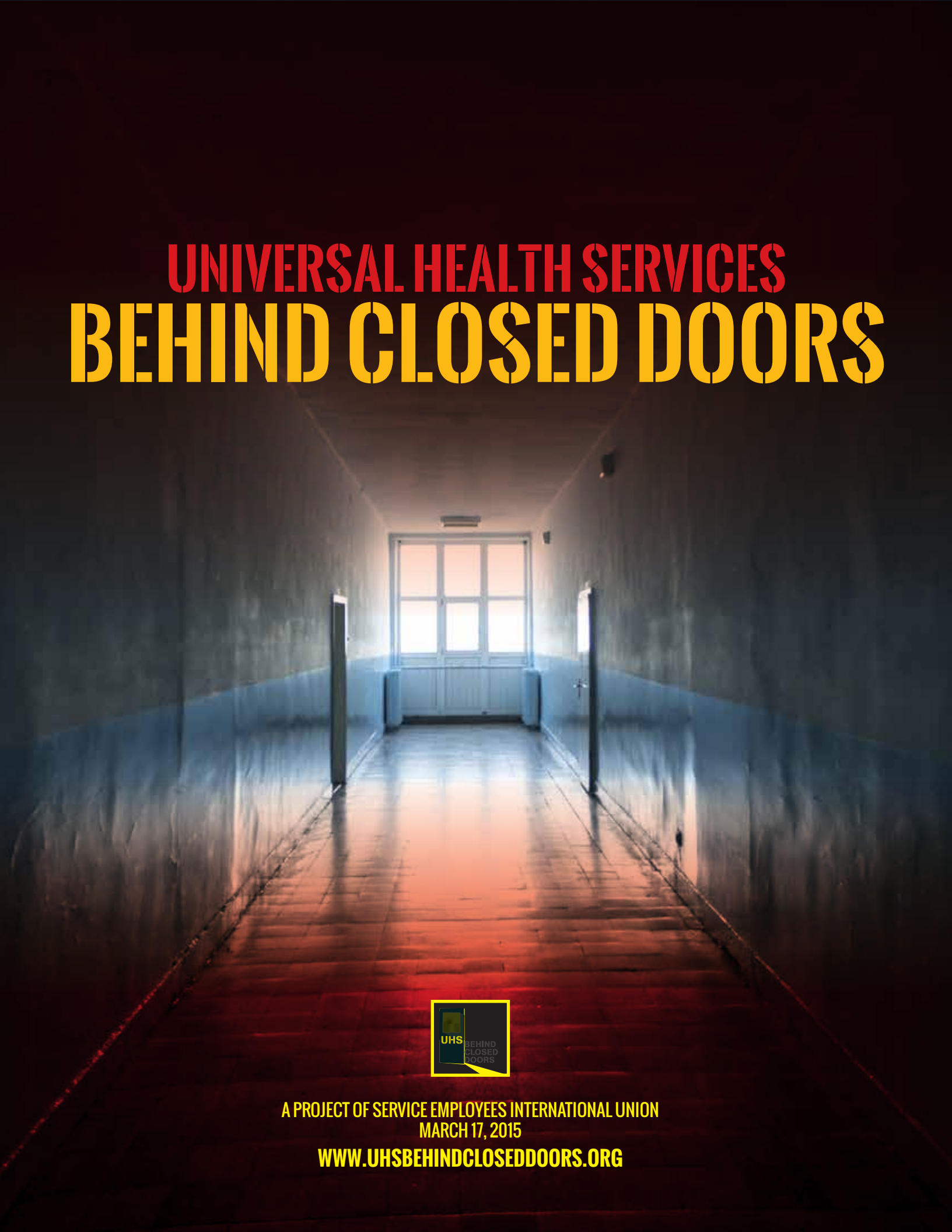
UNIVERSAL HEALTH SERVICES
BEHIND CLOSED DOORS
UHS
BEHIND CLOSED DOORS
A PROJECT OF SERVICE EMPLOYEES INTERNATIONAL UNION
MARCH 17, 2015
WWW.UHSBEHINDCLOSEDDOORS.ORG

EXECUTIVE SUMMARY

WHY YOU SHOULD CARE ABOUT UHS:

UHS receives significant amounts of government funding to care for some of the most vulnerable members of society.

UHS received approximately $4.3 billion from Medicare and Medicaid in 2014 for providing health care services to elderly, poor and disabled Americans. This includes $2.2 billion for behavioral health care and $2.1 billion for general acute care. Medicare and Medicaid account for more than half (53%) of UHS's total revenue.[1, 2]

The company also received up to $395 million in revenue in 2014 from the U.S. military for behavioral health care.[3, 4]

UHS dominates the delivery of behavioral health care in the United States.

The largest provider of inpatient behavioral health care in the country, UHS operates 1 out of every 5 psychiatric beds in the United States. The company owns nearly 200 of the estimated 500 total freestanding behavioral health hospitals in the U.S.[5,6]

There are no other providers even close to the same size in the sector. UHS executives have said: "after you get past our $4 billion of revenues, the market becomes a lot smaller and a lot more fragmented fairly quickly. The next largest providers are probably in the billion dollar range."[7]

UHS is highly profitable.

UHS operates as a publicly traded for-profit company and its stock is traded on the New York Stock Exchange. Its behavioral healthcare business is highly profitable. For every dollar that this business generates in revenue, UHS takes nearly a quarter of that in profit.[8] The company's behavioral health profit margin was 25% higher in the most recent fiscal year than it was ten years prior in 2004.[9]

WHY YOU SHOULD BE CONCERNED ABOUT UHS:

UHS facilities have had serious problems that may be linked to understaffing.

The company's executives have told investors that reducing staffing costs and keeping occupancy high helps the company stay profitable.[10, 11] However, cutting staff too low can be dangerous for patients and workers. Analysis of inspection reports issued by government regulators and lawsuits, most of which were filed by UHS employees and patients, reveals a number of disturbing incidents tied to inadequate staffing at UHS facilities.

UHS allegedly committed fraud against government programs and is being investigated by federal authorities.

UHS has paid millions of dollars to settle lawsuits which alleged that the company billed for services it did not adequately provide. Similar lawsuits are currently ongoing. Additionally, the DHHS Office of the Inspector General and the U.S. Department of Justice are currently investigating 19 facilities. Three Florida facilities are under investigation for criminal fraud and federal and state officials have instituted Medicare and Medicaid payment suspensions at one facility.

UHS's corporate compliance structure is not adequate and also does not protect employees from retaliation.

Unlike other large investor-owned hospital companies, UHS has no separate, independent committee on its Board of Directors to oversee quality of care and compliance issues. SEIU attended UHS's annual shareholder meeting in May 2014 to ask the company to create this committee, but the company's CEO said that this is "not required."[12]

Former UHS employees have said they were retaliated against for reporting abuse, blowing the whistle or bringing safety concerns to supervisors – even when their professional and personal ethics required them to do so. For example, two therapists who worked for UHS in Florida allege that they were fired shortly after reporting issues through UHS's corporate compliance program.[13] Two other UHS employees said they were fired for calling 911 for help during a "melee" at their facility.[14]

If UHS were to install an independent oversight committee on its Board of Directors, UHS employees would have another avenue to advocate for patient care.

RECOMMENDATIONS

Make sure the #1 provider of behavioral health makes quality its #1 priority.

Tell UHS to take patient care more seriously by creating a dedicated committee on its Board of Directors to oversee quality of care and compliance with healthcare laws and regulations. Tell UHS that this committee should be staffed by independent medical and compliance experts. This committee should monitor all allegations against UHS facilities and have the authority to make improvements when needed.

If UHS fails to create an independent quality and compliance committee, an independent monitor should be installed on the board until the investigations are resolved.

UHS's acute and behavioral health care services have repeatedly been under multiple federal and state investigations.[15,16,17] Now that UHS and several of its facilities are under subpoena by the Department of Health and Human Services Office of the Inspector General ("OIG"), and with three facilities under investigation by the Department of Justice Criminal Frauds Section, heightened quality and compliance oversight should be mandatory. If UHS is not willing to form an independent compliance committee on its board, then federal authorities such as the Centers for Medicare and Medicaid Services should install an independent monitor until the investigations are resolved.

Require a higher standard of care for UHS's most vulnerable patients.

Several patients have committed suicide inside UHS facilities due to failures in monitoring and safety. Further, SEIU data analysis performed using publicly available Medicare claims data[a] shows that UHS claims have suicidal ideation[b] as a diagnosis code at rates far above its peers. Given the overwhelming number of suicidal patients who seek inpatient treatment at UHS facilities, UHS should be required by regulators to provide 1-to-1 monitoring for these high-risk patients, in order to prevent tragedies like those illustrated below.

Demand public transparency for the $3.9 billion that UHS receives annually in public funding.

Several years ago, SEIU Nevada published a report titled *Failure to Care*, regarding concerns over the quality and safety of patient care at behavioral health facilities operated by UHS. *Failure to Care* called for greater transparency, especially for quality measures, and since that report was issued, CMS started collecting quality data for psychiatric hospitals. CMS should expand public quality reporting through the Hospital Compare website[18] to include additional measures that are relevant to patients and families. These could include patient satisfaction, staffing levels, 30-day readmission rates, and adverse events such as healthcare associated infections and patient injuries. MedPAC supports the development of a readmission measure and encourages the agency to include it in Hospital Compare IPF quality metrics as soon as possible.[19]

Additionally, CMS should collect information from its designated State Survey Agencies about the number and severity of survey violations at freestanding psychiatric hospitals and residential treatment centers. This information should also be made available to the public.[20]

Protect workers from retaliation by UHS.

UHS employees need a safe and effective way to report problems and issues at their facilities. A third party agency should receive reports from workers regarding concerns about patient care and fraudulent activities, and should not reveal the workers' identities to UHS. One way to achieve this is to have a federal authority such as the Centers for Medicare and Medicaid Services set up a national hotline for UHS workers.

Require inpatient freestanding psychiatric providers to expressly certify full compliance with all Medicare program rules and regulations on each reimbursement claim as a condition of payment.

Medicare pays freestanding psychiatric providers a large amount of money to provide medical care. Currently, many Medicare program rules and regulations are treated as conditions of participation in the program rather than conditions of payment, meaning that violating one of these laws will not necessarily prevent payment from the government. In order for Medicare beneficiaries and public payers to be confident they are receiving services performed in compliance with all Medicare program rules and regulations, the government should require all freestanding psychiatric providers to expressly certify, on each claim, that they are providing care that fully complies with these conditions as conditions of payment from the government.

Follow our ongoing research at www.UHSBehindClosedDoors.org.

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INTRODUCTION

Several years ago, SEIU Nevada published a report titled *Failure to Care*, regarding concerns over the quality and safety of patient care at behavioral health facilities operated by Universal Health Services, Inc.

Since then, the situation has only become more alarming.

At the time, UHS was the second largest provider of inpatient behavioral health in the country. After UHS acquired its largest competitor in 2010, it now operates approximately one in five psychiatric hospital beds in the United States.

The company's behavioral health business has become even more profitable since the report was published, and while profits have grown, UHS has spent less on staffing. The company's stock price has also doubled.[21]

At the same time, more than a dozen facilities have received subpoenas from the Department of Health and Human Services, Office of the Inspector General, including three that are under investigation for criminal fraud. Troublingly, we have found many additional disturbing patient care failures that have occurred since *Failure to Care*. The company has also settled lawsuits for retaliating against whistleblowers and for alleged fraudulent schemes.

SEIU is a leading advocacy organization for working people, and it is our responsibility to pursue justice for all. We believe in and will fight for a just society where all workers are valued and people respected, where all families and communities thrive, and where we leave a better and more equal world for generations to come. As part of this commitment, we believe it is our obligation to hold corporations accountable and we do so by a variety of lawful means including encouraging changes in public policy, enforcing existing laws, encouraging responsible corporate policy and publicizing bad actors.[22]

SEIU members who work at UHS's acute care and behavioral health hospitals attended UHS's annual shareholder meeting in May 2014. We were concerned because, unlike its competitors, UHS's Board of Directors does not have a separate committee dedicated to overseeing quality of care and compliance with healthcare laws and regulations. We asked the company to create this committee in light of the numerous investigations and patient care breakdowns, but the company's CEO said that this is "not required."[23]

We are hopeful that the information in this report will inspire those who read it to look more closely at what goes on "behind closed doors" at UHS, and to take action to hold the company to a higher standard so that patients can get the best care possible at UHS facilities.

In addition to this report, our ongoing research is available online at www.UHSBehindClosedDoors.org.

CORPORATE BACKGROUND: WHO IS UHS?

Universal Health Services (UHS) operates as a publicly traded for-profit company and its stock is traded on the New York Stock Exchange. UHS is the fourth largest publicly traded hospital company by revenue with over $8 billion in annual revenue in 2014.[24] Unlike its for-profit peers that derive nearly all revenue from the acute care business, UHS's revenue is split evenly between acute care and behavioral health. UHS operates 24 acute care hospitals, 5 ambulatory surgical centers and 198 behavioral health facilities in the United States, Puerto Rico and the U.S. Virgin Islands. The company also operates 18 facilities in the United Kingdom.[25,c]

UHS is headquartered in King of Prussia, Pennsylvania.[26]

Largest inpatient behavioral health provider in the United States

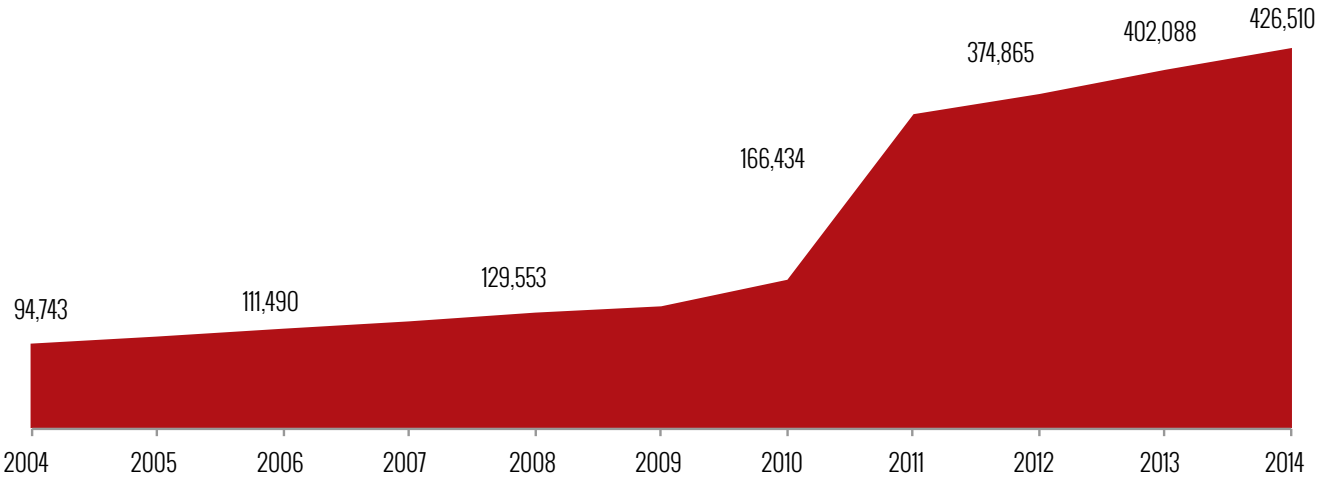
UHS has called itself "by far the largest provider of behavioral services in the country."[27] After a series of acquisitions, the company represents about 20% of the overall inpatient behavioral health market.[28] Its freestanding behavioral health hospitals make up around 40% of the estimated 500 total in the U.S.[29,30]

Figure 1 shows the total admissions at UHS's behavioral health facilities in each year from 2004 to 2014. In 2014, UHS had over 425,000 admissions, four and a half times the number of admissions at its facilities ten years ago.

UHS's inpatient behavioral health services are provided in different settings. The company operates psychiatric beds within its acute care hospitals and also operates free-standing psychiatric hospitals, residential treatment centers ("RTCs") and juvenile justice facilities.

Figure 1
UHS Total Admissions from its Behavioral Health Facilities Admissions grew 4.5 times from 2004 to 2014

Source: Analysis of UHS SEC filings. Underlying figures available upon request.



Despite its market dominance, UHS is seeking to further expand by adding beds to its facilities at a "600, 650-bed a year expansion pace, at least through 2015 and 2016."[31] The company has also indicated that it wants to expand beyond its own facilities by partnering with acute care hospitals. In 2014 an executive said, "I think there's a big opportunity to get control in some form or fashion of the behavioral beds that today are found in acute care hospitals around the country. And estimates are that still 50% of the behavioral beds in the US are being operated by acute care hospitals."[32]

Seeking to take advantage of increased coverage for mental health services

A key reason that UHS is growing its behavioral health business could be that coverage for mental health was expanded when Congress passed mental health parity legislation in 2008. The rules, which took effect July 1, 2014, require private insurance companies to provide more coverage for mental health services, with the goal of attaining parity with medical and surgical coverage.[33]

After the rule was published, UHS CFO Steve Filton told investors that mental health parity is "quite positive to the industry." This is because the rule applies to all insurance plans, including small and individual group plans. Additionally, final regulations issued by the Centers for Medicare and Medicaid Services in 2013 "apply to a broader level of services" including residential business in addition to acute behavioral services.[34] Lastly, according to Mr. Filton, the final rules "make the utilization review and this whole length of stay issue, we hope, more favorable to the industry."[35]

This last point is noteworthy because UHS has been facing pressure on the number of days that its patients have been staying at its facilities.[36] Such pressure could arise if payers such as the government or commercial insurance companies question whether longer lengths of stay are medically necessary. As UHS's CFO explains, "95%-plus of our reimbursement in the behavioral space is on a per-diem basis, that is, payers pay us for the number of days that a patient is in the facility. And obviously if they spend less days in a facility, then we're going to be paid less for a single admission [...]."[37]

Before the final rule was released, UHS Chairman and CEO Alan Miller estimated in an interview that mental health parity rules combined with the Affordable Care Act could together lead to 60 million people gaining coverage for mental health services. For his company, he concluded, "It's extremely positive."[38]

Behavioral health business is profitable for UHS

UHS's behavioral health segment comprises about half of the company's total annual revenue but because it is so much more profitable, this business segment generated 65% of the company's total income before income taxes (profit) in the first 9 months of 2014.[39]

For every dollar of net revenue that UHS behavioral facilities generated in

2014, the company took almost one quarter as income before income taxes (profit margin).[40] This profit margin, depicted by the red line in Figure 2, has risen by 25% since 2004.

Figure 2 also shows the amount of annual income before taxes for the past ten years. UHS's behavioral health income before taxes in 2014 was $944 million, 7.3 times its income before taxes ten years ago.

Reliant on government funding while benefiting from "minimal attention"

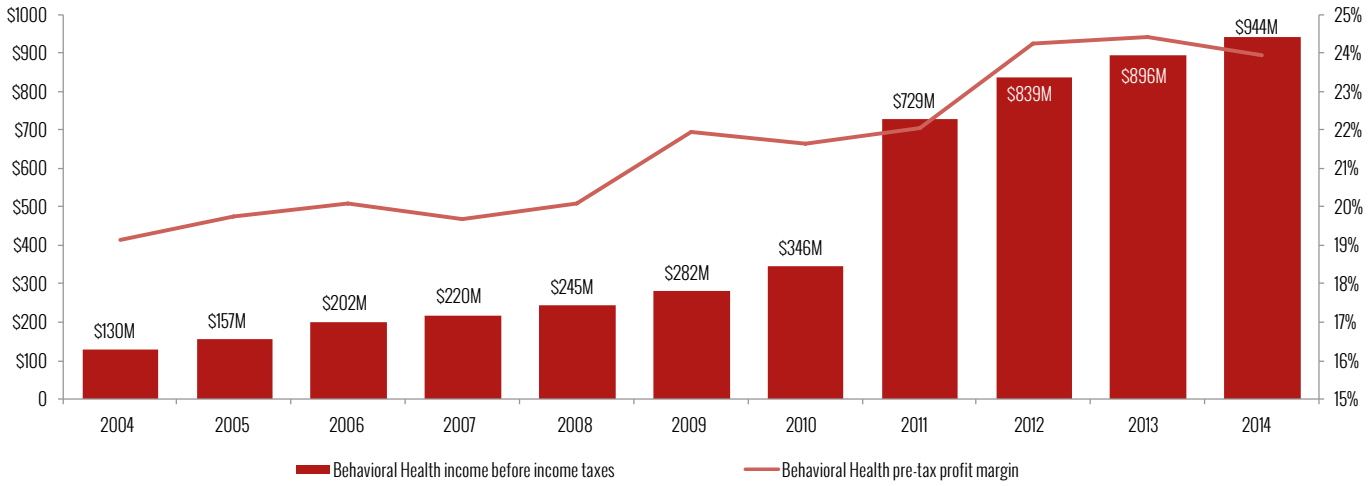
More than half of UHS's revenue comes from federal and state government programs funded by taxpayers. UHS reported that in 2014, 55% of its behavioral segment's net revenue came from Medicare and Medicaid programs,[41] an estimated total of $2.2 billion.[42]

UHS executives have also talked about "focusing on the military and behavioral problems in the military as a source of growth,"[43] describing it as "a small piece of our overall behavioral business, but a fairly profitable piece."[44] It may account for hundreds of millions of dollars in 2014.[45,d]

While reaping the benefits of government funding, UHS cites lower government scrutiny as a favorable quality of operating in the behavioral health sector. UHS's CFO said that, "[T]he good news about that is it tends to get, I don't want to say no attention, but a fairly minimal amount of attention from payers, which I think is generally a good thing."[46]

Figure 2
Behavioral Facilities - Annual income before income taxes (profit) UHS's profit in 2014 was 7.3 times its profit 10 years ago

Source: Analysis of UHS SEC filings. Underlying figures available upon request.



PROFIT MOTIVES AND PATIENT CARE PROBLEMS

Adequate staff for the number and acuity of patients is essential in behavioral health.

Providing enough staff to meet patients' needs is an essential requirement for all hospitals.[47] Psychiatric staffing levels must take into account patients' risk of violence and suicide as well as their medical needs, which tend to be higher than the general population. Research suggests that higher levels of staffing lead to better patient outcomes.[48]

UHS's high profits are tied to cuts in staffing costs.

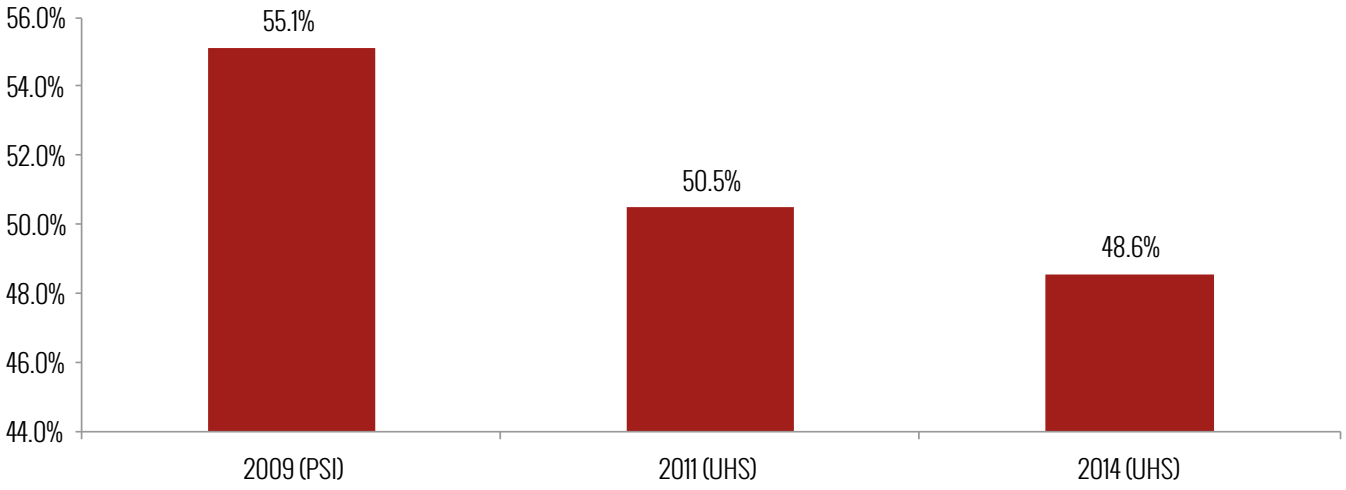
Salaries, wages and benefits are typically the largest costs in the behavioral health industry. In 2014, UHS cut staffing costs in its behavioral division to their lowest level in the last decade, with just 48.6% of revenue going to staff salaries, wages and benefits.[49]

Analysis of financial data also shows that UHS spent less of its revenue on salaries, wages and benefits than its rival company Psychiatric Solutions, Inc.,[50] which UHS purchased in 2010.[51] Notably, this metric has also declined at UHS since UHS purchased PSI.[52] In fact, the percent of revenue spent by PSI on salaries, wages and benefits in 2009, the last full year before being acquired by UHS, was 55.1% as depicted in Figure 3. After UHS acquired the company and integrated those facilities into its business, the proportion of revenue spent on salaries, wages and benefits at UHS behavioral health facilities was just over fifty percent. In 2014, this percent fell even lower.[53, 54, 55]

This trend is consistent with a recent statement made by UHS's CFO Steve Filton to investors related to how UHS

Figure 3
UHS has spent less and less on salaries, wages and benefits as a percent of revenue, even lower than its competitor which it bought in November 2010

Source: Analysis of UHS and PSI SEC filings. Underlying figures available upon request.



planned to expand margins at its acquired PSI facilities:

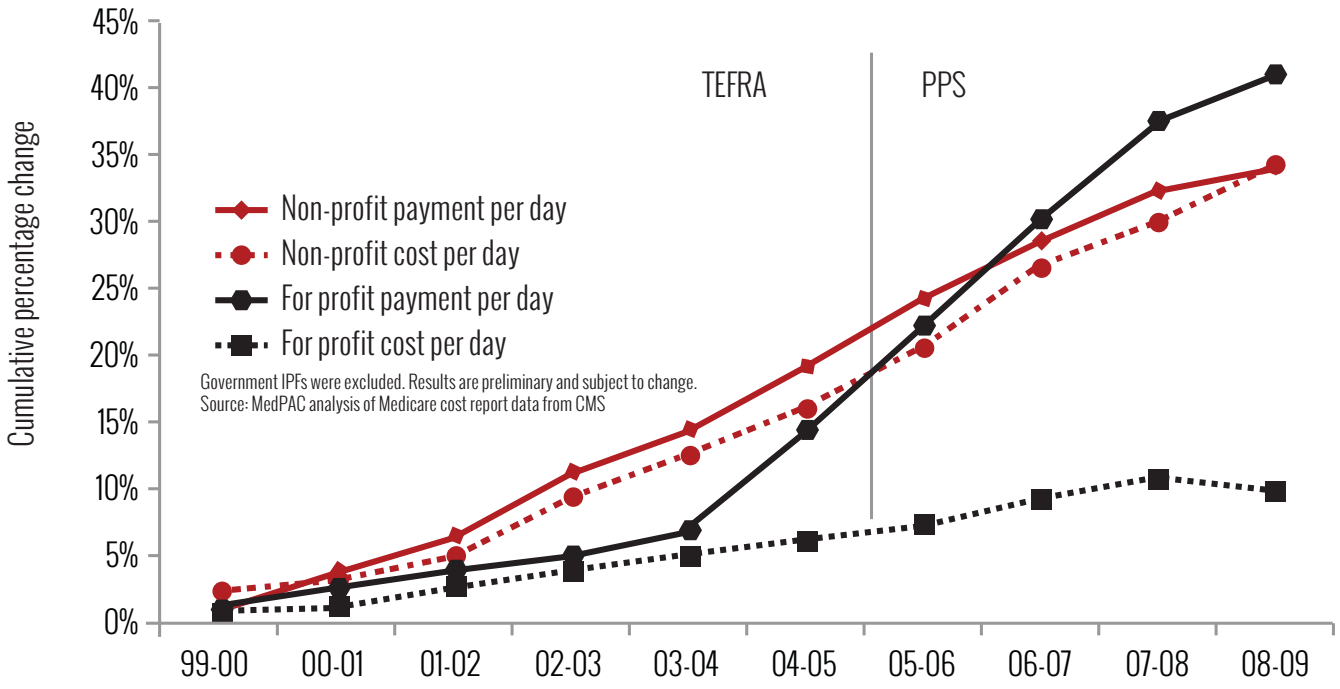
> "Well, the bottom line, I think, is when you look at the behavioral business model and you look at our financial statements, you will see that at least 50% of our expenses are salary and wages and salary-related, and probably the next biggest functional expense line is maybe 5% of expenses. So when you really talk about the management of expenses and behavioral, one, one-A, one-B, and one-C are all salary and related expenses. So for sure, when you talk about a gap in our margins, a good chunk of that has to come from a more efficient use of people, headcount, people in the right positions, etc., and frankly, that's a big part of our focus going into it. And we're being very cautious about it. I mean, in a business that first and foremost, is all about quality care for patients, we're not running this business on kind of a pure numerical model that says you need this many people and if you have five more than that, we're just going to cut back to that. We want to understand in every setting what everybody is supposed to be doing, what they're doing, how they're trained to do it, whether they're properly trained to do it, and that over time, I think, get to the most efficient staffing model. So that's probably the bulk of our effort over the course of the first couple of years in this integration process."[56]

Research has found that for-profit psychiatric hospitals kept their costs low while payments soared.

MedPAC, the independent agency advising the U.S. Congress on issues affecting the Medicare program, published preliminary research in 2011 finding that both for-profit hospitals such as those owned by UHS, and non-profit behavioral hos-

Figure 4
Cumulative change in freestanding IPFs' payments and costs per day, by ownership

Source: MedPAC Presentation - "Improving payment and care under Medicare's inpatient psychiatric benefit." October 6, 2011.



pitals have received increases in their payments from 1999 to 2009. While non-profit hospitals reacted to higher revenue by greatly increasing their spending on patient care, for-profit hospitals kept costs down. Staffing costs are typically the largest costs in the behavioral health industry.

UHS makes sure its facilities are full, at times "managing" patients' treatment for profit.

The company's executives have been open about this strategy.

CFO Steve Filton has acknowledged that UHS sees full facilities as profitable ones, saying, "We operate this business at fairly high occupancy rates and operating margins. I think those two things are tied together."[57]

In 2005 he admitted that "skilled" corporate-level managers were somehow extending the amount of time patients stayed at UHS facilities, because it was "easier and cheaper" to keep patients in the hospital rather than admit new ones:

> "I will say that I think the length of stay improvement reflects the fact that our managers in the behavioral division have gotten I think more skilled at managing their business …. If you can get paid for an increased days [sic], it's easier and cheaper than generating another admission, and I think they're doing a good job of that in this tight capacity environment."[58]

PSI ACQUISITION

UHS doubled its size by acquiring Psychiatric Solutions in 2010.

Until it was acquired by UHS, Psychiatric Solutions, Inc ("PSI") had been the largest national for-profit freestanding behavioral health chain and UHS's biggest competitor. UHS paid $3.04 billion to acquire the company in November 2010.[141]

In 2013 UHS said of the PSI facilities, "When we bought them…their operating margins were slightly below UHS's. … I think they are now, after two years operating really at par."[142]

UHS had previously indicated that it would increase the PSI facilities' profitability not by increasing revenue but by cutting costs, saying the increase in profits "will come from more efficient management of the operating expenses than from anything that actually happens on the top line."[143]

CEO and Chairman Alan Miller said the acquisition "establishes an industry leader with the scale and scope to impact mental health issues at the national level."[144]

While UHS runs full facilities, failures related to inadequate staffing have cropped up around the country.

Numerous inspection reports and lawsuits citing problems related to inadequate staffing have been discovered in a preliminary analysis of UHS facilities.

Below are findings and allegations of inadequate staffing at UHS facilities.

In **Arizona**, state regulators found that the number of nursing staff in Valley Hospital's Psychiatric Intensive Care Unit and Rapid Stabilization unit did not match the number required by the facility's FTE (full-time equivalent) calculator for at least 3 days in April 2013 and 2 days in May 2013.[59]

In **California**, A former mental health tech at Sierra Vista Hospital alleges she was terminated because Sierra Vista Hospital chose not to accommodate her workplace injury and because she made complaints about the health and safety conditions at the hospital. Specifically, she alleges that she was fired in retaliation for complaining about staff threatening patients, unsanitary and unsafe patient environments (e.g. dirty restrooms resulting in several MRSA outbreaks), and concerns over sexual assaults on patients by staff. She also claims the facility had insufficient staffing and, on occasion, had only one staff member to care for 20 patients. This case is currently awaiting a trial date.[60]

In **Florida**, Manatee Palms Youth Services was cited twice by state regulators in 2013 for failing to meet the required number of staff for adequate supervision. In one case, a patient engaged in self-harming behavior while she was supposed to be under close observation. When the Florida Agency for Health Care Administration interviewed a mental health technician at the facility, it was revealed that "her assignments often result in her being responsible for patients on rooms not close to each other which made completing the 15 minute checks difficult."[61,62]

In **Georgia**, the state Healthcare Facility Regulation Division cited Lighthouse Care Center of Augusta for violations related to staffing, hospital governance, discharge records, and emergency restraint procedures. Surveyors found that contrary to the rule, a registered nurse had not been present on more than 25% of night shifts within a three month period.[63]

In **Illinois**, Riveredge Hospital was found by the state health department to have inadequate staffing levels. Facility policy required an additional nurse to be added to a unit when patient census reached 17. However, review of staff schedules showed multiple instances where the facility did not provide the additional nurse.[64]

In **Nevada**, the Bureau of Health Care Quality and Compliance cited Spring Mountain Treatment Center for failing to follow its staffing plan. State surveyors found that the facility repeatedly understaffed its shifts. For example, on the night of 10/20/10, of the 68 patients present, three required line of sight monitoring and one needed one-on-one observation. The facility was staffed with

only three registered nurses that night, despite the large patient census and staffing grid requirements that called for four registered nurses when the census was between 67-71 patients. On 10/21, there were 67 patients, eight of which needed line of sight monitoring, but again only three nurses and seven techs were assigned. On 7/20 and 7/21, there were 73 patients and 69 patients, respectively, but only 3 registered nurses were assigned.[65]

In **North Carolina**, Old Vineyard Behavioral Health was cited by the Centers for Medicare and Medicaid Services because the facility failed to provide each unit with a separately functioning staff. Review of staffing assignment sheets and interviews revealed that instead of providing one licensed nurse for each unit, one nurse sometimes covered duties on two units at once, switching places with an MHT when she moved between them.[66]

In **Texas**, the Centers for Medicare and Medicaid Services cited Laurel Ridge Treatment Center in two related inspections for failing to ensure that the number and qualifications of doctors of medicine and osteopathy was adequate to provide essential psychiatric services. The facility was cited for failing to ensure a physician was available to perform a one hour, face-to-face evaluation of a secluded patient. CMS' interview with the facility Nursing Director revealed that an evaluation was not performed because there was no physician physically present in the facility after 11:00 pm, since the facility utilized telemedicine for facility admissions past this hour. She added that 'it was up to the attending physician whether they wanted to come in to do a face-to-face assessment.'[67]

Other inspection reports cite unfortunate consequences for patients linked to staffing.

In **Florida**, Manatee Palms Group Homes was cited by the Florida Agency for Health Care Administration for failing to protect the rights of children by not having sufficient and appropriate staff to supervise patients, resulting in patient exposure "to potential abuse and harm." Three adolescent/teen patients ran away from the facility, even though two of these patients were ordered to be under close observation and had histories of running away. One patient reported that while she was away from the facility she received money for having sexual relations with two adult males. As a result of the sexual misconduct allegations, Child Protective Services was called and the Sheriff's Office conducted an investigation.[68]

In **North Carolina**, Old Vineyard Behavioral Health was cited by the Division of Health Service Regulation for failures to protect clients by failing to monitor them during a disruptive incident. Video evidence showed one resident knocking out ceiling tiles and tearing metal support beams from the ceiling in the hallway. A separate camera captured two residents in their bedroom engaging in 15 sexual acts over the course of 1 hour and 15 minutes. One of the residents, a 14-year-old, reported the sexual contact to staff and said that his 17-year-old roommate forced him to do it. While observation sheets for these residents documented periodic observations, video showed that staff never entered the room to monitor them. Further investigation revealed that because of the incident in the hallway, one staff member was responsible for observing eight residents at the time, instead of the usual

four residents. When interviewed, the lead mental health counselor on the shift said, ”eight patients is too much for effective monitoring. [...] I should have called for additional staff for proper milieu management.”[69]

In **Texas**, inspectors from CMS determined that River Crest Hospital failed to ”maintain an adequate number of registered nurses, licensed practical nurses and mental health workers to provide the nursing care necessary under each patient’s active treatment program.” CMS found that one evening shift had only one registered nurse, one LVN and one mental health technician to supervise 14 child and adolescent patients, four of whom were on line of sight monitoring precautions. Based on the facility’s staffing grid, there should have been one more mental health technician on this shift. In the middle of this understaffed shift, a patient eloped from the facility by jumping over the fence. When he was returned by law enforcement, facility staff apparently failed to search him for contraband. Five minutes after returning, the patient placed a staff member ”in a choke hold and held a rusty fork to her neck.”[70]

Some patients could not get help with daily living tasks and personal hygiene.

At Valley Hospital in **Arizona**, over the course of two days, six RN’s were ordered to lower their professional assessment of patient acuity from level ”4“ to ”3.” Interviews with other employees revealed that nurses were unable to complete daily 15 minute rounds and medicating duties, and had to make patients wait 24-72 hours for supervised shave and laundry. State surveyors assessed these problems as issues related to Valley Hospital’s failure to properly implement the acuity plan, which informs hospital staffing levels based on the needs of individual patients.[71]

In **Florida**, the Agency for Health Care Administration found that Emerald Coast Behavioral Hospital failed to staff the behavioral intensive care unit with adequate numbers of personnel to provide care to patients as needed. The unit includes patients who are low functioning and actively suicidal, aggressive, or unable to maintain themselves and likely to act out; records showed only 2-3 staff on the unit for 14 patients. Staff were observed spending most of their time providing assistance to patients and taking only a few breaks to complete paperwork, but “[e]ven with staff diligence, the numbers were inadequate to meet the needs of patients.” The records describe several failures in patient care, including a patient who was observed to be unsteady on her feet, needing staff assistance to walk. On one morning she needed help to change out of urine-soaked pants. The patient was observed to be in bed during that afternoon, and staff ”stated that the nurse wanted her to stay in bed because she was so unsteady on her feet.” On another day this patient was observed ”wearing a paper shirt and pants that were way too large for her,” causing her to expose herself intermittently. The unit’s one mental health technician had to leave the unit to search for clothes that would fit her.[72]

Some facilities cut back on security and housekeeping staff.

In January 2013, National Deaf Academy was cited by Florida’s Agency for Health Care Administration after a patient escaped from the facility through the front

door. The patient had previously tried to run into traffic and escape precautions were ordered. The facility's written policies noted that security personnel shall be "vigilant in their observation of the client behaviors" when these precautions were ordered, but staff confirmed that the facility had eliminated its security personnel some time ago.[73]

At The Vines Hospital in **Florida**, dust, debris, dead insects and food particles were found in patient bedrooms and public spaces. The Lead Housekeeper indicated "there is not enough staff," and the Lead Mental Health Technician said techs sometimes have to clean rooms. The Plan of Correction indicated a change in housekeeping staffing hours.[74]

In our review, we found an alarming number of patient deaths at UHS facilities.

A patient in Florida was murdered by his roommate during a lapse in observation.

In Florida, at The Vines Hospital, video evidence confirmed that a psychotic patient described by staff as "uncontrollable," was left unsupervised behind a closed door with a roommate for two hours. When staff opened the door, the patient was sitting on top of his roommate, who died shortly thereafter. The patient was referred to the police and charged with second-degree murder. When interviewed, an employee said, "Sometimes there are not enough staff to care for the residents and residents do not receive the care they should."[75]

Two patients died from reactions to medication at UHS facilities.

A patient at Highlands Behavioral Health in **Colorado** was found to be unresponsive in the facility's seclusion room and later died. Inspectors with the Colorado Department of Public Health and Environment cited the facility for five deficiencies related to the patient's care, including failures in appropriately administering narcotic medications per physician's orders and conducting proper welfare checks to ensure patient safety. The patient's autopsy revealed he died from medication toxicity and cerebral/pulmonary edema.[76]

In **Massachusetts**, a patient at Arbour Hospital went into cardiac arrest and died after she was given high blood pressure medications in combination with chemical restraint medications, to which she was allergic. Even though the admitting physician noted the patient's allergy to the restraint medications, he authorized their administration. Furthermore, the patient's vital signs and reactions to the medications were not monitored. Both the facility's clinical director and the risk manager stated that there was no protocol in place for evaluating the effects of chemical restraints. Additionally, during the patient's cardiac episode, the defibrillator was not used because staff had not been properly trained to handle medical emergency, or "code blue" incidents.[77]

Patients have committed suicide inside of UHS hospitals that were supposed to keep them safe from self-harm.

In **Tennessee**, the family of Matthew Goodman filed a lawsuit against Lakeside Behavioral Health Systems alleg-

ing that their 21-year-old son who was a patient of the facility was able to hang himself with a belt due to the negligence of the facility. The lawsuit alleged that the facility failed to remove the patient's belt and failed to keep him under continuous employee observation as warranted by his mental state, and that he was already dead when discovered. The family also alleges that "[A]t Lakeside, there have been numerous incidents of violence including assaults and rapes. . . .These incidents were a result, at least in part, of insufficient staffing by the Defendant." The plaintiffs asked for $7.5 million and reached a confidential settlement agreement with the facility.[78]

Peachford Behavioral Health System in **Georgia** was cited by the Centers for Medicare and Medicaid Services for failing to protect a patient's right to care in a safe setting and not having an effective system for monitoring patients for continuous safety. A young patient died after being found hanging from towels and a bed sheet over a bathroom door. Review of video surveillance showed that other patients and staff were attending a group activity at the time of the suicide and staff failed to observe the patient for 47 minutes.[79]

The State of **Georgia's** Healthcare Facility Regulation Division cited SummitRidge Center for a nursing service violation after a patient committed suicide by hanging him/herself with a bed sheet. The patient was under an order to be visually observed every 15 minutes, but when he/she should have been attending a group session, video evidence showed the patient entering his/her bedroom and closing the door at 9:48 a.m. The patient was not observed again by staff until 10:54 a.m. when he/she was found unresponsive and hanging from a bathroom door. The patient was pronounced dead by a Medical Examiner at approximately 12:44 p.m. In its plan of correction, the facility agreed to re-train staff on observation procedures and to replace its bathroom doors with vinyl breakaway curtains.[80]

In March 2011 in **Missouri**, a patient committed suicide in bed at the Two Rivers Behavioral Health System facility. The patient had not been placed on 1:1 observation even though staff knew patient was suicidal and agitated the day before death. Staff failed to conduct appropriate 15 minute checks to make sure the patient was breathing while asleep. When staff checked the patient for 5:00 a.m. vital signs, they found that she was not breathing and had a nylon strap from a medical device and a stretchy rubber toy wrapped around her neck. It took staff several minutes to begin resuscitation procedures and cut the items from around the patient's neck.[81]

Improper discharges have put vulnerable patients and others at risk.

The family of a deceased former patient alleges that he was improperly discharged from Friends Hospital in **Pennsylvania** without family notification, even though he experienced hallucinations and presented a danger to himself. Shortly after being discharged, the patient wandered into the woods and, according to the autopsy report, committed suicide by jumping into a creek. The facility is accused of failing to consult with the patient's referring physician prior to discharge, to make proper discharge arrangements, and to thoroughly search and complete a missing persons report with the police. The family also charges the facility with negligence for failing to

establish and/or enforce emergency policies and procedures to retrieve so-called "walk-aways" or eloped patients. They allege that the facility had inadequate alert/security systems and insufficient personnel "given the size and forestation of the campus."[82]

The **Kentucky** Office of the Inspector General cited The Ridge Behavioral Health System after it discharged a patient without notifying the patient's emergency legal guardian. One day after discharge, the patient was admitted on an involuntary basis for psychiatric evaluation and treatment at an acute care hospital, following an incident at a bank.[83]

Texoma Medical Center in **Texas** was cited by the Centers for Medicare and Medicaid Services for failing to ensure patient rights and safety. An "actively psychotic" patient was discharged from the Behavioral Health Center without safe transportation. Hospital staff said that there was no ride available for the patient and offered her walking directions. The patient eventually left the facility with an unidentified male."[84]

UHS has closed or sold a number of facilities following issues with quality and compliance

Since 2011, UHS has closed or sold 22 of its behavioral health facilities. At least 16 of those facilities had faced legal, regulatory or quality-of-care complaints before UHS stopped operating them.[85]

The most recent case involves the Rock River Academy for girls in Illinois, which a December 2014 investigative series in the *Chicago Tribune* described as "violent, chaotic and under-resourced." The *Tribune* found that many students were fleeing the facility and some were being drawn into prostitution. State officials suspended new admissions to Rock River in December and ordered corrective action, but UHS decided to close the facility instead.[86]

Keys of Carolina was closed as state officials attempted to revoke its license, following a settlement in a lawsuit that alleged retaliation for regulatory reports.

This residential treatment facility in Charlotte, NC is currently under federal investigation by the Office of the Inspector General.[87] The facility was closed voluntarily by UHS in February 2013, but it was reported that, "State officials said conditions in the facility were 'found to be detrimental to the health and safety of the clients' and was in the process of revoking the facility's license. The Keys had begun appealing the action when it notified the state it was closing." The facility had been cited for serious deficiencies in an August 2012 inspection.[88] Additionally, the facility settled a lawsuit in March 2012, in which former employee Teresa Weeks alleged that she was improperly fired for reporting patient care issues to regulatory agencies.[89] See more below.

Marion Youth Center closed less than three months before reaching a multi-million dollar settlement.

This facility in Marion, Virginia closed January 8, 2012.[90] UHS reportedly said that the facility was closing because "Its lease has run out and could not be re-

newed."[91] Two and a half months after the closure, UHS announced a settlement with the U.S. Department of Justice, with the company agreeing to pay $6.85 million "to settle allegations that they provided substandard psychiatric counseling and treatment to adolescents in violation of Medicaid requirements, falsified records and submitted false claims to the Medicaid program." Daniel R. Levinson, Inspector General of the Department of Health and Human Services said, "Any organization providing substandard health services then sending inflated bills to taxpayers, as UHS is alleged to have done, can expect intense scrutiny by government investigators."[92]

Residents were removed from Milton Girls Juvenile Residential Facility following revelations of abuse.

This facility in Milton, Florida closed in December 2012, "on the heels of an admissions freeze the [Department of Juvenile Justice] enacted … amid allegations of unsafe conditions."[93] The closure followed release of video surveillance showing physical abuse of a resident. Further investigation by the Florida Department of Juvenile Justice ("DJJ") resulted in the arrest of a male staff member for allegedly sexually assaulting six girls at the facility.[94] The staff member was found guilty of sexual misconduct and sentenced to 25 years in prison.[95]

Upon removing the adolescents from the facility, a DJJ spokesman wrote in a statement, "As a result of several significant health, safety and security concerns with the administration and operation of the program, it is clear that the best interests of the youth can no longer be served at Milton," and reportedly added that many residents "expressed concerns for their personal safety."[96]

The Department of Juvenile Justice chose to look elsewhere for "better quality services" following reports of widespread sexual victimization at Bristol Youth Academy.

The Department of Juvenile Justice announced it would not extend its contract with this UHS facility in Bristol, Florida in August 2013. A DJJ spokeswoman cited less need for beds as a reason for the closure, but local news also reported that she said:

> "When we previously attempted to procure a new contract for this program, we did not get a response that we believed was adequate in terms of the services that we were looking for," Collins said, stating they were asking for "better quality services at a price that is fair to Florida taxpayers."[97]

The U.S. Department of Justice reported statistics in June 2013 showing that more than 10% of Bristol Youth Academy residents reported sexual victimization by staff.[98]

Gulf Coast Youth Academy was terminated after critical issues were not corrected; staff members were fired for calling 911.

This facility in Fort Walton Beach, Florida closed October 31, 2013. The Florida Department of Juvenile Justice terminated its contract after it was placed on default status for uncorrected "critical issues." Local news reported,

> "The Youth Academy had been placed in "default" status following two incidents Aug. 5 and 6 involving unruly youths. Four teachers were injured trying to break up a brawl Aug. 5. Two required medical treatment. In an Aug. 14 letter signed by Laura Moneyham, DJJ's assistant secretary for residential services, the facility was reprimanded for its failure to implement safety and security practices. In the wake of what had occurred Aug. 5 and 6, the Youth Academy was placed on default status for failing to correct "critical issues" previously identified by the DJJ. The facility had until Sept. 3 correct the problems, Moneyham said in the August letter.
>
> She notified Gulf Coast Treatment Center on Sept. 19 that its contract had been terminated."

Following the notice of termination, a former staff member told local news that she was fired for calling 911 for help during another incident in which "out-of-control teens threw tables, kicked staff and stole and broke equipment."[99]

Other UHS facilities have faced limitations on admissions and serious threats of closure

Some of these measures appear to be related to specific patient care incidents.

Arbour-HRI, **Massachusetts** – placed under an admissions moratorium in November 2013 by the Department of Mental Health, "after receiving a report about a female patient being forcibly searched, an incident that state Mental Health Commissioner Marcia Fowler described in an interview Monday as 'a very serious human rights violation.' The inspectors identified a range of problems, including dirty conditions and untrained or inexperienced staff, she said."[100]

The Meadows Psychiatric Centre, **Pennsylvania** – barred from admitting new patients to its child and adolescent wards in May 2011 after a riot among patients triggered inspections by the Department of Public Welfare, which "found violations of patient rights, including the excessive use of restraints or seclusion, frequent understaffing, inadequate individualized treatment methods, poor record-keeping and a deteriorating physical plant — the combination of which created potentially unsafe conditions for patients**."**[101]

The Vines Residential Treatment Center, **Florida** – placed under an admissions moratorium February 22, 2013 – March 14, 2013.[102] The moratorium was issued after a staff member broke a child's arm in a spiral fracture and the child had to wait until the next morning to be treated by a doctor.[103]

Others have been the result of uncorrected problems.

Two Rivers Psychiatric Hospital, **Missouri** – given notice of termination from the Medicare and Medicaid programs in April 2011 due to "alleged failure to alleviate an 'immediate jeopardy' situation." The facility was able to able to reach a settlement with CMS resulting in the rescission of the termination notice.[104]

Manatee Palms Youth Services, **Florida** – placed under an intake hold by the Florida Agency for Health Care Administration on April 16, 2010. AHCA found that the facility failed to correct deficiencies related to risk management processes, failing to investigate and resolve incidents, and failing to ensure that medical attention was promptly provided to patients.[105]

The Pines Residential Treatment Center, **Virginia** – placed under an admissions freeze in April 2011 by Virginia state officials as "the result of ongoing performance issues that must be corrected to ensure safety and effective treatment for the troubled children there."[106]

Communities and former employees have prompted actions by regulators.

Westwood Lodge, **Massachusetts** – The Department of Mental Health reduced the number of patients allowed at the facility from 89 to 75 in February 2012. DMH and local residents were concerned about the hospital's security plan after multiple patients eloped from the facility.[107]

Michiana Behavioral Health, **Indiana** – the facility's license was placed on "conditional" status after weekly protests by former employees sparked an audit which cited the facility "for failing to comply with state statutes about using drugs to control patients' behavior."[108]

Multiple UHS facilities in Chicago have been banned from accepting wards of the Department of Children and Families.

Garfield Park Hospital, **Illinois** – placed under an intake hold by Illinois DCFS on March 19, 2013, after opening February 2013. An investigative report found evidence of violence, frequent use of emergency medications and "medical records being altered to cover up problems."[109]

Hartgrove Hospital, **Illinois** – placed under an intake hold by Illinois DCFS in September 2011. According to the *Chicago Tribune*, an investigative report by the state found the facility "often was understaffed and over capacity — a dangerous combination that created opportunities for frequent attacks by patients on other patients and hospital staff."[110]

Riveredge Psychiatric Hospital and Streamwood Behavioral Health, **Illinois** – remain under intake holds by Illinois DCFS following their acquisition by UHS in November 2010.[111]

One facility in Florida has had Medicare and Medicaid payments suspended pursuant to a federal investigation.

River Point Behavioral Health, **Florida** – placed under payment suspensions for the Medicare and Florida Medicaid programs in April 2014, pursuant to investigations by the U.S. Department of Justice's Civil Division and Criminal Frauds Section. The suspensions remain in effect as of February 2015.[112]

More inspection reports and patient lawsuits can be found online at www.UHSBehindClosedDoors.org

ALLEGATIONS OF HEALTHCARE FRAUD

Federal civil and criminal authorities are currently investigating UHS.

A growing number of UHS facilities are being investigated by the federal government. In February 2015, UHS disclosed that the Department of Justice expanded its investigation to six additional facilities in 2014, bringing the total number of facilities under investigation to 19.

The Office of the Inspector General of the U.S. Department of Health and Human Services ("OIG") delivered 11 subpoenas in February, April and June of 2013, with two other facilities having been placed under investigation separately. Six additional facilities were added to the investigation in 2014.

Three of these facilities, Wekiva Springs Center, River Point Behavioral Health and National Deaf Academy, have been referred to the Department of Justice's Criminal Frauds Section. In April 2014, federal and state officials instituted Medicare and Medicaid payment suspensions at River Point Behavioral Health. These suspensions remain in effect.[113]

Regarding the nature of these investigations, UHS has disclosed that: "The DOJ has advised us that the civil aspect of the coordinated investigation in connection with the behavioral health facilities named above is a False Claim Act investigation focused on billings submitted to government payers in relation to services provided at those facilities."[114] CFO Steve Filton has also told Wall Street analysts, "I think, A.J., as you suggest, the trend in behavioral care has been to have these investigations focus on clinical practices. And I would say that the content of the subpoenas would suggest that's largely the focus here."[115]

UHS has previously paid millions of dollars to settle lawsuits that alleged fraud against government health care and education programs.

The U.S. Department of Justice accused UHS of operating a non-therapeutic facility; the case settled for $6.85 million.[116]

The United States intervened in this false claims whistleblower lawsuit brought by three former therapists. The United States alleged that "Defendants presented or caused the presentation of claims to DMAS that falsely or fraudulently claimed payment for residential treatment facility room and board at KMYC, when in fact juvenile detention

facility room and board was provided," and that its claims "named an 'attending physician, and fraudulently made it appear that treatment and treatment planning was provided under the direction of a licensed psychiatrist when, in fact, neither active treatment nor physician supervision was provided." The lawsuit was settled for $6.85 million in March 2012.

UHS day schools allegedly violated contracts and submitted false claims; the case settled for $4.25 million.[117]

The parents of a former student, along with former school teachers and administrators, sued UHS of Delaware (UHS) in 2009, alleging that UHS filed false claims, breached the terms of its contracts with public school districts and violated California law in connection with a number of special needs non-public schools and a central bookkeeping office in Grand Terrace, California, which it owned and operated.

The suit alleged that UHS employed several teachers who were either inappropriately credentialed or not credentialed at all. For example, the lead plaintiff, who has autism, attended a UHS school in Elmira which allegedly charged public school districts significant monthly fees, as high as $231,000 in one month, for special education services delivered to 80 students, but which had between zero and three properly-certified special education teachers on staff at any given time. The plaintiffs alleged that the company's practice was to "warehouse" students with any available salaried or hourly employee and then invoice the respective school districts as though the contracted services had been properly performed. They alleged that UHS falsely attested to its compliance with the contract terms, created false records, and submitted false claims to the California State Department of Education for reimbursement.

In August 2012, UHS entered into a settlement agreement with the California Attorney General and the Plaintiffs; although the company did not admit liability in the agreement, UHS agreed to pay $4.25 million to settle the case.

Former staff alleged "systemic criminal fraud" at Marion Youth Center; the case settled.[118]

A former Director of Education sued UHS regarding her employment at the Marion Youth Center. Her complaint alleged that she was effectively fired "because of her investigation of, reporting of, opposition to, and refusal to participate in, her employer's blatant and systemic criminal fraud against Medicaid engaged in by defendants at the Marion Youth Center in Marion, Virginia." She alleged that she "noticed that on the weekends the Youth Center was not providing any supervision to the residents," that the CEO told staff "the census of the Youth Center must be kept up and that therefore discharges needed to be delayed," that the facility conducted "'drive by' therapy sessions" billed as full 30-minute sessions, as well as "the admission of residents who did not meet the criteria for admission." The case settled in 2012 in a confidential agreement.

Five nurses claimed their acute care hospital's psychiatric unit engaged in improper admissions and altered charts at the instruction of a UHS employee; the case was settled.[119]

Five nurses at Verdugo Hills Hospital filed a lawsuit against their hospital and Horizon Health Corporation, a subsidiary of UHS that provides hospital management services.[120] The nurses alleged that beginning in February 2011, a new Program Director employed by Horizon to manage the hospital's geriatric psychiatric unit instructed nurses to engage in improper admissions practices and accept all patients regardless of bed availability.

According to their complaint, overflow patients were held in the ER or Medical Surgery Unit, which resulted in compromised care and created short staffing on the geropsych unit when nursing assistants went to monitor the overflow patients in other units. The nurses also claimed that the program director discharged patients, often before a medical physician signed discharge orders or before all appropriate care was rendered, to open up beds for new patients. They claimed this practice was especially common for Medicaid patients. Finally, the nurses alleged they were instructed by the program director to engage in "negative charting," or exaggerating a patient's behavior in their medical charts even when they were calm or cooperative in order to increase government reimbursements for care rendered. The case was settled confidentially in May 2013.

Additional lawsuits alleging fraud are still being fought in U.S. courts.

Former Staff Therapists allege retaliation for reporting quality and legal compliance issues and emailing Alan Miller.[121]

Two former National Deaf Academy Staff Therapists filed a lawsuit in April 2013, alleging they were retaliated against for reporting multiple legal compliance and quality issues during their respective tenures at the facility (from approximately January 2012 through October 2012). They allege that NDA and UHS falsified records, and even instructed employees to falsify records, to misrepresent therapy sessions that did not occur or the presence of a licensed healthcare professional. They also allege the facility unnecessarily admitted patients or unnecessarily delayed their discharge and detained them.

They also allegedly observed abusive conditions and practices at the facility, including the excessive use of physical or chemical restraints. They claim that the administration refused to report incidents of suspected abuse to the Department of Children and Families and instructed staff to only use corporate UHS forms to document such incidents.

Their second amended complaint states "UHS was directly involved in the decision to subject [Gilrain and Sav-

age] to the retaliatory terminations from [National Deaf Academy] which are at issue. Specifically, Plaintiff Gilrain was terminated from [National Deaf Academy] only hours after he sent an email to the UHS Corporate Compliance Officer and human resources [on or about Sept 4, 2012] detailing and objecting to incidents of unlawful conduct. Similarly, Plaintiff Savage was terminated [on or about October 17, 2012] approximately two weeks after she submitted a written complaint objecting to incidents of unlawful conduct at [National Deaf Academy] to UHS President Alan Miller." The case is ongoing as of March 8, 2015.

Unlicensed staff and client's death led to false claims suit, now on appeal.[122]

The parents of a patient who died while in the care of Arbour Counseling Services sued the facility and related companies under the federal False Claims Act, alleging that the facility violated that law by presenting claims for reimbursement from MassHealth (Medicaid) based on services rendered by providers employed by Arbour Counseling Services who were not licensed, not supervised, and/or not qualified to provide services to patients. The parents (Relators) allege that the reimbursement claims made by these practitioners were false, and that claims made by the clinic were false due to non-compliance with core staffing requirements. According to their complaint, one practitioner prescribed medication, despite not being permitted to do so unless under the direct supervision of a board certified psychiatrist. The complaint also alleges that a side effect of this medication, Trileptal, caused the Relator's daughter to develop seizures, and ultimately led to her death. The district court judge dismissed the case after finding that, although "[t]he allegations of this complaint raise serious questions about the quality of care provided," the False Claims Act was not the proper vehicle for pursuing these claims. The Relators have asked the United States Court of Appeals for the First Circuit to review the decision to dismiss the case. The Commonwealth of Massachusetts led by Attorney General Martha Coakley has filed an *amicus curiae* brief asking the appeals court to reverse the trial court's dismissal.[123]

COMPLIANCE AND RETALIATION

Employees who expose problems at UHS facilities face a company with a long history of retaliation.

In public, UHS encourages its employees to report problems to their managers or its Compliance Program, saying, "UHS will not retaliate or tolerate any retaliation against you for reporting in good faith."[124] UHS's Compliance Manual states "Our leaders help to create a culture that promotes the highest standards of ethics and compliance. This culture must encourage everyone in the organization to share concerns when they arise, without fear of retaliation."[125]

Behind closed doors, however, UHS has a history of retaliating against workers who advocate for better patient care. According to lawsuits and reports, UHS workers have been fired for reporting care issues to regulators and company management and the company even has policies that have discouraged workers from reporting emergencies and assaults. UHS company policy requires workers to notify management of potential problems, but its aggressive retaliation history suggests management might not like what they hear.

In 2011 outside experts reported retaliation threats made against workers who provided information during an investigation at Hartgrove Hospital in Chicago, IL.

A report by the University of Illinois at Chicago reportedly found the facility "often was understaffed and over capacity," and that "Hartgrove staff were reportedly told by UHS (parent company) officials that anyone suspected of providing information to the UIC reviewers would be fired." Despite the alleged threats, "a number of employees stepped forward and provided them with much of the data in the report," which led the Illinois Department of Children and Family Services to institute an intake hold on the facility.[126]

Teresa Weeks was a Mental Health Technician at Keys of Carolina in Charlotte, NC who alleged she was fired after reporting care issues to local management and to state officials.

She alleged in a lawsuit that she repeatedly raised issues with management about staff training levels, staff safety, client supervision and client safety. She also brought these issues to the North Carolina Department of Social Services, the North Carolina Department of Labor, and the Occupational Safety and Health Administration. She alleged that "the director of nursing and the facility manager accused the Plaintiff of creating power struggles, of being negative, and of being difficult. They also gave the Plaintiff false write-ups in order to

create a pretext for firing her." The lawsuit was settled in March 2012.[127]

Megan Johnson, Leslie Webb, and Kimberly Stafford-Payne were Therapists at Marion Youth Center in Virginia who allege they were fired after refusing to participate in a fraudulent scheme at the facility.

Three therapists at this Virginia UHS facility alleged that UHS "engaged in various activities and techniques to increase improperly and fraudulently the … reimbursement that Defendant received from Medicaid," including overbilling for therapy sessions, billing brief interactions as full therapy sessions ("drive by" therapy), provoking residents to justify a longer length of stay, billing for therapy sessions provided by an unlicensed, unsupervised therapist, altering records, delaying discharges, and "deliberately understaffing the Youth Center."[128] The relators alleged that they were fired because they "refused to go along with the Medicaid fraud and triggered the investigation of the Youth Center by the Virginia licensing authorities."[129] The U.S. and Virginia authorities eventually joined their false claims whistleblower case[130] and achieved a $6.85 million settlement of allegations that the company provided substandard psychiatric counseling and treatment to adolescents in violation of Medicaid requirements, falsified records and submitted false claims to the Medicaid program. The workers received an additional undisclosed amount for their employment claims.[131]

Despite the company policy that requires employees to report suspected problems, some workers have allegedly been fired for reporting issues to management.

Kyle Gilrain and Carol Savage were Therapists at National Deaf Academy in Mt. Dora, FL who were allegedly fired after reporting issues to CEO Alan Miller and other UHS management.

The two filed a lawsuit in April 2013 alleging they were retaliated against for reporting multiple legal compliance and quality issues during their respective tenures at the facility. Among other charges, they allege that they observed abusive conditions and practices at the facility, including the excessive use of physical or chemical restraints. They claim that the administration refused to report incidents of suspected abuse to the Department of Children and Families and instructed staff to only use corporate UHS forms to document such incidents. Their second amended complaint states that "UHS was directly involved in the decision to subject [Gilrain and Savage] to the retaliatory terminations from NDA which are at issue. … Gilrain was terminated from NDA only hours after he sent an email to the UHS

Corporate Compliance Officer and human resources detailing and objecting to incidents of unlawful conduct. Similarly, Savage was terminated approximately two weeks after she submitted a written complaint objecting to incidents of unlawful conduct at NDA to UHS President Alan Miller." The case is ongoing as of March 8, 2015.[132]

Barbara Jones was Director of Education at Marion Youth Center in Virginia who alleged she was fired after refusing to participate in a fraudulent scheme at the facility.

A former Director of Education sued UHS regarding her employment at the Marion Youth Center. Her complaint alleged that she was effectively fired "because of her investigation of, reporting of, opposition to, and refusal to participate in, her employer's blatant and systemic criminal fraud against Medicaid engaged in by defendants at the Marion Youth Center in Marion, Virginia." She alleged that she "noticed that on the weekends the Youth Center was not providing any supervision to the residents," that the CEO told staff "the census of the Youth Center must be kept up and that therefore discharges needed to be delayed," that the facility conducted "'drive by' therapy sessions" billed as full 30-minute sessions, and she witnessed "the admission of residents who did not meet the criteria for admission." The case settled in 2012.[133]

Latelle Barton was a Psychiatric Assistant at Del Amo Hospital in Torrance, CA who alleged he was fired after making several reports of patient care issues to facility management.

He brought suit alleging he was retaliated against and fired for making numerous complaints to his superiors about unsafe patient care and conditions at Del Amo Hospital. He allegedly raised concerns about patient neglect and failures in assessing patients for suicide or injury. For example, he claimed a patient's suicide could have been prevented, had his supervisors and hospital managers acted on his warnings about the safety risks of wheeled beds. According to the complaint, no precautions were taken and the patient later hung himself by rolling the bed to the door. The complaint also alleged that the hospital compromised patient care and safety as a result of its intentional understaffing, untrained staff, non-medical personnel directing patient care, and inadequate medical equipment and medical protocols. The case was settled.[134]

Jessica Sanchez was a Mental Health Technician in the Intensive Care Unit at Sierra Vista Hospital in Sacramento, CA who alleges she was fired, in part, due to raising care issues.

In an ongoing lawsuit, she alleges she was terminated because the facility chose not to accommodate her workplace injury and because she made complaints about the health and safety conditions at the hospital. Specifically, she alleges that she was fired in retaliation for complaining about staff threatening patients, unsanitary and unsafe patient environments (e.g. dirty restrooms resulting in several MRSA outbreaks), and concerns over sexual assaults on patients by staff. She also claims the facility had insufficient staffing and, on occasion, had only one staff member to care for 20 patients. This case is currently awaiting a trial date.[135]

Uche Maduagwu was a Registered Nurse at Del Amo Hospital in Torrance, CA and alleges he was defamed then fired after raising patient care issues to facility management.

He filed a lawsuit against Del Amo Hospital for defamation and retaliation in violation of the California Labor Code. The lawsuit alleges that the Defendants used patently false and defamatory accusations as a pretext to justify, cause, and execute his suspension and termination. The plaintiff also alleges that he was retaliated against because he made multiple complaints about Defendants' unsafe patient safety conditions, including but not limited to, short staffing nurse-to-patient ratio, health and safety issues regarding psych patient care, and other violations of state statutes and regulations. This case is active as of March 8, 2015.[136]

Gloria Freeman worked as the Pharmacy Director at Sierra Vista Hospital in Sacramento, CA and alleges she was retaliated against for communicating about routine job responsibilities.

In an ongoing lawsuit, she alleges that the CEO required her to perform monitoring rounds and conduct group counseling sessions with psychiatric patients even though she was not trained as a hospital manager or mental health professional. She also alleges that she complained to facility management about issues with the pharmacy's refrigerators and electrical failures at the facility. She alleges that when she suggested updating the facility's Hazardous Substances Policy in a group email, the CEO wrote back, "You need to stop the emails NOW around this issue." She also complained to her staffing agency that the facility violated its contract by allowing unauthorized personnel to access the pharmacy. She alleges that following these complaints, she injured her knee and was not allowed to return to work at Sierra Vista despite having a note from her doctor clearing her for work with minor accommodations.[137]

UHS has gone so far as to ask workers not to report assaults to authorities or call 911 in emergencies

Taqwa Whitley and Courtney Jordan were Youth Care Workers at Gulf Coast Youth Academy in Fort Walton Beach, FL who were reportedly fired for calling 911.

Local news reported that the two were fired for calling 911 for help on a night when "out-of-control teens threw tables, kicked staff and stole and broke equipment" at the juvenile justice facility. Whitley, who was monitoring video at the time, said she was concerned for the safety of residents and staff after residents stole a supervisor's radio and broke a security camera. According to the report, "Protocol at the Youth Academy requires a program director to make any non-medical related 911 calls [...]. There were no program directors at the center that night […]." The local Sheriff told the newspaper, "If it's true that people were fired for calling us, that's ridiculous." Gulf Coast Youth Academy's contract with the Florida Department of Juvenile Justice had been terminated shortly before this incident, after "failing to correct 'critical issues.'"[138]

Omobolanle Olayinka was a Child Care Counselor at Mid Valley Youth Center in Van Nuys, CA who alleged she was fired for raising workplace issues and reporting assaults to police.

In a lawsuit, she alleged she was wrongfully terminated in retaliation for making complaints about workplace discrimination and harassment, as well as for reporting repeated physical assaults by facility residents. She claimed the residents assaulted her on several occasions, during which they threw objects at her, spit on her face, and even physically attacked her, sending her to the ER twice. She alleged she reported the assaults to her supervisors, but they did not take any precautionary actions and repeatedly told her not to report the incidents to police or file charges. Following one such incident, according to her allegations the facility allowed a resident who attacked her back on to the floor on which she worked, even though she had pressed police charges against him. About a year after the case was filed, the parties reached a settlement, resulting in the dismissal of the case.[139]

UHS THROUGH THE EYES OF WORKERS

At Old Vineyard Behavioral Health in North Carolina, one RN was made responsible for simultaneously monitoring four patients on two different units, all with histories of being sexual offenders with aggressive behaviors, while also dispensing medications. When interviewed, the nurse said, "I was watching (all 4 of the residents - 3 on Phoenix 12 and 1 on Phoenix 9) from the med(ication) room. I was watching the dayroom the best I could." Despite her efforts, a 13-year-old male patient later reportedly performed oral sex on another patient in the dayroom, saying "I was afraid he was going to clobber me."[164]

In a separate incident four years later, Old Vineyard was found by the Centers for Medicare and Medicaid Services to have failed to ensure the protection of patients' right to be free from abuse. One nurse said that she was not able to protect a patient because, "I am rarely able to leave our glass bubble (nursing station). We have 18 patients with one nurse. (RN #2) stayed over but she said she wasn't helping with the new admissions until her day shift charting was done. I had four admissions."[165]

At a facility in California, a pharmacist alleges that the CEO required her to perform monitoring rounds and conduct group counseling sessions with psychiatric patients even though she was not trained as a hospital manager or mental health professional. She alleges that when she wrote a group email to other employees suggesting an update for the facility's Hazardous Substances Policy, the CEO wrote back, "You need to stop the emails NOW around this issue." She alleges that she then injured her knee and was not allowed to return to work despite having a doctor's note clearing her for work with minor accommodations. The pharmacist's lawsuit is ongoing.[166]

In Florida, two Staff Therapists allege in a lawsuit that after raising compliance and safety issues at their facility, "Gilrain was terminated from NDA only hours after he sent an email to the UHS Corporate Compliance Officer and human resources detailing and objecting to incidents of unlawful conduct. Similarly, Plaintiff Savage was terminated approximately two weeks after she submitted a written complaint objecting to incidents of unlawful conduct at NDA to UHS President Alan Miller."[167]

SEIU members asked UHS to create a dedicated committee on its Board of Directors to oversee patient quality of care and compliance with healthcare laws and regulations.

UHS is under multiple federal and state investigations and there have been repeated lapses in patient safety and quality and allegations of noncompliance with regulatory requirements. Further, the above examples suggest that employees seeking to advocate for the patients that they provide care for at UHS facilities are not adequately protected from being punished when they raise concerns.

In letters written to UHS's Board of Directors and at the company's annual meeting last May, SEIU members called on the company to improve its oversight over quality of care and compliance with healthcare laws and regulations. Specifically, we asked that UHS create a dedicated committee on its Board of Directors to oversee patient quality of care and compliance with healthcare laws and regulations. This type of committee exists at UHS's competitors. We believe that the largest provider of inpatient behavioral health in the country should at least meet, if not exceed, the best practices in the industry.

Unfortunately, even with the ongoing investigations and patient care breakdowns outlined above, UHS has maintained that its "Board of Directors has a well-functioning audit committee and, working in conjunction with an extensive quality department, determined that an additional oversight organization is not required."[140]

GET TO KNOW UHS'S CEO

BIOGRAPHY

UHS's founder Alan B. Miller is the longest-serving CEO in the publicly traded for-profit hospital sector,[145,146] having founded the company 36 years ago in 1979.[147] Alan Miller is 77 years old.[148] He grew up in New York City, and has an MBA in Marketing from the Wharton School of Business.[149] He began his career in advertising before founding his first for-profit hospital company with his Wharton roommate.[150] In addition to being both CEO and Chairman of UHS, Miller controls a class of shares that allows him to elect 80% of the board.[151]

COMPENSATION

Alan Miller's 8,380,990 UHS shares are worth approximately $956 million.[152] Additionally, his total compensation from UHS was $13.2 million in 2013, up 13% from 2012.[153] This included country club dues, tax and accounting services, maintenance costs for his home and automobile, and life insurance premiums.[154]

Alan Miller's total compensation of $13.2 million in 2013 was equal to $6,323 for every hour in a 40-hour workweek. In contrast, UHS is currently offering potential employees $9.00 to $9.75 per hour to work as a Mental Health Associate PRN at a behavioral health hospitals in Kentucky. UHS is "currently seeking PRN Mental Health Associates to work varied shifts on all units and patient populations," and "[maintain] the therapeutic milieu … that is conducive to quality patient care." This employee also intervenes in patient behavior by verbal or physical means as required, maintains observation of patients, documents vital signs, assists patients with activities of daily living, and leads educational discussions.[155]

This employee would make approximately $20,280 per year with a 40-hour weekly schedule – 648 times less than Alan Miller's 2013 compensation.

ALAN MILLER ON...

Selecting his causes:

The Alan B. Miller Family Foundation, headed by Alan Miller,[156] has donated thousands of dollars to public charities that serve underprivileged children and families, such as UNICEF, Friends of Yemin Orde, Friendship Circle, the Jewish Relief Agency, and Ronald McDonald House.

While these charities will provide basic necessities to people in need, UHS facilities such as Arbour-HRI Hospital, National Deaf Academy and Old Vineyard Behavioral Health have been cited for failing to provide patients with basic necessities including food, blankets, towels and bed sheets.[158,159,160]

Not being a surgeon:

"[B]eing in health care, we're actually saving people's lives and putting their bodies back together and fixing their mental problems and personality disorders. That's a life work. […] Other than being a surgeon, which I wasn't suited for, or being a hands-on treatment person or a provider, what else could [I] do that would incorporate [my] talents? I mean I'm good at business […]."[161]

Employee relations:

When UHS workers traveled to the UHS shareholder meeting in May 2014, one RN spoke to CEO Alan Miller and gave him a bracelet with the words "Corona Nurses Care," a message of her facility's union organizing campaign. The nurse later recounted, "We shook hands and I looked him in the eye [...]. I tried to explain to him what the bracelet message, 'Corona Nurses Care,' means to RNs at UHS Corona. I gave him the bracelet so he won't forget about us."[162]

Less than a week later, Alan Miller told the press: "Nothing did happen [...]. Before they left, one lady gave me a rubber band, which said, 'We care.' She said, 'I know you care.'"[163]

SOURCES

1 UHS Investor Presentation at Ratings Agency Meetings. November 7, 2014. Slide 6.

2 Net revenue of behavioral segment. UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.142.

3 Percent of behavioral segment from U.S. military. UHS Q1 2014 Earnings Call. April 25, 2014. p.4.

4 Net revenue of behavioral segment. UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.142.

5 UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.1.

6 UHS at Cowen Group Health Care Conference. March 5, 2012. p.3.

7 UHS at Credit Suisse Healthcare Conference. November 12, 2014. p.2.

8 UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.61.

9 Data compiled from UHS SEC filings.

10 UHS at RBC Capital conference. March 2, 2011. p.4.

11 UHS at JP Morgan Conference. January 15, 2014. p.4.

12 Von Bergen, Jane. "Acutely aware of the needs of hospital patients and staff skills." May 27, 2014 - http://articles.philly.com/2014-05-27/business/50125475_1_health-business-health-care-mental-health

13 *Kyle Gilrain and Carol Savage vs. The National Deaf Academy, LLC*. Fifth Judicial Circuit Court of Florida. Case No. 2013 CA 001190 (filed September 6, 2013. Second Amended Complaint - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/07/FL-Lake-Co.-2013-Gilrain-v.-Natl-Deaf-Academy-complaint-1.pdf

14 "Two employees fired after Youth Academy melee." Northwest Florida Daily News. September 27, 2013 - http://www.nwfdailynews.com/local/two-employees-fired-after-youth-academy-melee-1.209782

15 UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. pp.35-37.

16 UHS Form 10-K for the year ending December 31, 2011. Filed February 27, 2012. pp.34-36.

17 UHS Form 10-K for the year ending December 31, 2008. Filed February 26, 2009. pp.28-31.

18 "Press release: Data from Inpatient Psychiatric Facilities Increase Transparency for Consumers Evaluating Facilities." Centers for Medicare and Medicaid Services. April 17, 2014 - http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-04-17.html

19 MedPAC Comment Letter on CMS File Code CMS-1606-P. June 2, 2014. p.3.

20 State Survey Agencies are responsible for ensuring compliance with CMS conditions of participation – CMS.gov "Survey & Certification – Enforcement." Retrieved August 28, 2014 - http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/index.html

21 Yahoo Finance. UHS closing price quoted on January 3, 2007 ($55.81) and March 6, 2015 ($114.05).

22 SEIU Policy on Campaigns for Corporate Social Responsibility.

23 Von Bergen, Jane. "Acutely aware of the needs of hospital patients and staff skills." May 27, 2014 - http://articles.philly.com/2014-05-27/business/50125475_1_health-business-health-care-mental-health

24 See revenue data from "13 Largest For-Profit Hospital Operators." Becker's Hospital Review. July 16, 2013. http://beckershospitalreview.com/lists/13-largest-for-profit-hospital-operators.html

25 UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.1.

26 UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.2.

27 UHS at UBS Global Healthcare Conference. May 21, 2013. pp.2-3.

28 UHS at JP Morgan Conference. January 15, 2014. p.3.

29 UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.1.

30 UHS at Cowen Group Health Care Conference. March 5, 2012. p.3.

31 UHS at R.W. Baird conference. September 3, 2014. p.4.

32 UHS at Wells Fargo Healthcare Conference. June 18, 2014. p.2.

33 "The Mental Health Parity and Addiction Equity Act." The Center for Consumer Information & Insurance Oversight. Centers for Medicare and Medicaid Services. Retrieved March 8, 2015 - http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

34 UHS at Credit Suisse Healthcare Conference. November 13, 2013. p.4.

35 UHS at Credit Suisse Healthcare Conference. November 13, 2013. p.4.

36 UHS at Credit Suisse Healthcare Conference. November 13, 2013. pp.2,3.

37 UHS at Credit Suisse Healthcare Conference. November 13, 2013. p.4.

38 "Obamacare Positive for Universal Health: CEO Miller." Bloomberg TV. October 17, 2013 - http://www.bloomberg.com/video/obamacare-positive-for-universal-health-ceo-miller-CKPwcGNgTkCl~yveaaX7~g.html

39 UHS Investor Presentation at Ratings Agency Meetings. November 7, 2014. Slide 3.

40 UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.61.

41 UHS Investor Presentation at Ratings Agency Meetings. November 7, 2014. Slide 6.

42 Net revenue of behavioral segment. UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.142.

43 UHS Q3 2011 Earnings Call. October 28, 2011.

44 UHS at UBS Conference. May 19, 2014. p.3.

45 Net revenue of behavioral segment. UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.142.

46 UHS at Cowen Health Care conference. March 4, 2013. p.5.

47 CMS State Operations Manual. Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. p.200.

48 Journal of the American Psychiatric Nurses Association. APNA Position Statement: Staffing Inpatient Psychiatric Units. p.17.

49 Data compiled from UHS SEC filings.

50 Data compiled from UHS and Psychiatric Solutions SEC filings.

51 UHS Form 10-K for the year ending December 31, 2012. Filed February 28, 2013. p.62.

52 Data compiled from IJHS and Psychiatric Solutions SEC filings.

53 Total facility Salaries, wages and employee benefits divided by Revenue as adjusted for the deduction of Provision for doubtful accounts. Psychiatric Solutions, Inc Form 10-K for the year ending December 31, 2009. Filed February 25, 2010. p.24-25.

54 Salaries, wages and benefits as a % of Net Revenues at all behavioral health facilities, for the year ending December 31, 2014. UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.61.

55 Salaries, wages and benefits as a % of Net Revenues at all behavioral health facilities for the year ending December 31, 2011. UHS Form 10-K for the year ending December 31, 2012. Filed February 28, 2013. p.62.

56 UHS at RBC Capital conference. March 2, 2011. p4.

57 UHS at JP Morgan Conference. January 15, 2014. p.4.

58 Steve Filton on UHS Q1 2005 Earnings Call. April 28, 2005. p.3.

59 Statement of deficiencies for Valley Hospital. May 2, 2013 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/AZ-Valley-Hospital-2013.05.02.pdf

60 *Jessica Sanchez vs. BHC Sierra Vista Hospital Inc.* Superior Court of California, County of Sacramento. Case Number 34-2013-00154381 (filed November 7, 2013). Complaint and Docket retrieved from https://services.saccourt.ca.gov/PublicCaseAccess/Civil/SearchByCaseNumber

61 Statement of deficiencies for Manatee Palms Youth Services. May 21, 2013 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/FL.Manatee_Palms_Youth_Services_2013.05.21_AHCA.pdf

62 Statement of deficiencies for Manatee Palms Youth Services. January 17, 2013 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/FL.Manatee_Palms_Youth_Services_2013.01.17_AHCA.pdf

63 Statement of deficiencies for Lighthouse Care Center of Atlanta. February 24, 2012 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/05/GA-lighthouse-2012.02.24.pdf

64 Statement of deficiencies for Riveredge Hospital. June 13, 2013 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/IL-Riveredge-Hospital-2013.06.13.pdf

65 Statement of deficiencies for Spring Mountain Treatment Center. November 3, 2010 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/05/NV-SOD-Spring-Mountain-2010.11.03.pdf

66 Statement of deficiencies for Old Vineyard Behavioral Health. November 4, 2009 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/05/NC-Old-Vineyard-2009.11.04-11.pdf

67 Two-part statement of deficiencies for Laurel Ridge Treatment Center. June 13, 2013 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/TX-Laurel-Ridge-Treatment-Center-2013.06.13-2.pdf;

http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/TX-Laurel-Ridge-Treatment-Center-2013.06.13-11.pdf

68 Statement of deficiencies for Manatee Palms Group Homes. February 13, 2012 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/FL.Manatee-Palms-Group-Homes-2012.02.13.pdf

69 Statement of deficiencies for Old Vineyard Behavioral Health. April 29, 2010 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/05/NC-Old-Vineyard-2010.04.29.pdf

70 Statement of deficiencies for River Crest Hospital. February 5, 2014 - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/TX-River-Crest-2014.02.05-B.pdf

71 Statement of deficiencies for Valley Hospital. July 1, 2013 - http://uhsbehindclosed-doors.org/wp-content/uploads/2014/04/AZ-Valley-Hospital-2013.07.01.pdf

72 Statement of deficiencies for Emerald Coast Behavioral Hospital. December 19, 2012 - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/FL.Emerald-Coast-Behavioral-Hospital-2012.12.19-CMS.pdf

73 Statement of deficiencies for National Deaf Academy. January 17, 2013 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/05/FL.National-Deaf-Academy-2013.01.17-R.pdf

74 Statement of deficiencies for Vines Hospital. October 29, 2013 - http://uhsbehind-closeddoors.org/wp-content/uploads/2014/04/FL.Vines-Hospital-2013.10.29.pdf

75 Statement of deficiencies for Vines Hospital. December 5, 2012 - http://uhsbehind-closeddoors.org/wp-content/uploads/2014/05/FL.Vines-Hospital-2012.12.05.pdf

76 Statement of deficiencies for Highlands Behavioral Health System. July 27, 2013 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/CO-Highlands-Behavioral-Health-System-2013.07.27.pdf

77 Statement of deficiencies for Arbour Hospital. February 23, 2010 - http://uhsbehind-closeddoors.org/wp-content/uploads/2014/04/MA-SOD-Arbour-2010.02.23.pdf

78 *Jack and Roseanne Goodman v. UHS*. U.S. District Court for the Western District of Tennessee. Case No. 2:10-cv-02079 (filed February 3, 2010). Complaint - http://uhs-behindcloseddoors.org/wp-content/uploads/2014/04/Goodman-v-UHS-complaint.pdf; Docket - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/Goodman-v-UHS-Docket.pdf

79 Statement of deficiencies for Peachford Behavioral Health System. April 21, 2011 - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/GA-Peachford-Behavioral-SOD-2011.04.21-CMS.pdf

80 Statement of deficiencies for SummitRidge. September 29, 2011 - http://uhsbehind-closeddoors.org/wp-content/uploads/2014/05/GA-Summit-ridge-2011.09.29.pdf

81 Statement of deficiencies for Two Rivers Behavioral Health. March 18, 2011 - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/MO-Two-Rivers-Behavioral-Health-2011.03.18-CMS.pdf; CMS Termination letter for Two Rivers Behavioral Health - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/MO-Two-Rivers-CMS-program-termination-letter.pdf

82 *Alexander, E. v. Friends Hospital*. Philadelphia County Court of Common Pleas. Case ID 131101333 (filed November 14, 2013). Second Amended Complaint (filed March 18, 2014) - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/PA-Philadelphia-2013-Alexander-E-v.-Friends-Hospital.pdf; Docket retrieved from http://www.courts.phila.gov/casesearch/

83 Statement of deficiencies for The Ridge Behavioral Health System. September 26, 2012 - http://uhsbehindcloseddoors.org/wp-content/uploads/2015/01/KY-SOD-The-Ridge-Behavioral-2012.09.26.pdf

84 Statement of deficiencies for Texoma Medical Center. June 21, 2013 - http://uhs-behindcloseddoors.org/wp-content/uploads/2014/04/TX-Texoma-Medical-Center-2013.06.21.pdf

85 Based on comparison of UHS 10-K facilities' lists for the years ending 2010-2014.

86 "Center for troubled girls will close, cites decision by DCFS," Chicago Tribune, January 28, 2015.

87 UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. pp.35-37.

88 "Psychiatric facility closing doors in February." December 7, 2012. WSOC TV - http://www.wsoctv.com/videos/news/psychiatric-facility-closing-doors-in-february/vjyHR/

89 *Teresa Weeks vs. Keystone Charlotte, LLC*. United States District Court for the Western District of North Carolina. Case No. 3:11 CV 193 (filed April 18, 2011). Complaint - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/Weeks-v-UHS-complaint.pdf; Dismissal (filed March 7, 2012) - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/Weeks-v-UHS-dismissal.pdf

90 "Plant Shut-Downs, Closings & Layoffs Profile – Marion Youth Center." Plant Shut-Downs, Closings & Layoffs. December 26, 2011.

91 "Rick Santorum-Linked Universal Health Services Facility: Fraud, Assault And Alleged 'Exorcism'." The Huffington Post. January 6, 2012 - http://www.huffingtonpost.com/2012/01/06/rick-santorum-uhs_n_1186443.html

92 U.S. Department of Justice, "Residential Youth Treatment Facility for Medicaid Recipients in Marion, Virginia Agrees to Resolve False Claims Act Allegations," March 28, 2012 - http://www.justice.gov/opa/pr/2012/March/12-civ-391.html

93 "Worker arrested after 6 girls allege sex abuse at Milton juvenile facility." Pensacola News Journal. February 12, 2013.

94 "Worker arrested after 6 girls allege sex abuse at Milton juvenile facility." Pensacola News Journal. February 12, 2013.

95 "Former med tech gets 25 years in sex case." Pensacola News Journal. April 17, 2014 - http://www.pnj.com/story/news/2014/04/17/former-med-tech-gets-25-years-in-sex-case/7809815/

96 "Department of Juvenile Justice, Milton girls facility cut ties." Pensacola News Journal. December 22, 2012.

97 "DJJ announces closure of Bristol Youth Academy." The Calhoun Liberty Journal. August 23, 2013 - http://www.cljnews.com/20130823djj-announces-closure-of-bristol-youth-academy

98 "Report: Florida youth facilities report staff sexual misconduct." The Miami Herald. July 5, 2013.

99 "Two employees fired after Youth Academy melee." Northwest Florida Daily News. September 27, 2013 - http://www.nwfdailynews.com/local/two-employees-fired-after-youth-academy-melee-1.209782

100 "New curb on Brookline mental health hospital." The Boston Globe. November 26, 2013 - http://www.bostonglobe.com/metro/2013/11/26/arbour/tIsXAMwvCkHZi4DS8iuddM/story.html

101 "Meadows plans upgrades after inspection finds safety concerns." Centre Daily Times. May 22, 2011.

102 Agency for Health Care Administration. "The Vines facility profile." FloridaHealthFinder.gov. Retrieved March 9, 2015 - http://www.floridahealthfinder.gov/facilitylocator/FacilityProfilePage.aspx?id=249485

103 State of Florida, Agency for Health Care Administration. Immediate Moratorium on Admissions (filed February 22, 2013) - http://apps.ahca.myflorida.com/dm_web/DMWeb_DocsFO/4461370.pdf

104 UHS Form 10-K for the year ending December 31, 2012. Filed February 28, 2013. p.34

105 AHCA Emergency Order of Immediate Moratorium on Admissions for Manatee Palms Youth Services. April 16, 2010 - http://apps.ahca.myflorida.com/dm_web/DMWeb_DocsFO/3854724.pdf

106 Bryant, Janie. "Va. cracks down on youth treatment center." The Virginian-Pilot. April 26, 2011 - http://hamptonroads.com/2011/04/va-cracks-down-youth-treatment-center

107 Bolton, Michelle. "Hospital security lapses focus of meeting tomorrow." The Boston Globe. March 4, 2012 - http://www.boston.com/yourtown/westwood/articles/2012/03/04/public_meeting_march_5_on_security_at_westwood_lodge_psychiatric_facility/

108 Dits, Joseph. "Psychiatric facility given 'conditional' status." South Bend Tribune. May 22, 2013.

109 Jackson, David. "Reports blister Chicago psychiatric hospital for youths." The Chicago Tri bune. April 25, 2013 - http://articles.chicagotribune.com/2013-04-25/news/ct-met-psych-hospital-20130425_1_uic-report-uic-team-dcfs

110 Shelton, Deborah. "UIC report slams Hartgrove psychiatric hospital." The Chicago Tribune. September 28, 2011 - http://articles.chicagotribune.com/2011-09-28/health/ct-met-psych-hospital-report-20110928_1_uic-report-psychiatric-hospital-sexual-assaults

111 Jackson, David. "Reports blister Chicago psychiatric hospital for youths." The Chicago Tri bune. April 25, 2013 - http://articles.chicagotribune.com/2013-04-25/news/ct-met-psych-hospital-20130425_1_uic-report-uic-team-dcfs

112 UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.35.

113 UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.35-37

114 UHS Form 10-K for the year ending December 31, 2014. Filed February 26, 2015. p.36.

115 UHS Q4 2012 Earnings Call. March 1, 2013. p.3.

116 *US ex rel Megan Johnson vs. Keystone Marion*. United States District Court for the Western District of Virginia. Case No. 1:07-cv-00054 (filed June 14, 2007). US Amended Complaint (filed November 24, 2010) - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/US-vs-Marion-Youth-Center-US-Amended-Complaint.pdf; Settlement Agreement (filed March 28, 2012) - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/US-vs-Marion-Youth-Center-US-Settlement-Agreement.pdf

117 *Martin v. UHS of Delaware*. Superior Court of the State of California, County of Sacramento. Case No. 34-2009-00044335 (filed May 18, 2009). Third amended complaint (filed September 29, 2011) - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/CA-Sac-2009-Martin-v.-UHS-of-Delaware-3rd-amended-complaint.pdf; Settlement order (filed August 9, 2012) - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/CA-Sac-2009-Martin-v.-UHS-of-Delaware-Settlement-order.pdf

118 *Barbara Jones v. UHS*. U.S. District Court for the Western District of Virginia. Case No. 1:10-cv-00046 (filed July 29, 2010). Complaint - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/Jones-v-UHS-et-al-complaint.pdf; Order (filed February 29, 2012) - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/Jones_v_UHS_et_al_dismissal_settlement.pdf

119 *Irene Deanon v. Verdugo Hills Hospital et al*. Los Angeles Superior Court. Case No. BC484022 (filed May 3, 2012). Amended complaint (filed June 15, 2012); Joint Ex Parte Application for Order Approving Settlement (filed May 1, 2013); Detailed Docket, available https://www.lacourt.org/paonlineservices/civilimages/publicmain.aspx?

120 Horizon Health Corporation, "Horizon Health Privacy Policy." Retrieved September 2, 2014. p.5 - http://www.horizonhealth.com/index.php/privacy-policy/

121 *Kyle Gilrain and Carol Savage vs. The National Deaf Academy, LLC*. Fifth Judicial Circuit Court of Florida. Case No. 2013 CA 001190 (filed September 6, 2013. Second Amended Complaint - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/07/FL-Lake-Co.-2013-Gilrain-v.-Natl-Deaf-Academy-complaint-1.pdf; Docket - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/07/FL-Lake-Co.-Gilrain-v.-Natl-Deaf-Academy-Docket.pdf

122 United States of America ex rel Julio Escobar et al v. Universal Health Services, Inc. United States District Court for the District of Massachusetts. Case No. 1:11-cv-11170 (filed July 1, 2011). Second Amended Complaint (filed Feb. 25, 2013).- http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/US-ex-rel-Escobar-v-UHS-second-amended-complaint.pdf

United States of America ex rel Julio Escobar et al v. Universal Health Services, Inc. United States District Court for the District of Massachusetts. Case No. 1:11-cv-11170 (filed July 1, 2011). Docket. - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/US-ex-rel-Escobar-v-UHS-Docket.pdf

123 *United States of America ex rel Julio Escobar et al v. Universal Health Services, Inc.* United States District Court for the District of Massachusetts. Case No. 1:11-cv-11170 (filed July 1, 2011). Brief for Amicus Curiae, Commonwealth of Massachusetts, in support of reversal filed with the U.S. Court of Appeals for the First Circuit. Case No. 14-

1423 (filed Aug. 26, 2014).

124 Universal Health Services, "UHS Compliance Program."Accessed August 21, 2014, available at http://www.uhsinc.com/compliance-and-ethics/uhs-compliance-program/

125 Universal Health Services, "UHS Compliance Manual", p.5. Accessed September 8, 2014, available at http://www.uhsinc.com/media/244567/uhs_compliance-manual.pdf

126 Shelton, Deborah. "UIC Report hammers hospital." Chicago Tribune. September 28, 2011 - http://articles.chicagotribune.com/2011-09-28/health/ct-met-psych-hospital-report-20110928_1_uic-report-psychiatric-hospital-sexual-assaults

127 *Teresa Weeks vs. Keystone Charlotte, LLC*. United States District Court for the Western District of North Carolina. Case No. 3:11 CV 193 (filed April 18, 2011). Complaint - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/Weeks-v-UHS-complaint.pdf; Dismissal - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/Weeks-v-UHS-dismissal.pdf

128 *US ex rel Megan Johnson vs. Keystone Marion.* United States District Court for the Western District of Virginia. Case No. 1:07-cv-00054 (filed June 14, 2007). Complaint (filed June 14 2007). p.5.

129 *US ex rel Megan Johnson vs. Keystone Marion.* United States District Court for the Western District of Virginia. Case No. 1:07-cv-00054 (filed June 14, 2007). Complaint (filed June 14 2007). pp.11-13.

130 *US ex rel Megan Johnson vs. Keystone Marion*. United States District Court for the Western District of Virginia. Case No. 1:07-cv-00054 (filed June 14, 2007). Second Amended Complaint (filed Nov. 10, 2010). - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/US-vs-Marion-Youth-Center-US-Amended-Complaint.pdf

131 U.S. Department of Justice, "Residential Youth Treatment Facility for Medicaid Recipients in Marion, Virginia Agrees to Resolve False Claims Act Allegations," March 28, 2012 - http://www.justice.gov/opa/pr/2012/March/12-civ-391.html

132 *Kyle Gilrain and Carol Savage vs. The National Deaf Academy, LLC*. Fifth Judicial Circuit Court of Florida. Case No. 2013 CA 001190 (filed September 6, 2013. Second Amended Complaint - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/07/FL-Lake-Co.-2013-Gilrain-v.-Natl-Deaf-Academy-complaint-1.pdf;

133 *Barbara Jones vs. Universal Health Services Inc*. U.S. District Court for the Western District of Virginia. Case No. 1:10-cv-00046(filed July 29, 2010 - Complaint - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/Jones-v-UHS-et-al-complaint.pdf; Dismissal Settlement - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/Jones_v_UHS_et_al_dismissal_settlement.pdf

134 *Latelle Barton, Jr. vs. Del Amo Hospital, Inc*. Superior Court of California, County of Los Angeles, Central District. Case No. BC463326(filed June 10, 2011) - Complaint - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/CA-LA-2011-Barton-v.-Del-Amo-Hospital-Complaint.pdf; Docket - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/CA-LA-2011-Barton-v.-Del-Amo-Hospital-Docket.pdf; Document List - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/CA-LA-2011-Barton-v.-Del-Amo-Hospital-Docket.pdf

135 *Jessica Sanchez vs. BHC Sierra Vista Hospital Inc.* Superior Court of California, County of Sacramento. Case Number 34-2013-00154381 (filed November 7, 2013) - Complaint - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/CA-Sac-2013-Sanchez-v.-BHC-Sierra-Vista-Complaint.pdf; Docket - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/CA-Sac-Sanchez-Docket.pdf

136 *Uche Maduagwu vs. Del Amo Hospital Limited Partnership*. Superior Court of California, County of Los Angeles. Case No. BC535147 (filed February 7, 2014). Complaint - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/05/CA-LA-2014-Maduagwu-v.-Del-Amo-Complaint.pdf; Docket - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/05/CA-LA-2014-Maduagwu-v-Del-Amo-Docket.pdf

137 *Gloria Freeman vs. Cardinal Health Pharmacy Services, et al*. United States District Court for the Eastern District of California. Case No. 2:14-cv-01994 (filed August 27, 2014). Notice of Removal from Sacramento County Superior Court - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/Freeman-v-Sierra-Vista-PACER-Notice-of-Removal.pdf

138 McLaughlin, Tom. "Two employees fired after Youth Academy melee." Daily News. September 27, 2013 - http://www.nwfdailynews.com/local/two-employees-fired-after-youth-academy-melee-1.209782

139 *Omobolanle B. Olayinka vs. Universal Health Services Inc*. Superior Court of California, County of Los Angeles. Case No. LC088809 (filed March 4, 2010). First Amended Complaint (filed August 19, 2010). - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/CA-LA-Olayinka-v.-UHS.pdf; Docket - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/CA-LA-OLayinka-Docket.pdf

140 Von Bergen, Jane. "Acutely aware of the needs of hospital patients and staff skills." May 27, 2014 - http://articles.philly.com/2014-05-27/business/50125475_1_health-business-health-care-mental-health

141 UHS Form 10-K for the year ending December 31, 2011. Filed February 27, 2012. p.3.

142 UHS at Cowen Health Care Conference. March 4, 2013. p.4.

143 UHS at RBC Capital conference. March 2, 2011. p4.

144 Burling, Stacey. "UHS completes $3.1 billion Psychiatric Solutions acquisition." November 16, 2010 - http://articles.philly.com/2010-11-16/business/24952973_1_psychiatric-solutions-uhs-psi-facilities

145 George Washington University Hospital. Facebook post. May 13, 2014. Retrieved September 2, 2014 - https://m2.facebook.com/story.php?story_fbid=709507502423763&id=106860256021827

146 UHS at Barclays Conference. March 14, 2012. p.1.

147 Universal Health Services, "About Universal Health Services, Inc." Retrieved March 9, 2015 - http://www.uhsinc.com/aboutuhs.php

148 UHS 2014 Proxy Filing. p.11.

149 Biography of Alan Miller. The Horatio Alger Association - http://www.horatioalger.org/members_info.cfm?memberid=MIL10

150 Biography of Alan Miller. The Horatio Alger Association - http://www.horatioalger.org/members_info.cfm?memberid=MIL10

151 UHS 2014 Proxy Filing. p.47.

152 UHS 2014 Proxy Filing. p.7.

153 UHS 2014 Proxy Filing. p.32.

154 UHS 2014 Proxy Filing. p.32.

155 Universal Health Services, "Louisville Support Jobs - Mental Health Associate PRN at Universal Health Services." Retrieved March 9, 2015 - http://jobs.uhsinc.com/louisville/support/jobid6988866-mental-health-associate-prn-jobs

156 Alan B. Miller Family Foundation. Form 990 for the year ending January 31, 2013. p.19.

157 Alan B. Miller Family Foundation. Form 990 for the year ending January 31, 2013. pp.14-16.

158 "Regulators find Brookline psychiatric hospital deficient again." The Boston Globe. May 30, 2014 - http://www.bostonglobe.com/lifestyle/health-wellness/2014/05/29/federal-investigators-find-lack-treatment-for-mentally-ill-patients-arbour-hri-ceo-leaves/qy5YZZo364KjVgr9UhLueP/story.html

159 Statement of Deficiencies for National Deaf Academy. February 28, 2013. p.5 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/08/FL.National-Deaf-Academy-2013.02.28-R.pdf

160 Statement of Deficiencies for Old Vineyard Behavioral Health. November 4, 2009. p.5 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/05/NC-Old-Vineyard-2009.11.04-11.pdf

161 Von Bergen, Jane M. "Alan Miller: From Mad Man to magnate." The Inquirer. May 26, 2014. http://www.philly.com/philly/blogs/jobs/INQ_JOBBING_Alan-Miller-From-Mad-Man-to-magnate.html

162 "Corona Nurses Care." July, 2014. United Nurses Association of California Blog - http://www.unacuhcp.org/corona-nurses-care-way-pennsylvania/

163 Von Bergen, Jane. "Acutely aware of the needs of hospital patients and staff skills." May 27, 2014 - http://articles.philly.com/2014-05-27/business/50125475_1_health-business-health-care-mental-health

164 Statement of Deficiencies for Old Vineyard Behavioral Health. April 16, 2009 - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/05/NC-Old-Vineyard-2009.04.16-2.pdf

165 Statement of Deficiencies for Old Vineyard Behavioral Health. May 3, 2013 - http://uhsbehindcloseddoors.org/wp-content/uploads/1970/01/NC-Old-Vineyard-2013.05.03-CMS.pdf

166 Gloria Freeman vs. Cardinal Health Pharmacy Services, LLC. Superior Court of California, County of Sacramento. Case No. 34-2013-00154710 (filed Nov. 14, 2013. Plaintiff's First Amended Complaint (filed Jan. 27, 2014) - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/04/CA-Sac-2013-Freeman-Amended-complaint.pdf

167 Kyle Gilrain and Carol Savage vs. The National Deaf Academy, LLC. Fifth Judicial Circuit Court of Florida. Case No. 2013 CA 001190 (filed September 6, 2013. Second Amended Complaint - http://uhsbehindcloseddoors.org/wp-content/uploads/2014/07/FL-Lake-Co.-2013-Gilrain-v.-Natl-Deaf-Academy-complaint-1.pdf

Notes

a. Analysis performed upon claims data from the Medicare Inpatient Standard Analytical File Limited Data Set, as well as upon data obtained from Medicare Cost Reports. Methodology is available upon request.

b. Suicidal ideation diagnoses are identified by their ICD-9 diagnosis code – V62.84.

c. UHS recently acquired 18 facilities in the United Kingdom, as noted in the company's Form 10-Q for the period ending September 30, 2014.

d. UHS disclosed in its first quarter 2014 earnings call that "the military -- and even though that's a relatively small part of our overall business probably less than 10% in all division." (p.4) Applying 10% to UHS's behavioral health net revenue for 2013 of $3,667,967 (taken from UHS's 2013 10k filing, p.142) yields $367 million.

UNIVERSAL HEALTH SERVICES FACILITIES

ACUTE CARE HOSPITALS

CALIFORNIA

Corona Regional Medical Center
Inland Valley Campus, Wildomar
Palmdale Regional Medical Center
Rancho Springs Campus, Murrietta
Temecula Valley Hospital, Temecula

D.C.

The George Washington University Hospital

FLORIDA

Lakewood Ranch Medical Center, Bradenton
Manatee Memorial Hospital, Bradenton
Wellington Regional, West Palm Beach

NEVADA

Centennial Hills Hospital, Las Vegas
Desert Springs Hospital, Las Vegas
Northern Nevada Medical Center, Sparks
Spring Valley Hospital, Las Vegas
Summerlin Hospital, Las Vegas
Valley Hospital Medical Center, Las Vegas

OKLAHOMA

St. Mary's Regional Medical Center, Enid

SOUTH CAROLINA

Aiken Regional Medical Centers, Aiken

TEXAS

Doctors' Hospital of Laredo, Laredo
Edinburg Regional Medical Center and Children's Hospital, Edinburg
Fort Duncan Regional, Eagle Pass
McAllen Heart Hospital, McAllen
McAllen Medical Center, McAllen
Northwest Texas Healthcare System, Amarillo
Texoma Medical Center, Denison

BEHAVIORAL HEALTH

ALABAMA

Alabama Clinical Schools, Birmingham
Hill Crest Behavioral Health, Birmingham
Laurel Oaks Behavioral Health, Dothan

ALASKA

Good Samaritan Counseling, Anchorage
North Star Bragaw, Anchorage
North Star DeBarr RTC, Anchorage
North Star Hospital, Anchorage
North Star Palmer RTC, Palmer

ARIZONA

Calvary Addiction Recovery Center, Phoenix
Palo Verde Behavioral Health, Tucson
Quail Run Behavioral Health, Phoenix
Valley Hospital, Phoenix

ARKANSAS

Pinnacle Pointe Hospital, Little Rock
Rivendell Behavioral Health Services, Benton
Springwoods, Fayetteville
The Bridgeway, North Little Rock

CALIFORNIA

Alhambra Hospital, Rosemead
Canyon Ridge Hospital, Chino
Del Amo Hospital, Torrance
Fremont Hospital, Fremont
Heritage Oaks Hospital, Sacramento
Sierra Vista Hospital, Sacramento

COLORADO

Cedar Springs Behavioral Health, Colorado Springs
Centennial Peaks, Louisville
Highlands Behavioral Health, Highlands Ranch

CONNECTICUT

Stonington Institute, North Stonington

DELAWARE

Dover Behavioral Health, Dover
Rockford Center, Newark

D.C.

Psychiatric Institute of Washington

FLORIDA

Atlantic Shores Hospital, Fort Lauderdale
Behavioral Educational Services, Riverdale
Central Florida Behavioral Hospital, Orlando
Emerald Coast Behavioral Hospital, Panama City
Fort Lauderdale Hospital, Fort Lauderdale
Gulf Coast Youth Services, Ft. Walton Beach
La Amistad Behavioral Health, Maitland
NDA Behavioral Health System, Mount Dora*
Okaloosa Youth Academy, Crestview
Palm Shores Behavioral Health, Bradenton
River Point Behavioral Health, Jacksonville*
SandyPines Hospital, Tequesta
Schick Shadel of Florida, Cooper City
Suncoast Behavioral Health, Bradenton
University Behavioral Center, Orlando
Vines Hospital, Ocala
Wekiva Springs, Jacksonville*
Windmoor Healthcare, Clearwater

GEORGIA

Anchor Hospital, Atlanta
Coastal Behavioral Health, Savannah
Coastal Harbor Treatment Center, Savannah*
Crescent Pines, Stockbridge
Lake Bridge Behavioral Health, Macon
Laurel Heights Hospital, Atlanta
Lighthouse Care Center of Augusta, Augusta
Peachford Behavioral Health System, Atlanta
St. Simons by the Sea, St. Simons*
SummitRidge, Lawrenceville
Talbott Recovery Campus, Atlanta
Turning Point Hospital, Moultrie*

IDAHO

Boulder Creek Academy, Bonners Ferry
Intermountain Hospital, Boise
Northwest Academy, Bonners Ferry

ILLINOIS

Chicago Children's Center for Behavioral Health, Chicago
Garfield Park Hospital, Chicago
Hartgrove Hospital, Chicago*
Lincoln Prairie Behavioral Health, Springfield
Riveredge Hospital, Forest Park*
Rock River Residential Center, Rockford (scheduled to close)*
Streamwood Behavioral Health, Streamwood*
The Pavilion, Champaign

INDIANA

Bloomington Meadows Hospital, Bloomington
Columbus Behavioral Center for Children and Adolescents, Columbus
Michiana Behavioral Health Center, Plymouth
Midwest Center for Youth and Families, Kouts
Valle Vista Hospital, Greenwood
Wellstone Regional Hospital, Jeffersonville

KENTUCKY

Brook Hospital—Dupont, Louisville
Brook Hospital—KMI, Louisville
Cumberland Hall, Hopkinsville
Lincoln Trail Behavioral Health, Radcliff
Rivendell Behavioral Health Services of Kentucky, Bowling Green
The Ridge Behavioral Health, Lexington

LOUISIANA

Brentwood Hospital, Shreveport
River Oaks Hospital, New Orleans

MASSACHUSETTS

Arbour Counseling Services, Rockland
Arbour Senior Care, Rockland
Arbour-Fuller Hospital, South Attleboro
Arbour-HRI Hospital, Brookline*
Pembroke Hospital, Pembroke
The Arbour Hospital, Boston
Westwood Lodge Hospital, Westwood

MICHIGAN

Forest View Hospital, Grand Rapids
Havenwyck Hospital, Auburn Hills
Turning Point Youth Center, St. Johns

MINNESOTA

Pride Institute, Eden Prairie

MISSISSIPPI

Alliance Health Center, Meridian
Brentwood Behavioral Health, Flowood
Diamond Grove Center, Louisville
Parkwood Behavioral Health, Olive Branch

MISSOURI

Heartland Behavioral Health Services, Nevada
St. Louis Behavioral Medicine Institute, St. Louis
Two Rivers Psychiatric Hospital, Kansas City

NEVADA

Spring Mountain Sahara, Las Vegas
Spring Mountain Treatment Center, Las Vegas
West Hills Hospital, Reno
Willow Springs Center, Reno

NEW JERSEY

Hampton Behavioral Health, Westhampton
Summit Oaks Hospital, Summit

NEW MEXICO

Mesilla Valley Hospital, Las Cruces

NORTH CAROLINA

Brynn Marr Hospital, Jacksonville
Holly Hill Hospital, Raleigh
Old Vineyard Behavioral Health, Winston-Salem*

NORTH DAKOTA

Prairie St John's, Fargo

OHIO

Arrowhead Behavioral Health, Maumee
Belmont Pines Hospital, Youngstown
Foundations for Living, Mansfield
Fox Run Hospital, St. Clairsville
Windsor—Laurelwood Center, Willoughby

OKLAHOMA

Cedar Ridge Hospital, Oklahoma City
Cedar Ridge RTC, Oklahoma City
Shadow Mountain Behavioral Health, Tulsa

OREGON

Cedar Hills Hospital, Beaverton

PENNSYLVANIA

Brooke Glen Behavioral Hospital, Fort Washington
Clarion Psychiatric Center, Clarion
Fairmount Behavioral Health, Philadelphia
Foundations Behavioral Health, Doylestown
Friends Hospital, Philadelphia*
KeyStone Center, Wallingford
Roxbury Treatment Center, Shippensburg*
The Horsham Clinic, Ambler
The Meadows Psychiatric Center, Centre Hall*

PUERTO RICO

Community Cornerstones, Rio Piedras
First Hospital Panamericano—Cidra
First Hospital Panamericano—Ponce
First Hospital Panamericano—San Juan

SOUTH CAROLINA

Aurora Pavilion, Aiken
Lighthouse Care Center of Conway, Conway
Palmetto Lowcountry Behavioral Health, North Charleston
Palmetto Pee Dee Behavioral Health, Florence
Palmetto Summerville, Summerville
The Carolina Center for Behavioral Health, Greer
Three Rivers Behavioral Health, West Columbia
Three Rivers Residential Treatment-Midlands Campus, West Columbia

TENNESSEE

Cedar Grove RTC, Murfreesboro
Compass Intervention Center, Memphis
Hermitage Hall, Nashville
Lakeside Behavioral Health System, Memphis
McDowell Center for Children, Dyersburg
Mountain Youth Academy, Mountain City
Natchez Trace Youth Academy, Waverly
Oak Plains Academy, Ashland City
Rolling Hills Hospital, Franklin
Upper East TN Juvenile Detention Facility, Johnson City

TEXAS

Austin Lakes Hospital, Austin
Austin Oaks Hospitals, Austin
Behavioral Hospital of Bellaire, Houston*
Cypress Creek Hospital, Houston
El Paso Behavioral Health System, El Paso
Glen Oaks Hospital, Greenville
Hickory Trail Hospital, DeSoto
Kingwood Pines Hospital, Kingwood
Laurel Ridge Treatment Center, San Antonio
Mayhill Hospital, Denton
Meridell Achievement Center, Austin
Millwood Hospital, Arlington
River Crest Hospital, San Angelo
San Marcos Treatment Center, San Marcos
South Texas Behavioral Health, McAllen
Texas NeuroRehab Center, Austin
The Pavilion at Northwest Texas Healthcare System, Amarillo
The Recovery Center, Wichita Falls
Timberlawn Mental Health System, Dallas
TMC Behavioral Health Center, Denison
University Behavioral Health of Denton
West Oaks Hospital, Houston

UNITED KINGDOM

Cygnet Health Care

UTAH

Benchmark Behavioral Health, Woods Cross
Center for Change, Orem
Copper Hills Youth Center, West Jordan
Cottonwood Treatment Center, S. Salt Lake City
Provo Canyon Behavioral Hospital, Orem
Provo Canyon School, Provo
Salt Lake Behavioral Health, Salt Lake City*

VIRGIN ISLANDS

Virgin Islands Behavioral Services, St. Croix

VIRGINIA

Cumberland Hospital, New Kent
First Home Care, Portsmouth
Harbour Point (Pines), Portsmouth*
Hughes Center, Danville
Kempsville Center of Behavioral Health, Norfolk
Liberty Point Behavioral Health, Stauton
Newport News Behavioral Health Center, Newport News
North Spring Behavioral Healthcare, Leesburg
Poplar Springs Hospital, Petersburg
Virginia Beach Psychiatric Center, Virginia Beach

WASHINGTON

Fairfax Hospital, Kirkland
Fairfax Hospital—Everett
Schick Shadel Hospital, Burin

WEST VIRGINIA

River Park Hospital, Huntington

WYOMING

Wyoming Behavioral Institute, Casper

*** FACILITIES IN RED WITH ASTERISKS ARE UNDER FEDERAL INVESTIGATION**

A PROJECT OF SERVICE EMPLOYEES INTERNATIONAL UNION
MARCH 17, 2015

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