

Universal Health Services - Turning 144 Planned Beds into Staffed Behavioral-Health Capacity

Internal ID: S&F-STR-565

Topic: Operations Strategy, Capital Allocation

Industry: Health Care Facilities

Source: Strategy & Finance

Publication date: 5 October 2026

License: Not specified

Decision date and information cutoff: 27 February 2023

Decision scope: Ramp and program design for the announced UHS-LVHN behavioral-health joint venture

Case convention: This is an author-created operating decision exercise based on information available by the cutoff. Project plans and partner statements are historical; no later construction or operating outcomes are included.

The decision

On 13 February 2023, Universal Health Services (UHS) and Lehigh Valley Health Network (LVHN) announced a joint venture to build a 144-bed behavioral-health hospital in Hanover Township, Pennsylvania, across from LVHN-Muhlenberg. At the time, the partners projected a spring 2024 groundbreaking and fall 2025 opening. The planned facility was 97,000 square feet. [P2], lines 216-219.

LVHN said regional behavioral-health needs exceeded capacity and that the new hospital would nearly triple its existing inpatient beds. That is LVHN's assessment, not an independently measured local demand forecast in the materials available here. The release also described LVHN's existing inpatient, outpatient, partial-hospitalization, residential, substance-use, consultation-liaison, integrated behavioral-health and telepsychiatry services. [P2], lines 220-226, 240-241.

Assignment: Assume you are advising the joint venture's operating-planning team. Recommend how the partners should ramp the announced 144-bed facility and define its initial service program. Which patient groups and levels of care should be prioritized, how should the hospital connect to existing services, and what staffing and clinical-readiness gates should control bed activation? The decision is how to operate the announced project-not whether to pursue it.

Capacity is more than a bed count

UHS's 2022 Form 10-K reported 24,259 average licensed behavioral-health beds and 24,159 average available behavioral-health beds across its facilities. Reported occupancy was 70.4% of licensed beds and 70.7% of available beds. These are UHS-wide aggregates across different markets, facilities and patient needs. They do not establish demand or capacity conditions in the Lehigh Valley. "Licensed" and "available" do not mean that a bed is currently staffed and ready for a particular patient. UHS did not reconcile these averages to site-level workforce constraints. [P1], "Behavioral Health Care Services," pp. 51-52.

The staffing issue was material. UHS reported that shortages at certain behavioral-health facilities had limited patient volumes. Management attributed labor-cost pressure to vacancies, premium compensation and temporary staffing. Same-facility salaries, wages and benefits were 55.0% of behavioral-health revenue in 2022. The disclosure does not say that the Hanover project would face the same staffing conditions or provide its hiring plan. [P1], Item 1A, p. 15; Item 7, pp. 46-47; “Behavioral Health Care Services,” pp. 51-52.

UHS’s same-facility behavioral-health revenue grew 4.2% in 2022, while income before tax fell 2% to \$1.017 billion and the income-before-tax margin fell from 19.4% to 18.2%. These figures describe UHS’s same-facility behavioral-health services, not this joint venture’s projected economics. UHS reported \$734 million in companywide capital expenditures in 2022 and forecast \$725 million to \$875 million for 2023; it did not allocate either amount to Hanover. [P1], “Behavioral Health Care Services,” pp. 51-52; Item 7, pp. 69-70.

Existing services create pathways-and questions

LVHN’s release listed services across an extensive care continuum, from inpatient and partial hospitalization to outpatient, residential, substance-use, consultation-liaison, integrated behavioral-health and telepsychiatry programs. Those service categories are not interchangeable. Clinical eligibility, acuity, safety, payer coverage, geography and available follow-up can determine whether a patient can appropriately receive care in a particular setting. The release did not disclose program capacity, wait times, referral pathways or transfer performance. [P2], lines 226, 240-241.

An operating plan could therefore link the hospital to existing programs through referral protocols, discharge planning and follow-up while preserving clinical judgment about the right level of care. It could also prioritize inpatient capacity for patients whose needs require it. The evidence in this packet does not establish which local bottleneck is binding or how many of the planned beds would be staffed at opening.

Exhibit 1. UHS-wide context and project facts

Measure	Reported figure / plan	Scope and caution
Announced facility	144 beds; 97,000 sq. ft.	Hanover Township JV plan; future timing as stated 13 Feb. 2023. [P2]
UHS average licensed behavioral-health beds, 2022	24,259	Company-wide average; not local or staffed capacity. [P1]
UHS average available behavioral-health beds, 2022	24,159	Company-wide average; “available” does not establish staffed readiness at each site. [P1]
Occupancy of licensed / available beds	70.4% / 70.7%	UHS-wide reported occupancy; not a Lehigh Valley demand measure. [P1]
Same-facility behavioral-health revenue growth	4.2%	UHS same-facility measure; not a JV revenue forecast. [P1]
Salaries, wages and benefits	55.0% of same-facility behavioral-health revenue	UHS-wide same-facility cost measure; no project-level staffing cost is disclosed. [P1]
Companywide capital expenditure	\$734m in 2022; \$725m-\$875m forecast for 2023	Not allocated to the JV. [P1]

The public materials did not disclose the JV’s construction budget, ownership split, staffing ramp, payer mix, reimbursement assumptions, operating break-even or return forecast. No local demand estimate or project-level financial estimate can be calculated from this exhibit.

Exhibit 2. Three ramp and program approaches

Approach	Potential benefit	Principal risk
Inpatient-first activation: prepare the full announced inpatient program and bring beds online as quickly as readiness permits	Directly addresses LVHN’s stated capacity concern and may add access for patients requiring inpatient care	Physical capacity may outrun staffing, referrals or appropriate downstream discharge options; the local volume need is not independently quantified
Workforce-gated ramp: activate beds in cohorts tied to clinical staffing, referral evidence and operational readiness	Protects care quality and limits the gap between licensed, available and staffed beds	May defer access if need is greater than early cohorts can serve; strict gates can become overly cautious
Inpatient with continuum coordination: ramp inpatient capacity while building explicit links to appropriate outpatient, partial, residential and other services	May improve transitions and manage multiple points of constraint	Requires partner governance and service-level capacity; other levels of care cannot substitute for inpatient care when clinically inappropriate

These are classroom alternatives, not a publicly disclosed UHS or LVHN plan. A defensible recommendation should specify the service mix, workforce sequence, clinical safeguards, decision rights and evidence that would change the ramp.

Questions for discussion

1. What evidence supports the claim that regional inpatient capacity is insufficient? What local data would you request before setting an opening census or mix?
2. How should licensed, available and staffed beds be distinguished in the operating plan?
3. Which services in LVHN's continuum can support referrals, step-down and follow-up, and which patient needs require inpatient care? Why can't the categories be treated as substitutes?
4. What staffing, referral, quality and discharge gates should govern bed activation?
5. What governance should UHS and LVHN use to reconcile workforce constraints, clinical authority, investment and access goals?

Sources and conventions

P1. Universal Health Services, Inc., [2022 Form 10-K](#), filed 27 February 2023; year ended 31 December 2022. "Behavioral Health Care Services," pp. 51-52; workforce risk, Item 1A, p. 15; labor discussion, Item 7, pp. 46-47; capital resources, pp. 69-70.

P2. Lehigh Valley Health Network and UHS, ["Announce Plans to Build New Behavioral Health Hospital"](#), 13 February 2023. Facility facts and projected timing, lines 216-219; LVHN's local-capacity statements, lines 220-226; existing services, lines 226 and 240-241.

LVHN's demand and capacity statements are attributed. UHS-wide metrics are not local utilization data. Licensed and available beds are not assumed to be staffed. Service settings are not presumed substitutable. Project economics and detailed clinical/workforce plans were not disclosed. No information after 27 February 2023 is used.