually reduces actual payments below the base rate after 10 days. Figure 4 compares the frequency of different lengths of stay in UHS facilities to other privately operated free-standing psychiatric facilities, and there appears to be a clear clustering of above average frequency at UHS for lengths of stay between 5 and 13 days.



This picture seems much too close for comfort to what we would expect to see if health care decisions were being made at UHS psychiatric facilities based on the desire to maintain high occupancy and high margins, rather than ensuring either the best possible care or fulsome compliance with law and regulation.

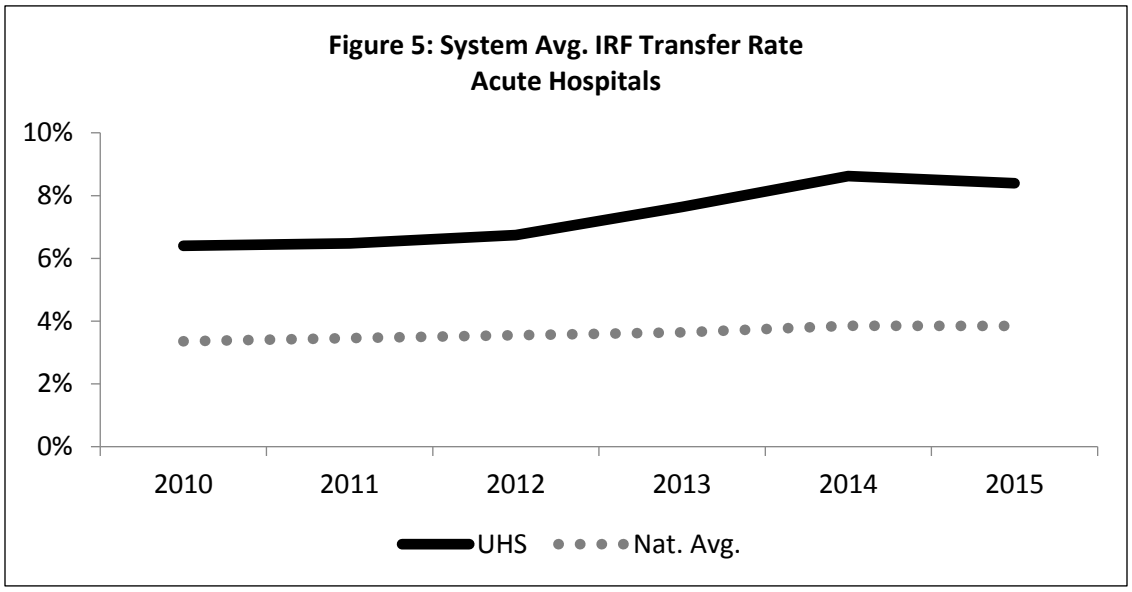
Three years after we raised concerns with you over the clear and increasing divergence between admissions practices at UHS and its competitors, this divergence and the risks it indicates for shareholders have not abated. Instead, these large differentials have persisted and may have grown. Given the Federally-led investigation of UHS, allowing these divergent practices – and even encouraging them, as CFO Filton appears to have done – generates unacceptable risks of adverse enforcement actions against the company. However, our concerns with UHS's inadequate oversight of regulatory and compliance risk extends beyond its dominant psychiatric care segment, and includes admission and discharge practices at its acute care hospitals.

[3] UHS Q1 earnings call April 28, 2005.

UHS Acute Care Hospitals Transfer Discharged Patients to Rehabilitation Facilities at Unusually High Rates

In our March 2016 letter to you, we drew your attention to data indicating that UHS acute care hospitals transfer discharged patients to Inpatient Rehabilitation Facilities ("IRFs) at much higher rates than either the national average or other publicly-traded hospital companies. We noted that regulators were focusing on such transfers as a possible source of excess costs, and that UHS's high rate of such transfers did not align with other indicators of the likelihood of patients requiring a stay at such a facility, such as the rate of transfers to skilled nursing facilities or the expected rate of such transfers based on national average transfer rates by diagnosis group and patient age. Since UHS-owned IRFs are a frequent destination for these discharges – UHS IRF reimbursements rose from 8% to 11% of total IRF and Acute Care Medicare reimbursements from 2010 to 2014 – there is clearly the potential for this unusually high transfer rate to attract regulatory attention and generate increased risk of adverse enforcement actions.

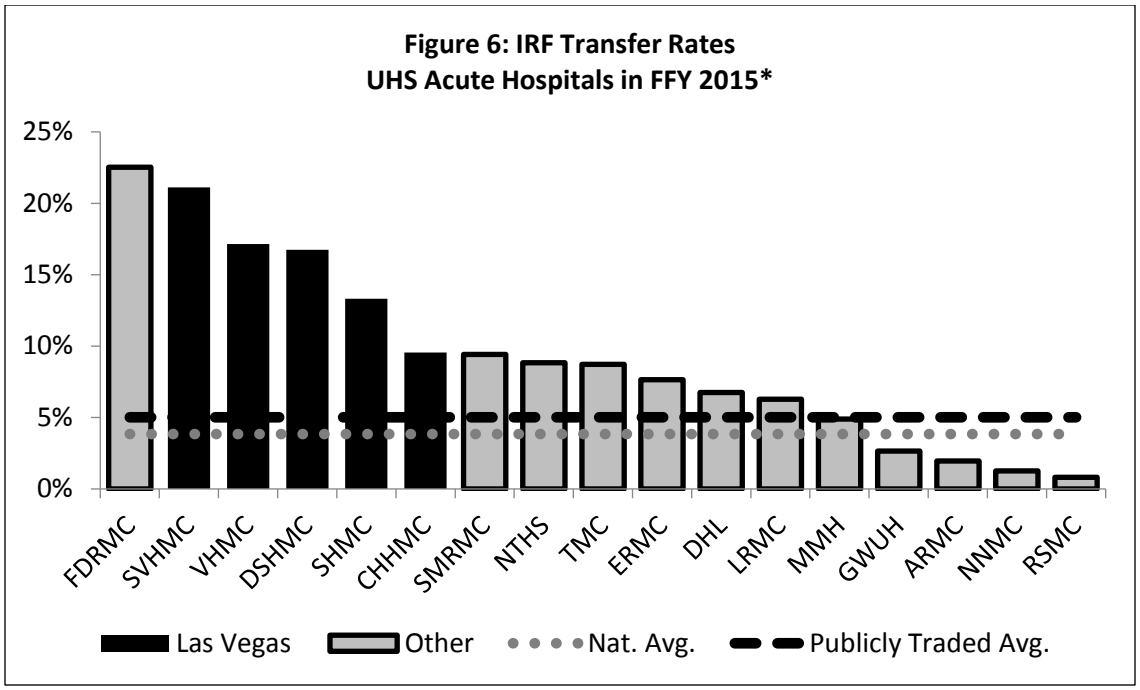
With an additional year of data now available, we can see that the high IRF transfer rate we pointed to continues to characterize UHS acute care hospitals' discharge practices.[4] First, UHS's Medicare reimbursements for IRF services continue to grow, at a 6.2% compound annualized rate since 2010. Moreover, Figure 5 illustrates the basic point that UHS acute care hospitals are more than twice s as likely to transfer a discharged patient to an IRF as an average hospital nationally.



Individual UHS acute care hospitals in some cases exhibit extremely high levels of IRF transfers, particularly those hospitals serving the Las Vegas, NV market. Figure 6 provides an updated look at the 17 UHS acute care hospitals where sufficient data was available to compare their IRF transfer rates to the national average and the average for hospitals operated by publicly traded companies:[5]

[4] Based upon SEIU analysis performed of claims data from the Medicare Inpatient Standard Analytical File Limited Data Set, as well as upon data obtained from Medicare Cost Reports. Further methodology is available upon request.

[5] Abbreviations are used for UHS hospital names in this and following charts for brevity, and the full names associated with these abbreviations are listed here. FDRMC: Fort Duncan Regional Medical Center. SVHMC: Spring Valley Hospital Medical Center. VHMC: Valley Hospital Medical Center. DSHMC: Desert Springs Hospital Medical

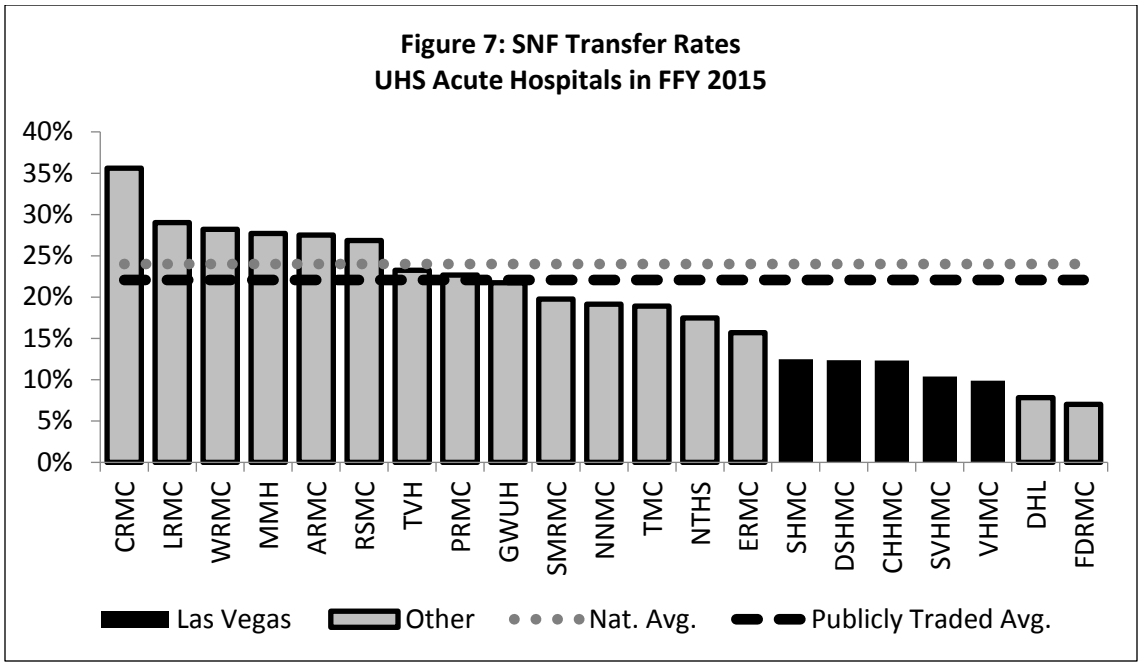


**excluding four hospitals for which a transfer rate could not be reliably calculated*

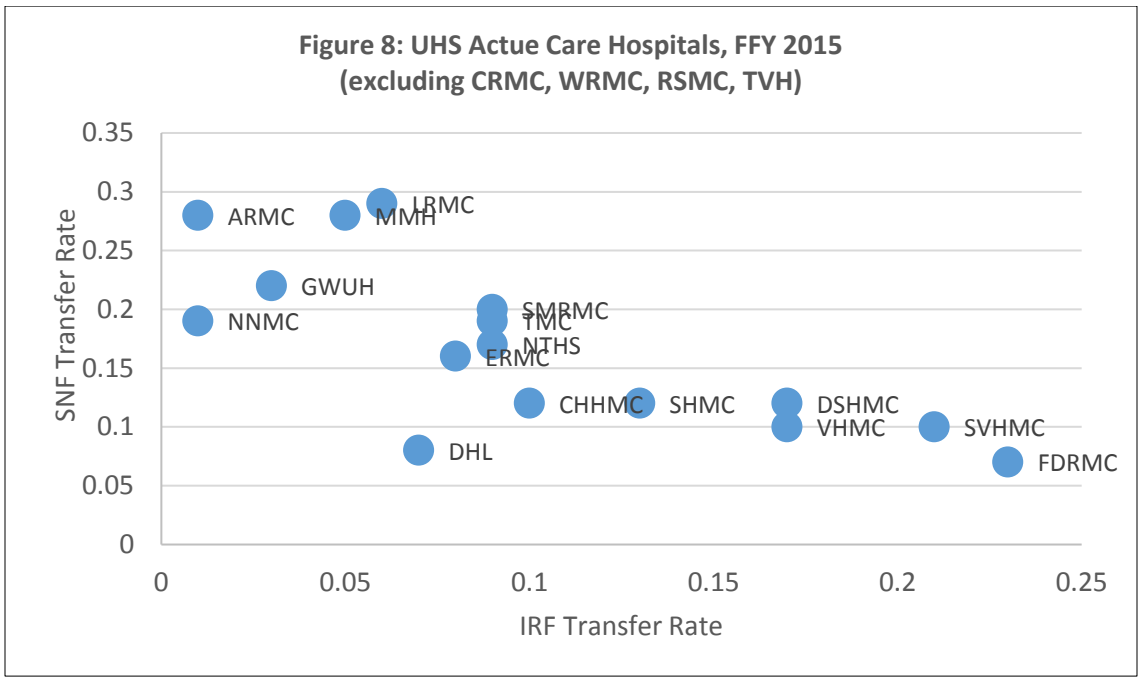
Just as our March 2016 letter showed for FFY 2014, we can see that the bulk of UHS's acute care facilities exhibit IRF transfer rates well above both hospitals nationally and UHS's publicly traded competitors. For the Las Vegas market, these rates are very high, more than three times the national rate in four cases, and twice that rate in the two others.

Such high IRF transfer rates imply that UHS's hospitals must be treating and discharging patients whose acuity or age require a higher level of post-hospitalization care in order to fully recover. But if this were the case, we might expect both that UHS hospitals would also exhibit high rates of discharge to skilled nursing facilities ("SNFs"), and that UHS hospitals should exhibit a patient mix featuring higher acuity and age than the rest of the industry. As Figure 7 shows, far from that being the case, UHS hospitals are generally well below the national average in their rate of transfers to SNFs (note that Figure 7 contains data for four additional hospitals for which an IRF transfer rate could not be calculated):

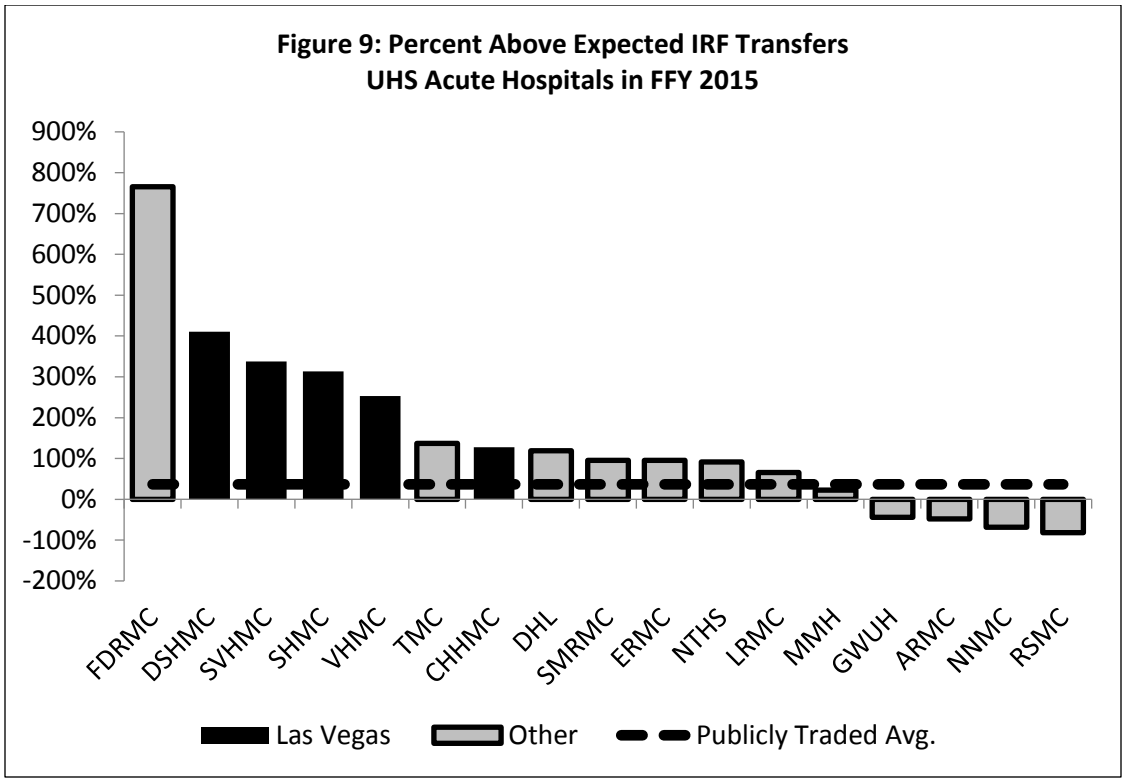
Center. SHMC: Summerlin Hospital Medical Center. CHHMC: Centennial Hills Hospital Medical Center. SMRMC: Saint Mary's Regional Medical Center. TMC: Texoma Medical Center. NTHS: Northwest Texas Healthcare System. LRMC: Lakewood Ranch Medical Center. ERMC: Edinburg Regional Medical Center. DHL: Doctors Hospital of Laredo. MMH: Manatee Memorial Hospital. GWUH: George Washington University Hospital. ARMC: Aiken Regional Medical Centers. NNMC: Northern Nevada Medical Center. CRMC: Corona Regional Medical Center. PRMC: Palmdale Regional Medical Center. RSMC: Rancho Springs Medical Center. WRMC: Wellington Regional Medical Center. TVH: Temecula Valley Hospital.



Indeed, for the 17 hospitals shown in Figure 6, there is a clear negative correlation between the frequency with which UHS hospitals transfer patients to IRFs vs. SNFs.



The relationship between patient diagnosis and age, and likelihood of needing post-discharge inpatient rehabilitation services can be assessed more directly using national average IRF transfer rates by patient Diagnosis-Related Group ("DRG") and age group. When compared to these national benchmarks, many UHS acute care hospitals clearly exceed expectations, again including the facilities serving the Las Vegas market:

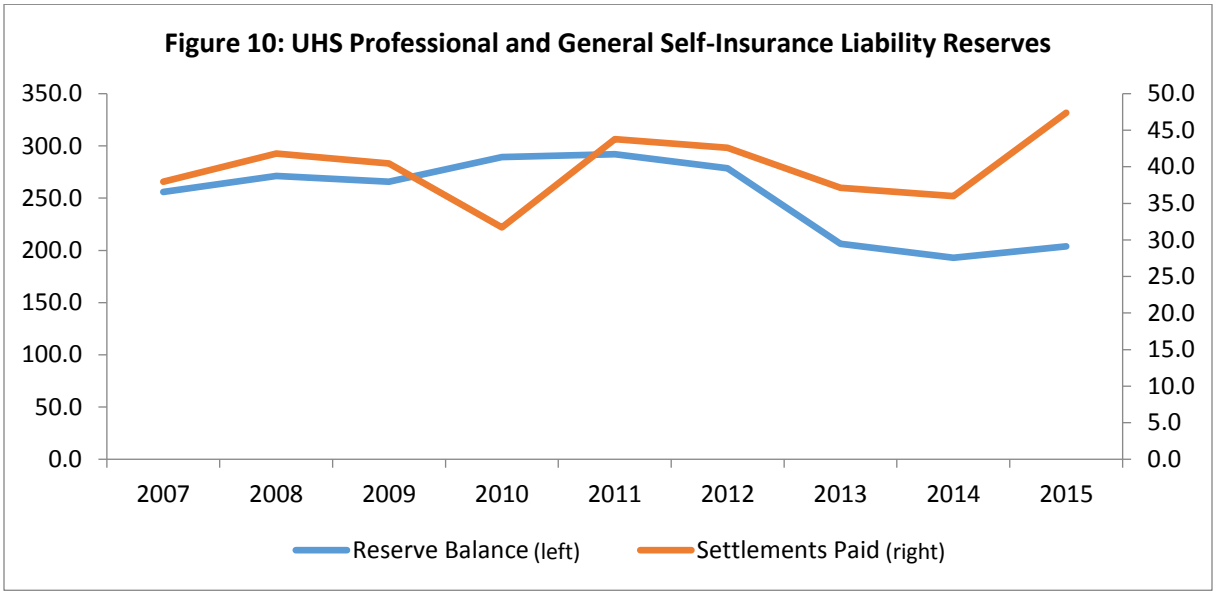


As we can see in Figure 9, 12 of UHS's acute care hospitals in FFY 2015 had IRF transfer rates above the average for other publicly traded hospitals. Moreover, visual inspection of Figures 7, 8, and 9 demonstrates that those hospitals who are furthest above expectations also exhibit the highest absolute IRF transfer rates, and the lowest SNF transfer rates, reinforcing our concern that IRF transfers at UHS hospitals may reflect factors other than patient need in a way that creates significant risk of adverse enforcement actions. This risk may be quite substantial, both because Medicare administrators are focusing on these transfers as a possible source of excessive payments, but also because UHS itself owns IRF facilities in many of these markets and as we noted earlier has enjoyed rapid growth in its Medicare reimbursements for IRF services. Using the model underlying Figure 9, we estimate that potentially excessive admissions at UHS IRFs – driving by potentially excessive IRF transfers from UHS acute care hospitals – may have contributed $27 million in overpayments by Medicare in FFY 2015, and $134 million from 2010 to 2015.

Shrinking Reserves While Liabilities Grow

As we pointed out in our March 2015 letter, the combination of an ongoing, multi-agency Federal criminal investigation of the company with clear empirical indicators of compliance risk affecting both the psychiatric and acute care segments should at the very least result in a stable allocation of resources toward reserves against adverse enforcement actions, settlements, or litigation outcomes. But far from increasing its reserves for professional and general liability, since 2010 UHS has been sharply reducing this reserve even as its self-insured claims have grown and its settlement payments have increased. This has resulted in a 28% drop in the balance of UHS's professional and general liability reserve. Since 2014, UHS's professional and general liability reserve has fallen to 2% of total assets, by far the lowest relative reserve level of all the publicly traded hospital companies.

Figure 10 illustrates the simultaneous decline in professional and general liabilities, even as the settlements paid by the company out of this reserve have grown.

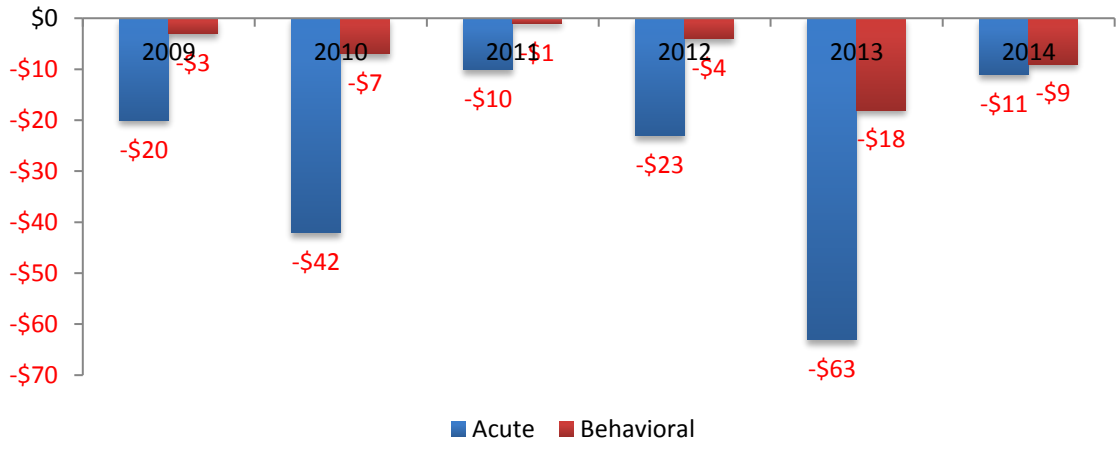


The company has explained the decline in this reserve by pointing to methodological changes in its estimating procedure, first 2010 by increasing the weight of company-specific factors (to 75% from 50%) and to decrease general industry factors (from 50% to 25%), and then in 2013 by eliminating general industry factors from the methodology altogether. UHS explained the first of these changes by arguing that the growing number of facilities it operates provides a "statistically significant data group," and also because its "historical professional and general liability experience … has developed favorably as compared to general industry trends."[6]

However, as Figure 11 shows, the vast majority of the reserve reductions – 85% in 2010 and 75% in 2013- were allocated to UHS's acute care segment. During this time UHS did not operate more than 24 acute care hospitals out of an estimated 5,000 community hospitals in the US. It is very hard to understand how such a small number of hospitals could constitute a large enough sample to obviate the need to directly take into account national industry trends in developing its estimates.

[6] UHS Form 10K for the year ending December 31, 2010. Filed February 28, 2011, pg. 128.

Figure 11: Reductions in UHS's Professional and General Liability Self-Insurance Reserves



We appreciate the difficulty of developing reliable estimates of future liabilities in a changing industry subject to extensive state and federal regulation. Nevertheless, given the scrutiny facing the company, it would seem only prudent for UHS to recognize that the reserve reductions from 2010 to 2014 went too far, and to reverse course by building up this reserve ahead of further adverse settlements.

Governance Reform and New Directors Needed to Protect Shareholders' Investment

Since UHS disclosed on March 31, 2015 that the corporation as a whole was subject to a criminal investigation led by the Department of Justice's Criminal Fraud Section, its share price has moved sideways even as the broad market has steadily risen. We believe that shareholders such as ourselves have justified concerns that this investigation will generate adverse consequences for UHS, whether in the form of regulatory enforcement actions, financial settlements, or private litigation. We are convinced that the looming risks facing UHS could have been ameliorated or even avoided if the company had been willing to adopt the governance changes enacted by its competitors over the past decade, including the creation of a separate board committee charged with overseeing regulatory compliance and quality of patient care. The board's unwillingness to adopt such a change –despite Chairman and CEO Miller's statement at the 2015 annual meeting that the board would consider it – seems sadly consistent with UHS's general approach to corporate governance and shareholder accountability.

UHS has what is in our experience a uniquely entrenched governance structure. In addition to having a classified board – an increasingly endangered species in US markets – UHS divides its shares into four classes, of which only one (the class B or public shares) provides voting power proportional to economic exposure. The other three classes all provide their holders, when voting on matters other than director elections, with voting power equal to 10, 100, or 1000 times that of the public shareholders, and these classes of shares are overwhelmingly held by company insiders, including Chairman and CEO Miller. But even beyond these entrenchments, UHS also divides its already classified directors so that only two of the seven board members are even subject to elections in which the outside, public shareholders have a vote. Consequently, public shareholders have an effective opportunity to oppose an incumbent director only twice every three years.

It is long past time for UHS to modernize its board of directors by eliminating these entrenching mechanisms and ensuring that all directors are accountable to all shareholders on an annual basis, while also establishing that voting power among shareholders must be proportional to economic exposure. While we appreciate Mr. Millers' past contributions as founder of the company, the fact remains that he chose to sell the vast majority of his economic stake in the company to the investing public. UHS has for many years now been included in many popular equity indexes, and so many of its shareholders – including the funds we work with – will obtain stakes in the company through passively-managed index funds. As a consequence, UHS cannot defend its governance practices by claiming that shareholders accepted its peculiar institutions when they chose to purchase shares: first, because many if not most shareholders have obtained that exposure through a mechanical (index) rather than discretionary mechanism, and second because even if a shareholder had consented to this dog's breakfast of a governance structure in the past, subsequent events – including those described in this letter – have demonstrated just how inadequate it is as a defense against excessive and unnecessary risk.

We have repeatedly engaged you in an effort to convince the UHS board to undertake this much needed modernization proactively. We have hoped that you and your fellow directors would recognize the benefits that an open and democratic governance structure would provide both for outside shareholders but also for the corporation itself. Unfortunately, and despite occasional contrary indicators, the board has failed to act and the problems fester. If the board does not publicly commit to modernizing its structure prior to issuing its proxy statement for this years' annual meeting, we will publicly oppose Mr. Gibbs candidacy for re-election.

As always, we would be happy to discuss our analysis and concerns with you and other members of the board at your convenience. Please contact my colleague, CtW Investment Group Research Director Richard Clayton at (202) 721-6038 to arrange such a meeting.

Sincerely

Dieter Waizenegger
Executive Director, CtW Investment Group