

**UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
Washington, D.C. 20549**

**Form 10-K**

(Mark One)

**ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2019

Or

**TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from \_\_\_\_\_ to \_\_\_\_\_

Commission File Number 1-11239

**HCA Healthcare, Inc.**

(Exact Name of Registrant as Specified in its Charter)

Delaware  
(State or Other Jurisdiction of  
Incorporation or Organization)  
One Park Plaza  
Nashville, Tennessee  
(Address of Principal Executive Offices)

27-3865930  
(I.R.S. Employer  
Identification No.)

37203  
(Zip Code)

Registrant's telephone number, including area code: ( 615 ) 344-9551

Securities Registered Pursuant to Section 12(b) of the Act:

Title of Each Class	Trading Symbol(s)	Name of Each Exchange on Which Registered
Common Stock, \$0.01 Par Value	HCA	New York Stock Exchange

Securities Registered Pursuant to Section 12(g) of the Act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes  No

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes  No

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes  No

Indicate by check mark whether the Registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the Registrant was required to submit such files). Yes  No

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	<input checked="" type="checkbox"/>	Accelerated filer	<input type="checkbox"/>
Non-accelerated filer	<input type="checkbox"/>	Smaller reporting company	<input type="checkbox"/>
		Emerging growth company	<input type="checkbox"/>

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes  No

As of January 31, 2020, there were 338,427,300 outstanding shares of the Registrant's common stock. As of June 30, 2019, the aggregate market value of the common stock held by nonaffiliates was approximately \$36.403 billion. For purposes of the foregoing calculation only, Hercules Holding II and the Registrant's directors and executive officers have been deemed to be affiliates.

**DOCUMENTS INCORPORATED BY REFERENCE**

Portions of the Registrant's definitive proxy materials for its 2020 Annual Meeting of Stockholders are incorporated by reference into Part III hereof.

INDEX

	<u>Page Reference</u>
<b>Part I</b>	
Item 1. <a href="#">Business</a>	3
Item 1A. <a href="#">Risk Factors</a>	30
Item 1B. <a href="#">Unresolved Staff Comments</a>	47
Item 2. <a href="#">Properties</a>	47
Item 3. <a href="#">Legal Proceedings</a>	48
Item 4. <a href="#">Mine Safety Disclosures</a>	48
<b>Part II</b>	
Item 5. <a href="#">Market for Registrant’s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities</a>	49
Item 6. <a href="#">Selected Financial Data</a>	51
Item 7. <a href="#">Management’s Discussion and Analysis of Financial Condition and Results of Operations</a>	53
Item 7A. <a href="#">Quantitative and Qualitative Disclosures about Market Risk</a>	73
Item 8. <a href="#">Financial Statements and Supplementary Data</a>	73
Item 9. <a href="#">Changes in and Disagreements with Accountants on Accounting and Financial Disclosure</a>	73
Item 9A. <a href="#">Controls and Procedures</a>	73
Item 9B. <a href="#">Other Information</a>	75
<b>Part III</b>	
Item 10. <a href="#">Directors, Executive Officers and Corporate Governance</a>	75
Item 11. <a href="#">Executive Compensation</a>	75
Item 12. <a href="#">Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters</a>	76
Item 13. <a href="#">Certain Relationships and Related Transactions, and Director Independence</a>	76
Item 14. <a href="#">Principal Accountant Fees and Services</a>	76
<b>Part IV</b>	
Item 15. <a href="#">Exhibits and Financial Statement Schedules</a>	77
Item 16. <a href="#">Form 10-K Summary</a>	90
<a href="#">Signatures</a>	91

**PART I**

**Item 1. Business**

**General**

HCA Healthcare, Inc. is one of the leading health care services companies in the United States. At December 31, 2019, we operated 184 hospitals, comprised of 179 general, acute care hospitals; three psychiatric hospitals; and two rehabilitation hospitals. In addition, we operated 123 freestanding surgery centers. Our facilities are located in 21 states and England.

The terms “Company,” “HCA,” “we,” “our” or “us,” as used herein and unless otherwise stated or indicated by context, refer to HCA Healthcare, Inc. and its affiliates. The term “affiliates” means direct and indirect subsidiaries of HCA Healthcare, Inc. and partnerships and joint ventures in which such subsidiaries are partners. The terms “facilities” or “hospitals” refer to entities owned and operated by affiliates of HCA, and the term “employees” refers to employees of affiliates of HCA.

Our primary objective is to provide a comprehensive array of quality health care services in the most cost-effective manner possible. Our general, acute care hospitals typically provide a full range of services to accommodate such medical specialties as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics and obstetrics, as well as diagnostic and emergency services. Outpatient and ancillary health care services are provided by our general, acute care hospitals, freestanding surgery centers, freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic centers and rehabilitation facilities. Our psychiatric hospitals provide a full range of mental health care services through inpatient, partial hospitalization and outpatient settings.

Our common stock is traded on the New York Stock Exchange (symbol “HCA”). Through our predecessors, we commenced operations in 1968. The Company was incorporated in Delaware in October 2010. Our principal executive offices are located at One Park Plaza, Nashville, Tennessee 37203, and our telephone number is (615) 344-9551.

**Available Information**

We file certain reports with the Securities and Exchange Commission (the “SEC”), including annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. The SEC maintains an Internet site at <http://www.sec.gov> that contains the reports, proxy and information statements and other information we file. Our website address is [www.hcahealthcare.com](http://www.hcahealthcare.com). Please note that our website address is provided as an inactive textual reference only. We make available free of charge, through our website, our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and all amendments to those reports filed or furnished pursuant to Section 13 or 15(d) of the Exchange Act, as soon as reasonably practicable after such material is electronically filed with or furnished to the SEC. The information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

Our Code of Conduct is available free of charge upon request to our Corporate Secretary, HCA Healthcare, Inc., One Park Plaza, Nashville, Tennessee 37203, and is also available on the Ethics and Compliance and Corporate Governance portion of our website at [www.hcahealthcare.com](http://www.hcahealthcare.com).

---

## [Table of Contents](#)

### **Business Strategy**

We are committed to providing the communities we serve with high quality, cost-effective health care while growing our business and creating long-term value for our stockholders. To achieve these objectives, we align our efforts around the following growth agenda:

- grow our presence in existing markets;
- achieve industry-leading performance in clinical and satisfaction measures;
- recruit and employ physicians to meet the need for high quality health services;
- continue to leverage our scale and market positions to grow the Company; and
- pursue a disciplined development strategy.

### **Health Care Facilities**

We currently own, manage or operate hospitals, freestanding surgery centers, freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic and imaging centers, radiation and oncology therapy centers, comprehensive rehabilitation and physical therapy centers, physician practices and various other facilities.

At December 31, 2019, we owned and operated 179 general, acute care hospitals with 48,443 licensed beds. Most of our general, acute care hospitals provide medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic services and emergency services. The general, acute care hospitals also provide outpatient services such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology and physical therapy. Each hospital has an organized medical staff and a local board of trustees or governing board, made up of members of the local community.

At December 31, 2019, we operated three psychiatric hospitals with 412 licensed beds. Our psychiatric hospitals provide therapeutic programs, including child, adolescent and adult psychiatric care and adolescent and adult alcohol and drug abuse treatment and counseling.

We also operate outpatient health care facilities, which include freestanding ambulatory surgery centers (“ASCs”), freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic and imaging centers, comprehensive rehabilitation and physical therapy centers, radiation and oncology therapy centers, physician practices and various other facilities. These outpatient services are an integral component of our strategy to develop comprehensive health care networks in select communities. Most of our ASCs are operated through partnerships or limited liability companies, with majority ownership of each partnership or limited liability company typically held by a general partner or member that is an affiliate of HCA.

Certain of our affiliates provide a variety of management services to our health care facilities, including patient safety programs, ethics and compliance programs, national supply contracts, equipment purchasing and leasing contracts, accounting, financial and clinical systems, governmental reimbursement assistance, construction planning and coordination, information technology systems and solutions, legal counsel, human resources services and internal audit services.

### **Sources of Revenue**

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or payment rates for such services. Reimbursement rates for inpatient and outpatient services vary significantly depending on the type of third-party payer, the type of service (e.g., medical/surgical, intensive care or psychiatric) and the geographic location of the hospital. Inpatient occupancy levels fluctuate for various reasons, many of which are beyond our control.

## [Table of Contents](#)

We receive payments for patient services from the federal government under the Medicare program, state governments under their respective Medicaid or similar programs, managed care plans (including plans offered through the American Health Benefit Exchanges (“Exchanges”)), private insurers and directly from patients. Our revenues by primary third-party payer classification and other (including uninsured patients) for the years ended December 31, 2019, 2018 and 2017 are summarized in the following table (dollars in millions):

	Years Ended December 31,					
	2019	Ratio	2018	Ratio	2017	Ratio
Medicare	\$10,798	21.0%	\$ 9,831	21.1%	\$ 9,285	21.3%
Managed Medicare	6,452	12.6	5,497	11.8	4,680	10.7
Medicaid	1,572	3.1	1,358	2.9	1,316	3.0
Managed Medicaid	2,450	4.8	2,403	5.1	2,165	5.0
Managed care and other insurers	26,544	51.6	24,467	52.4	23,342	53.5
International (managed care and other insurers)	1,162	2.3	1,156	2.5	1,097	2.5
Other	2,358	4.6	1,965	4.2	1,729	4.0
Revenues	<u>\$51,336</u>	<u>100.0%</u>	<u>\$46,677</u>	<u>100.0%</u>	<u>\$43,614</u>	<u>100.0%</u>

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons, persons with end-stage renal disease and persons with Lou Gehrig’s Disease. Medicaid is a federal-state program, administered by the states, that provides hospital and medical benefits to qualifying individuals who are unable to afford health care. All of our general, acute care hospitals located in the United States are eligible to participate in Medicare and Medicaid programs. Amounts received under Medicare and Medicaid programs are generally significantly less than established hospital gross charges for the services provided.

Our hospitals generally offer discounts from established charges to certain group purchasers of health care services, including private health insurers, employers, health maintenance organizations (“HMOs”), preferred provider organizations (“PPOs”) and other managed care plans, including health plans offered through the Exchanges. These discount programs generally limit our ability to increase revenues in response to increasing costs. See Item 1, “Business — Competition.” For services under Medicare, Medicaid, HMOs, PPOs and other managed care plans, patients are generally responsible for any exclusions, deductibles or coinsurance features of their coverage. The amount of such exclusions, deductibles and coinsurance continues to increase. Collection of amounts due from individuals is typically more difficult than from government health care programs or other third-party payers. We provide discounts to uninsured patients who do not qualify for Medicaid or for financial relief under our charity care policy. We may attempt to provide assistance to uninsured patients to help determine whether they may qualify for Medicaid, other federal or state assistance or charity care under our charity care policy. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

### *Medicare*

In addition to the reimbursement reductions and adjustments discussed below, the Budget Control Act of 2011 (the “BCA”) requires automatic spending reductions to reduce the federal deficit, including Medicare spending reductions of up to 2% per fiscal year, with a uniform percentage reduction across all Medicare programs. In 2013, the Centers for Medicare & Medicaid Services (“CMS”) began imposing a 2.0% reduction on Medicare payments, and these reductions have been extended through 2029.

### *Inpatient Acute Care*

Under the Medicare program, we receive reimbursement under a prospective payment system (“PPS”) for general, acute care hospital inpatient services. Under the hospital inpatient PPS, fixed payment amounts per inpatient discharge are established based on the patient’s assigned Medicare severity diagnosis-related group

---

## [Table of Contents](#)

(“MS-DRG”). MS-DRGs classify treatments for illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. MS-DRG weights represent the average resources for a given MS-DRG relative to the average resources for all MS-DRGs. MS-DRG payments are adjusted for area wage differentials. Hospitals, other than those defined as “new,” receive PPS reimbursement for inpatient capital costs based on MS-DRG weights multiplied by a geographically adjusted federal rate. When the cost to treat certain patients falls well outside the normal distribution, providers typically receive additional “outlier” payments. These payments are financed by offsetting reductions in the inpatient PPS rates. A high-cost outlier threshold is set annually at a level that will result in estimated outlier payments equaling 5.1% of total inpatient PPS payments for the fiscal year.

MS-DRG rates are updated, and MS-DRG weights are recalibrated, using cost-relative weights each federal fiscal year (which begins October 1). The index used to update the MS-DRG rates (the “market basket”) gives consideration to the inflation experienced by hospitals and entities outside the health care industry in purchasing goods and services. Each federal fiscal year, the annual market basket update is reduced by a productivity adjustment based on the Bureau of Labor Statistics (“BLS”) 10-year moving average of changes in specified economy-wide productivity, as required by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the “Affordable Care Act”). A decrease in payment rates or an increase in rates that is below the increase in our costs may adversely affect our results of operations.

For federal fiscal year 2019, CMS increased the MS-DRG rate by approximately 1.85%. This increase reflected a market basket update of 2.9%, adjusted by the following percentage points: a 0.75 reduction required by the Affordable Care Act, a negative 0.8 productivity adjustment, and a positive 0.5 adjustment in accordance with the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”). For federal fiscal year 2020, CMS increased the MS-DRG rate by approximately 3.1%. This increase reflects a market basket update of 3.0%, adjusted by the following percentage points: a negative 0.4 productivity adjustment and a positive 0.5 adjustment required by MACRA. Additional adjustments may apply, depending on patient-specific or hospital-specific factors. For example, the two midnight rule limits payments to hospitals when services to Medicare beneficiaries are payable as inpatient services. In addition, under the post-acute care transfer policy, Medicare reimbursement rates may be reduced when an inpatient hospital discharges a patient in a specified MS-DRG to certain post-acute care settings, including, effective October 1, 2018, hospice care.

CMS has implemented and is implementing a number of programs and requirements intended to transform Medicare from a passive payer to an active purchaser of quality goods and services. For example, hospitals that do not successfully participate in the Hospital Inpatient Quality Reporting Program are subject to a 25% reduction of the market basket update. Hospitals that do not demonstrate meaningful use of electronic health records (“EHRs”) are subject to a 75% reduction of the market basket update.

Medicare does not allow an inpatient hospital discharge to be assigned to a higher paying MS-DRG if certain designated hospital acquired conditions (“HACs”) were not present on admission and the identified HAC is the only condition resulting in the assignment of the higher paying MS-DRG. In this situation, the case is paid as though the secondary diagnosis was not present. There are currently 14 categories of conditions on the list of HACs. In addition, the 25% of hospitals with the worst risk-adjusted HAC scores in the designated performance period receive a 1% reduction in their inpatient PPS Medicare payments. CMS has also established three National Coverage Determinations that prohibit Medicare reimbursement for erroneous surgical procedures performed on an inpatient or outpatient basis.

Payments to hospitals may also be reduced based on readmission rates. Each federal fiscal year, inpatient payments are reduced if a hospital experiences “excess” readmissions within the 30-day time period from the date of discharge for conditions designated by CMS. For federal fiscal year 2017 and subsequent years, CMS has designated six conditions or procedures, including heart attack, pneumonia and total hip arthroplasty. Hospitals with what CMS defines as excess readmissions for these conditions or procedures receive reduced payments for

---

## [Table of Contents](#)

all inpatient discharges, not just discharges relating to the conditions or procedures subject to the excess readmission standard. The amount by which payments are reduced is determined by assessing a hospital's performance relative to hospitals with similar proportions of dual eligible patients, subject to a cap established by CMS. The reduction in payments to hospitals with excess readmissions can be up to 3% of a hospital's base payments. Each hospital's performance is publicly reported by CMS.

In addition, CMS reduces the inpatient PPS payment amount for all discharges by 2.0%. The total amount collected from these reductions is pooled and used to fund payments to reward hospitals that meet certain quality performance standards established by CMS. CMS scores each hospital based on achievement (relative to other hospitals) and improvement ranges (relative to the hospital's own past performance) for each applicable performance standard. Because the Affordable Care Act provides that the pool will be fully distributed, hospitals that meet or exceed the quality performance standards receive greater reimbursement under the value-based purchasing program than they would have otherwise. Hospitals that do not achieve the necessary quality performance receive reduced Medicare inpatient hospital payments. Hospitals are scored on a number of individual measures that are categorized into four domains: clinical outcomes; efficiency and cost reduction; safety; and person and community engagement. CMS estimates that \$1.9 billion will be available to hospitals as incentive payments in federal fiscal year 2020 under the Hospital Value-Based Purchasing Program.

### *Outpatient*

CMS reimburses hospital outpatient services (and certain Medicare Part B services furnished to hospital inpatients who have no Part A coverage) on a PPS basis. CMS uses fee schedules to pay for physical, occupational and speech therapies, durable medical equipment, clinical diagnostic laboratory services, nonimplantable orthotics and prosthetics, freestanding surgery center services and services provided by independent diagnostic testing facilities. In addition, certain items and services furnished by off-campus provider-based departments, subject to certain exceptions, are not covered as outpatient department services under the outpatient PPS, but are reimbursed under the Medicare Physician Fee Schedule ("Physician Fee Schedule"), subject to adjustments as specified by CMS. In calendar year 2019, CMS began a two-year phase-in of an expanded site-neutral policy under which clinic visit services provided at all off-campus provider-based departments are reimbursed at the Physician Fee Schedule rate, which is generally lower than the PPS rate. Previously, this rate did not apply to "excepted" provider-based departments. However, in September 2019, a federal judge invalidated the expansion of the site-neutral payment policy for 2019. CMS is appealing this decision, but it is reprocessing the 2019 claims paid at the lower rates. For calendar year 2020, CMS issued a final rule implementing year two of the policy phase-in. Hospitals have also challenged the policy for 2020, but the case has not yet been decided.

Hospital outpatient services paid under PPS are classified into groups called ambulatory payment classifications ("APCs"). Services for each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit. The APC payment rates are updated for each calendar year. Each calendar year, the annual market basket update is further reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity as required by the Affordable Care Act. For calendar year 2019, CMS increased APC payment rates by an estimated 1.35%. This increase reflected a market basket increase of 2.9% with a negative 0.8 percentage point productivity adjustment and a negative 0.75 percentage point adjustment required by the Affordable Care Act. For calendar year 2020, CMS increased APC payment rates by an estimated 2.6%. This increase reflects a market basket increase of 3.0% with a negative 0.4 percentage point productivity adjustment. Together with other policy changes, CMS estimates that the calendar year 2020 rates will increase Medicare outpatient PPS payments by 1.3%. CMS requires hospitals to submit quality data relating to outpatient care to avoid receiving a 2.0 percentage point reduction in the annual payment update under the outpatient PPS.

The 340B program allows participating hospitals to purchase certain outpatient drugs from manufacturers at discounted rates. These hospitals are reimbursed for the discounted drugs under the same Medicare payment

## [Table of Contents](#)

methodology and rates as are applied to non-340B-discounted drugs. In a final rule effective January 1, 2018, the U.S. Department of Health and Human Services (“HHS”) reduced the Medicare payments under the outpatient PPS for most drugs obtained at the 340B-discounted rates. HHS continued to apply the reduced rates in 2019. On May 6, 2019, the United States District Court for the District of Columbia reaffirmed its ruling that the adoption of the 2018 rule had exceeded HHS’ statutory authority and reached the same conclusion with respect to a final rule for the 2019 rates. The court has remanded to the agency to craft appropriate remedies to implement the holding. HHS is appealing the decision but has also announced its intent to survey hospitals for drug acquisition cost data, which it may use to craft a remedy. Depending upon the remedy and the outcome of any appeal, this case could result in a decrease to the Company’s outpatient Medicare reimbursement. For calendar year 2020, HHS will continue to pay the reduced rates that took effect in 2018, although this is also the subject of ongoing litigation.

### Rehabilitation

CMS reimburses inpatient rehabilitation facilities (“IRFs”) on a PPS basis. Under the IRF PPS, patients are classified into case mix groups that reflect the relative resource intensity typically associated with the patient’s clinical condition. The case mix groups are based upon impairment, age, functional motor and cognitive scores, and comorbidities (additional diseases or disorders from which the patient suffers). IRFs are paid a predetermined amount per discharge that reflects the patient’s case mix group and is adjusted for facility-specific factors, such as area wage levels, proportion of low-income patients, and location in a rural area. Each federal fiscal year, the IRF rates are updated using a market basket index, which is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For federal fiscal year 2019, CMS increased IRF payment rates by an estimated 1.3%, reflecting an IRF market basket update of 2.9% with a negative 0.8 percentage point productivity adjustment and a 0.75 percentage point reduction required by the Affordable Care Act, among other payment adjustments. For federal fiscal year 2020, CMS increased IRF payment rates by an estimated 2.5%, reflecting an IRF market basket update of 2.9% with a negative 0.4 percentage point productivity adjustment. In addition, CMS requires IRFs to report quality measures to avoid receiving a reduction of 2.0 percentage points to the market basket update. CMS has indicated that it is working toward a unified payment system for post-acute care services, including those provided by IRFs.

In order to qualify for classification as an IRF, at least 60% of a facility’s inpatients during the most recent 12-month CMS-defined review period must have required intensive rehabilitation services for one or more of 13 specified conditions. IRFs must also meet additional coverage criteria, including patient selection and care requirements relating to pre-admission screenings, post-admission evaluations, ongoing coordination of care and involvement of rehabilitation physicians. A facility that fails to meet the 60% threshold, or other criteria to be classified as an IRF, will be paid under either the acute care hospital inpatient or outpatient PPS, which generally provide for lower payment amounts. As of December 31, 2019, we had two rehabilitation hospitals and 63 hospital rehabilitation units.

### Psychiatric

Inpatient hospital services furnished in psychiatric hospitals and psychiatric units of general, acute care hospitals and critical access hospitals are reimbursed on a PPS basis. The inpatient psychiatric facility (“IPF”) PPS is based upon a per diem payment, with adjustments to account for certain patient and facility characteristics. The IPF PPS contains an “outlier” policy for extraordinarily costly cases and an adjustment to a facility’s base payment if it maintains a full-service emergency department. CMS has established the IPF PPS payment rate in a manner intended to be budget neutral. Each federal fiscal year, IPF payment rates are updated using a market basket index, which is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For federal fiscal year 2019, CMS increased IPF payment rates by an estimated 1.1%, which reflects a 2.9% IPF market basket update with a negative 0.8 percentage point productivity adjustment, a negative 0.75 percentage point adjustment as required by the Affordable Care Act, and other payment adjustments. For federal fiscal year 2020, CMS increased IPF payment

## [Table of Contents](#)

rates by an estimated 1.75%, which reflects a 2.9% IPF market basket increase with a negative 0.4 percentage point productivity adjustment and a 0.75 percentage point reduction required by statute, among other payment adjustments. Inpatient psychiatric facilities are required to report quality measures to CMS to avoid receiving a 2.0 percentage point reduction to the market basket update. As of December 31, 2019, we had three psychiatric hospitals and 55 hospital psychiatric units.

### *Ambulatory Surgery Centers*

CMS reimburses ASCs using a predetermined fee schedule. Reimbursements for ASC overhead costs are limited to no more than the overhead costs paid to hospital outpatient departments under the Medicare hospital outpatient PPS for the same procedure. If CMS determines that a procedure is commonly performed in a physician's office, the ASC reimbursement for that procedure is limited to the reimbursement allowable under the Physician Fee Schedule, with limited exceptions. All surgical procedures, other than those that pose a significant safety risk or generally require an overnight stay, are payable as ASC procedures. From time to time, CMS expands the services that may be performed in ASCs, which may result in more Medicare procedures that historically have been performed in hospitals being moved to ASCs, reducing surgical volume in our hospitals. Also, more Medicare procedures that historically have been performed in ASCs may be moved to physicians' offices. Some commercial third-party payers have adopted similar policies.

Historically, CMS updated reimbursement rates for ASCs based on changes to the consumer price index. However, for calendar years 2019 through 2023, CMS updates to ASC reimbursement rates will be based on the hospital market basket index, partly to promote site-neutrality between hospitals and ASCs. For each federal fiscal year, the ASC payment system update is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For calendar year 2019, CMS increased ASC payment rates by 2.1%, which reflected a market basket increase of 2.9%, less a 0.8 percentage point productivity adjustment. For calendar year 2020, CMS increased ASC payment rates by 2.6%, which reflects a market basket increase of 3.0% and a negative 0.4 percentage point productivity adjustment. In addition, CMS has established a quality reporting program for ASCs under which ASCs that fail to report on specified quality measures receive a 2.0 percentage point reduction to the consumer price index update.

### *Physician Services*

Physician services are reimbursed under the Physician Fee Schedule system, under which CMS has assigned a national relative value unit ("RVU") to most medical procedures and services that reflects the various resources required by a physician to provide the services, relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service, practice expense (overhead) attributable to the service and malpractice insurance expense attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs and are then aggregated. While RVUs for various services may change in a given year, any alterations are required by statute to be virtually budget neutral, such that total payments made under the Physician Fee Schedule may not differ by more than \$20 million from what payments would have been if adjustments were not made. CMS annually reviews resource inputs for select services as part of the potentially misvalued code initiative. To determine the payment rate for a particular service, the sum of the geographically adjusted RVUs is multiplied by a conversion factor. For 2020, CMS updated the conversion factor based on a budget neutrality adjustment of 0.14%.

Medicare payments are adjusted based on participation in the Quality Payment Program ("QPP"), a payment methodology intended to reward high-quality patient care. Physicians and certain other health care clinicians are required to participate in one of two QPP tracks. Under both tracks, performance data collected in each performance year will affect Medicare payments two years later. CMS expects to transition increasing financial risk to providers as the QPP evolves. The Advanced Alternative Payment Model ("APM") track makes incentive payments available for participation in specific innovative payment models approved by CMS. Providers may earn a 5% Medicare incentive payment between 2019 and 2024 and will be exempt from the reporting

---

## [Table of Contents](#)

requirements and payment adjustments imposed under the Merit-Based Incentive Payment System (“MIPS”) if the provider has sufficient participation (based on percentage of payments or patients) in an Advanced APM. Alternatively, providers may participate in the MIPS track. Currently, providers electing this option may receive payment incentives or be subject to payment reductions based on their performance with respect to clinical quality, resource use, clinical improvement activities, and meeting Promoting Interoperability standards related to the meaningful use of EHRs. Performance data collected in 2020 will result in payment adjustments of up to 9% in 2022. MIPS consolidates components of three previously established physician incentive programs: the Physician Quality Reporting System, the Physician Value-Based Payment Modifier, and the Medicare EHR Incentive Program.

### *Other*

Under PPS, the payment rates are adjusted for area differences in wage levels by a factor (“wage index”) reflecting the relative wage level in the geographic area compared to the national average wage level and taking into account occupational mix. The redistributive impact of wage index changes is not anticipated to have a material financial impact for 2020.

Medicare reimburses hospitals for a portion (65%) of deductible and coinsurance amounts that are uncollectable from Medicare beneficiaries.

CMS has implemented contractor reform whereby CMS competitively bids the Medicare fiscal intermediary and Medicare carrier functions to Medicare Administrative Contractors (“MACs”), which are geographically assigned across 12 jurisdictions to service both Part A and Part B providers. While providers with operations across multiple geographies had the option of having all hospitals use one home office MAC, we chose to use the MACs assigned to the geographic areas in which our hospitals are located. CMS periodically re-solicits bids, and the MAC servicing a geographic area can change as a result of the bid competition. MAC transition periods can impact claims processing functions and the resulting cash flows.

CMS contracts with third parties to promote the integrity of the Medicare program through reviews of quality concerns and detections, and corrections of improper payments. Quality Improvement Organizations (“QIOs”), for example, are groups of physicians and other health care quality experts that work on behalf of CMS to ensure that Medicare pays only for goods and services that are reasonable and necessary, and that are provided in the most appropriate setting. Under the Recovery Audit Contractor (“RAC”) program, CMS contracts with RACs on a contingency basis to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The compensation for RACs is based on their review of claims submitted to Medicare for billing compliance, including correct coding and medical necessity, and the amount of overpayments and underpayments they identify. CMS limits the number of claims that RACs may audit by limiting the number of records that RACs may request from hospitals based on each provider’s claim denial rate for the previous year. CMS has implemented the RAC program on a permanent, nationwide basis and expanded the RAC program to the Managed Medicare program and Medicare Part D. CMS is transitioning some of its other integrity programs to a consolidated model by engaging Unified Program Integrity Contractors (“UPICs”) to perform audits, investigations and other integrity activities.

We have established policies and procedures to respond to requests from and payment denials by RACs and other Medicare contractors. Payment recoveries resulting from reviews and denials are appealable through administrative and judicial processes, and we pursue reversal of adverse determinations at appropriate appeal levels. We incur additional costs related to responding to requests and denials, including costs associated with responding to requests for records and pursuing the reversal of payment denials and losses associated with overpayments that are not reversed upon appeal. Currently, there are significant delays in the Medicare appeals process. Depending upon changes to and the growth of the RAC program and other Medicare integrity programs and our success in appealing claims in future periods, our cash flows and results of operations could be negatively impacted.

---

## [Table of Contents](#)

Medicare reimburses teaching hospitals for portions of the direct and indirect costs of graduate medical education (“GME”) through statutory formulas that are generally based on the number of medical residents and which take into account patient volume or the number of hospital beds. Accrediting organizations review GME programs for compliance with educational standards. Many of our hospitals operate GME or other residency programs to train physicians and other allied health professionals.

### *Managed Medicare*

Under the Managed Medicare program (also known as Medicare Part C, or Medicare Advantage), the federal government contracts with private health insurers to provide members with Medicare Part A, Part B and Part D benefits. Managed Medicare plans can be structured as HMOs, PPOs or private fee-for-service plans. In addition to covering Part A and Part B benefits, the health insurers may choose to offer supplemental benefits and impose higher premiums and plan costs on beneficiaries. CMS makes fee payment adjustments based on service benchmarks and quality ratings and publishes star ratings to assist beneficiaries with plan selection. According to CMS, over one-third of all Medicare enrollees participate in managed Medicare plans.

### *Medicaid*

Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid program payments are made under a PPS or are based on negotiated payment levels with individual hospitals. Medicaid reimbursement is often less than a hospital’s cost of services. The Affordable Care Act requires states to expand Medicaid coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level. However, states may opt out of the expansion without losing existing federal Medicaid funding. A number of states, including Texas and Florida, have opted out of the Medicaid expansion. Some states use, or have applied to use, waivers granted by CMS to implement expansion, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. The presidential administration and a number of members of Congress have indicated their intent to increase state flexibility in the administration of Medicaid programs, including allowing states to condition enrollment on work or other community engagement.

Because most states must operate with balanced budgets and because the Medicaid program is often the state’s largest program, states can be expected to adopt or consider adopting legislation designed to reduce their Medicaid expenditures. Budgetary pressures have, in recent years, resulted and likely will continue to result in decreased spending, or decreased spending growth, for Medicaid programs in many states. Certain states in which we operate have adopted broad-based provider taxes to fund the non-federal share of Medicaid programs. Many states have also adopted, or are considering, legislation designed to reduce coverage, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states’ Medicaid systems.

Federal funds under the Medicaid program may not be used to reimburse providers for medical assistance provided to treat certain provider-preventable conditions. Each state Medicaid program must deny payments to providers for the treatment of health care-acquired conditions designated by CMS as well as other provider-preventable conditions that may be designated by the state.

Congress has expanded the federal government’s involvement in fighting fraud, waste and abuse in the Medicaid program through the Medicaid Integrity Program. CMS employs UPICs to perform post-payment audits of Medicaid claims, identify overpayments, and perform other program integrity activities, many of which were previously performed by Medicaid Integrity Contractors. The UPICs collaborate with states and coordinate provider investigations across the Medicare and Medicaid programs. In addition, state Medicaid agencies are required to establish Medicaid RAC programs. These programs vary by state in design and operation.

---

## [Table of Contents](#)

### *Managed Medicaid*

Enrollment in managed Medicaid plans has increased in recent years, as state governments seek to control the cost of Medicaid programs. Managed Medicaid programs enable states to contract with one or more entities for patient enrollment, care management and claims adjudication. The states usually do not relinquish program responsibilities for financing, eligibility criteria and core benefit plan design. We generally contract directly with one or more of the designated entities, usually a managed care organization. The provisions of these programs are state-specific. Many states direct managed care plans to pass through supplemental payments to designated providers, independent of services rendered, to ensure consistent funding of providers that serve large numbers of low-income patients. However, in an effort to more closely tie funds to delivery and outcomes, CMS began limiting these “pass-through payments” to managed Medicaid plans in 2016 and will ultimately prohibit such payments by 2027.

### *Accountable Care Organizations and Bundled Payment Initiatives*

An Accountable Care Organization (“ACO”) is a network of providers and suppliers that work together to invest in infrastructure and redesign delivery processes to attempt to achieve high quality and efficient delivery of services. Promoting accountability and coordination of care, ACOs are intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS are eligible to share in a portion of the amounts saved by the Medicare program. There are several types of ACO programs, including the Medicare Shared Savings Program, which was established pursuant to the Affordable Care Act, and the Next Generation ACO Model.

The Center for Medicare & Medicaid Innovation (“CMMI”) is responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for health care that create savings under the Medicare and Medicaid programs, while improving quality of care. For example, providers participating in bundled payment initiatives agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care, accepting accountability for costs and quality of care. By rewarding providers for increasing quality and reducing costs and penalizing providers if costs exceed a set amount, these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. Hospitals may receive supplemental Medicare payments or owe repayments to CMS depending on whether overall CMS spending per episode exceeds or falls below a target specified by CMS and whether quality standards are met. The CMMI has implemented bundled payment models, including the Bundled Payment Care Improvement Advanced (“BPCI Advanced”) program, which is voluntary and expected to run through December 2023. Participation in bundled payment programs is generally voluntary, but CMS has required providers in selected geographic areas to participate in a mandatory bundled program for specified orthopedic procedures, which is scheduled to run through December 2020. HHS has indicated that it plans to implement additional bundled payment programs, some of which will be mandatory.

HHS continues to focus on shifting from traditional fee-for-service reimbursement models to alternative payment models that tie reimbursement to quality and/or value, including bundled payment and pay-for-performance programs. Several private third-party payers are increasingly employing such reimbursement models, which may increasingly shift financial risk to providers.

### *Disproportionate Share Hospital and Medicaid Supplemental Payments*

In addition to making payments for services provided directly to beneficiaries, Medicare makes additional payments to hospitals that treat a disproportionately large number of low-income patients (Medicaid and Medicare patients eligible to receive Supplemental Security Income). Disproportionate Share Hospital (“DSH”) payment adjustments are determined annually based on certain statistical information required by HHS and are paid as a percentage addition to MS-DRG payments. CMS also distributes a payment to each DSH hospital that is allocated according to the hospital’s proportion of uncompensated care costs relative to the uncompensated care amount of other DSH hospitals.

---

## [Table of Contents](#)

Some states make additional payments to providers through the Medicaid program for certain specific claims. These supplemental payments may be in the form of Medicaid DSH payments, which help to offset hospital uncompensated care costs, or upper payment limit supplemental payments, which are intended to address the difference between Medicaid fee-for-service payments and Medicare reimbursement rates. CMS is considering changes to both types of payments. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. States have broad discretion to define which hospitals qualify for Medicaid DSH payments and the amount of such payments. The Affordable Care Act and subsequent legislation provide for reductions to the Medicaid DSH hospital program. Under the budget bill signed into law in February 2018, Medicaid DSH payments will be reduced by \$4 billion in 2020 and by \$8 billion per year from 2021 through 2025. However, Congress has delayed the implementation of these reductions until May 23, 2020.

### *TRICARE*

TRICARE is the Department of Defense's health care program for members of the armed forces. For inpatient services, TRICARE reimburses hospitals based on a DRG system modeled on the Medicare inpatient PPS. For outpatient services, TRICARE reimburses hospitals based on a PPS that is similar to that utilized for services furnished to Medicare beneficiaries.

### *Annual Cost Reports*

All hospitals participating in the Medicare, Medicaid and TRICARE programs, whether paid on a reasonable cost basis or under a PPS, are required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require the submission of annual cost reports covering the revenues, costs and expenses associated with the services provided by each hospital to Medicare beneficiaries and Medicaid recipients.

Annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. These audits often require several years to reach the final determination of amounts due to or from us under these programs. Providers also have rights of appeal, and it is common to contest issues raised in audits of cost reports.

### *Managed Care and Other Discounted Plans*

Most of our hospitals offer discounts from established charges to certain large group purchasers of health care services, including managed care plans and private health insurers. Admissions reimbursed by commercial managed care and other insurers were 28% of our total admissions for each of the years ended December 31, 2019, 2018 and 2017, respectively. Managed care contracts are typically negotiated for terms between one and three years. While we generally received contracted annual average increases of approximately 4% from managed care payers during 2019, there can be no assurance that we will continue to receive increases in the future. Price transparency initiatives may impact our ability to obtain or maintain favorable contract terms. Further, it is not clear what impact, if any, health reform efforts at the federal and state levels, consolidation within the third-party payer industry and vertical integration among third-party payers and health care providers will have on our ability to negotiate reimbursement rates.

---

## [Table of Contents](#)

### *Uninsured and Self-Pay Patients*

Self-pay revenues are derived from providing health care services to patients without health insurance coverage and from the patient responsibility portion of payments for our health care services that are not covered by an individual's health plan. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government health care programs or private third-party payers. Any increases in uninsured individuals, changes to the payer mix or greater adoption of health plan structures that result in higher patient responsibility amounts could increase amounts due from individuals.

A high percentage of our uninsured patients are initially admitted through our emergency rooms. For the year ended December 31, 2019, approximately 84% of our admissions of uninsured patients occurred through our emergency rooms. The Emergency Medical Treatment and Labor Act ("EMTALA") requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the individual to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment. In addition, health insurers are required to reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place. The financial impact of the obligation to screen for and stabilize emergency medical conditions has been offset, in part, by provisions of the Affordable Care Act that decrease the number of uninsured individuals. However, effective January 1, 2019, Congress eliminated the financial penalty associated with the individual mandate. Further, final rules issued in 2018 expand the availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. It is difficult to predict the impact of these changes, but they may result in fewer individuals electing to obtain public or private health insurance or affect the scope of such coverage, if purchased.

### **Hospital Utilization**

We believe the most important factors relating to the overall utilization of a hospital are the quality and market position of the hospital and the number and quality of physicians and other health care professionals providing patient care within the facility. Generally, we believe the ability of a hospital to be a market leader is determined by its breadth of services, level of technology, quality and condition of the facilities, emphasis on quality of care and convenience for patients and physicians. Other factors that impact utilization include the growth in local population, local economic conditions and market penetration of managed care programs.

## Table of Contents

The following table sets forth certain operating statistics for our health care facilities. Health care facility operations are subject to certain seasonal fluctuations, including decreases in patient utilization during holiday periods and increases in the cold weather months.

	Years Ended December 31,				
	2019	2018	2017	2016	2015
Number of hospitals at end of period	184	179	179	170	168
Number of freestanding outpatient surgery centers at end of period	123	123	120	118	116
Number of licensed beds at end of period(a)	49,035	47,199	46,738	44,290	43,771
Weighted average licensed beds(b)	48,480	46,857	45,380	44,077	43,620
Admissions(c)	2,108,927	2,003,753	1,936,613	1,891,831	1,868,789
Equivalent admissions(d)	3,646,335	3,420,406	3,286,432	3,191,519	3,122,746
Average length of stay (days)(e)	4.9	4.9	4.9	4.9	4.9
Average daily census(f)	28,134	26,663	26,000	25,340	25,084
Occupancy rate(g)	58%	57%	57%	58%	58%
Emergency room visits(h)	9,161,129	8,764,431	8,624,137	8,378,340	8,050,159
Outpatient surgeries(i)	1,009,947	971,537	941,231	932,213	909,386
Inpatient surgeries(j)	566,635	548,220	540,304	537,306	529,900

- (a) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.
- (b) Represents the average number of licensed beds, weighted based on periods owned.
- (c) Represents the total number of patients admitted to our hospitals and is used by management and certain investors as a general measure of inpatient volume.
- (d) Equivalent admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Equivalent admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The equivalent admissions computation “equates” outpatient revenue to the volume measure (admissions) used to measure inpatient volume, resulting in a general measure of combined inpatient and outpatient volume.
- (e) Represents the average number of days admitted patients stay in our hospitals.
- (f) Represents the average number of patients in our hospital beds each day.
- (g) Represents the percentage of hospital licensed beds occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.
- (h) Represents the number of patients treated in our emergency rooms.
- (i) Represents the number of surgeries performed on patients who were not admitted to our hospitals. Pain management and endoscopy procedures are not included in outpatient surgeries.
- (j) Represents the number of surgeries performed on patients who have been admitted to our hospitals. Pain management and endoscopy procedures are not included in inpatient surgeries.

## Competition

Generally, other hospitals in the communities we serve provide services similar to those offered by our hospitals. Additionally, in recent years the number of freestanding specialty hospitals, surgery centers, emergency departments, urgent care centers and diagnostic and imaging centers in the geographic areas in which we operate has increased significantly. As a result, most of our hospitals operate in a highly competitive environment. In some cases, competing facilities are more established than our hospitals. Some competing facilities are physician-owned or are owned by tax-supported government agencies and many others are owned by not-for-profit entities that may be supported by endowments, charitable contributions and/or tax revenues and are exempt from sales, property and income taxes. Such exemptions and support are not available to our hospitals and may provide the tax-supported or not-for-profit entities an advantage in funding capital expenditures. In

---

## [Table of Contents](#)

certain localities there are large teaching hospitals that provide highly specialized facilities, equipment and services that may not be available at most of our hospitals. We also face competition from specialty hospitals and from both our own and unaffiliated freestanding ASCs for market share in certain high margin services. Psychiatric hospitals frequently attract patients from areas outside their immediate locale and, therefore, our psychiatric hospitals and units compete with both local and regional hospitals, including the psychiatric units of general, acute care hospitals.

Trends toward clinical and pricing transparency may impact our competitive position in ways that are difficult to predict. For example, hospitals are currently required to publish online a list of their standard charges for items and services. In 2019, CMS issued a final rule that, beginning in 2021, will require hospitals to publish additional types of standard charges for all items and services, including discounted cash prices and payer-specific and de-identified negotiated charges, in a publicly accessible online file. Hospitals will also be required to publish a consumer-friendly list of charges for certain “shoppable” services (i.e., services that can be scheduled by a patient in advance) and associated ancillary services. The 2019 rule is the subject of ongoing court challenges.

Our strategies are designed to ensure our hospitals are competitive. We believe our hospitals compete within local communities on the basis of many factors, including the quality of care, ability to attract and retain quality physicians, skilled clinical personnel and other health care professionals, location, breadth of services, technology offered, and quality and condition of the facilities. We focus on operating outpatient services with accessibility and convenient service for patients and predictability and efficiency for physicians.

Two of the most significant factors to the competitive position of a hospital are the number and quality of physicians affiliated with or employed by the hospital. Although physicians may at any time terminate their relationship with a hospital we operate, our hospitals seek to retain physicians with varied specialties on the hospitals’ medical staffs and to attract other qualified physicians. We believe physicians refer patients to a hospital on the basis of the quality and scope of services it renders to patients and physicians, the quality of physicians on the medical staff, the location of the hospital and the quality of the hospital’s facilities, equipment and employees. Accordingly, we strive to maintain and provide quality facilities, equipment, employees and services for physicians and patients. Our hospitals face competition from competitors that are implementing physician alignment strategies, such as employing physicians, acquiring physician practice groups and participating in ACOs or other clinical integration models.

Another major factor in the competitive position of our hospitals is our ability to negotiate service contracts with group purchasers of health care services. Managed care plans attempt to direct and control the use of hospital services and obtain discounts from hospitals’ established gross charges. Similarly, employers and traditional health insurers continue to attempt to contain costs through negotiations with hospitals for managed care programs and discounts from established gross charges. Generally, hospitals compete for service contracts with group purchasers of health care services on the basis of price, market reputation, geographic location, quality and range of services, quality of the medical staff and convenience. Our future success will depend, in part, on our ability to retain and renew our contracts with third-party payers and enter into new contracts on favorable terms. Other health care providers may impact our ability to enter into contracts with third-party payers or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Price transparency initiatives and increasing vertical integration efforts involving third-party payers and health care providers, among other factors, may increase these challenges. Moreover, the trend toward consolidation among private third-party payers tends to increase payer bargaining power over fee structures. In addition, health reform efforts, such as the Affordable Care Act’s limitations on rescissions of coverage and pre-existing condition exclusions, may lead to private third-party payers increasingly demanding reduced fees or being unwilling to negotiate reimbursement increases. Health plans increasingly utilize narrow networks that restrict the number of participating providers or tiered networks that impose significantly higher cost sharing obligations on patients that obtain services from providers in a disfavored tier. These trends may continue regardless of potential repeal or replacement of, or changes to, the

---

## [Table of Contents](#)

Affordable Care Act, or other health reform efforts. The importance of obtaining contracts with group purchasers of health care services varies from community to community, depending on the market strength of such organizations.

State certificate of need (“CON”) laws, which place limitations on a health care facility’s ability to expand services and facilities, make capital expenditures and otherwise make changes in operations, may also have the effect of restricting competition. We currently operate health care facilities in a number of states with CON laws or that require other types of approvals for the establishment or expansion of certain facility types or services. Before issuing a CON or other approval, these states consider the need for additional, changes in, or expanded health care facilities or services. Removal of these requirements could reduce barriers to entry and increase competition in our service areas. In those states that do not require state approval or that set relatively high levels of expenditures before they become reviewable by state authorities, competition in the form of new services, facilities and capital spending is more prevalent. See Item 1, “Business — Regulation and Other Factors.”

We and the health care industry as a whole face the challenge of continuing to provide quality patient care while dealing with rising costs and strong competition for patients. Changes in medical technology, existing and future legislation, regulations and interpretations and contracting for provider services by third-party payers remain ongoing challenges.

Admissions, average lengths of stay and reimbursement amounts continue to be negatively affected by third-party payer pre-admission authorization requirements, utilization review and pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Increased competition, admission constraints and third-party payer pressures are expected to continue. To meet these challenges, we intend to expand and update our facilities or acquire or construct new facilities where appropriate, enhance the provision of a comprehensive array of outpatient services, offer market competitive pricing to group purchasers of health care services, upgrade facilities and equipment and offer new or expanded programs and services.

### **Regulation and Other Factors**

#### *Licensure, Certification and Accreditation*

Health care facility construction and operation are subject to numerous federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, fire prevention, rate-setting, building codes and environmental protection. Facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe our health care facilities are properly licensed under applicable state laws. Each of our acute care hospitals located in the United States is eligible to participate in Medicare and Medicaid programs and is accredited by The Joint Commission. If any facility were to lose its Medicare or Medicaid certification, the facility would be unable to receive reimbursement from federal health care programs. From time to time, we may acquire a facility that is not accredited but for which we will seek accreditation. If any facility were to lose accreditation, the facility would be subject to state surveys, potentially be subject to increased scrutiny by CMS and likely lose payment from private third-party payers. Management believes our facilities are in substantial compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change, and, in order to remain qualified, it may become necessary for us to make changes in our facilities, equipment, personnel and services. The requirements for licensure, certification and accreditation also include notification or approval in the event of the transfer or change of ownership or certain other changes. Failure to provide required notifications or obtain necessary approvals in these circumstances can result in the inability to complete an acquisition or change of ownership, loss of licensure, lapses in reimbursement or other penalties.

#### *Certificates of Need*

In some states where we operate hospitals and other health care providers, the construction or expansion of health care facilities, the acquisition of existing facilities, the transfer or change of ownership, capital

---

## [Table of Contents](#)

expenditures and the addition of new beds or services may be subject to review by and prior approval of, or notifications to, state regulatory agencies under a CON program. Such laws generally require the reviewing state agency to determine the public need for additional or expanded health care facilities and services or other change. Failure to provide required notifications or obtain necessary state approvals can result in the inability to expand facilities, complete an acquisition or expenditure or change ownership or other penalties.

### *State Rate Review*

Some states have adopted legislation mandating rate or budget review for hospitals or have adopted taxes on hospital revenues, assessments or licensure fees to fund indigent health care within the state. In the aggregate, indigent tax provisions have not materially, adversely affected our results of operations. Although we do not currently operate facilities in states that mandate rate or budget reviews, we cannot predict whether we will operate in such states in the future, or whether the states in which we currently operate may adopt legislation mandating such reviews.

### *Federal Health Care Program Regulations*

Participation in any federal health care program, including the Medicare and Medicaid programs, is heavily regulated by statute and regulation. If a hospital or other provider fails to substantially comply with the numerous conditions of participation in the Medicare and Medicaid programs or performs certain prohibited acts, the provider's participation in the federal health care programs may be terminated, or civil and/or criminal penalties may be imposed. Civil monetary penalties are adjusted annually based on updates to the consumer price index and were increased under the Bipartisan Budget Act of 2018.

### *Anti-kickback Statute*

A section of the Social Security Act known as the "Anti-kickback Statute" prohibits providers and others from directly or indirectly soliciting, receiving, offering or paying any remuneration with the intent of generating referrals or orders for services or items covered by a federal health care program. Courts have interpreted this statute broadly and held that there is a violation of the Anti-kickback Statute if just one purpose of the remuneration is to generate referrals, even if there are other lawful purposes. Furthermore, the Affordable Care Act provides that knowledge of the law or the intent to violate the law is not required. Violations of the Anti-kickback Statute may be punished by criminal fines of up to \$100,000 per violation, imprisonment, substantial civil monetary penalties per violation that are subject to annual adjustment based on updates to the consumer price index and damages of up to three times the total amount of the remuneration and/or exclusion from participation in federal health care programs, including Medicare and Medicaid. In addition, submission of a claim for services or items generated in violation of the Anti-kickback Statute may be subject to additional penalties under the federal False Claims Act ("FCA") as a false or fraudulent claim.

The HHS Office of Inspector General (the "OIG"), among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse and waste. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. The OIG provides guidance to the industry through various methods, including advisory opinions and "Special Fraud Alerts." These Special Fraud Alerts do not have the force of law, but identify features of arrangements or transactions that the government believes may cause the arrangements or transactions to violate the Anti-kickback Statute or other federal health care laws. The OIG has identified several incentive arrangements that constitute suspect practices, including: (a) payment of any incentive by a hospital each time a physician refers a patient to the hospital, (b) the use of free or significantly discounted office space or equipment in facilities usually located close to the hospital, (c) provision of free or significantly discounted billing, nursing or other staff services, (d) free training for a physician's office staff in areas such as management techniques and laboratory techniques, (e) guarantees which provide, if the physician's income fails to reach a predetermined level, the hospital will pay any portion of the remainder, (f) low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital, (g) payment of

---

## [Table of Contents](#)

the costs of a physician's travel and expenses for conferences, (h) coverage on the hospital's group health insurance plans at an inappropriately low cost to the physician, (i) payment for services (which may include consultations at the hospital) which require few, if any, substantive duties by the physician, (j) purchasing goods or services from physicians at prices in excess of their fair market value, (k) rental of space in physician offices, at other than fair market value terms, by persons or entities to which physicians refer, and (l) physician-owned entities (frequently referred to as physician-owned distributorships or PODs) that derive revenue from selling, or arranging for the sale of, implantable medical devices ordered by their physician-owners for use on procedures that physician-owners perform on their own patients at hospitals or ASCs. The OIG has encouraged persons having information about hospitals who offer the above types of incentives to physicians to report such information to the OIG.

The OIG also issues "Special Advisory Bulletins" as a means of providing guidance to health care providers. These bulletins, along with the Special Fraud Alerts, have focused on certain arrangements that could be subject to heightened scrutiny by government enforcement authorities, including: (a) contractual joint venture arrangements and other joint venture arrangements between those in a position to refer business, such as physicians, and those providing items or services for which Medicare or Medicaid pays, and (b) certain "gainsharing" arrangements, i.e., the practice of giving physicians a share of any reduction in a hospital's costs for patient care attributable in part to the physician's efforts.

In addition to issuing Special Fraud Alerts and Special Advisory Bulletins, the OIG issues compliance program guidance for certain types of health care providers. The OIG guidance identifies a number of risk areas under federal fraud and abuse statutes and regulations. These areas of risk include compensation arrangements with physicians, recruitment arrangements with physicians and joint venture relationships with physicians.

As authorized by Congress, the OIG has published safe harbor regulations that outline categories of activities deemed protected from prosecution under the Anti-kickback Statute. Currently, there are statutory exceptions and safe harbors for various activities, including the following: certain investment interests, space rental, equipment rental, practitioner recruitment, personnel services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, freestanding surgery centers, ambulance replenishing, and referral agreements for specialty services.

The fact that conduct or a business arrangement does not fall within a safe harbor or is identified in a Special Fraud Alert, Special Advisory Bulletin or other guidance does not necessarily render the conduct or business arrangement illegal under the Anti-kickback Statute. However, such conduct and business arrangements may lead to increased scrutiny by government enforcement authorities.

We have a variety of financial relationships with physicians and others who either refer or influence the referral of patients to our hospitals, other health care facilities and employed physicians, including employment contracts, leases, medical director agreements and professional service agreements. We also have similar relationships with physicians and facilities to which patients are referred from our facilities and other providers. In addition, we provide financial incentives, including minimum revenue guarantees, to recruit physicians into the communities served by our hospitals. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements, including joint ventures and financial relationships with physicians and other referral sources and persons and entities to which we refer patients, do not qualify for safe harbor protection.

Although we believe our arrangements with physicians and other referral sources and referral recipients have been structured to comply with current law and available interpretations, there can be no assurance regulatory authorities enforcing these laws will determine these financial arrangements comply with the Anti-kickback Statute or other applicable laws. An adverse determination could subject us to liabilities under the Social Security Act and other laws, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal health care programs.

---

## [Table of Contents](#)

### *Stark Law*

The Social Security Act also includes a provision commonly known as the “Stark Law.” The Stark Law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship, if these entities provide certain “designated health services” reimbursable by Medicare or Medicaid unless an exception applies. The Stark Law also prohibits entities that provide designated health services reimbursable by Medicare and Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires the entities to refund amounts received for items or services provided pursuant to the prohibited referral on a timely basis. “Designated health services” include inpatient and outpatient hospital services, clinical laboratory services and radiology services. Sanctions for violating the Stark Law include denial of payment, substantial civil monetary penalties per claim submitted and exclusion from the federal health care programs. Failure to refund amounts received as a result of a prohibited referral on a timely basis may constitute a false or fraudulent claim and may result in civil penalties and additional penalties under the FCA. The statute also provides for a penalty for a circumvention scheme. These penalties are updated annually based on changes to the consumer price index.

There are exceptions to the self-referral prohibition for many of the customary financial arrangements between physicians and providers, including employment contracts, leases and recruitment agreements. Unlike safe harbors under the Anti-kickback Statute with which compliance is voluntary, a financial relationship must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law. Although there is an exception for a physician’s ownership interest in an entire hospital, the Affordable Care Act prohibits physician-owned hospitals established after December 31, 2010 from billing for Medicare or Medicaid patients referred by their physician owners. As a result, the law effectively prevents the formation of new physician-owned hospitals that participate in Medicare or Medicaid. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand services.

Through a series of rulemakings, CMS has issued final regulations implementing the Stark Law. While these regulations were intended to clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. Further, we do not always have the benefit of significant regulatory or judicial interpretation of the Stark Law and its implementing regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and are subject to continuing legal and regulatory change. We cannot assure that every relationship complies fully with the Stark Law.

### *Similar State Laws*

Many states in which we operate also have laws similar to the Anti-kickback Statute that prohibit payments to physicians for patient referrals and laws similar to the Stark Law that prohibit certain self-referrals. These state laws often apply regardless of the source of payment for care, and little precedent exists for their interpretation or enforcement. These statutes typically provide for criminal and civil penalties, as well as loss of licensure.

### *Other Fraud and Abuse Provisions*

Certain federal fraud and abuse laws apply to all health benefit programs and provide for criminal penalties. The Social Security Act also imposes criminal and civil penalties for making false claims and statements to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered or for misrepresenting actual services rendered in order to obtain higher reimbursement, billing for unnecessary goods and services and cost report fraud. Federal enforcement officials have the ability to exclude from Medicare and Medicaid any business entities and any investors, officers and managing employees associated with business entities that have committed health care fraud, even if the officer or managing employee had no knowledge of the fraud. Criminal and civil penalties may be imposed for a number of other prohibited activities, including failure

---

## [Table of Contents](#)

to return known overpayments, certain gainsharing arrangements, billing Medicare amounts that are substantially in excess of a provider's usual charges, offering remuneration to influence a Medicare or Medicaid beneficiary's selection of a health care provider, contracting with an individual or entity known to be excluded from a federal health care program, making or accepting a payment to induce a physician to reduce or limit services, and soliciting or receiving any remuneration in return for referring an individual for an item or service payable by a federal health care program. Like the Anti-kickback Statute, these provisions are very broad. Civil penalties may be imposed for the failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments and accurately prepare cost reports.

Some of these provisions, including the federal Civil Monetary Penalty Law, require a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute. Substantial civil monetary penalties may be imposed under the federal Civil Monetary Penalty Law. These penalties will be updated annually based on changes to the consumer price index. In some cases, violations of the Civil Monetary Penalty Law may result in penalties of up to three times the remuneration offered, paid, solicited or received. In addition, a violator may be subject to exclusion from federal and state health care programs. Federal and state governments increasingly use the federal Civil Monetary Penalty Law, especially where they believe they cannot meet the higher burden of proof requirements under the Anti-kickback Statute. Further, individuals can receive up to \$1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least \$100 of Medicare funds under the Medicare Integrity Program.

### *The Federal False Claims Act and Similar State Laws*

We are subject to state and federal laws that govern the submission of claims for reimbursement and prohibit the making of false claims or statements. One of the most prominent of these laws is the FCA, which may be enforced by the federal government directly or by a *qui tam* plaintiff, or whistleblower, on the government's behalf. The government may use the FCA to prosecute Medicare and other government program fraud in areas such as coding errors, billing for services not provided and submitting false cost reports. In addition, the FCA covers payments made in connection with the Exchanges created under the Affordable Care Act, if those payments include any federal funds. When a private party brings a *qui tam* action under the FCA, the defendant is not made aware of the lawsuit until the government commences its own investigation or makes a determination whether it will intervene. If a defendant is determined by a court of law to be liable under the FCA, the defendant may be required to pay three times the actual damages sustained by the government, plus substantial mandatory civil penalties for each separate false claim. These penalties are updated annually based on changes to the consumer price index.

There are many potential bases for liability under the FCA. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA defines the term "knowingly" broadly. Though simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity constitutes a "knowing" submission under the FCA and, therefore, may create liability. Submission of claims for services or items generated in violation of the Anti-kickback Statute constitutes a false or fraudulent claim under the FCA. Whistleblowers and the federal government have taken the position, and some courts have held, that providers who allegedly have violated other statutes, such as the Stark Law, have thereby submitted false claims under the FCA. False claims under the FCA also include the knowing and improper failure to report and refund amounts owed to the government in a timely manner following identification of an overpayment. An overpayment is deemed to be identified when a person has, or should have through reasonable diligence, determined that an overpayment was received and quantified the overpayment.

Every entity that receives at least \$5 million annually in Medicaid payments must have written policies for all employees, contractors or agents, providing detailed information about false claims, false statements and whistleblower protections under certain federal laws, including the FCA, and similar state laws. In addition,

---

## [Table of Contents](#)

federal law provides an incentive to states to enact false claims laws comparable to the FCA. A number of states in which we operate have adopted their own false claims provisions as well as their own whistleblower provisions under which a private party may file a civil lawsuit in state court. We have adopted and distributed policies pertaining to the FCA and relevant state laws.

### *HIPAA Administrative Simplification and Privacy and Security Requirements*

The Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and implementing regulations require the use of uniform electronic data transmission standards and code sets for certain health care claims and payment transactions submitted or received electronically. In addition, HIPAA requires that each provider use a National Provider Identifier. These provisions are intended to encourage electronic commerce in the health care industry.

The privacy and security regulations promulgated pursuant to HIPAA extensively regulate the use and disclosure of individually identifiable health information, known as “protected health information,” and require covered entities, including health plans and most health care providers, to implement administrative, physical and technical safeguards to protect the security of such information. Certain provisions of the security and privacy regulations apply to business associates (entities that handle protected health information on behalf of covered entities), and business associates are subject to direct liability for violation of these provisions. In addition, a covered entity may be subject to penalties as a result of a business associate violating HIPAA, if the business associate is found to be an agent of the covered entity.

Covered entities must report breaches of unsecured protected health information to affected individuals without unreasonable delay but not to exceed 60 days after discovery of the breach by a covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than 500 individuals. All non-permitted uses or disclosures of unsecured protected health information are presumed to be breaches unless the covered entity or business associate establishes that there is a low probability the information has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information.

Violations of the HIPAA privacy and security regulations may result in criminal penalties and in substantial civil penalties per violation. These civil penalties are updated annually based on updates to the consumer price index. HHS enforces the regulations and performs compliance audits. In addition to enforcement by HHS, state attorneys general are authorized to bring civil actions seeking either injunction or damages in response to violations that threaten the privacy of state residents. HHS may resolve HIPAA violations through informal means, such as allowing a covered entity to implement a corrective action plan, but HHS has the discretion to move directly to impose monetary penalties and is required to impose penalties for violations resulting from willful neglect. We enforce compliance in accordance with HIPAA privacy and security regulations. The Information Protection and Security Department monitors our compliance with the HIPAA privacy and security regulations. The HIPAA privacy regulations and security regulations have and will continue to impose significant costs on our facilities in order to comply with these standards.

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. Our facilities remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties. For example, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions in response to data breaches. The California Consumer Privacy Act of 2018 (the “CCPA”) affords consumers expanded privacy protections effective January 1, 2020. The potential effects of this legislation are far-reaching and may require us to modify our data processing practices and policies and to incur substantial costs and expenses to comply. For example, the CCPA gives California residents expanded rights to access and require deletion of their personal information, opt out of certain personal information sharing and

---

## [Table of Contents](#)

receive detailed information about how their personal information is used. The CCPA provides for civil penalties for violations, as well as a private right of action for data breaches.

Many foreign data privacy regulations (including the European Union’s General Data Protection Regulation (the “GDPR”)) are more stringent than those in the United States. In the case of non-compliance with a material provision of the GDPR (such as non-adherence to the core principles of processing personal data), regulators have the authority to levy a fine in an amount that is up to the greater of € 20 million or 4% of global annual turnover in the prior year. If it is determined that non-compliance is related to a non-material provision (such as failure to comply with technical measures), regulators may impose a fine in an amount that is up to the greater of € 10 million or 2% of the global annual turnover from the prior year. These administrative fines are discretionary and based, in each case, on a multi-factored approach.

### *EMTALA*

All of our hospitals in the United States are subject to EMTALA. This federal law requires any hospital participating in the Medicare program to conduct an appropriate medical screening examination of every individual who presents to the hospital’s emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize the condition or make an appropriate transfer of the individual to a facility able to handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual’s ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer an individual or if the hospital delays appropriate treatment in order to first inquire about the individual’s ability to pay. Penalties for violations of EMTALA include exclusion from participation in the Medicare program and civil monetary penalties. These civil monetary penalties are adjusted annually based on updates to the consumer price index. In addition, an injured individual, the individual’s family or a medical facility that suffers a financial loss as a direct result of a hospital’s violation of the law can bring a civil suit against the hospital.

The government broadly interprets EMTALA to cover situations in which individuals do not actually present to a hospital’s emergency room, but present for emergency examination or treatment to the hospital’s campus, generally, or to a hospital-based clinic that treats emergency medical conditions or are transported in a hospital-owned ambulance, subject to certain exceptions. At least one court has interpreted the law also to apply to a hospital that has been notified of a patient’s pending arrival in a non-hospital owned ambulance. EMTALA does not generally apply to individuals admitted for inpatient services. The government has expressed its intent to investigate and enforce EMTALA violations actively.

### *Corporate Practice of Medicine/Fee Splitting*

Some of the states in which we operate have laws prohibiting corporations and other entities from employing physicians, practicing medicine for a profit and making certain direct and indirect payments to, or entering into fee-splitting arrangements with, health care providers designed to induce or encourage the referral of patients to, or the recommendation of, particular providers for medical products and services. Possible sanctions for violation of these restrictions include loss of license and civil and criminal penalties. In addition, agreements between the corporation and the physician may be considered void and unenforceable. These statutes vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies.

### *Health Care Industry Investigations*

Significant media and public attention has focused in recent years on the hospital industry. This media and public attention, changes in government personnel and other factors have led to increased scrutiny of the health care industry. Except as may be disclosed in our SEC filings, we are not aware of any material investigations of the Company under federal or state health care laws or regulations. It is possible that governmental entities could initiate investigations or litigation in the future at facilities we operate and that such matters could result in

---

## [Table of Contents](#)

significant penalties, as well as adverse publicity. It is also possible that our executives and managers could be included in governmental investigations or litigation or named as defendants in private litigation.

Our substantial Medicare, Medicaid and other governmental billings result in heightened scrutiny of our operations. We continue to monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards.

Because the law in this area is complex and constantly evolving, governmental investigations or litigation may result in interpretations that are inconsistent with our practices or industry practices.

In public statements surrounding current investigations, governmental authorities have taken positions on a number of issues, including some for which little official interpretation previously has been available, that appear to be inconsistent with practices that have been common within the industry and that previously have not been challenged in this manner. In some instances, government investigations that have in the past been conducted under the civil provisions of federal law may now be conducted as criminal investigations.

Both federal and state government agencies have increased their focus on and coordination of civil and criminal enforcement efforts in the health care area. The OIG and the Department of Justice (“DOJ”) have, from time to time, established national enforcement initiatives, targeting all hospital providers that focus on specific billing practices or other suspected areas of abuse. The Affordable Care Act includes additional federal funding of \$350 million over 10 years to fight health care fraud, waste and abuse, including \$10 million in federal fiscal year 2020. In addition, governmental agencies and their agents, such as MACs, fiscal intermediaries and carriers, may conduct audits of our health care operations. Private third-party payers may conduct similar post-payment audits, and we also perform internal audits and monitoring.

In addition to national enforcement initiatives, federal and state investigations have addressed a wide variety of routine health care operations such as: cost reporting and billing practices, including for Medicare outliers; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. We engage in many of these routine health care operations and other activities that could be the subject of governmental investigations or inquiries. For example, we have significant Medicare and Medicaid billings, numerous financial arrangements with physicians who are referral sources to our hospitals, and joint venture arrangements involving physician investors. Certain of our individual facilities have received, and other facilities may receive, government inquiries from, and may be subject to investigation by, federal and state agencies. Any additional investigations of the Company, our executives or managers could result in significant liabilities or penalties to us, as well as adverse publicity.

### **Health Care Reform**

The health care industry is subject to changing political, regulatory, and other influences, along with various scientific and technological initiatives. In recent years, the U.S. Congress and certain state legislatures have passed a large number of laws and regulations intended to effect major change within the U.S. health care system, including the Affordable Care Act. The Affordable Care Act affects how health care services are covered, delivered and reimbursed through expanded health insurance coverage, reduced growth in Medicare program spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs that tie reimbursement to quality and integration. However, there is uncertainty regarding the future of the Affordable Care Act. The law has been subject to legislative and regulatory changes and court challenges. The presidential administration and a number of members of Congress have stated their intent to repeal or make additional significant changes to the Affordable Care Act, its implementation or interpretation. For example, final rules issued in 2018 expand the availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. Further, the President of the United States signed an executive order that directs agencies to minimize “economic and regulatory burdens” of the Affordable Care Act, which may result in additional changes

---

## [Table of Contents](#)

in how the law is implemented. Effective January 1, 2019, the penalty associated with the individual mandate to maintain health insurance was eliminated. As a result of this change, in December 2018, the United States District Court for the North District of Texas found the individual mandate to be unconstitutional and determined that the rest of the Affordable Care Act was, therefore, invalid. In December 2019, the Fifth Circuit Court of Appeals upheld this decision with respect to the individual mandate, but remanded for further consideration of how this affects the rest of the law. Pending the appeals process, the law remains in place. The elimination of the individual mandate penalty and other changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased.

As currently structured, the Affordable Care Act expands coverage through a combination of private sector health insurance requirements, public program expansion and other reforms. Expansion of coverage through the private sector has been driven by requirements applicable to health insurers, employers, and individuals. For example, health insurers are prohibited from imposing annual coverage limits, dropping coverage, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. Expansion in public program coverage has been driven primarily by expanding the categories of individuals eligible for Medicaid coverage and permitting individuals with relatively higher incomes to qualify. A number of states, including Texas and Florida, have opted out of the Medicaid expansion provisions, which they may do without losing federal funding. For states that have not participated in the Medicaid expansion, the maximum income level required for individuals and families to qualify for Medicaid varies widely from state to state. Some states are using waivers granted by CMS to expand their Medicaid programs, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. In addition, some states are proposing or have implemented various health reform initiatives at the state level. For example, some states have proposed public health insurance options, and some states have passed or are considering legislation to address out-of-network billing.

The Affordable Care Act has had a net positive effect on the Company to date, before considering the impact of Medicare reductions that began in 2010, and it is expected that the law, as presently implemented, will continue to have a positive contribution to the Company's results of operations. However, there is uncertainty regarding the ongoing net effect of the Affordable Care Act due to efforts to change, repeal or replace the Affordable Care Act, court challenges, and the development of agency guidance, among other factors. There is also uncertainty regarding the potential impact of other reform efforts at the federal and state levels. For example, some presidential candidates and members of Congress have proposed measures that would expand government-sponsored coverage, including single-payer proposals (often referred to as "Medicare for All"), and some states are considering similar measures. Other initiatives and proposals, including those aimed at price transparency and out-of-network charges, may impact prices and the relationships between health care providers and insurers. These issues are further discussed in Item 1A, "Risk Factors."

### **General Economic and Demographic Factors**

The health care industry is impacted by the overall United States economy. Budget deficits at federal, state and local government entities have had a negative impact on spending for many health and human service programs, including Medicare, Medicaid and similar programs, which represent significant payer sources for our hospitals and other providers. We anticipate that the federal deficit, the growing magnitude of Medicare and Medicaid expenditures and the aging of the United States population will continue to place pressure on government health care programs. Other risks we face during periods of economic weakness and high unemployment include potential declines in the population covered under managed care agreements, increased patient decisions to postpone or cancel elective and nonemergency health care procedures (including delaying surgical procedures), potential increases in the uninsured and underinsured populations, increased adoption of health plan structures that shift financial responsibility to patients and increased difficulties in collecting patient receivables for copayment and deductible amounts.

---

## [Table of Contents](#)

### **Compliance Program**

We maintain a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. The program is intended to monitor and raise awareness of various regulatory issues among employees and to emphasize the importance of complying with governmental laws and regulations. As part of the ethics and compliance program, we provide annual ethics and compliance training to our employees and encourage all employees to report any violations to their supervisor, an ethics and compliance officer or to the Company's ethics line available 24 hours a day by phone and internet portal.

### **Antitrust Laws**

The federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, market allocation, bid-rigging, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties. Antitrust enforcement in the health care industry is currently a priority of the Federal Trade Commission and the DOJ. We believe we are in compliance with such federal and state laws, but courts or regulatory authorities may reach a determination in the future that could adversely affect our operations.

### **Environmental Matters**

We are subject to various federal, state and local statutes and ordinances regulating the discharge of materials into the environment. We do not believe that we will be required to expend any material amounts in order to comply with these laws and regulations.

### **Insurance**

As is typical in the health care industry, we are subject to claims and legal actions by patients in the ordinary course of business. Subject, in most cases, to a \$15 million per occurrence self-insured retention, our facilities are insured by our 100% owned insurance subsidiary for losses up to \$50 million per occurrence. The insurance subsidiary has obtained reinsurance for professional liability risks generally above a retention level of \$25 million per occurrence. We also maintain professional liability insurance with unrelated commercial carriers for losses in excess of amounts insured by our insurance subsidiary.

We purchase, from unrelated insurance companies, coverage for cyber security incidents, directors and officers liability and property loss in amounts we believe are adequate. The cyber security and directors and officers liability coverage each include a \$5 million corporate deductible. In addition, we will continue to purchase coverage for our directors and officers on an ongoing basis. The property coverage includes varying deductibles depending on the cause of the property damage. These deductibles range from 2% to 5% of the affected property values for certain flood and wind and earthquake related incidents.

### **Employees and Medical Staffs**

At December 31, 2019, we had approximately 280,000 employees, including approximately 70,000 part-time employees. References herein to "employees" refer to employees of our affiliates. We are subject to various state and federal laws that regulate wages, hours, benefits and other terms and conditions relating to employment. At December 31, 2019, certain employees at 37 of our domestic hospitals are represented by various labor unions. One election was held in January 2020 that resulted in the addition of a number of employees to an existing bargaining unit at one of our facilities in California. While no other elections are scheduled in 2020, it is possible that employees at additional hospitals may unionize in the future. We consider our employee relations to be good and have not experienced work stoppages that have materially, adversely affected our business or results

## [Table of Contents](#)

of operations. Our hospitals, like most hospitals, have experienced rising labor costs. In some markets, nurse and medical support personnel availability has become a significant operating issue to health care providers. To address this challenge, we have implemented several initiatives to improve retention, recruiting, compensation programs and productivity.

Our hospitals are staffed by licensed physicians, including both employed physicians and physicians who are not employees of our hospitals. Some physicians provide services in our hospitals under contracts, which generally describe a term of service, provide and establish the duties and obligations of such physicians, require the maintenance of certain performance criteria and fix compensation for such services. Any licensed physician may apply to be accepted to the medical staff of any of our hospitals, but the hospital's medical staff and the appropriate governing board of the hospital, in accordance with established credentialing criteria, must approve acceptance to the staff. Members of the medical staffs of our hospitals often also serve on the medical staffs of other hospitals and may terminate their affiliation with one of our hospitals at any time.

We may be required to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary or contract personnel. As a result, our labor costs could increase. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. If there is additional union organizing activity and to the extent a significant portion of our employee base unionizes, our costs could increase materially. In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse-staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs, and have an adverse impact on revenues if we are required to limit patient admissions in order to meet the required ratios.

### **Information about our Executive Officers**

As of February 1, 2020, our executive officers were as follows:

<u>Name</u>	<u>Age</u>	<u>Position(s)</u>
Samuel N. Hazen	59	Chief Executive Officer and Director
Jennifer L. Berres	49	Senior Vice President and Chief Human Resource Officer
Phillip G. Billington	52	Senior Vice President — Internal Audit Services
Jeff E. Cohen	48	Senior Vice President — Government Relations
Michael S. Cuffe, M.D.	54	President — Physician Services Group
Jane D. Englebright	62	Senior Vice President and Chief Nursing Officer
Jon M. Foster	58	President — American Group
Charles J. Hall	66	President — National Group
A. Bruce Moore, Jr.	59	President — Service Line and Operations Integration
Sandra L. Morgan	57	Senior Vice President — Provider Relations
J. William B. Morrow	49	Senior Vice President — Finance and Treasurer
P. Martin Paslick	60	Senior Vice President and Chief Information Officer
Jonathan B. Perlin, M.D.	58	President — Clinical Services Group and Chief Medical Officer
Deborah M. Reiner	58	Senior Vice President — Marketing and Communications
William B. Rutherford	56	Executive Vice President and Chief Financial Officer
Joseph A. Sowell, III	63	Senior Vice President and Chief Development Officer
Kathryn A. Torres	56	Senior Vice President — Payer Contracting and Alignment
Robert A. Waterman	66	Senior Vice President and General Counsel
Kathleen M. Whalen	56	Senior Vice President and Chief Ethics and Compliance Officer
Christopher F. Wyatt	42	Senior Vice President and Controller

*Samuel N. Hazen* was appointed Chief Executive Officer effective January 1, 2019 and was appointed as a director in September 2018. From November 2016 through December 2018, Mr. Hazen served as the Company's President and Chief Operating Officer. Prior to that, he served as Chief Operating Officer of the Company from

---

## [Table of Contents](#)

January 2015 to November 2016 and as President — Operations of the Company from 2011 to 2015. He also served as President — Western Group from 2001 to 2011 and as Chief Financial Officer — Western Group of the Company from 1995 to 2001. Prior to that time, Mr. Hazen served in various hospital, regional and division Chief Financial Officer positions with the Company, Humana Inc. and Galen Health Care, Inc.

*Jennifer L. Berres* was appointed Senior Vice President and Chief Human Resource Officer effective November 1, 2019. Ms. Berres joined HCA in 1993 and served in various capacities, including as Vice President — Human Resources from April 2013 through October 2019.

*Phillip G. Billington* was appointed Senior Vice President — Internal Audit Services effective January 1, 2019. Mr. Billington previously served as Vice President — Corporate Internal Audit from June 2005 to December 2018. Prior to joining HCA, Mr. Billington worked as a managing director for FTI Consulting, Inc., a director for KPMG LLP and was a senior manager at Arthur Andersen LLP.

*Jeff E. Cohen* was appointed Senior Vice President — Government Relations effective October 1, 2019. Prior to joining HCA, Mr. Cohen spent 20 years with the Federation of American Hospitals, most recently as Executive Vice President of Public Affairs, where he managed all advocacy, public affairs and communications for the association.

*Dr. Michael S. Cuffe* has served as President — Physician Services Group since October 2011. From October 2011 to January 2015, Dr. Cuffe also served as a Vice President of the Company. Prior to that time, Dr. Cuffe served Duke University Health System as Vice President for Ambulatory Services and Chief Medical Officer from March 2011 to October 2011 and Vice President Medical Affairs from June 2005 to March 2011. He also served Duke University School of Medicine as Vice Dean for Medical Affairs from June 2008 to March 2011, Deputy Chair of the Department of Medicine from August 2009 to August 2010 and Associate Professor of Medicine from March 2005 to October 2011. Prior that time, Dr. Cuffe served in various leadership roles with the Duke Clinical Research Institute, Duke University Medical Center and Duke University School of Medicine.

*Dr. Jane D. Englebright* was appointed Senior Vice President and Chief Nursing Officer in January 2015. Dr. Englebright previously served as Vice President and Chief Nursing Officer from 2007 to January 2015. Dr. Englebright joined HCA in 1992 as a critical care nurse at Lewisville Medical Center in Texas and became Chief Nursing Officer of HCA's San Antonio Community Hospital in 1996. Dr. Englebright currently serves on The Joint Commission's Board of Commissioners.

*Jon M. Foster* was appointed President — American Group in January 2013. Prior to that, Mr. Foster served as President — Southwest Group from February 2011 to January 2013 and as Division President for the Central and West Texas Division from January 2006 to February 2011. Mr. Foster joined HCA in March 2001 as President and CEO of St. David's HealthCare in Austin, Texas and served in that position until February 2011. Prior to joining the Company, Mr. Foster served in various executive capacities within the Baptist Health System in Knoxville, Tennessee and The Methodist Hospital System in Houston, Texas.

*Charles J. Hall* was appointed President — National Group in February 2011. Prior to that, Mr. Hall served as President — Eastern Group from October 2006 to February 2011. Mr. Hall had previously served the Company as President — North Florida Division from April 2003 until October 2006, as President of the East Florida Division from January 1999 until April 2003, as a Market President in the East Florida Division from January 1998 until December 1998, as President of the South Florida Division from February 1996 until December 1997, and as President of the Southwest Florida Division from October 1994 until February 1996, and in various other capacities since 1987.

*A. Bruce Moore, Jr.* was appointed President — Service Line and Operations Integration in February 2011. Prior to that, Mr. Moore had served as President — Outpatient Services Group since January 2006. Mr. Moore served as Senior Vice President and as Chief Operating Officer — Outpatient Services Group from July 2004 to

---

## [Table of Contents](#)

January 2006 and as Senior Vice President — Operations Administration from July 1999 until July 2004. Mr. Moore served as Vice President — Operations Administration of the Company from September 1997 to July 1999, as Vice President — Benefits from October 1996 to September 1997, and as Vice President — Compensation from March 1995 until October 1996.

*Sandra L. Morgan* was appointed Senior Vice President — Provider Relations in January 2015. Prior to that time, she served as Vice President — National Sales from April 2008 to January 2015. From 2000 to 2008, Ms. Morgan served in various capacities with Pfizer Inc., including Vice President of Managed Care for the Customer Business Unit from 2005 to 2008.

*J. William B. Morrow* was appointed Senior Vice President — Finance and Treasurer in February 2017. Mr. Morrow served as Vice President — Finance and Treasurer from July 2016 through January 2017. From 2011 to 2016, Mr. Morrow served the Company as Vice President — Development/Special Assets. Mr. Morrow served as a partner in the law firm of Waller Lansden Dortch & Davis from 2006 to October 2011. Prior to becoming a partner, Mr. Morrow was an associate at Waller Lansden Dortch & Davis and at Cleary Gottlieb Steen & Hamilton.

*P. Martin Paslick* was appointed Senior Vice President and Chief Information Officer in June 2012. Prior to that time, he served as Vice President and Chief Operating Officer of Information Technology & Services from March 2010 to May 2012 and Vice President — Information Technology & Services Field Operations from September 2006 to February 2010. From January 1998 to September 2006, he served in various Vice President roles in the Company's Information Technology & Services department. Mr. Paslick joined the Company in 1985.

*Dr. Jonathan B. Perlin* was appointed President — Clinical Services Group and Chief Medical Officer in November 2007. Dr. Perlin had served as Chief Medical Officer and Senior Vice President — Quality of the Company from August 2006 to November 2007. Prior to joining the Company, Dr. Perlin served as Under Secretary for Health in the U.S. Department of Veterans Affairs since April 2004. Dr. Perlin joined the Veterans Health Administration in November 1999 where he served in various capacities, including as Deputy Under Secretary for Health from July 2002 to April 2004, and as Chief Quality and Performance Officer from November 1999 to September 2002. He also served as Senior Advisor to the Acting Secretary of the U.S. Department of Veterans Affairs from July 2014 to September 2014 and as Chairman for the American Hospital Association in 2015.

*Deborah M. Reiner* was appointed Senior Vice President — Marketing and Communications in October 2017. Prior to that time, she served as Vice President of Marketing and Customer Relationship Management from August 2017 to October 2017 and Vice President of Customer Relationship Management from January 2012 to August 2017. Ms. Reiner joined the Company in 2000 and served in various roles with the Company's Mountain Division from 2000 to 2012.

*William B. Rutherford* has served as Executive Vice President and Chief Financial Officer since January 2014. Mr. Rutherford previously served as Chief Operating Officer of the Company's Clinical and Physician Services Group from January 2011 to January 2014 and Chief Financial Officer of the Company's Outpatient Services Group from November 2008 to January 2011. Prior to that time, Mr. Rutherford was employed by Summit Consulting Group of Tennessee from July 2007 to November 2008 and was Chief Operating Officer of Psychiatric Solutions, Inc. from March 2006 to June 2007. Mr. Rutherford also previously served in various positions with the Company from 1986 to 2005, including Chief Financial Officer of what was then the Company's Eastern Group, Director of Internal Audit and Director of Operations Support.

*Joseph A. Sowell, III* was appointed as Senior Vice President and Chief Development Officer in December 2009. From 1987 to 1996 and again from 1999 to 2009, Mr. Sowell was a partner at the law firm of Waller Lansden Dortch & Davis where he specialized in the areas of health care law, mergers and acquisitions, joint

## [Table of Contents](#)

ventures, private equity financing, tax law and general corporate law. He also co-managed the firm's corporate and commercial transactions practice. From 1996 to 1999, Mr. Sowell served as the head of development, and later as the Chief Operating Officer of Arcon Healthcare.

*Kathryn A. Torres* was appointed Senior Vice President — Payer Contracting and Alignment (formerly Senior Vice President — Employer and Payer Engagement) in July 2016. Ms. Torres joined HCA in 1993 and served in various capacities, including as Vice President of Employer and Payer Engagement and Vice President — Strategy.

*Robert A. Waterman* has served as Senior Vice President and General Counsel since November 1997. Mr. Waterman served as a partner in the law firm of Latham & Watkins from September 1993 to October 1997; he was Chair of the firm's health care group during 1997.

*Kathleen M. Whalen* was appointed Senior Vice President and Chief Ethics and Compliance Officer effective January 1, 2019. Prior to that time, Ms. Whalen served as Vice President — Ethics and Compliance from August 2013 through December 2018 and Assistant Vice President — Ethics and Compliance Program Development from March 2000 through July 2013. Prior to joining HCA in January 1998, Ms. Whalen served as Associate Counsel to President Clinton with responsibility for the White House's ethics program. She began her government service in the ethics division of the General Counsel's Office at the U.S. Commerce Department. Prior to that, she practiced labor and employment law in Dayton, Ohio.

*Christopher F. Wyatt* was appointed Senior Vice President and Controller in April 2016. Prior to that time, Mr. Wyatt served the Company as Vice President and Chief Financial Officer — IT&S from January 2013 to April 2016 and Chief Financial Officer — Clinical Services Group from October 2010 until January 2013. From 2000 to 2010, Mr. Wyatt served in various capacities with Ernst & Young LLP.

### **Item 1A. Risk Factors**

If any of the events discussed in the following risk factors were to occur, our business, financial position, results of operations, cash flows or prospects could be materially, adversely affected. Additional risks and uncertainties not presently known, or currently deemed immaterial, may also constrain our business and operations.

*Our substantial leverage could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of our variable rate debt and prevent us from meeting our obligations.*

We are highly leveraged. As of December 31, 2019, our total indebtedness was \$33.722 billion. As of December 31, 2019, we had availability of \$1.967 billion under our senior secured revolving credit facility and \$1.270 million under our asset-based revolving credit facility, after giving effect to letters of credit and borrowing base limitations. Our high degree of leverage could have important consequences, including:

- increasing our vulnerability to downturns or adverse changes in general economic, industry or competitive conditions and adverse changes in government regulations;
- requiring a substantial portion of cash flows from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flows to fund our operations, capital expenditures and future business opportunities;
- exposing us to the risk of increased interest rates to the extent that our existing unhedged borrowings are at variable rates of interest or we seek to refinance our debt in a rising rate environment;
- limiting our ability to make strategic acquisitions or causing us to make nonstrategic divestitures;

---

## [Table of Contents](#)

- limiting our ability to obtain additional financing for working capital, capital expenditures, share repurchases, dividends, product or service line development, debt service requirements, acquisitions and general corporate or other purposes; and
- limiting our ability to adjust to changing market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged.

We and our subsidiaries have the ability to incur additional indebtedness in the future, subject to the restrictions contained in our senior secured credit facilities and the indentures governing our outstanding notes. If new indebtedness is added to our current debt levels, interest rates and the related risks that we now face could intensify.

*We may not be able to generate sufficient cash to service all of our indebtedness and may not be able to refinance our indebtedness on favorable terms. If we are unable to do so, we may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.*

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which are subject to prevailing economic and competitive conditions and to certain financial, business and other factors beyond our control. We cannot assure you we will maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness.

In addition, we conduct our operations through our subsidiaries. Accordingly, repayment of our indebtedness is dependent on the generation of cash flows by our subsidiaries and their ability to make such cash available to us by dividend, debt repayment or otherwise. Our subsidiaries may not be able to, or may not be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each subsidiary is a distinct legal entity, and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries.

We may find it necessary or prudent to refinance our outstanding indebtedness, the terms of which may not be favorable to us. Our ability to refinance our indebtedness on favorable terms, or at all, is directly affected by the then current global economic and financial conditions which affect the availability of debt financing and the rates at which such financing is available. In addition, our ability to incur secured indebtedness (which would generally enable us to achieve better pricing than the incurrence of unsecured indebtedness) depends in part on the value of our assets, which depends, in turn, on the strength of our cash flows and results of operations, and on economic and market conditions and other factors.

If our cash flows and capital resources are insufficient to fund our debt service obligations or we are unable to refinance our indebtedness, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital or restructure our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. If our operating results and available cash are insufficient to meet our debt service obligations, we could face substantial liquidity problems and might be required to dispose of material assets or operations to meet our debt service and other obligations. We may not be able to consummate those dispositions, or the proceeds from the dispositions may not be adequate to meet any debt service obligations then due.

*Our debt agreements contain restrictions that limit our flexibility in operating our business.*

Our senior secured credit facilities and, to a lesser extent, the indentures governing our outstanding notes contain various covenants that limit our ability to engage in specified types of transactions. These covenants limit our and certain of our subsidiaries' ability to, among other things:

- incur additional indebtedness or issue certain preferred shares;

---

## [Table of Contents](#)

- pay dividends on, repurchase or make distributions in respect of our capital stock or make other restricted payments;
- make certain investments;
- sell or transfer assets;
- create liens;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets; and
- enter into certain transactions with our affiliates.

Under our asset-based revolving credit facility, borrowing availability is subject to a borrowing base of 85% of eligible accounts receivable less customary reserves, with any reduction in the borrowing base commensurately reducing our ability to access this facility as a source of liquidity. In addition, under the asset-based revolving credit facility, when (and for as long as) the combined availability under our asset-based revolving credit facility and our senior secured revolving credit facility is less than a specified amount for a certain period of time or, if a payment or bankruptcy event of default has occurred and is continuing, funds deposited into any of our depository accounts will be transferred on a daily basis into a blocked account with the administrative agent and applied to prepay loans under the asset-based revolving credit facility and to collateralize letters of credit issued thereunder.

Under our senior secured credit facilities, we are required to satisfy and maintain specified financial ratios. Our ability to meet those financial ratios may be affected by events beyond our control, and there can be no assurance we will continue to meet those ratios. A breach of any of these covenants could result in a default under both the cash flow credit facility and the asset-based revolving credit facility. Upon the occurrence of an event of default under these senior secured credit facilities, the lenders thereunder could elect to declare all amounts outstanding under the senior secured credit facilities to be immediately due and payable and terminate all commitments to extend further credit, which would also result in an event of default under a significant portion of our other outstanding indebtedness. If we were unable to repay those amounts, the lenders under the senior secured credit facilities could proceed against the collateral granted to them to secure such indebtedness. We have pledged a significant portion of our assets under our senior secured credit facilities and that collateral is also pledged as collateral under our first lien notes. If any of the lenders under the senior secured credit facilities accelerate the repayment of borrowings, there can be no assurance there will be sufficient assets to repay the senior secured credit facilities, the first lien notes and our other indebtedness.

*Our results of operations may be adversely affected by health care reform efforts, including court challenges to, and efforts to repeal, replace or otherwise significantly change the Affordable Care Act. We are unable to predict what, if any, and when such changes will be made in the future.*

In recent years, the U.S. Congress and certain state legislatures have passed a large number of laws and regulations intended to effect major change within the U.S. health care system, including the Affordable Care Act. The Affordable Care Act affects how health care services are covered, delivered and reimbursed through expanded health insurance coverage, reduced growth in Medicare program spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs that tie reimbursement to quality and integration. However, there is uncertainty regarding the future of the Affordable Care Act. The law has been subject to legislative and regulatory changes and court challenges. The presidential administration and a number of members of Congress have stated their intent to repeal or make additional significant changes to the Affordable Care Act, its implementation or interpretation. For example, final rules issued in 2018 expand the availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. Further, the President of the United States signed an executive order that directs agencies to minimize “economic and regulatory burdens” of the Affordable Care Act, which may result in additional changes in how the law is implemented.

---

## [Table of Contents](#)

Effective January 1, 2019, the penalty associated with the individual mandate to maintain health insurance was eliminated. As a result of this change, in December 2018, the United States District Court for the North District of Texas found the individual mandate to be unconstitutional and determined that the rest of the Affordable Care Act was, therefore, invalid. In December 2019, the Fifth Circuit Court of Appeals upheld this decision with respect to the individual mandate, but remanded for further consideration of how this affects the rest of the law. Pending the appeals process, the law remains in place. The elimination of the individual mandate penalty and other changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased, either of which may have an adverse effect on our business.

There is uncertainty regarding whether, when, and how the Affordable Care Act may be further changed, the ultimate outcome of court challenges and how the law will be interpreted and implemented. Changes by Congress or government agencies could eliminate or alter provisions beneficial to us, while leaving in place provisions reducing our reimbursement or otherwise negatively impacting our business. There is also uncertainty regarding whether, when, and what other health reform initiatives will be adopted and the impact of such efforts on providers and other health care industry participants. Further, the outcome of the 2020 federal election and its potential impact on health reform efforts is unknown. Some presidential candidates and members of Congress have proposed measures that would expand government-sponsored coverage, including single-payer proposals (often referred to as “Medicare for All”), and some states are considering similar measures. CMS has indicated that it intends to increase flexibility in state Medicaid programs, including by expanding the scope of waivers under which states may implement Medicaid expansion provisions, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. CMS administrators have also signaled interest in changing Medicaid payment models. Other health reform initiatives and proposals, such as those addressing out-of-network charges, may impact prices, our relationships with patients and payers, and our competitive position. Other industry participants, such as private payers and large employer groups and their affiliates, may also introduce financial or delivery system reforms. We are unable to predict the nature and success of such initiatives. Health care reform initiatives, including changes to or repeal or invalidation of the Affordable Care Act, may have an adverse effect on our business, results of operations, cash flow, capital resources, and liquidity.

*Changes in government health care programs may adversely affect our revenues.*

A significant portion of our patient volume is derived from government health care programs, principally Medicare and Medicaid. Specifically, we derived 41.5% of our revenues from the Medicare and Medicaid programs in 2019. Changes in government health care programs, including Medicaid waiver programs, may reduce the reimbursement we receive and could adversely affect our business and results of operations. The Affordable Care Act has made significant changes to Medicare and Medicaid, and future health reform efforts or further efforts to repeal or significantly change the Affordable Care Act may impact these programs.

In recent years, legislative and regulatory changes have resulted in limitations on and, in some cases, reductions in levels of payments to health care providers for certain services under the Medicare program. Congress has established automatic spending reductions that extend through 2029. However, the percentage reduction for Medicare may not be more than 2% for a fiscal year, with a uniform percentage reduction across all Medicare programs. We are unable to predict what other deficit reduction initiatives may be proposed by Congress. These reductions are in addition to reductions mandated by the Affordable Care Act and other laws. Further, from time to time, CMS revises the reimbursement systems used to reimburse health care providers, including changes to the MS-DRG system and other payment systems, which may result in reduced Medicare payments. For example, under a site neutrality policy, clinic visit services provided by off-campus provider-based departments that were formerly paid under the outpatient PPS are now paid under the Physician Fee Schedule, subject to certain exceptions that are being phased out through calendar years 2019 and 2020. Although a federal judge invalidated the expansion of the policy for calendar year 2019, in a decision that CMS is appealing, CMS issued a final rule implementing year two of the policy phase-in for 2020. CMS is also considering proposals to reduce drug costs and has reduced Medicare payment rates under the outpatient PPS for

---

## [Table of Contents](#)

most drugs obtained at 340B discounted rates, although the final rules implementing the 340B reductions are the subject of ongoing court challenges. CMS may implement changes to how items or services are reimbursed that result in payment reductions for other services.

Because most states must operate with balanced budgets and because the Medicaid program is often a state's largest program, some states have enacted or may consider enacting legislation designed to reduce their Medicaid expenditures. Further, many states have also adopted, or are considering, legislation designed to reduce coverage, enroll Medicaid recipients in managed care programs, dis-enroll Medicaid recipients who fail to meet work requirements and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. Periods of economic weakness may increase the budgetary pressures on many states, and these budgetary pressures may result in decreased spending, or decreased spending growth, for Medicaid programs and the Children's Health Insurance Program in many states. Some states that provide Medicaid supplemental payments are reviewing these programs or have filed waiver requests with CMS to replace these programs, and CMS has performed and continues to perform compliance reviews of some states' programs and is considering changes to the requirements for such programs, which could result in Medicaid supplemental payments being reduced or eliminated. Further, legislation and administrative actions at the federal level may significantly alter the funding for, or structure of, the Medicaid program. For example, from time to time, Congress considers proposals to restructure the Medicaid program to involve block grants that would be administered by the states. CMS has announced its intent to introduce additional flexibilities for Medicaid program operation, including block grants and increased use of value-based care models.

In some cases, private third-party payers rely on all or portions of Medicare payment systems to determine payment rates. Changes to government health care programs that reduce payments under these programs may negatively impact payments from private third-party payers.

Current or future health care reform and deficit reduction efforts, changes in laws or regulations regarding government health care programs, other changes in the administration of government health care programs and changes by private third-party payers in response to health care reform and other changes to government health care programs could have a material, adverse effect on our financial position and results of operations.

### *Our hospitals face competition for staffing, which may increase labor costs.*

Our operations are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians, as well as our physicians. We compete with other health care providers in recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our hospitals, including nurses and other nonphysician health care professionals. In some markets, the availability of nurses and other medical support personnel has been a significant operating issue to health care providers. We may be required to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary or contract personnel. As a result, our labor costs could increase. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. If there is additional union organizing activity and to the extent a significant portion of our employee base unionizes, it is possible our labor costs could increase materially. When negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur during the negotiation process, and our continued operation during any strikes could increase our labor costs. In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. If our labor costs increase, we may not be able to offset these increased costs as a significant percentage of our revenues consists of fixed, prospective payments. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control labor costs, could have a material, adverse effect on our results of operations.

---

## [Table of Contents](#)

*We may be unable to attract, hire, and retain a highly qualified and diverse workforce, including key management.*

The talents and efforts of our employees, particularly our key management, are vital to our success. Our management team has significant industry experience and would be difficult to replace. In addition, institutional knowledge may be lost in any potential managerial transition. We may be unable to retain them or to attract other highly qualified employees, particularly if we do not offer employment terms that are competitive with the rest of the labor market. Failure to attract, hire, develop, motivate, and retain highly qualified and diverse employee talent, or failure to develop and implement an adequate succession plan for the management team, could disrupt our operations and adversely affect our business and our future success.

*Our performance depends on our ability to recruit and retain quality physicians.*

The success of our hospitals depends in part on the number and quality of the physicians on the medical staffs of our hospitals, the admitting and utilization practices of those physicians, maintaining good relations with those physicians and controlling costs related to the employment of physicians. Although we employ some physicians, physicians are often not employees of the hospitals at which they practice, and, in many of the markets we serve, most physicians have admitting privileges at other hospitals in addition to our hospitals. We continue to face increasing competition to recruit physicians. Such physicians may terminate their affiliation with our hospitals at any time. We may face increased challenges in this area as the physician population reaches retirement age, especially if there is a shortage of physicians willing and able to provide comparable services. If we are unable to provide adequate support personnel or technologically advanced equipment and hospital facilities that meet the needs of those physicians and their patients, they may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline.

*Our hospitals face competition for patients from other hospitals and health care providers.*

The health care business is highly competitive, and competition among hospitals and other health care providers for patients has intensified in recent years. Generally, other hospitals in the communities we serve provide services similar to those offered by our hospitals. CMS publicizes on its Hospital Compare website performance data related to quality measures and data on patient satisfaction surveys that hospitals submit in connection with their Medicare reimbursement. The Hospital Compare website provides an overall rating that synthesizes various quality measures into a single star rating for each hospital. Federal law provides for the future expansion of the number of quality measures that must be reported. Further, hospitals are currently required by law to publish online a list of their standard charges for items and services. A CMS final rule implements expanded transparency requirements beginning in 2021, but these additional requirements are the subject of ongoing court challenges. If any of our hospitals achieve poor results (or results that are lower than our competitors) on quality measures or on patient satisfaction surveys or if our standard charges are higher or are perceived to be higher than our competitors, our competitive position could be negatively affected.

The number of freestanding specialty hospitals, surgery centers, emergency departments, urgent care centers and diagnostic and imaging centers in the geographic areas in which we operate has increased. Many individuals are seeking a broader range of services at outpatient facilities as a result of the growing availability of stand-alone outpatient health care facilities, the increase in payer reimbursement policies that restrict inpatient coverage and the increase in the services that can be provided on an outpatient basis, including high margin services. Consequently, most of our hospitals operate in a highly competitive environment, which may put pressure on our pricing, ability to contract with third-party payers and the Company's strategy for volume growth. Some of the facilities that compete with our hospitals are physician-owned or are owned by governmental agencies or not-for-profit corporations supported by endowments, charitable contributions and/or tax revenues and can finance capital expenditures and operations on a tax-exempt basis. Recent consolidations of not-for-profit hospital entities may intensify this competitive pressure. There is also increasing consolidation in the third-party payer industry, including vertical integration efforts among third-party payers and health care providers, and

---

## [Table of Contents](#)

increasing efforts by payers to influence or direct the patient's choice of provider by the use of narrow networks or other strategies. Health care industry participants are increasingly implementing physician alignment strategies, such as employing physicians, acquiring physician practice groups and participating in ACOs or other clinical integration models. Other industry participants, such as large employer groups and their affiliates, may intensify competitive pressure and affect the industry in ways that are difficult to predict.

Our hospitals compete with specialty hospitals and with both our own and unaffiliated freestanding ASCs and other outpatient providers for market share in certain high margin services and for quality physicians and personnel. If ASCs and other outpatient providers are better able to compete in this environment than our hospitals, our hospitals may experience a decline in patient volume, and we may experience a decrease in margin, even if those patients use our providers. In states that do not require a CON or other type of approval for the purchase, construction or expansion of health care facilities or services, competition in the form of new services, facilities and capital spending is more prevalent. Some states that have historically imposed CON or similar prior approval requirements have removed or are considering removing these requirements, which may reduce barriers to entry and increase competition in our service areas. If our competitors are better able to attract patients, make capital expenditures and maintain modern and technologically upgraded facilities and equipment, recruit physicians, expand services or obtain favorable third-party payer contracts at their facilities than our hospitals and other providers, we may experience an overall decline in patient volume. See Item 1, "Business — Competition."

*A deterioration in the collectability of uninsured and patient due accounts could adversely affect our results of operations.*

The primary collection risks for our accounts receivable relate to the uninsured patient accounts and patient accounts for which the primary third-party payer has paid the amounts covered by the applicable agreement, but patient responsibility amounts (exclusions, deductibles and copayments) remain outstanding. Medicare reimburses hospitals for 65% of eligible Medicare bad debts. To be eligible for reimbursement, the amounts claimed must meet certain criteria, including that the debt is related to unpaid deductible or coinsurance amounts and that the hospital first attempted to collect the fees from the Medicare beneficiary.

The estimates for implicit price concessions are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal and state governmental and private employer health care coverage, the rate of growth in uninsured patient admissions and other collection indicators. At December 31, 2019, estimated implicit price concessions of \$6.953 billion had been recorded to adjust our revenues and accounts receivable to the estimated amounts we expect to collect. The estimated cost of total uncompensated care increased from \$3.021 billion for 2017 to \$3.318 billion for 2018 and to \$3.733 billion for 2019.

Any increase in the amount or deterioration in the collectability of uninsured accounts receivable will adversely affect our cash flows and results of operations. Our facilities may experience growth in total uncompensated care as a result of a number of factors, including conditions impacting the overall economy and high unemployment. Effective January 2019, Congress eliminated the financial penalty associated with the Affordable Care Act's individual mandate. Further, final rules issued in 2018 expand the availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. These changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased. The presidential administration and a number of members of Congress continue to make other efforts to repeal or significantly change the Affordable Care Act, and the law remains subject to court challenges. See Item 1A, "Risk Factors — Our results of operations may be adversely affected by health care reform efforts, including court challenges to, and efforts to repeal, replace or otherwise significantly change the Affordable Care Act. We are unable to predict what, if any, and when such changes will be made in the future."

---

## [Table of Contents](#)

We provide uninsured discounts and charity care for individuals, including for those residing in states that choose not to implement the Medicaid expansion or that modify the terms of the program, for undocumented aliens who are not permitted to enroll in an Exchange or government health care programs and for certain others who may not have insurance. Some patients may choose to enroll in lower cost Medicaid plans or other health insurance plans with lower reimbursement levels. We may also be adversely affected by the growth in patient responsibility accounts as a result of increases in the adoption of health plan structures that shift greater responsibility for care to individuals through greater exclusions and copayment and deductible amounts.

*We may not be reimbursed for the cost of expensive, new technology.*

As healthcare technology continues to advance, the price of purchasing such new technology has significantly increased for providers. Some payers have not adapted their payment systems to adequately cover the cost of these technologies for providers and patients. If payers do not adequately reimburse us for these new technologies, we may be unable to acquire such technologies or we may nevertheless determine to acquire or utilize these technologies in order to treat our patients. In either case, our results of operations and financial position could be adversely affected.

*A cybersecurity incident could result in the compromise of our facilities, confidential data or critical data systems. A cybersecurity incident could also give rise to potential harm to patients; remediation and other expenses; and exposing us to liability under HIPAA, consumer protection laws, common law theories or other laws. Such incidents could subject us to litigation and foreign, federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.*

We, directly and through third-party vendors, collect and store on our networks and devices sensitive information, including intellectual property, proprietary business information and personally identifiable information of our patients and employees. We have made significant investments in technology to adopt and meaningfully use EHR and in the use of medical devices that store sensitive data and are integral to the provision of patient care. In addition, medical devices manufactured by third parties that are used within our facilities are increasingly connected to the internet, hospital networks and other medical devices. The secure maintenance of this information and technology is critical to our business operations. We have implemented multiple layers of security measures to protect the confidentiality, integrity and availability of this data and the systems and devices that store and transmit such data. We utilize current security technologies, and our defenses are monitored and routinely tested internally and by external parties. Despite these efforts, threats from malicious persons and groups, new vulnerabilities and advanced new attacks against information systems and devices against us or our third-party vendors create risk of cybersecurity incidents, including ransomware, malware and phishing incidents. We are regularly the target of attempted cybersecurity and other threats that could have a security impact. There can be no assurance that we or our third-party vendors will not be subject to cybersecurity incidents that bypass our security measures, impact the integrity, availability or privacy of personal health information or other data subject to privacy laws or disrupt our information systems, devices or business, including our ability to provide various health care services. As a result, cybersecurity, physical security and the continued development and enhancement of our controls, processes and practices designed to protect our facilities, information systems and data from attack, damage or unauthorized access remain a priority for us. As cyber threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures or to investigate and remediate any cybersecurity vulnerabilities or incidents. The occurrence of any of these events could result in (i) harm to patients; (ii) business interruptions and delays; (iii) the loss, misappropriation, corruption or unauthorized access of data; (iv) litigation and potential liability under privacy, security, breach notification and consumer protection laws, common law theories or other applicable laws; (v) reputational damage and (vi) foreign, federal and state governmental inquiries, any of which could have a material, adverse effect on our financial position and results of operations and harm our business reputation.

---

## [Table of Contents](#)

*Our operations could be impaired by a failure of our information systems.*

The performance of our information systems is critical to our business operations. In addition to our shared services initiatives, our information systems are essential to a number of critical areas of our operations, including:

- accounting and financial reporting;
- billing and collecting accounts;
- coding and compliance;
- clinical systems and medical devices;
- medical records and document storage;
- inventory management;
- negotiating, pricing and administering managed care contracts and supply contracts; and
- monitoring quality of care and collecting data on quality measures necessary for full Medicare payment updates.

Information systems may be vulnerable to damage from a variety of sources, including telecommunications or network failures, human acts and natural disasters. We have taken precautionary measures to prevent unanticipated problems that could affect our information systems. Nevertheless, we or our third-party vendors that we rely upon may experience system failures. The occurrence of any system failure could result in interruptions, delays, the loss or corruption of data and cessations or interruptions in the availability of systems, all of which could have a material, adverse effect on our financial position and results of operations and harm our business reputation.

*If our volume of patients with private health insurance coverage declines or we are unable to retain and negotiate favorable contracts with private third-party payers, including managed care plans, our revenues may be reduced.*

Private third-party payers, including HMOs, PPOs and other managed care plans, typically reimburse health care providers at a higher rate than Medicare, Medicaid or other government health care programs. Reimbursement rates are set forth by contract when our facilities are in-network, and payers utilize plan structures to encourage or require the use of in-network providers. Revenues derived from private third-party payers (domestic only) accounted for 51.6%, 52.4% and 53.5% of our revenues for 2019, 2018 and 2017, respectively. As a result, our ability to maintain or increase patient volumes covered by private third-party payers and to maintain and obtain favorable contracts with private third-party payers significantly affects the revenues and operating results of our facilities.

Private third-party payers, including managed care plans, continue to demand discounted fee structures, and the ongoing trend toward consolidation among payers tends to increase their bargaining power over fee structures. Payers may utilize plan structures such as narrow networks and tiered networks that limit beneficiary provider choices or impose significantly higher cost sharing obligations when care is obtained from providers in a disfavored tier. Other health care providers may impact our ability to enter into managed care contracts or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care plans to contract with us. In addition to increasing negotiating leverage of private third-party payers, alignment efforts between third-party payers and health care providers may result in other competitive advantages, such as greater access to performance and pricing data. Our future success will depend, in part, on our ability to retain and renew our third-party payer contracts and enter into new contracts on terms favorable to us, which may be impacted by price transparency initiatives. Cost-reduction strategies by large employer groups

---

## [Table of Contents](#)

and their affiliates, such as directly contracting with a limited number of providers, may also limit our ability to negotiate favorable terms in our contracts and otherwise intensify competitive pressure. It is not clear what impact, if any, future health reform efforts or the repeal of, or further changes to, the Affordable Care Act will have on our ability to negotiate reimbursement increases and participate in third-party payer networks on favorable terms. If we are unable to retain and negotiate favorable contracts with third-party payers or experience reductions in payment increases or amounts received from third-party payers, our revenues may be reduced.

*If we fail to comply with extensive laws and government regulations, we could suffer penalties or be required to make significant changes to our operations.*

The health care industry is required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things:

- billing and coding for services and properly handling overpayments;
- appropriateness and classification of level of care provided, including proper classification of inpatient admissions, observation services and outpatient care;
- relationships with physicians and other referral sources and referral recipients;
- necessity and adequacy of medical care;
- quality of medical equipment and services;
- qualifications of medical and support personnel;
- confidentiality, maintenance, data breach, identity theft and security issues associated with health-related and personal information and medical records;
- screening, stabilization and transfer of individuals who have emergency medical conditions;
- licensure, certification and enrollment with government programs;
- hospital rate or budget review;
- debt collection, limits on balance billing and billing for out of network services;
- communications with patients and consumers;
- preparing and filing of cost reports;
- operating policies and procedures;
- activities regarding competitors;
- addition of facilities and services; and
- environmental protection.

Among these laws are the federal Anti-kickback Statute, the federal Stark Law, the FCA and similar state laws. We have a variety of financial relationships with physicians and others who either refer or influence the referral of patients to our hospitals, other health care facilities and employed physicians or who are the recipients of referrals, and these laws govern those relationships. The OIG has enacted safe harbor regulations that outline practices deemed protected from prosecution under the Anti-kickback Statute. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements, including joint ventures and financial relationships with physicians and other referral sources and persons and entities to which we refer patients, do not qualify for safe harbor protection. Failure to qualify for a safe harbor does not mean the arrangement necessarily violates the Anti-kickback Statute but may subject the arrangement to greater scrutiny. However, we cannot offer assurance that practices outside of a safe harbor will not be found to violate the Anti-kickback Statute. Allegations of violations of the Anti-kickback Statute may be brought under the federal Civil Monetary Penalty Law, which requires a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute.

---

## [Table of Contents](#)

Our financial relationships with referring physicians and their immediate family members must comply with the Stark Law by meeting an exception. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex and are subject to continuing legal and regulatory change. Thus, we cannot provide assurance that every relationship complies fully with the Stark Law. Unlike the Anti-kickback Statute, failure to meet an exception under the Stark Law results in a violation of the Stark Law, even if such violation is technical in nature.

Additionally, if we violate the Anti-kickback Statute or Stark Law, or if we improperly bill for our services, we may be found to violate the FCA, either under a suit brought by the government or by a private person under a *qui tam*, or “whistleblower,” suit. See Item 1, “Business — Regulation and Other Factors.”

We also operate health care facilities in the United Kingdom and have operations and commercial relationships with companies in other foreign jurisdictions and, as a result, are subject to certain U.S. and foreign laws applicable to businesses generally, including anti-corruption laws. The Foreign Corrupt Practices Act regulates U.S. companies in their dealings with foreign officials, prohibiting bribes and similar practices, and requires that they maintain records that fairly and accurately reflect transactions and appropriate internal accounting controls. In addition, the United Kingdom Bribery Act has wide jurisdiction over certain activities that affect the United Kingdom.

A variety of state, national, foreign and international laws and regulations apply to the collection, use, retention, protection, security, disclosure, transfer and other processing of personal data. For example, the CCPA which affords consumers expanded privacy protections such as the right to know what personal information is collected and how it is used, went into effect on January 1, 2020. California residents also have the right to request a business to delete their personal information unless it is necessary for the business to maintain for certain purposes. They have the right to know if their personal information is being sold or shared and the right to opt-out of the sale or disclosure. Failure to comply with the CCPA may result in attorney general enforcement action and damage to our reputation. The CCPA also provides for civil penalties for violations, as well as a private right of action for data breaches that may increase data breach litigation. The potential effects of this legislation are far-reaching and may require us to modify our data processing practices and policies and to incur substantial costs and expenses to comply. The European Union’s General Data Protection Regulation (the “GDPR”) contains stricter privacy restrictions than laws and regulations in the United States and provides for significant fines in the event of violations. These administrative fines are based on a multi-factored approach. We expect that there will continue to be new laws, regulations and industry standards concerning privacy, data protection and information security proposed and enacted in various jurisdictions, which could impact our operations and cause us to incur substantial costs.

We send short message service, or SMS, text messages to patients. While we obtain consent from these individuals to send text messages, federal or state regulatory authorities or private litigants may claim that the notices and disclosures we provide, form of consents we obtain or our SMS texting practices are not adequate or violate applicable law. In addition, we must ensure that our SMS texting practices comply with regulations and agency guidance under the Telephone Consumer Protection Act (the “TCPA”), a federal statute that protects consumers from unwanted telephone calls, faxes and text messages. While we strive to adhere to strict policies and procedures that comply with the TCPA, the Federal Communications Commission, as the agency that implements and enforces the TCPA, may disagree with our interpretation of the TCPA and subject us to penalties and other consequences for noncompliance. Determination by a court or regulatory agency that our SMS texting practices violate the TCPA could subject us to civil penalties and could require us to change some portions of our business. Even an unsuccessful challenge by patients or regulatory authorities of our activities could result in adverse publicity and could require a costly response from and defense by us.

We engage in consumer debt collection and credit reporting for HCA-affiliated hospitals and certain non-affiliated hospitals. The federal Fair Debt Collection Practices Act, the Fair Credit Reporting Act and the TCPA restrict the methods that companies may use to contact and seek payment from consumer debtors

---

## [Table of Contents](#)

regarding past due accounts and to report to consumer reporting agencies on the status of those accounts. Many states impose additional requirements on debt collection and credit reporting practices, and some of those requirements may be more stringent than the federal requirements.

If we fail to comply with these or other applicable laws and regulations, which are subject to change, we could be subject to liabilities, including civil penalties, money damages, the loss of our licenses to operate one or more facilities, exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs, civil lawsuits and criminal penalties. The costs of compliance with, and the other burdens imposed by, these and other laws or regulatory actions may increase our operational costs, result in interruptions or delays in the availability of systems and/or result in a patient volume decline. We may also face audits or investigations by one or more domestic or foreign government agencies relating to our compliance with these regulations. An adverse outcome under any such investigation or audit could result in liability, result in adverse publicity, and adversely affect our business.

We do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. In the future, different interpretations or enforcement of, or amendment to, these or other laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated these or other laws, or the public announcement that we are being investigated for possible violations of these or other laws, could have a material, adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly. In addition, other legislation or regulations at the federal or state level may be adopted that adversely affect our business.

*Changes to physician utilization practices and treatment methodologies, third-party payer controls designed to reduce inpatient services or surgical procedures and other factors outside our control that impact demand for medical services may reduce our revenues.*

Controls imposed by Medicare, managed Medicare, Medicaid, managed Medicaid and private third-party payers designed to reduce admissions, intensity of services, surgical volumes and lengths of stay, in some instances referred to as “utilization review,” have affected and are expected to increasingly affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by third-party payers, and may involve prior authorization requirements. The Medicare program also issues national or local coverage determinations that restrict the circumstances under which Medicare pays for certain services. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by third-party payers’ preadmission authorization requirements, coverage restrictions, utilization review and by pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Additionally, trends in physician treatment protocols and health plan design, such as health plans that shift increased costs and accountability for care to patients, could reduce our surgical volumes and admissions in favor of lower intensity and lower cost treatment methodologies.

Volume, admission and case-mix trends may be impacted by other factors beyond our control, such as changes in volume of certain high acuity services, variations in the prevalence and severity of outbreaks of influenza and other illnesses and medical conditions, seasonal and severe weather conditions, changes in treatment regimens and medical technology and other advances. These factors may reduce the demand for services we offer and decrease the reimbursement that we receive. Significant limits on the scope of services reimbursed, cost controls, changes to physician utilization practices, treatment methodologies, reimbursement rates and fees and other factors beyond our control could have a material, adverse effect on our business, financial position and results of operations.

---

## [Table of Contents](#)

*Our overall business results may suffer during periods of general economic weakness.*

Budget deficits at federal, state and local government entities have had a negative impact on spending, and may continue to negatively impact spending, for health and human service programs, including Medicare, Medicaid and similar programs, which represent significant third-party payer sources for our hospitals. We anticipate that the federal deficit, the growing magnitude of Medicare and Medicaid expenditures and the aging of the United States population will continue to place pressure on government health care programs. Other risks we face during periods of economic weakness and high unemployment include potential declines in the population covered under managed care agreements, increased patient decisions to postpone or cancel elective and nonemergency health care procedures (including delaying surgical procedures), potential increases in the uninsured and underinsured populations, increased adoption of health plan structures that shift financial responsibility to patients and further difficulties in collecting patient receivables for copayment and deductible receivables.

*The industry trend toward value-based purchasing may negatively impact our revenues.*

There is a trend in the health care industry toward value-based purchasing of health care services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events (also called “never events”). The Affordable Care Act also prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. The 25% of hospitals with the worst risk-adjusted HAC scores in the designated performance period receive a 1% reduction in their inpatient PPS Medicare payments.

Hospitals with excess readmission rates for conditions designated by HHS receive a reduction in their inpatient PPS operating Medicare payments for all Medicare inpatient discharges, not just discharges relating to the conditions subject to the excess readmission standard. The reduction in payments to hospitals with excess readmissions can be up to 3% of a hospital’s base payments.

HHS has implemented a value-based purchasing program for inpatient hospital services that reduces inpatient hospital payments for all discharges by 2% in each federal fiscal year. HHS pools the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS estimates that \$1.9 billion in value-based incentive payments will be available to hospitals in federal fiscal year 2020 based on achievement (relative to other hospitals) and improvement (relative to the hospital’s own past performance). Hospitals that meet or exceed the quality performance standards will receive greater reimbursement under the value-based purchasing program than they would have otherwise.

CMS has developed several alternative payment models that are intended to reduce costs and improve quality of care for Medicare beneficiaries and has signaled its intent to have states apply similar strategies in the Medicaid context. Examples of alternative payment models include bundled payment models in which, depending on whether overall CMS spending per episode exceeds or falls below a target specified by CMS and whether quality standards are met, hospitals may receive supplemental Medicare payments or owe repayments to CMS. Generally, participation in bundled payment programs is voluntary, but CMS requires hospitals in selected markets to participate in a bundled payment initiative for orthopedic services, which is scheduled to run through December 2020. CMS has indicated that it is developing more voluntary and mandatory bundled payment models. Participation in mandatory or voluntary demonstration projects, particularly demonstrations with the potential to affect payment, may negatively impact our results of operations.

Some private third-party payers are also transitioning toward alternative payment models or implementing other value-based care strategies. For example, many large private third-party payers currently require hospitals

---

## [Table of Contents](#)

to report quality data, and several private third-party payers do not reimburse hospitals for certain preventable adverse events. Further, we have implemented a policy pursuant to which we do not bill patients or third-party payers for fees or expenses incurred due to certain preventable adverse events.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. It is unclear whether these and other alternative payment models will successfully coordinate care and reduce costs or whether they will decrease aggregate reimbursement. We are unable at this time to predict our future payments or whether we will be subject to payment reductions under these programs or how this trend will affect our results of operations. If we are unable to meet or exceed the quality performance standards under any applicable value-based purchasing program, perform at a level below the outcomes demonstrated by our competitors, or otherwise fail to effectively provide or coordinate the efficient delivery of quality health care services, our reputation in the industry may be negatively impacted, we may receive reduced reimbursement amounts and we may owe repayments to payers, causing our revenues to decline.

*We have been and could become the subject of government investigations, claims and litigation.*

Health care companies are subject to numerous investigations by various government agencies. Further, under the FCA, private parties have the right to bring *qui tam*, or “whistleblower,” suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions. Certain of our individual facilities and/or affiliates have received, and other facilities and/or affiliates may receive, government inquiries from, and may be subject to investigation by, federal and state agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material, adverse effect on our financial position, results of operations and liquidity.

Government agencies and their agents, such as the MACs, fiscal intermediaries and carriers, as well as the OIG, CMS and state Medicaid programs, conduct audits of our health care operations. CMS and state Medicaid agencies contract with RACs and other contractors on a contingency fee basis to conduct post-payment reviews to detect and correct improper payments in the Medicare program, including managed Medicare plans, and the Medicaid programs. RAC denials are appealable; however, there are currently significant delays in the Medicare appeals process, which negatively impacts our ability to appeal RAC payment denials. Private third-party payers may conduct similar post-payment audits, and we also perform internal audits and monitoring. Depending on the nature of the conduct found in such audits and whether the underlying conduct could be considered systemic, the resolution of these audits could have a material, adverse effect on our financial position, results of operations and liquidity.

Should we be found out of compliance with applicable laws, regulations or programs, depending on the nature of the findings, our business, our financial position and our results of operations could be negatively impacted.

*Health care technology initiatives, particularly those related to patient data and interoperability, may adversely affect our operations.*

The federal government is working to promote the adoption of health information technology and the promotion of nationwide health information exchange to improve health care. For example, HHS incentivizes the adoption and meaningful use of certified EHR technology through its Promoting Interoperability Programs. Eligible hospitals and eligible professionals, including our hospitals and employed professionals, are subject to reduced payments from Medicare if they fail to demonstrate meaningful use of certified EHR technology. As these technologies have become widespread, the focus has shifted to increasing patient access to health care data and interoperability. The 21<sup>st</sup> Century Cures Act prohibits information blocking by health care providers and certain other entities, which is defined as engaging in activities likely to interfere with, prevent, or materially

---

## [Table of Contents](#)

discourage access, exchange or use of electronic health information, except as required by law or specified by HHS as a reasonable and necessary activity. Current and future initiatives related to health care technology and interoperability may require changes to our operations, impose new and complex compliance obligations and require investments in infrastructure. We may be subject to financial penalties for failure to comply. It is difficult to predict how these initiatives will affect our relationships with providers and vendors, participation in health care information exchanges or networks, the exchange of patient data, and patient engagement.

*The emergence and effects related to a pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations.*

If a pandemic, epidemic, outbreak of an infectious disease or other public health crisis were to occur in an area in which we operate, our operations could be adversely affected. Such a crisis could diminish the public trust in health care facilities, especially hospitals that fail to accurately or timely diagnose, or are treating (or have treated) patients affected by infectious diseases. If any of our facilities were involved, or perceived as being involved, in treating patients from such an infectious disease, patients might cancel elective procedures or fail to seek needed care at our facilities, and our reputation may be negatively affected. Further, a pandemic, epidemic or outbreak might adversely affect our operations by causing a temporary shutdown or diversion of patients, by disrupting or delaying production and delivery of materials and products in the supply chain or by causing staffing shortages in our facilities. We have disaster plans in place and operate pursuant to infectious disease protocols, but the potential emergence of a pandemic, epidemic or outbreak is difficult to predict and could adversely affect our operations.

*State efforts to regulate the construction or expansion of health care facilities could impair our ability to operate and expand our operations.*

Some states, particularly in the eastern part of the country, require health care providers to obtain prior approval, often known as a CON, for the purchase, construction or expansion of health care facilities, to make certain capital expenditures or to make changes in services or bed capacity. In giving approval, these states consider the need for additional or expanded health care facilities or services. We currently operate health care facilities in a number of states with CON laws or that require other types of approvals for the establishment or expansion of certain facility types or services. The failure to obtain any required CON or other required approval could impair our ability to operate or expand operations. Any such failure could, in turn, adversely affect our ability to attract patients and physicians to our facilities and grow our revenues, which would have an adverse effect on our results of operations.

*We may encounter difficulty acquiring hospitals and other health care businesses, encounter challenges integrating the operations of acquired hospitals and other health care businesses and become liable for unknown or contingent liabilities as a result of acquisitions.*

A component of our business strategy is acquiring hospitals and other health care businesses. We may encounter difficulty acquiring new facilities or other businesses as a result of competition from other purchasers that may be willing to pay purchase prices that are higher than we believe are reasonable. Some states require CONs in order to acquire a hospital or other facility or to expand facilities or services. In addition, the acquisition of health care facilities often involves licensure approvals or reviews and complex change of ownership processes for Medicare and other payers. Further, many states have laws that restrict the conversion or sale of not-for-profit hospitals to for-profit entities. These laws may require prior approval from the state attorney general, advance notification of the attorney general or other regulators and community involvement. Attorneys general in states without specific requirements may exercise broad discretionary authority over transactions involving the sale of not-for-profits under their general obligations to protect the use of charitable assets. These legislative and administrative efforts often focus on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the non-profit seller and may include consideration of commitments for capital improvements and charity care by the purchaser. Also, the increasingly challenging regulatory and enforcement

---

## [Table of Contents](#)

environment may negatively impact our ability to acquire health care businesses if they are found to have material unresolved compliance issues, such as repayment obligations. Resolving compliance issues as well as completion of oversight, review or approval processes could seriously delay or even prevent our ability to acquire hospitals or other businesses and increase our acquisition costs.

We may be unable to timely and effectively integrate hospitals and other businesses that we acquire with our ongoing operations, or we may experience delays implementing operating procedures and systems. Hospitals and other health care businesses that we acquire may have unknown or contingent liabilities, including liabilities for failure to comply with health care and other laws and regulations, medical and general professional liabilities, workers' compensation liabilities and tax liabilities. Although we typically exclude significant liabilities from our acquisition transactions and seek indemnification from the sellers for these matters, we could experience difficulty enforcing those obligations, experience liability in excess of any indemnification obtained or otherwise incur material liabilities for the pre-acquisition conduct of acquired businesses. Such liabilities and related legal or other costs could harm our business and results of operations.

*Our facilities are heavily concentrated in Florida and Texas, which makes us sensitive to regulatory, economic, environmental and competitive conditions and changes in those states.*

We operated 184 hospitals at December 31, 2019, and 91 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities' combined revenues represented approximately 48% of our consolidated revenues for the year ended December 31, 2019. This concentration makes us particularly sensitive to regulatory, economic, environmental and competitive conditions and changes in those states. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in those states could have a disproportionate effect on our overall business results.

In addition, our hospitals in Florida, Texas and other coastal states are located in hurricane-prone areas. In the past, hurricanes have had a disruptive effect on the operations of our hospitals in Florida, Texas and other coastal states and the patient populations in those states. Our business activities could be harmed by a particularly active hurricane season or even a single storm, either of which may be intensified by climate change, and the property insurance we obtain may not be adequate to cover losses from future hurricanes or other natural disasters.

*We may be subject to liabilities from claims by taxing authorities.*

We are subject to examination by federal, state and foreign taxing authorities. Management believes HCA Healthcare, Inc., its predecessors, subsidiaries and affiliates properly reported taxable income and paid taxes in accordance with applicable laws and agreements established with the IRS, state and foreign taxing authorities and final resolution of any disputes will not have a material, adverse effect on our results of operations or financial position. However, if payments due upon final resolution of any issues exceed our recorded estimates, such resolutions could have a material, adverse effect on our results of operations or financial position.

*We may be subject to liabilities from claims brought against our facilities.*

We are subject to litigation relating to our business practices, including claims and legal actions by patients and others in the ordinary course of business alleging malpractice, product liability or other legal theories. Many of these actions seek large sums of money as damages and involve significant defense costs. We insure a portion of our professional liability risks through a 100% owned insurance subsidiary. Management believes our reserves for self-insured retentions and insurance coverage are sufficient to cover insured claims arising out of the operation of our facilities. Our 100% owned insurance subsidiary has entered into certain reinsurance contracts; however, the subsidiary remains liable to the extent that the reinsurers do not meet their obligations under the reinsurance contracts. If payments for claims exceed actuarially determined estimates, are not covered by insurance, or reinsurers, if any, fail to meet their obligations, our results of operations and financial position could be adversely affected.

---

## [Table of Contents](#)

*We are exposed to market risk related to changes in the market values of securities and interest rate changes.*

We are exposed to market risk related to changes in market values of securities. The investments of our 100% owned insurance subsidiaries were \$462 million at December 31, 2019. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At December 31, 2019, we had a net unrealized gain of \$18 million on the insurance subsidiaries' investment securities.

We are exposed to market risk related to market illiquidity. Investment securities of our 100% owned insurance subsidiaries could be impaired by the inability to access the capital markets. Should the 100% owned insurance subsidiaries require significant amounts of cash in excess of normal cash requirements to pay claims and other expenses on short notice, we may have difficulty selling these investments in a timely manner or be forced to sell them at a price less than what we might otherwise have been able to in a normal market environment. We may be required to recognize credit-related impairments on long-term investments in future periods should issuers default on interest payments or should the fair market valuations of the securities deteriorate due to ratings downgrades or other issue specific factors.

We are also exposed to market risk related to changes in interest rates that impact the amount of the interest expense we incur with respect to our floating rate obligations as well as the value of certain investments. We periodically enter into interest rate swap agreements to manage our exposure to these fluctuations. Our interest rate swap agreements involve the exchange of fixed and variable rate interest payments between two parties, based on common notional principal amounts and maturity dates. The notional amounts of the swap agreements represent balances used to calculate the exchange of cash flows and are not our assets or liabilities.

*Discontinuation, reform or replacement of LIBOR may adversely affect our business.*

As of December 31, 2019, we had \$6.205 billion of borrowings under our senior secured credit facilities that bore interest at a floating rate based on LIBOR and \$3.237 billion of unfunded commitments under those facilities. The U.K. Financial Conduct Authority announced in 2017 that it intends to phase out LIBOR by the end of 2021. If the phase out occurs as planned, the interest rate applicable to our floating rate debt will be calculated based on an alternative, comparable or successor rate which may have a material adverse impact on the cost of the floating rate portion of our indebtedness. The timing and result of the phase out of LIBOR are unclear, and efforts of industry groups to develop a suitable successor are not guaranteed to result in a viable or widely adopted replacement for LIBOR. If LIBOR becomes unavailable before a suitable replacement is widely adopted, it could have a material adverse impact on the availability of floating rate financing.

As of December 31, 2019, we also had \$2.500 billion of interest rate swap agreements based on LIBOR. If LIBOR becomes unavailable, it is unclear how payments under those agreements would be calculated. Relevant industry groups are seeking to create a standard protocol addressing the expected discontinuation of LIBOR, but there can be no assurance that such a protocol will be developed or implemented with respect to our swap agreements.

*There can be no assurance that we will continue to pay dividends.*

In January 2018, the Board of Directors initiated a cash dividend program under which the Company commenced and expects to continue to pay a regular quarterly cash dividend. The declaration, amount and timing of such dividends are subject to capital availability and determinations by our Board of Directors that cash dividends are in the best interest of our stockholders and are in compliance with all respective laws and our agreements applicable to the declaration and payment of cash dividends. Our ability to pay dividends will depend upon, among other factors, our cash flows from operations, our available capital and potential future capital requirements for strategic transactions, including acquisitions, debt service requirements, share repurchases and investing in our existing markets as well as our results of operations, financial condition and other factors beyond our control that our Board of Directors may deem relevant. A reduction in or elimination of our dividend payments could have a negative effect on our stock price.

## [Table of Contents](#)

*Certain of our investors may continue to have influence over us.*

On November 17, 2006, HCA Inc. was acquired by a private investor group, including affiliates of HCA founder, Dr. Thomas F. Frist, Jr. and certain other investors. Through their investment in Hercules Holding II and other holdings, certain of the Frist-affiliated investors continue to hold a significant interest in our outstanding common stock (approximately 21% as of January 31, 2020). In addition, pursuant to a shareholders agreement we entered into with Hercules Holding II and the Frist-affiliated investors, certain representatives of these investors have the continued right to nominate certain of the members of our Board of Directors. As a result, certain of these investors potentially have the ability to influence our decisions to enter into corporate transactions (and the terms thereof) and prevent changes in the composition of our Board of Directors and any transaction that requires stockholder approval.

### **Item 1B. Unresolved Staff Comments**

None.

### **Item 2. Properties**

The following table lists, by state, the number of hospitals (general, acute care, psychiatric and rehabilitation) directly or indirectly owned and operated by us as of December 31, 2019:

<u>State</u>	<u>Hospitals</u>	<u>Beds</u>
Alaska	1	250
California	5	1,858
Colorado	7	2,411
Florida	45	12,410
Georgia	9	2,469
Idaho	2	468
Indiana	1	278
Kansas	4	1,374
Kentucky	2	384
Louisiana	3	914
Mississippi	1	130
Missouri	5	1,058
Nevada	3	1,421
New Hampshire	2	306
North Carolina	7	1,181
South Carolina	3	949
Tennessee	13	2,576
Texas	46	13,395
Utah	8	1,011
Virginia	11	3,300
<u>International</u>		
England	6	892
	<u>184</u>	<u>49,035</u>

In addition to the hospitals listed in the above table, we directly or indirectly operate 123 freestanding surgery centers. We also operate medical office buildings in conjunction with some of our hospitals. These office buildings are primarily occupied by physicians who practice at our hospitals. Fourteen of our general, acute care hospitals and two of our other properties have been mortgaged to support our obligations under our senior secured cash flow credit facility and first lien secured notes.

---

## [Table of Contents](#)

We maintain our headquarters in approximately 2,127,000 square feet of space in the Nashville, Tennessee area. In addition to the headquarters in Nashville, we maintain regional service centers related to our shared services initiatives. These service centers are located in markets in which we operate hospitals.

We believe our headquarters, hospitals and other facilities are suitable for their respective uses and are, in general, adequate for our present needs. Our properties are subject to various federal, state and local statutes and ordinances regulating their operation. Management does not believe that compliance with such statutes and ordinances will materially affect our financial position or results of operations.

### **Item 3.      *Legal Proceedings***

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. We are also subject to claims and suits arising in the ordinary course of business, including claims for personal injuries or wrongful restriction of, or interference with, physicians' staff privileges. In certain of these actions the claimants may seek punitive damages against us which may not be covered by insurance. We are also subject to claims by various taxing authorities for additional taxes and related interest and penalties. The resolution of any such lawsuits, claims or legal and regulatory proceedings could have a material, adverse effect on our results of operations, financial position or liquidity.

#### *Government Investigations, Claims and Litigation*

Health care companies are subject to numerous investigations by various governmental agencies. Under the federal False Claims Act ("FCA"), private parties have the right to bring *qui tam*, or "whistleblower," suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions. Certain of our individual facilities have received, and from time to time, other facilities may receive, government inquiries from, and may be subject to investigation by, federal and state agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material, adverse effect on our results of operations, financial position or liquidity.

Texas operates a state Medicaid program pursuant to a waiver from CMS under Section 1115 of the Social Security Act ("Program"). The Program includes uncompensated-care pools; payments from these pools are intended to defray the uncompensated costs of services provided by our and other hospitals to Medicaid eligible or uninsured individuals. Separately, we and other hospitals provide charity care services in several communities in the state. In 2018, the Civil Division of the U.S. Department of Justice and the U.S. Attorney's Office for the Southern District of Texas requested information about whether the Program, as operated in Harris County, complied with the laws and regulations applicable to provider related donations, and the Company cooperated with that request. On May 21, 2019, a *qui tam* lawsuit asserting violations of the FCA and the Texas Medicaid Fraud Prevention Act related to the Program, as operated in Harris County, was unsealed by the U.S. District Court for the Southern District of Texas. Both the federal and state governments declined to intervene in the *qui tam* lawsuit. The Company believes that our participation is and has been consistent with the requirements of the Program and is vigorously defending against the lawsuit being pursued by the relator. We cannot predict what effect, if any, the *qui tam* lawsuit could have on the Company.

### **Item 4.      *Mine Safety Disclosures***

None.

**PART II****Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities**

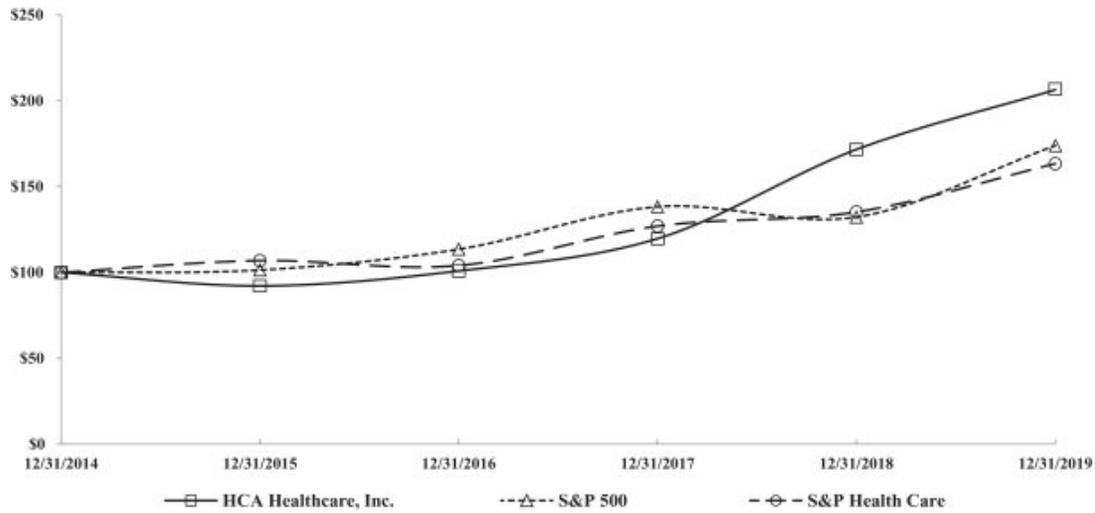
During January 2020 and 2019, our Board of Directors authorized share repurchase programs for up to \$4 billion (\$2 billion for each authorization) of our outstanding common stock. Repurchases made during the fourth quarter of 2019, as detailed below, were made pursuant to the January 2019 share repurchase authorization and were made in the open market.

The following table provides certain information with respect to our repurchases of common stock from October 1, 2019 through December 31, 2019 (dollars in millions, except per share amounts).

<b>Period</b>	<b>Total Number of Shares Purchased</b>	<b>Average Price Paid per Share</b>	<b>Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs</b>	<b>Approximate Dollar Value of Shares That May Yet Be Purchased Under Publicly Announced Plans or Programs</b>
October 1, 2019 through October 31, 2019	898,323	\$ 120.23	898,323	\$ 1,405
November 1, 2019 through November 30, 2019	585,739	\$ 136.44	585,739	\$ 1,325
December 1, 2019 through December 31, 2019	585,429	\$ 143.49	585,429	\$ 1,241
Total for Fourth Quarter 2019	<u>2,069,491</u>	\$ 131.40	<u>2,069,491</u>	\$ 1,241

Our common stock is traded on the New York Stock Exchange ("NYSE") (symbol "HCA"). On January 27, 2020, our Board of Directors declared a quarterly dividend of \$0.43 per share on our common stock payable on March 31, 2020 to stockholders of record at the close of business on March 2, 2020. Future declarations of quarterly dividends and the establishment of future record and payment dates are subject to the final determination of our Board of Directors. Our ability to declare future dividends may also from time to time be limited by the terms of our debt agreements. During 2019, our Board of Directors declared four quarterly dividends of \$0.40 per share, or \$1.60 per share in the aggregate, on our common stock. At the close of business on February 7, 2020, there were approximately 390 holders of record of our common stock.

**STOCK PERFORMANCE GRAPH**  
**COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN**  
 Among HCA Healthcare, Inc., the S&P 500 Index and the S&P Health Care Index



	<u>12/31/2014</u>	<u>12/31/2015</u>	<u>12/31/2016</u>	<u>12/31/2017</u>	<u>12/31/2018</u>	<u>12/31/2019</u>
<b>HCA Healthcare, Inc.</b>	<b>\$ 100.00</b>	<b>\$ 92.15</b>	<b>\$ 100.86</b>	<b>\$ 119.69</b>	<b>\$ 171.61</b>	<b>\$ 206.36</b>
<b>S&amp;P 500</b>	<b>100.00</b>	<b>101.38</b>	<b>113.51</b>	<b>138.29</b>	<b>132.23</b>	<b>173.86</b>
<b>S&amp;P Health Care</b>	<b>100.00</b>	<b>106.89</b>	<b>104.01</b>	<b>126.98</b>	<b>135.19</b>	<b>163.34</b>

The graph shows the cumulative total return to our stockholders beginning as of December 31, 2014 through December 31, 2019, in comparison to the cumulative returns of the S&P 500 Index and the S&P Health Care Index. The graph assumes \$100 invested on December 31, 2014 in our common stock and in each index with the subsequent reinvestment of dividends. The stock performance shown on the graph represents historical stock performance and is not necessarily indicative of future stock price performance.

[Table of Contents](#)

Item 6. *Selected Financial Data*

**HCA HEALTHCARE, INC.**  
**SELECTED FINANCIAL DATA**  
**AS OF AND FOR THE YEARS ENDED DECEMBER 31**  
**(Dollars in millions, except per share amounts)**

	<u>2019</u>	<u>2018</u>	<u>2017</u>	<u>2016</u>	<u>2015</u>
<b>Summary of Operations:</b>					
Revenues	<b>\$51,336</b>	\$46,677	\$43,614	\$41,490	\$39,678
Salaries and benefits	<b>23,560</b>	21,425	20,059	18,897	18,115
Supplies	<b>8,481</b>	7,724	7,316	6,933	6,638
Other operating expenses	<b>9,481</b>	8,608	8,051	7,496	7,056
Equity in earnings of affiliates	<b>(43)</b>	(29)	(45)	(54)	(46)
Depreciation and amortization	<b>2,596</b>	2,278	2,131	1,966	1,904
Interest expense	<b>1,824</b>	1,755	1,690	1,707	1,665
Losses (gains) on sales of facilities	<b>(18)</b>	(428)	(8)	(23)	5
Losses on retirement of debt	<b>211</b>	9	39	4	135
Legal claim (benefits) costs	<b>—</b>	—	—	(246)	249
	<b><u>46,092</u></b>	<u>41,342</u>	<u>39,233</u>	<u>36,680</u>	<u>35,721</u>
Income before income taxes	<b>5,244</b>	5,335	4,381	4,810	3,957
Provision for income taxes	<b>1,099</b>	946	1,638	1,378	1,261
Net income	<b>4,145</b>	4,389	2,743	3,432	2,696
Net income attributable to noncontrolling interests	<b>640</b>	602	527	542	567
Net income attributable to HCA Healthcare, Inc.	<b><u>\$ 3,505</u></b>	<u>\$ 3,787</u>	<u>\$ 2,216</u>	<u>\$ 2,890</u>	<u>\$ 2,129</u>
<b>Per common share data:</b>					
Basic earnings per share	<b>\$ 10.27</b>	\$ 10.90	\$ 6.12	\$ 7.53	\$ 5.14
Diluted earnings per share	<b>\$ 10.07</b>	\$ 10.66	\$ 5.95	\$ 7.30	\$ 4.99
Cash dividends declared per share	<b>\$ 1.60</b>	\$ 1.40	—	—	—
<b>Financial Position:</b>					
Assets	<b>\$45,058</b>	\$39,207	\$36,593	\$33,758	\$32,744
Working capital	<b>3,439</b>	2,644	3,819	3,252	3,716
Long-term debt, net, including amounts due within one year	<b>33,722</b>	32,821	33,058	31,376	30,488
Noncontrolling interests	<b>2,243</b>	2,032	1,811	1,669	1,553
Stockholders' deficit	<b>(565)</b>	(2,918)	(4,995)	(5,633)	(6,046)
<b>Cash Flow Data:</b>					
Cash provided by operating activities	<b>\$ 7,602</b>	\$ 6,761	\$ 5,426	\$ 5,653	\$ 4,734
Cash used in investing activities	<b>(5,720)</b>	(3,901)	(4,279)	(3,240)	(2,583)
Purchase of property and equipment	<b>(4,158)</b>	(3,573)	(3,015)	(2,760)	(2,375)
Cash used in financing activities	<b>(1,771)</b>	(3,075)	(1,061)	(2,508)	(1,976)

## Table of Contents

	2019	2018	2017	2016	2015
<b>Operating Data:</b>					
Number of hospitals at end of period	184	179	179	170	168
Number of freestanding outpatient surgical centers at end of period	123	123	120	118	116
Number of licensed beds at end of period(a)	49,035	47,199	46,738	44,290	43,771
Weighted average licensed beds(b)	48,480	46,857	45,380	44,077	43,620
Admissions(c)	2,108,927	2,003,753	1,936,613	1,891,831	1,868,789
Equivalent admissions(d)	3,646,335	3,420,406	3,286,432	3,191,519	3,122,746
Average length of stay (days)(e)	4.9	4.9	4.9	4.9	4.9
Average daily census(f)	28,134	26,663	26,000	25,340	25,084
Occupancy(g)	58%	57%	57%	58%	58%
Emergency room visits(h)	9,161,129	8,764,431	8,624,137	8,378,340	8,050,159
Outpatient surgeries(i)	1,009,947	971,537	941,231	932,213	909,386
Inpatient surgeries(j)	566,635	548,220	540,304	537,306	529,900
Days revenues in accounts receivable(k)	50	51	52	50	53
Outpatient revenues as a % of patient revenues(l)	39%	38%	38%	38%	40%

- (a) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.
- (b) Represents the average number of licensed beds, weighted based on periods owned.
- (c) Represents the total number of patients admitted to our hospitals and is used by management and certain investors as a general measure of inpatient volume.
- (d) Equivalent admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Equivalent admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The equivalent admissions computation “equates” outpatient revenue to the volume measure (admissions) used to measure inpatient volume, resulting in a general measure of combined inpatient and outpatient volume.
- (e) Represents the average number of days admitted patients stay in our hospitals.
- (f) Represents the average number of patients in our hospital beds each day.
- (g) Represents the percentage of hospital licensed beds occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.
- (h) Represents the number of patients treated in our emergency rooms.
- (i) Represents the number of surgeries performed on patients who were not admitted to our hospitals. Pain management and endoscopy procedures are not included in outpatient surgeries.
- (j) Represents the number of surgeries performed on patients who have been admitted to our hospitals. Pain management and endoscopy procedures are not included in inpatient surgeries.
- (k) Revenues per day is calculated by dividing the revenues for the fourth quarter of each year by the days in the quarter. Days revenues in accounts receivable is then calculated as accounts receivable at the end of the period divided by revenues per day.
- (l) Represents the percentage of patient revenues related to patients who are not admitted to our hospitals.

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS

**Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations***

The selected financial data and the accompanying consolidated financial statements present certain information with respect to the financial position, results of operations and cash flows of HCA Healthcare, Inc. which should be read in conjunction with the following discussion and analysis. The terms "HCA," "Company," "we," "our," or "us," as used herein, refer to HCA Healthcare, Inc. and its affiliates. The term "affiliates" means direct and indirect subsidiaries of HCA Healthcare, Inc. and partnerships and joint ventures in which such subsidiaries are partners.

**Forward-Looking Statements**

This annual report on Form 10-K includes certain disclosures which contain "forward-looking statements" within the meaning of the federal securities laws, which involve risks and uncertainties. Forward-looking statements include statements regarding expected share-based compensation expense, expected capital expenditures, expected dividends, expected net claim payments and all other statements that do not relate solely to historical or current facts, and can be identified by the use of words like "may," "believe," "will," "expect," "project," "estimate," "anticipate," "plan," "initiative" or "continue." These forward-looking statements are based on our current plans and expectations and are subject to a number of known and unknown uncertainties and risks, many of which are beyond our control, which could significantly affect current plans and expectations and our future financial position and results of operations. These factors include, but are not limited to, (1) the impact of our substantial indebtedness and the ability to refinance such indebtedness on acceptable terms, (2) the impact of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act"), including the effects of court challenges to, any repeal of, or changes to, the Affordable Care Act or additional changes to its implementation, the possible enactment of additional federal or state health care reforms and possible changes to other federal, state or local laws or regulations affecting the health care industry, including single-payer proposals (often referred to as "Medicare for All"), (3) the effects related to the continued implementation of the sequestration spending reductions required under the Budget Control Act of 2011, and related legislation extending these reductions, and the potential for future deficit reduction legislation that may alter these spending reductions, which include cuts to Medicare payments, or create additional spending reductions, (4) increases in the amount and risk of collectability of uninsured accounts and deductibles and copayment amounts for insured accounts, (5) the ability to achieve operating and financial targets, and attain expected levels of patient volumes and control the costs of providing services, (6) possible changes in Medicare, Medicaid and other state programs, including Medicaid supplemental payment programs or Medicaid waiver programs, that may impact reimbursements to health care providers and insurers and the size of the uninsured or underinsured population, (7) the highly competitive nature of the health care business, (8) changes in service mix, revenue mix and surgical volumes, including potential declines in the population covered under third-party payer agreements, the ability to enter into and renew third-party payer provider agreements on acceptable terms and the impact of consumer-driven health plans and physician utilization trends and practices, (9) the efforts of health insurers, health care providers, large employer groups and others to contain health care costs, (10) the outcome of our continuing efforts to monitor, maintain and comply with appropriate laws, regulations, policies and procedures, (11) increases in wages and the ability to attract and retain qualified management and personnel, including affiliated physicians, nurses and medical and technical support personnel, (12) the availability and terms of capital to fund the expansion of our business and improvements to our existing facilities, (13) changes in accounting practices, (14) changes in general economic conditions nationally and regionally in our markets, (15) the emergence of and effects related to pandemics, epidemics and infectious diseases, (16) future divestitures which may result in charges and possible impairments of long-lived assets, (17) changes in business strategy or development plans, (18) delays in receiving payments for services provided, (19) the outcome of pending and any future tax audits, disputes and litigation associated

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Forward-Looking Statements (continued)**

with our tax positions, (20) potential adverse impact of known and unknown government investigations, litigation and other claims that may be made against us, (21) the impact of potential cybersecurity incidents or security breaches, (22) our ongoing ability to demonstrate meaningful use of certified electronic health record ("EHR") technology and the impact of interoperability requirements, (23) the impact of natural disasters, such as hurricanes and floods, or similar events beyond our control, (24) changes in U.S. federal, state, or foreign tax laws including interpretive guidance that may be issued by taxing authorities or other standard setting bodies, and (25) other risk factors described in this annual report on Form 10-K. As a consequence, current plans, anticipated actions and future financial position and results of operations may differ from those expressed in any forward-looking statements made by or on behalf of HCA. You are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented in this report.

**2019 Operations Summary**

Net income attributable to HCA Healthcare, Inc. totaled \$3.505 billion, or \$10.07 per diluted share, for 2019, compared to \$3.787 billion, or \$10.66 per diluted share, for 2018. The 2019 results include gains on sales of facilities of \$18 million, or \$0.04 per diluted share, and losses on retirement of debt of \$211 million, or \$0.47 per diluted share. The 2018 results include gains on sales of facilities of \$428 million, or \$0.91 per diluted share, and losses on retirement of debt of \$9 million, or \$0.02 per diluted share. The 2019 results also include revenues of \$86 million, or \$0.19 per diluted share, related to the resolution of transaction price differences regarding certain out-of-network services performed in prior periods. The 2018 results also include a reduction in our provision for income taxes of \$67 million, or \$0.19 per share, for the remeasurement of certain of our deferred tax assets and liabilities for which we were unable to record reasonable estimates in 2017. During 2019 and 2018, we recorded reductions to the provision for professional liability risks of \$50 million, or \$0.11 per diluted share, and \$70 million, or \$0.15 per diluted share, respectively. During 2018, we recorded additional expenses and losses of revenues estimated at approximately \$31 million, or \$0.07 per diluted share, associated with the impact of hurricane Michael on our Florida facilities. This amount is prior to any insurance recoveries. During 2018, we recorded a benefit of \$49 million, or \$0.11 per diluted share, from an insurance recovery related to hurricane Harvey business interruption losses incurred during 2017, and we recorded a reduction to the provision for income taxes of \$28 million, or \$0.08 per diluted share, for tax credits related to certain 2017 hurricane-related expenses. Our provisions for income taxes for 2019 and 2018 included tax benefits of \$65 million, or \$0.19 per diluted share, and \$124 million, or \$0.35 per diluted share, respectively, related to employee equity award settlements. All "per diluted share" disclosures are based upon amounts net of the applicable income taxes. Shares used for diluted earnings per share were 348.226 million shares and 355.303 million shares for the years ended December 31, 2019 and 2018, respectively. During 2019 and 2018, we repurchased 7.949 million and 14.070 million shares, respectively, of our common stock.

Revenues increased to \$51.336 billion for 2019 from \$46.677 billion for 2018. Revenues increased 10.0% and 5.9%, respectively, on a consolidated basis and on a same facility basis for 2019, compared to 2018. The consolidated revenues increase can be primarily attributed to the combined impact of a 3.2% increase in revenue per equivalent admission and a 6.6% increase in equivalent admissions. The same facility revenues increase resulted primarily from a 2.3% increase in same facility revenue per equivalent admission and a 3.5% increase in same facility equivalent admissions.

During 2019, consolidated admissions increased 5.2% and same facility admissions increased 2.8%, compared to 2018. Inpatient surgical volumes increased 3.4% on a consolidated basis and increased 1.1% on a same facility basis during 2019, compared to 2018. Outpatient surgical volumes increased 4.0% on a

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**2019 Operations Summary (continued)**

consolidated basis and increased 1.6% on a same facility basis during 2019, compared to 2018. Emergency room visits increased 4.5% on a consolidated basis and increased 2.8% on a same facility basis during 2019, compared to 2018.

The estimated cost of total uncompensated care increased \$415 million for 2019, compared to 2018. Consolidated and same facility uninsured admissions increased 5.8% and 3.7%, respectively, and consolidated and same facility uninsured emergency room visits increased 5.8% and 3.9%, respectively, for 2019, compared to 2018.

Interest expense totaled \$1.824 billion for 2019, compared to \$1.755 billion for 2018. The \$69 million increase in interest expense for 2019 was due to the increase in the average debt balance.

Cash flows from operating activities increased \$841 million, from \$6.761 billion for 2018 to \$7.602 billion for 2019. The increase in cash flows from operating activities was primarily related to the increase in net income, excluding gains on sales of facilities and losses on retirement of debt, of \$222 million and increases related to income taxes of \$322 million and depreciation and amortization of \$318 million.

**Business Strategy**

We are committed to providing the communities we serve with high quality, cost-effective health care while growing our business and creating long-term value for our stockholders. To achieve these objectives, we align our efforts around the following growth agenda:

*Grow Our Presence in Existing Markets.* We believe we are well positioned in a number of large and growing markets that will allow us the opportunity to generate long-term, attractive growth through the expansion of our presence in these markets. We plan to continue recruiting and strategically collaborating with the physician community and developing comprehensive service lines such as cardiology, neurology, oncology, orthopedics and women's services. Additional components of our growth strategy include providing access and convenience through developing various outpatient facilities, including, but not limited to surgery centers, urgent care clinics, freestanding emergency care facilities and imaging centers.

*Achieve Industry-Leading Performance in Clinical and Satisfaction Measures.* Achieving high levels of patient safety, patient satisfaction and clinical quality are central goals of our business. To achieve these goals, we have implemented a number of initiatives including infection reduction initiatives, hospitalist programs, advanced health information technology and evidence-based medicine programs. We routinely analyze operational practices from our best-performing hospitals to identify ways to implement organization-wide performance improvements and reduce clinical variation. We believe these initiatives will continue to improve patient care, help us achieve cost efficiencies and favorably position us in an environment where our constituents are increasingly focused on quality, efficacy and efficiency.

*Recruit and Employ Physicians to Meet the Needs for High Quality Health Services.* We depend on the quality and dedication of the health care providers and other team members who serve at our facilities. We believe a critical component of our growth strategy is our ability to successfully recruit and strategically collaborate with physicians and other professionals to provide high quality care. We attract and retain physicians by providing high quality, convenient facilities with advanced technology, by expanding our specialty services and by building our outpatient operations. We believe our continued investment in the employment, recruitment and retention of physicians will improve the quality of care at our facilities.

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Business Strategy (continued)**

*Continue to Leverage Our Scale and Market Positions to Grow the Company.* We believe there is significant opportunity to continue to grow our company by fully leveraging the scale and scope of our organization. We continue to invest in initiatives such as care navigators, clinical data exchange and centralized patient transfer operations, which will enable us to improve coordination of care and patient retention across our markets. We believe our centrally managed business processes and ability to leverage cost-saving practices across our extensive network will enable us to continue to manage costs effectively. We continue to invest in our Parallon subsidiary group to leverage key components of our support infrastructure, including revenue cycle management, health care group purchasing, supply chain management and staffing functions.

*Pursue a Disciplined Development Strategy.* We continue to believe there are significant growth opportunities in our markets. We will continue to provide financial and operational resources to analyze and develop our in-market opportunities. To complement our in-market growth agenda, we intend to focus on selectively developing and acquiring new hospitals, outpatient facilities and other health care service providers. We believe the challenges faced by the hospital industry may continue to spur consolidation and we believe our size, scale, national presence and access to capital will position us well to participate in any such consolidation.

**Critical Accounting Policies and Estimates**

The preparation of our consolidated financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent liabilities and the reported amounts of revenues and expenses. Our estimates are based on historical experience and various other assumptions we believe are reasonable under the circumstances. We evaluate our estimates on an ongoing basis and make changes to the estimates and related disclosures as experience develops or new information becomes known. Actual results may differ from these estimates.

We believe the following critical accounting policies affect our more significant judgments and estimates used in the preparation of our consolidated financial statements.

*Revenues*

Revenues are recorded during the period the health care services are provided, based upon the estimated amounts due from payers. Estimates of contractual allowances under managed care health plans are based upon the payment terms specified in the related contractual agreements. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The estimated reimbursement amounts are made on a payer-specific basis and are recorded based on the best information available regarding management's interpretation of the applicable laws, regulations and contract terms. Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals. We have invested significant resources to refine and improve our billing systems and the information system data used to make contractual allowance estimates. We have developed standardized calculation processes and related employee training programs to improve the utility of our patient accounting systems.

The Emergency Medical Treatment and Labor Act ("EMTALA") requires any hospital participating in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition,

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Critical Accounting Policies and Estimates (continued)**

*Revenues (continued)*

to either stabilize the condition or make an appropriate transfer of the individual to a facility able to handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment. Federal and state laws and regulations, including but not limited to EMTALA, require, and our commitment to providing quality patient care encourages, the provision of services to patients who are financially unable to pay for the health care services they receive.

Prior to November 2017, patients treated at hospitals for non-elective care, who have income at or below 200% of the federal poverty level, were eligible for charity care. During November 2017, we expanded our charity policy to include patients who have income above 200%, but at or below 400%, of the federal poverty level and we limit the patient responsibility amounts for these patients to a percentage of their annual household income, computed on a sliding scale based upon their annual income and the applicable percentage of the federal poverty level. The federal poverty level is established by the federal government and is based on income and family size. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in revenues. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care. We may attempt to provide assistance to uninsured patients to help determine whether they may qualify for Medicaid, other federal or state assistance, or charity care. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Due to the complexities involved in the classification and documentation of health care services authorized and provided, the estimation of revenues earned and the related reimbursement are often subject to interpretations that could result in payments that are different from our estimates. Adjustments to estimated Medicare and Medicaid reimbursement amounts and disproportionate-share funds, which resulted in net increases to revenues, related primarily to cost reports filed during the respective year were \$51 million, \$29 million and \$41 million in 2019, 2018 and 2017, respectively. The adjustments to estimated reimbursement amounts, which resulted in net increases to revenues, related primarily to cost reports filed during previous years were \$13 million, \$51 million and \$56 million in 2019, 2018 and 2017, respectively. We expect adjustments during the next 12 months related to Medicare and Medicaid cost report filings and settlements will result in increases to revenues generally similar to the amounts recorded during these years.

The collection of outstanding receivables for Medicare, Medicaid, managed care payers, other third-party payers and patients is our primary source of cash and is critical to our operating performance. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. Implicit price concessions relate primarily to amounts due directly from patients. Estimated implicit price concessions are recorded for all uninsured accounts, regardless of the age of those accounts. Accounts are written off when all reasonable collection efforts have been performed.

The estimates for implicit price concessions are based upon management's assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical writeoffs and collections at facilities that represent a majority of our revenues and accounts receivable (the "hindsight analysis") as a primary source of information in estimating the collectability of our accounts receivable. We perform the hindsight analysis quarterly, utilizing rolling twelve-months accounts receivable collection and writeoff data. We believe our quarterly updates to the estimated implicit price

## HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

## Critical Accounting Policies and Estimates (continued)

*Revenues (continued)*

concession amounts at each of our hospital facilities provide reasonable estimates of our revenues and valuations of our accounts receivable. These routine, quarterly changes in estimates have not resulted in material adjustments to the valuations of our accounts receivable or period-to-period comparisons of our results of operations. At December 31, 2019 and December 31, 2018, estimated implicit price concessions of \$6.953 billion and \$6.280 billion, respectively, had been recorded to adjust our revenues and accounts receivable to the estimated amounts we expect to collect.

To quantify the total impact of and trends related to uninsured patient accounts, we believe it is beneficial to view total uncompensated care, which is comprised of charity care, uninsured discounts and implicit price concessions. A summary of the estimated cost of total uncompensated care for the years ended December 31, follows (dollars in millions):

	<u>2019</u>	<u>2018</u>	<u>2017</u>
Patient care costs (salaries and benefits, supplies, other operating expenses and depreciation and amortization)	<u>\$44,118</u>	<u>\$40,035</u>	<u>\$37,557</u>
Cost-to-charges ratio (patient care costs as percentage of gross patient charges)	<u>12.0%</u>	<u>12.4%</u>	<u>12.9%</u>
Total uncompensated care	<u>\$31,105</u>	<u>\$26,757</u>	<u>\$23,420</u>
Multiply by the cost-to-charges ratio	<u>12.0%</u>	<u>12.4%</u>	<u>12.9%</u>
Estimated cost of total uncompensated care	<u>\$ 3,733</u>	<u>\$ 3,318</u>	<u>\$ 3,021</u>

Days revenues in accounts receivable were 50 days, 51 days and 52 days at December 31, 2019, 2018 and 2017, respectively. Management expects a continuation of the challenges related to the collection of the patient due accounts. Adverse changes in the percentage of our patients having adequate health care coverage, increases in patient responsibility amounts under certain health care coverages, general economic conditions, patient accounting service center operations, payer mix, or trends in federal, state, and private employer health care coverage could affect the collection of accounts receivable, cash flows and results of operations.

*Professional Liability Claims*

We, along with virtually all health care providers, operate in an environment with professional liability risks. Our facilities are insured by our 100% owned insurance subsidiary for losses up to \$50 million per occurrence, subject, in most cases, to a \$15 million per occurrence self-insured retention. The insurance subsidiary has obtained reinsurance for professional liability risks generally above a retention level of \$25 million per occurrence. We purchase excess insurance on a claims-made basis for losses in excess of \$50 million per occurrence. Provisions for losses related to professional liability risks were \$497 million, \$447 million and \$466 million for the years ended December 31, 2019, 2018 and 2017, respectively. During 2019 and 2018, we recorded reductions to the provision for professional liability risks of \$50 million and \$70 million, respectively, due to the receipt of updated actuarial information.

Reserves for professional liability risks represent the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The estimated ultimate cost includes

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Critical Accounting Policies and Estimates (continued)**

*Professional Liability Claims (continued)*

estimates of direct expenses and fees paid to outside counsel and experts, but does not include the general overhead costs of our insurance subsidiary or corporate office. Individual case reserves are established based upon the particular circumstances of each reported claim and represent our estimates of the future costs that will be paid on reported claims. Case reserves are reduced as claim payments are made and are adjusted upward or downward as our estimates regarding the amounts of future losses are revised. Once the case reserves for known claims are determined, information is stratified by loss layers and retentions, accident years, reported years, and geographic location of our hospitals. Several actuarial methods are employed to utilize this data to produce estimates of ultimate losses and reserves for incurred but not reported claims, including: paid and incurred extrapolation methods utilizing paid and incurred loss development to estimate ultimate losses; frequency and severity methods utilizing paid and incurred claims development to estimate ultimate average frequency (number of claims) and ultimate average severity (cost per claim); and Bornhuetter-Ferguson methods which add expected development to actual paid or incurred experience to estimate ultimate losses. These methods use our company-specific historical claims data and other information. Company-specific claim reporting and payment data collected over an approximate 20-year period is used in our reserve estimation process. This company-specific data includes information regarding our business, including historical paid losses and loss adjustment expenses, historical and current case loss reserves, actual and projected hospital statistical data, professional liability retentions for each policy year, geographic information and other data.

Reserves and provisions for professional liability risks are based upon actuarially determined estimates. The estimated reserve ranges, net of amounts receivable under reinsurance contracts, were \$1.589 billion to \$1.903 billion at December 31, 2019 and \$1.514 billion to \$1.814 billion at December 31, 2018. Our estimated reserves for professional liability claims may change significantly if future claims differ from expected trends. We perform sensitivity analyses which model the volatility of key actuarial assumptions and monitor our reserves for adequacy relative to all our assumptions in the aggregate. Based on our analysis, we believe the estimated professional liability reserve ranges represent the reasonably likely outcomes for ultimate losses. We consider the number and severity of claims to be the most significant assumptions in estimating reserves for professional liabilities. A 2.5% change in the expected frequency trend could be reasonably likely and would increase the reserve estimate by \$32 million or reduce the reserve estimate by \$31 million. A 2.5% change in the expected claim severity trend could be reasonably likely and would increase the reserve estimate by \$117 million or reduce the reserve estimate by \$107 million. We believe adequate reserves have been recorded for our professional liability claims; however, due to the complexity of the claims, the extended period of time to resolve the claims and the wide range of potential outcomes, our ultimate liability for professional liability claims could change by more than the estimated sensitivity amounts and could change materially from our current estimates.

The reserves for professional liability risks cover approximately 2,300 and 2,200 individual claims at December 31, 2019 and 2018, respectively, and estimates for unreported potential claims. The time period required to resolve these claims can vary depending upon the jurisdiction and whether the claim is settled or litigated. The average time period between the occurrence and final resolution for our professional liability claims is approximately four years, although the facts and circumstances of each individual claim can result in an occurrence-to-resolution timeframe that varies from this average. The estimation of the timing of payments beyond a year can vary significantly.

Reserves for professional liability risks were \$1.827 billion and \$1.741 billion at December 31, 2019 and 2018, respectively. The current portion of these reserves, \$457 million and \$466 million at December 31, 2019

## HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)**Critical Accounting Policies and Estimates (continued)***Professional Liability Claims (continued)*

and 2018, respectively, is included in "other accrued expenses." Obligations covered by reinsurance and excess insurance contracts are included in the reserves for professional liability risks, as we remain liable to the extent reinsurers and excess insurance carriers do not meet their obligations. Reserves for professional liability risks (net of \$46 million and \$50 million receivable under reinsurance and excess insurance contracts at December 31, 2019 and 2018, respectively) were \$1.781 billion and \$1.692 billion at December 31, 2019 and 2018, respectively. The estimated total net reserves for professional liability risks at December 31, 2019 and 2018 are comprised of \$695 million and \$703 million, respectively, of case reserves for known claims and \$1.086 billion and \$989 million, respectively, of reserves for incurred but not reported claims.

Changes in our professional liability reserves, net of reinsurance recoverable, for the years ended December 31, are summarized in the following table (dollars in millions):

	<u>2019</u>	<u>2018</u>	<u>2017</u>
Net reserves for professional liability claims, January 1	<u>\$1,692</u>	<u>\$1,603</u>	<u>\$1,494</u>
Provision for current year claims	<u>499</u>	<u>486</u>	<u>467</u>
Favorable development related to prior years' claims	<u>(2)</u>	<u>(39)</u>	<u>(1)</u>
Total provision	<u>497</u>	<u>447</u>	<u>466</u>
Payments for current year claims	<u>8</u>	<u>3</u>	<u>7</u>
Payments for prior years' claims	<u>400</u>	<u>355</u>	<u>350</u>
Total claim payments	<u>408</u>	<u>358</u>	<u>357</u>
Net reserves for professional liability claims, December 31	<u><u>\$1,781</u></u>	<u><u>\$1,692</u></u>	<u><u>\$1,603</u></u>

*Income Taxes*

We calculate our provision for income taxes using the asset and liability method, under which deferred tax assets and liabilities are recognized by identifying the temporary differences that arise from the recognition of items in different periods for tax and accounting purposes. Deferred tax assets generally represent the tax effects of amounts expensed in our income statement for which tax deductions will be claimed in future periods. Interest and penalties payable to taxing authorities are included as a component of our provision for income taxes. We have elected to treat taxes incurred on global intangible low-taxed income as a period expense.

Although we believe we have properly reported taxable income and paid taxes in accordance with applicable laws, federal, state or foreign taxing authorities may challenge our tax positions upon audit. Significant judgment is required in determining and assessing the impact of uncertain tax positions. We report a liability for unrecognized tax benefits from uncertain tax positions taken or expected to be taken in our income tax returns. During each reporting period, we assess the facts and circumstances related to uncertain tax positions. If the realization of unrecognized tax benefits is deemed probable based upon new facts and circumstances, the estimated liability and the provision for income taxes are reduced in the current period. Final audit results may vary from our estimates.

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Results of Operations**

*Revenue/Volume Trends*

Our revenues depend upon inpatient occupancy levels, the ancillary services and therapy programs ordered by physicians and provided to patients, the volume of outpatient procedures and the charge and negotiated payment rates for such services. Gross charges typically do not reflect what our facilities are actually paid. Our facilities have entered into agreements with third-party payers, including government programs and managed care health plans, under which the facilities are paid based upon the cost of providing services, predetermined rates per diagnosis, fixed per diem rates or discounts from gross charges. We do not pursue collection of amounts related to patients who meet our guidelines to qualify for charity care; therefore, they are not reported in revenues. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care.

Revenues increased 10.0% to \$51.336 billion for 2019 from \$46.677 billion for 2018 and increased 7.0% for 2018 from \$43.614 billion for 2017. The increase in revenues in 2019 can be primarily attributed to the combined impact of a 3.2% increase in revenue per equivalent admission and a 6.6% increase in equivalent admissions compared to the prior year. The increase in revenues in 2018 can be primarily attributed to the combined impact of a 2.8% increase in revenue per equivalent admission and a 4.1% increase in equivalent admissions compared to the prior year.

Same facility revenues increased 5.9% for the year ended December 31, 2019 compared to the year ended December 31, 2018 and increased 6.5% for the year ended December 31, 2018 compared to the year ended December 31, 2017. The 5.9% increase for 2019 can be primarily attributed to the combined impact of a 2.3% increase in same facility revenue per equivalent admission and a 3.5% increase in same facility equivalent admissions. The 6.5% increase for 2018 can be primarily attributed to the combined impact of a 3.9% increase in same facility revenue per equivalent admission and a 2.5% increase in same facility equivalent admissions.

Consolidated admissions increased 5.2% during 2019 compared to 2018 and increased 3.5% during 2018 compared to 2017. Consolidated surgeries increased 3.7% during 2019 compared to 2018 and increased 2.6% during 2018 compared to 2017. Consolidated emergency room visits increased 4.5% during 2019 compared to 2018 and increased 1.6% during 2018 compared to 2017.

Same facility admissions increased 2.8% during 2019 compared to 2018 and increased 2.5% during 2018 compared to 2017. Same facility surgeries each increased 1.4% during 2019 compared to 2018 and during 2018 compared to 2017. Same facility emergency room visits increased 2.8% during 2019 compared to 2018 and increased 0.1% during 2018 compared to 2017.

Same facility uninsured emergency room visits increased 3.9% and same facility uninsured admissions increased 3.7% during 2019 compared to 2018. Same facility uninsured emergency room visits increased 3.8% and same facility uninsured admissions increased 8.5% during 2018 compared to 2017.

## HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)**Results of Operations (continued)***Revenue/Volume Trends (continued)*

The approximate percentages of our admissions related to Medicare, managed Medicare, Medicaid, managed Medicaid, managed care and insurers and the uninsured for the years ended December 31, 2019, 2018 and 2017 are set forth below.

	<u>Years Ended December 31,</u>		
	<u>2019</u>	<u>2018</u>	<u>2017</u>
Medicare	29%	30%	30%
Managed Medicare	18	17	16
Medicaid	5	5	6
Managed Medicaid	12	12	12
Managed care and insurers	28	28	28
Uninsured	8	8	8
	<u>100%</u>	<u>100%</u>	<u>100%</u>

The approximate percentages of our inpatient revenues related to Medicare, managed Medicare, Medicaid, managed Medicaid, and managed care and insurers for the years ended December 31, 2019, 2018 and 2017 are set forth below.

	<u>Years Ended December 31,</u>		
	<u>2019</u>	<u>2018</u>	<u>2017</u>
Medicare	28%	28%	28%
Managed Medicare	15	14	13
Medicaid	5	4	5
Managed Medicaid	5	6	5
Managed care and insurers	47	48	49
	<u>100%</u>	<u>100%</u>	<u>100%</u>

At December 31, 2019, we owned and operated 45 hospitals and 33 surgery centers in the state of Florida. Our Florida facilities' revenues totaled \$11.494 billion, \$10.892 billion and \$10.168 billion for the years ended December 31, 2019, 2018 and 2017, respectively. At December 31, 2019, we owned and operated 46 hospitals and 29 surgery centers in the state of Texas. Our Texas facilities' revenues totaled \$13.101 billion, \$12.023 billion and \$10.634 billion for the years ended December 31, 2019, 2018 and 2017, respectively. During 2019, 2018 and 2017, 56%, 57% and 56% of our admissions and 48%, 49% and 48%, respectively, of our revenues were generated by our Florida and Texas facilities. Uninsured admissions in Florida and Texas represented 72%, 70% and 70% of our uninsured admissions during 2019, 2018 and 2017, respectively.

We receive a significant portion of our revenues from government health programs, principally Medicare and Medicaid, which are highly regulated and subject to frequent and substantial changes. In December 2017, the Centers for Medicare & Medicaid Services ("CMS") announced that it will phase out federal matching funds for Designated State Health Programs under waivers granted under Section 1115 of the Social Security Act. Texas currently operates its Healthcare Transformation and Quality Improvement Program pursuant to a Medicaid waiver. In December 2017, CMS approved an extension of this waiver through September 30, 2022, but

**HCA HEALTHCARE, INC.**

**MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)**

**Results of Operations (continued)**

*Revenue/Volume Trends (continued)*

indicated that it will phase out some of the federal funding. Our Texas Medicaid revenues included Medicaid supplemental waiver payments of \$416 million, \$450 million and \$351 million during 2019, 2018 and 2017, respectively.

In addition, we receive supplemental payments in several other states. We are aware these supplemental payment programs are currently being reviewed by CMS and certain state agencies, and that some states have made waiver requests to CMS to replace their existing supplemental payment programs. It is possible these reviews and waiver requests will result in the restructuring of such supplemental payment programs and could result in the payment programs being reduced or eliminated. Because deliberations about these programs are ongoing, we are unable to estimate the financial impact the program structure modifications, if any, may have on our results of operations.

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

Results of Operations (continued)

Operating Results Summary

The following are comparative summaries of operating results for the years ended December 31, 2019, 2018 and 2017 (dollars in millions):

	2019		2018		2017	
	Amount	Ratio	Amount	Ratio	Amount	Ratio
Revenues	\$51,336	100.0	\$46,677	100.0	\$43,614	100.0
Salaries and benefits	23,560	45.9	21,425	45.9	20,059	46.0
Supplies	8,481	16.5	7,724	16.5	7,316	16.8
Other operating expenses	9,481	18.5	8,608	18.5	8,051	18.4
Equity in earnings of affiliates	(43)	(0.1)	(29)	(0.1)	(45)	(0.1)
Depreciation and amortization	2,596	5.0	2,278	4.9	2,131	4.9
Interest expense	1,824	3.6	1,755	3.8	1,690	3.9
Gain on sales of facilities	(18)	—	(428)	(0.9)	(8)	—
Losses on retirement of debt	211	0.4	9	—	39	0.1
	<u>46,092</u>	<u>89.8</u>	<u>41,342</u>	<u>88.6</u>	<u>39,233</u>	<u>90.0</u>
Income before income taxes	5,244	10.2	5,335	11.4	4,381	10.0
Provision for income taxes	1,099	2.1	946	2.0	1,638	3.7
Net income	4,145	8.1	4,389	9.4	2,743	6.3
Net income attributable to noncontrolling interests	640	1.3	602	1.3	527	1.2
Net income attributable to HCA Healthcare, Inc.	<u>\$ 3,505</u>	<u>6.8</u>	<u>\$ 3,787</u>	<u>8.1</u>	<u>\$ 2,216</u>	<u>5.1</u>
% changes from prior year:						
Revenues	10.0%		7.0%		5.1%	
Income before income taxes	(1.7)		21.8		(8.9)	
Net income attributable to HCA Healthcare, Inc.	(7.4)		70.9		(23.3)	
Admissions(a)	5.2		3.5		2.4	
Equivalent admissions(b)	6.6		4.1		3.0	
Revenue per equivalent admission	3.2		2.8		2.1	
Same facility % changes from prior year(c):						
Revenues	5.9		6.5		3.8	
Admissions(a)	2.8		2.5		1.1	
Equivalent admissions(b)	3.5		2.5		1.5	
Revenue per equivalent admission	2.3		3.9		2.2	

- (a) Represents the total number of patients admitted to our hospitals and is used by management and certain investors as a general measure of inpatient volume.
- (b) Equivalent admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Equivalent admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The equivalent admissions computation "equates" outpatient revenue to the volume measure (admissions) used to measure inpatient volume, resulting in a general measure of combined inpatient and outpatient volume.
- (c) Same facility information excludes the operations of hospitals and their related facilities that were either acquired, divested or removed from service during the current and prior year.

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Results of Operations (continued)**

*Years Ended December 31, 2019 and 2018*

Net income attributable to HCA Healthcare, Inc. totaled \$3.505 billion, or \$10.07 per diluted share, for 2019, compared to \$3.787 billion, or \$10.66 per diluted share, for 2018. The 2019 results include gains on sales of facilities of \$18 million, or \$0.04 per diluted share, and losses on retirement of debt of \$211 million, or \$0.47 per diluted share. The 2018 results include gains on sales of facilities of \$428 million, or \$0.91 per diluted share, and losses on retirement of debt of \$9 million, or \$0.02 per diluted share. The 2019 results include revenues of \$86 million, or \$0.19 per diluted share, related to the resolution of transaction price differences regarding certain out-of-network services performed in prior periods. The 2018 results include a reduction in our provision for income taxes of \$67 million, or \$0.19 per diluted share, for the remeasurement of certain of our deferred tax assets and liabilities for which we were unable to record reasonable estimates in 2017. During 2019 and 2018, we recorded reductions to the provision for professional liability risks of \$50 million, or \$0.11 per diluted share, and \$70 million, or \$0.15 per diluted share, respectively. During 2018, we recorded additional expenses and losses of revenues estimated at approximately \$31 million, or \$0.07 per diluted share, associated with the impact of hurricane Michael on our Florida facilities. This amount is prior to any insurance recoveries. During 2018, we recorded a benefit of \$49 million, or \$0.11 per diluted share, from an insurance recovery related to hurricane Harvey business interruption losses incurred during 2017, and we recorded a reduction to the provision for income taxes of \$28 million, or \$0.08 per diluted share, for tax credits related to certain 2017 hurricane-related expenses. Our provisions for income taxes for 2019 and 2018 included tax benefits of \$65 million, or \$0.19 per diluted share, and \$124 million, or \$0.35 per diluted share, respectively, related to employee equity award settlements. All "per diluted share" disclosures are based upon amounts net of the applicable income taxes. Shares used for diluted earnings per share were 348.226 million shares and 355.303 million shares for the years ended December 31, 2019 and 2018, respectively. During 2019 and 2018, we repurchased 7.949 million and 14.070 million shares, respectively, of our common stock.

During 2019, consolidated admissions increased 5.2% and same facility admissions increased 2.8% compared to 2018. Consolidated inpatient surgeries increased 3.4% and same facility inpatient surgeries increased 1.1% during 2019 compared to 2018. Consolidated outpatient surgeries increased 4.0%, and same facility outpatient surgeries increased 1.6% during 2019 compared to 2018. Emergency room visits increased 4.5% on a consolidated basis and increased 2.8% on a same facility basis during 2019 compared to 2018.

Revenues increased 10.0% to \$51.336 billion for 2019 from \$46.677 billion for 2018. The increase in revenues was primarily due to the combined impact of a 3.2% increase in revenue per equivalent admission and a 6.6% increase in equivalent admissions compared to 2018. Same facility revenues increased 5.9% due primarily to the combined impact of a 2.3% increase in same facility revenue per equivalent admission and a 3.5% increase in same facility equivalent admissions compared to 2018.

Salaries and benefits, as a percentage of revenues, were 45.9% each in 2019 and 2018. Salaries and benefits per equivalent admission increased 3.1% in 2019 compared to 2018. Same facility labor rate increases averaged 2.7% for 2019 compared to 2018. Share-based compensation expense was \$347 million in 2019 and \$268 million in 2018.

Supplies, as a percentage of revenues, were 16.5% each in 2019 and 2018. Supply costs per equivalent admission increased 3.0% in 2019 compared to 2018. Supply costs per equivalent admission increased 2.8% for medical devices, 8.6% for pharmacy supplies and 1.0% for general medical and surgical items in 2019 compared to 2018. Same facility supply costs per equivalent admission increased 1.6% for medical devices and 2.2% for general medical and surgical items and declined 2.1% for pharmacy supplies in 2019 compared to 2018.

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Results of Operations (continued)**

*Years Ended December 31, 2019 and 2018 (continued)*

Other operating expenses, as a percentage of revenues, were 18.5% each in 2019 and 2018. Other operating expenses are primarily comprised of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and nonincome taxes. Provisions for losses related to professional liability risks were \$497 million and \$447 million for 2019 and 2018, respectively.

Equity in earnings of affiliates was \$43 million for 2019 and \$29 million for 2018.

Depreciation and amortization, as a percentage of revenues, was 5.0% in 2019 and 4.9% in 2018. Depreciation expense was \$2.579 billion for 2019 and \$2.262 billion for 2018, and the \$317 million increase was due to both acquisitions and increased capital expenditures in 2019 (same facility depreciation amortization increased \$154 million).

Interest expense increased to \$1.824 billion for 2019 from \$1.755 billion for 2018. The increase in interest expense was due to an increase in the average debt balance. Our average debt balance was \$34.288 billion for 2019 compared to \$33.065 billion for 2018. The average interest rate for our long-term debt was 5.3% for both 2019 and 2018.

Gains on sales of facilities were \$18 million and \$428 million, respectively, for 2019 and 2018. The gains on sales of facilities for 2019 related primarily to sales of real estate and other investments. The gains on sales of facilities for 2018 related primarily to the sale of the two hospital facilities in our Oklahoma market.

During June 2019, we issued \$5.000 billion aggregate principal amount of senior secured notes comprised of \$2.000 billion aggregate principal amount of 4 1/8% notes due 2029, \$1.000 billion aggregate principal amount of 5 1/8% notes due 2039 and \$2.000 billion aggregate principal amount of 5 1/4% notes due 2049. During July 2019, we redeemed all \$600 million outstanding aggregate principal amount of 4.25% senior secured notes due 2019, all \$3.000 billion outstanding aggregate principal amount of 6.50% senior secured notes due 2020 and all \$1.350 billion outstanding aggregate principal amount of 5.875% senior secured notes due 2022. The pretax loss on retirement of debt for these redemptions was \$211 million. During 2018, we issued \$2.000 billion aggregate principal amount of senior notes comprised of \$1.000 billion aggregate principal amount of 5.375% notes due 2026 and \$1.000 billion aggregate principal amount of 5.625% notes due 2028. We used the net proceeds for general corporate purposes, including funding the purchase of a hospital, and the redemption of all \$1.500 billion aggregate principal amount of our existing 3.750% senior secured notes maturing in March 2019. The pretax loss on retirement of debt was \$9 million.

The effective tax rates were 23.9% and 20.0% for 2019 and 2018, respectively. The effective tax rate computations exclude net income attributable to noncontrolling interests as it relates to consolidated partnerships. Our provision for income taxes for 2018 included \$28 million of benefits for tax credits related to certain 2017 hurricane-related expenses and \$67 million of benefits related to the remeasurement of our deferred tax assets and liabilities due to the enactment of the Tax Act. Our provisions for income taxes for 2019 and 2018 also included tax benefits of \$65 million and \$124 million, respectively, related to employee equity award settlements. Excluding the effect of these adjustments, the effective tax rates for 2019 and 2018 would have been 25.3% and 24.6%, respectively.

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Results of Operations (continued)**

*Years Ended December 31, 2019 and 2018 (continued)*

Net income attributable to noncontrolling interests increased from \$602 million for 2018 to \$640 million for 2019. The increase in net income attributable to noncontrolling interests related primarily to a joint venture in one of our Texas markets and the operations of our surgery center partnerships.

For results of operations comparisons relating to years ending December 31, 2018 and 2017, refer to our annual report on Form 10-K, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations for the year ended December 31, 2018, filed with the Securities and Exchange Commission on February 21, 2019.

**Liquidity and Capital Resources**

Our primary cash requirements are paying our operating expenses, servicing our debt, capital expenditures on our existing properties, acquisitions of hospitals and other health care entities, repurchases of our common stock, distributions to stockholders and distributions to noncontrolling interests. Our primary cash sources are cash flows from operating activities, issuances of debt and equity securities and dispositions of hospitals and other health care entities.

Cash provided by operating activities totaled \$7.602 billion in 2019 compared to \$6.761 billion in 2018 and \$5.426 billion in 2017. The \$841 million increase in cash provided by operating activities for 2019, compared to 2018, was primarily related to the increase in net income, excluding gains on sales of facilities and losses on retirement of debt, of \$222 million and increases related to income taxes of \$322 million and depreciation and amortization of \$318 million. The \$1.335 billion increase in cash provided by operating activities for 2018, compared to 2017, was primarily related to the increase in net income, excluding gains on sales of facilities, of \$1.309 billion. Working capital totaled \$3.439 billion at December 31, 2019 and \$2.644 billion at December 31, 2018. The increase in working capital of \$795 million is primarily related to a decline in long-term debt due within one year of \$643 million. Cash payments for interest and income taxes increased \$147 million for 2019 compared to 2018 and declined \$289 million for 2018 compared to 2017.

Cash used in investing activities was \$5.720 billion, \$3.901 billion and \$4.279 billion in 2019, 2018 and 2017, respectively. Excluding acquisitions, capital expenditures were \$4.158 billion in 2019, \$3.573 billion in 2018 and \$3.015 billion in 2017. We expended \$1.682 billion, \$1.253 billion and \$1.212 billion for acquisitions of hospitals and health care entities during 2019, 2018 and 2017, respectively. Planned capital expenditures are expected to approximate \$4.0 billion to \$4.2 billion in 2020. At December 31, 2019, there were projects under construction which had an estimated additional cost to complete and equip over the next five years of approximately \$3.0 billion. We expect to finance capital expenditures with internally generated and borrowed funds. Cash received from sales of hospitals and health care entities declined \$747 million for 2019 compared to 2018 primarily related to the receipt during 2018 of \$758 million from the sale of the two hospitals in our Oklahoma market.

Cash used in financing activities totaled \$1.771 billion in 2019, \$3.075 billion in 2018 and \$1.061 billion in 2017. During 2019, we had a net increase of \$567 million in our indebtedness, paid dividends of \$550 million and paid \$1.031 billion for repurchases of common stock. During 2018, we had a net decline of \$344 million in our indebtedness, paid dividends of \$487 million and paid \$1.530 billion for repurchases of common stock. During 2017, we had a net increase of \$1.509 billion in our indebtedness and paid \$2.051 billion for repurchases

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Liquidity and Capital Resources (continued)**

of common stock. During 2019, 2018 and 2017, we made distributions to noncontrolling interests of \$542 million, \$441 million and \$448 million, respectively.

We, or our affiliates, may in the future repurchase portions of our debt or equity securities, subject to certain limitations, from time to time in either the open market or through privately negotiated transactions, in accordance with applicable SEC and other legal requirements. The timing, prices, and sizes of purchases depend upon prevailing trading prices, general economic and market conditions, and other factors, including applicable securities laws. During January 2020 and 2019, our Board of Directors authorized share repurchase programs for up to \$4 billion (\$2 billion for each authorization) of our outstanding common stock, and at December 31, 2019, there was \$1.241 billion of share repurchase authorization that remained available under the January 2019 authorization. Funds for the repurchase of debt or equity securities have, and are expected to, come primarily from cash generated from operations and borrowed funds. On January 27, 2020, our Board of Directors declared a quarterly dividend of \$0.43 per share on our common stock payable on March 31, 2020 to stockholders of record at the close of business on March 2, 2020. During 2019, our Board of Directors declared four quarterly dividends of \$0.40 per share, or \$1.60 per share in the aggregate, on our common stock. The timing and amount of future cash dividends will vary based on a number of factors, including future capital requirements for strategic transactions, share repurchases and investing in our existing markets, the availability of financing on acceptable terms, debt service requirements, changes to applicable tax laws or corporate laws, changes to our business model and periodic determinations by our Board of Directors that cash dividends are in the best interest of stockholders and are in compliance with all applicable laws and agreements of the Company.

In addition to cash flows from operations, available sources of capital include amounts available under our senior secured credit facilities (\$3.237 billion as of December 31, 2019 and \$3.187 billion as of January 31, 2020) and anticipated access to public and private debt and equity markets.

Investments of our insurance subsidiaries, held to maintain statutory equity levels and to provide liquidity to pay claims, totaled \$462 million and \$409 million at December 31, 2019 and 2018, respectively. The insurance subsidiary maintained net reserves for professional liability risks of \$175 million and \$183 million at December 31, 2019 and 2018, respectively. Our facilities are insured by our 100% owned insurance subsidiary for losses up to \$50 million per occurrence; however, this coverage is subject, in most cases, to a \$15 million per occurrence self-insured retention. Net reserves for the self-insured professional liability risks retained were \$1.606 billion and \$1.509 billion at December 31, 2019 and 2018, respectively. Claims payments, net of reinsurance recoveries, during the next 12 months are expected to approximate \$448 million. We estimate that approximately \$394 million of the expected net claim payments during the next 12 months will relate to claims subject to the self-insured retention.

*Financing Activities*

We are a highly leveraged company with significant debt service requirements. Our debt totaled \$33.722 billion and \$32.821 billion at December 31, 2019 and 2018, respectively. Our interest expense was \$1.824 billion for 2019 and \$1.755 billion for 2018.

During August 2018, we issued \$2.000 billion aggregate principal amount of senior unsecured notes comprised of \$1.000 billion aggregate principal amount of 5.375% notes due 2026 and \$1.000 billion aggregate principal amount of 5.625% notes due 2028. We used the net proceeds for general corporate purposes, including

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Liquidity and Capital Resources (continued)**

*Financing Activities (continued)*

funding the purchase of a hospital, and the redemption of all \$1.500 billion aggregate principal amount of our existing 3.750% senior secured notes maturing in March 2019.

During January 2019, we issued \$1.500 billion aggregate principal amount of senior unsecured notes comprised of \$1.000 billion aggregate principal amount of 5.875% notes due 2029 and \$500 million aggregate principal amount of 5.625% notes due 2028. We used the net proceeds to fund the purchase of a seven-hospital health system located in western North Carolina.

During June 2019, we issued \$5.000 billion aggregate principal amount of senior secured notes comprised of \$2.000 billion aggregate principal amount of 4 1/8% notes due 2029, \$1.000 billion aggregate principal amount of 5 1/8% notes due 2039 and \$2.000 billion aggregate principal amount of 5 1/4% notes due 2049. During July 2019, we redeemed all \$600 million outstanding aggregate principal amount of 4.25% senior secured notes due 2019, all \$3.000 billion outstanding aggregate principal amount of 6.50% senior secured notes due 2020 and all \$1.350 billion outstanding aggregate principal amount of 5.875% senior secured notes due 2022.

Management believes that cash flows from operations, amounts available under our senior secured credit facilities and our anticipated access to public and private debt markets will be sufficient to meet expected liquidity needs during the next twelve months.

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Contractual Obligations and Off-Balance Sheet Arrangements**

As of December 31, 2019, maturities of contractual obligations and other commercial commitments are presented in the table below (dollars in millions):

<b>Contractual Obligations(a)</b>	<b>Payments Due by Period</b>				
	<b>Total</b>	<b>Current</b>	<b>2-3 Years</b>	<b>4-5 Years</b>	<b>After 5 Years</b>
Long-term debt including interest, excluding the senior secured credit facilities(b)	\$42,756	\$ 1,667	\$ 6,061	\$ 7,227	\$ 27,801
Loans outstanding under the senior secured credit facilities, including interest(b)	7,132	266	3,031	1,284	2,551
Professional liability risks(c)	1,827	457	774	399	197
Right-of-use operating lease obligations	2,530	411	635	410	1,074
Other obligations(d)	25	22	2	1	—
<b>Total contractual obligations</b>	<b>\$54,270</b>	<b>\$ 2,823</b>	<b>\$ 10,503</b>	<b>\$ 9,321</b>	<b>\$ 31,623</b>

<b>Other Commercial Commitments Not Recorded on the Consolidated Balance Sheet</b>	<b>Commitment Expiration by Period</b>				
	<b>Total</b>	<b>Current</b>	<b>2-3 Years</b>	<b>4-5 Years</b>	<b>After 5 Years</b>
Surety bonds(e)	\$ 60	\$ 59	\$ 1	\$ —	\$ —
Letters of credit(e)	33	18	15	—	—
Physician commitments(f)	37	30	7	—	—
<b>Total commercial commitments</b>	<b>\$130</b>	<b>\$ 107</b>	<b>\$ 23</b>	<b>\$ —</b>	<b>\$ —</b>

- (a) We have not included obligations related to unrecognized tax benefits of \$550 million at December 31, 2019, as we cannot reasonably estimate the timing or amounts of cash payments, if any, at this time.
- (b) Estimates of interest payments assume that interest rates and borrowing spreads at December 31, 2019, remain constant during the period presented.
- (c) The estimation of the timing of payments for professional liability risks beyond a year can vary significantly. The time period required to resolve these claims can vary depending upon the jurisdiction and whether the claim is settled or litigated.
- (d) Amounts include physician commitments that are recorded in our consolidated balance sheet. Amounts also include future other obligations that are not recorded in our consolidated balance sheet.
- (e) Amounts relate primarily to instances in which we have agreed to indemnify various commercial insurers and lenders who have provided surety bonds and letters of credit to cover damages for legal cases which were awarded to plaintiffs by the courts, Medicaid provider bonds, educational administrative bonds and utility and construction deposits.
- (f) In consideration for physicians relocating to the communities in which our hospitals are located and agreeing to engage in private practice for the benefit of the respective communities, we make advances to physicians to assist in establishing the physicians' practices. The actual amount of these commitments to be advanced often depends upon the financial results of the physicians' private practice during the recruitment agreement payment period. The physician commitments reflected were based on our maximum exposure on effective agreements at December 31, 2019.

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Market Risk**

We are exposed to market risk related to changes in market values of securities. The investments in our 100% owned insurance subsidiaries were \$462 million at December 31, 2019. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At December 31, 2019, we had a net unrealized gain of \$18 million on the insurance subsidiaries' investment securities.

We are exposed to market risk related to market illiquidity. Investments in debt and equity securities of our 100% owned insurance subsidiaries could be impaired by the inability to access the capital markets. Should the 100% owned insurance subsidiaries require significant amounts of cash in excess of normal cash requirements to pay claims and other expenses on short notice, we may have difficulty selling these investments in a timely manner or be forced to sell them at a price less than what we might otherwise have been able to in a normal market environment. We may be required to recognize credit-related impairments on our investment securities in future periods should issuers default on interest payments or should the fair market valuations of the securities deteriorate due to ratings downgrades or other issue-specific factors.

We are also exposed to market risk related to changes in interest rates, and we periodically enter into interest rate swap agreements to manage our exposure to these fluctuations. Our interest rate swap agreements involve the exchange of fixed and variable rate interest payments between two parties, based on common notional principal amounts and maturity dates. The notional amounts of the swap agreements represent balances used to calculate the exchange of cash flows and are not our assets or liabilities. Our credit risk related to these agreements is considered low because the swap agreements are with creditworthy financial institutions. The interest payments under these agreements are settled on a net basis. These derivatives have been recognized in the financial statements at their respective fair values. Changes in the fair value of these derivatives, which are designated as cash flow hedges, are included in other comprehensive income.

With respect to our interest-bearing liabilities, approximately \$3.706 billion of long-term debt at December 31, 2019 was subject to variable rates of interest, while the remaining balance in long-term debt of \$30.016 billion at December 31, 2019 was subject to fixed rates of interest. Both the general level of interest rates and, for the senior secured credit facilities, our leverage affect our variable interest rates. Our variable debt is comprised primarily of amounts outstanding under the senior secured credit facilities. Borrowings under the senior secured credit facilities bear interest at a rate equal to an applicable margin plus, at our option, either (a) a base rate determined by reference to the higher of (1) the federal funds rate plus 0.50% and (2) the prime rate of Bank of America or (b) a LIBOR rate for the currency of such borrowing for the relevant interest period. The applicable margin for borrowings under the senior secured credit facilities may fluctuate according to a leverage ratio. The average effective interest rate for our long-term debt was 5.3% for both 2019 and 2018, respectively.

The estimated fair value of our total long-term debt was \$37.026 billion at December 31, 2019. The estimates of fair value are based upon the quoted market prices for the same or similar issues of long-term debt with the same maturities. Based on a hypothetical 1% increase in interest rates, the potential annualized reduction to future pretax earnings would be approximately \$37 million. To mitigate the impact of fluctuations in interest rates, we generally target a majority of our debt portfolio to be maintained at fixed rates.

We are exposed to currency translation risk related to our foreign operations. We currently do not consider the market risk related to foreign currency translation to be material to our consolidated financial statements or our liquidity.

HCA HEALTHCARE, INC.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION  
AND RESULTS OF OPERATIONS (Continued)

**Market Risk (continued)**

*Financial Instruments*

Derivative financial instruments are employed to manage risks, including interest rate exposures, and are not used for trading or speculative purposes. We recognize derivative instruments, such as interest rate swap agreements, in the consolidated balance sheets at fair value. Changes in the fair value of derivatives are recognized periodically either in earnings or in stockholders' equity, as a component of other comprehensive income, depending on whether the derivative financial instrument qualifies for hedge accounting, and if so, whether it qualifies as a fair value hedge or a cash flow hedge. Gains and losses on derivatives designated as cash flow hedges, to the extent they are effective, are recorded in other comprehensive income, and subsequently reclassified to earnings to offset the impact of the hedged items when they occur.

The net interest paid or received on interest rate swaps is recognized as interest expense. Gains and losses resulting from the early termination of interest rate swap agreements are deferred and amortized as adjustments to expense over the remaining period of the debt originally covered by the terminated swap.

**Effects of Inflation and Changing Prices**

Various federal, state and local laws have been enacted that, in certain cases, limit our ability to increase prices. Revenues for general, acute care hospital services rendered to Medicare patients are established under the federal government's prospective payment system. Total fee-for-service Medicare revenues were 21.0%, 21.1% and 21.3% of our revenues for 2019, 2018 and 2017, respectively.

Management believes hospital industry operating margins have been, and may continue to be, under significant pressure because of changes in payer and service mix and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. In addition, as a result of increasing regulatory and competitive pressures, our ability to maintain operating margins through price increases to non-Medicare patients is limited.

**Tax Examinations**

The Internal Revenue Service began an examination of the Company's 2016 and 2017 federal income tax returns during 2019. We are also subject to examination by state and foreign taxing authorities. Management believes HCA Healthcare, Inc., its predecessors, subsidiaries and affiliates properly reported taxable income and paid taxes in accordance with applicable laws and agreements established with the IRS, state and foreign taxing authorities, and final resolution of any disputes will not have a material, adverse effect on our results of operations or financial position. However, if payments due upon final resolution of any issues exceed our recorded estimates, such resolutions could have a material, adverse effect on our results of operations or financial position.

---

## [Table of Contents](#)

### **Item 7A. *Quantitative and Qualitative Disclosures about Market Risk***

Information with respect to this Item is provided under the caption “Market Risk” under Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations.”

### **Item 8. *Financial Statements and Supplementary Data***

Information with respect to this Item is contained in our consolidated financial statements indicated in the Index to Consolidated Financial Statements on Page F-1 of this annual report on Form 10-K.

### **Item 9. *Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None.

### **Item 9A. *Controls and Procedures***

#### **1. Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures**

Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of our disclosure controls and procedures, as such term is defined under Rule 13a-15(e) promulgated under the Securities Exchange Act of 1934, as amended (the “Exchange Act”). Based on this evaluation, our principal executive officer and our principal financial officer concluded that our disclosure controls and procedures were effective as of the end of the period covered by this annual report.

#### **2. Internal Control Over Financial Reporting**

##### **(a) Management’s Report on Internal Control Over Financial Reporting**

Our management is responsible for establishing and maintaining effective internal control over financial reporting, as such term is defined in Exchange Act Rule 13a-15(f). Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective, can provide only reasonable assurance with respect to financial statement preparation and presentation.

Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an assessment of the effectiveness of our internal control over financial reporting based on the framework in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework). Based on our assessment under the framework in Internal Control — Integrated Framework, our management concluded that our internal control over financial reporting was effective as of December 31, 2019.

Ernst & Young LLP, the independent registered public accounting firm that audited our consolidated financial statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which is included herein.

---

[Table of Contents](#)

(b) Attestation Report of the Independent Registered Public Accounting Firm

**Report of Independent Registered Public Accounting Firm**

The Board of Directors and Stockholders  
HCA Healthcare, Inc.

**Opinion on Internal Control over Financial Reporting**

We have audited HCA Healthcare, Inc.'s internal control over financial reporting as of December 31, 2019, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, HCA Healthcare, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2019, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of HCA Healthcare, Inc. as of December 31, 2019 and 2018, and the related consolidated statements of income, comprehensive income, stockholders' deficit, and cash flows for each of the three years in the period ended December 31, 2019, and the related notes and our report dated February 20, 2020 expressed an unqualified opinion thereon.

**Basis for Opinion**

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

**Definition and Limitations of Internal Control Over Financial Reporting**

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

## [Table of Contents](#)

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Nashville, Tennessee  
February 20, 2020

### (c) Changes in Internal Control Over Financial Reporting

During the fourth quarter of 2019, there have been no changes in our internal control over financial reporting that have materially affected or are reasonably likely to materially affect our internal control over financial reporting.

### **Item 9B. Other Information**

None.

## **PART III**

### **Item 10. Directors, Executive Officers and Corporate Governance**

The information required by this Item regarding the identity and business experience of our directors and executive officers is set forth under the heading “Nominees for Election” and “Election of Directors” in the definitive proxy materials of HCA to be filed in connection with our 2020 Annual Meeting of Stockholders with respect to our directors and is set forth in Item 1 of Part I of this annual report on Form 10-K with respect to our executive officers. The information required by this Item contained in such definitive proxy materials is incorporated herein by reference.

Information on the beneficial ownership reporting for our directors and executive officers required by this Item is contained under the caption “Delinquent Section 16(a) Reports” in the definitive proxy materials to be filed in connection with our 2020 Annual Meeting of Stockholders and is incorporated herein by reference.

Information on our Audit and Compliance Committee and Audit Committee Financial Experts required by this Item is contained under the caption “Corporate Governance” in the definitive proxy materials to be filed in connection with our 2020 Annual Meeting of Stockholders and is incorporated herein by reference.

We have a Code of Conduct which is applicable to all our directors, officers and employees (the “Code of Conduct”). The Code of Conduct is available on the Ethics and Compliance and Corporate Governance pages of our website at [www.hcahealthcare.com](http://www.hcahealthcare.com). To the extent required pursuant to applicable SEC regulations, we intend to post amendments to or waivers from our Code of Conduct (to the extent applicable to our chief executive officer, principal financial officer or principal accounting officer) at this location on our website or report the same on a Current Report on Form 8-K. Our Code of Conduct is available free of charge upon request to our Corporate Secretary, HCA Healthcare, Inc., One Park Plaza, Nashville, TN 37203.

### **Item 11. Executive Compensation**

The information required by this Item is set forth under the headings “Executive Compensation” and “Compensation Committee Interlocks and Insider Participation” in the definitive proxy materials to be filed in connection with our 2020 Annual Meeting of Stockholders, which information is incorporated herein by reference.

## [Table of Contents](#)

### **Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters**

Information about security ownership of certain beneficial owners required by this Item is set forth under the heading “Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters” in the definitive proxy materials to be filed in connection with our 2020 Annual Meeting of Stockholders, which information is incorporated herein by reference.

This table provides certain information as of December 31, 2019 with respect to our equity compensation plans:

#### **EQUITY COMPENSATION PLAN INFORMATION** **(Share and share unit amounts in millions)**

	<u>(a)</u>	<u>(b)</u>	<u>(c)</u>
	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))
Equity compensation plans approved by security holders	16.849(1)	\$ 71.79(1)	27.211(2)
Equity compensation plans not approved by security holders	—	—	—
<b>Total</b>	<b>16.849</b>	<b>\$ 71.79</b>	<b>27.211</b>

- (1) Includes 2.620 million restricted share units which vest solely based upon continued employment over a specific period of time and 3.035 million performance share units which vest based upon continued employment over a specific period of time and the achievement of predetermined financial targets over time. The performance share units reported reflect the number of performance share units that would vest upon achievement of target performance; the number of performance share units that vest can vary from zero (for actual performance less than 90% of target for 2019 grants and 80% of target for 2018 and prior grants) to two times the units granted (for actual performance of 110% or more of target for 2019 grants and 120% or more of target for 2018 and prior grants). The weighted average exercise price does not take these restricted share units and performance share units into account.
- (2) Includes 20.328 million shares available for future grants under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated, and 6.883 million shares of common stock reserved for future issuance under the HCA Holdings, Inc. Employee Stock Purchase Plan.
- \* For additional information concerning our equity compensation plans, see the discussion in Note 2 — Share-Based Compensation in the notes to the consolidated financial statements.

### **Item 13. Certain Relationships and Related Transactions, and Director Independence**

The information required by this Item is set forth under the headings “Certain Relationships and Related Party Transactions” and “Corporate Governance” in the definitive proxy materials to be filed in connection with our 2020 Annual Meeting of Stockholders, which information is incorporated herein by reference.

### **Item 14. Principal Accountant Fees and Services**

The information required by this Item is set forth under the heading “Ratification of Appointment of Independent Registered Public Accounting Firm” in the definitive proxy materials to be filed in connection with our 2020 Annual Meeting of Stockholders, which information is incorporated herein by reference.

PART IV

**Item 15. Exhibits and Financial Statement Schedules**

*(a) Documents filed as part of the report:*

1. *Financial Statements.* The accompanying Index to Consolidated Financial Statements on page F-1 of this annual report on Form 10-K is provided in response to this item.

2. *List of Financial Statement Schedules.* All schedules are omitted because the required information is either not present, not present in material amounts or presented within the consolidated financial statements.

*3. List of Exhibits*

- 2.1 — [Agreement and Plan of Merger, dated July 24, 2006, by and among HCA Inc., Hercules Holding II, LLC and Hercules Acquisition Corporation \(filed as Exhibit 2.1 to the Company's Current Report on Form 8-K filed July 25, 2006 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 2.2 — [Merger Agreement, dated November 22, 2010, by and among HCA Inc., HCA Holdings, Inc., and HCA Merger Sub LLC \(filed as Exhibit 2.1 to the Company's Current Report on Form 8-K filed November 24, 2010 \(File No. 000-18406\), and incorporated herein by reference\).](#)
- 3.1 — [Amended and Restated Certificate of Incorporation of the Company \(restated for SEC filing purposes only\) \(filed as Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 3.2 — [Amended and Restated Bylaws of the Company \(restated for SEC filing purposes only\) \(filed as Exhibit 3.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.1 — [Description of Registered Securities.](#)
- 4.2 — [Specimen Certificate for shares of Common Stock, par value \\$0.01 per share, of the Company \(filed as Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2017 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.3 — [Security Agreement, dated as of November 17, 2006, among HCA Inc., the subsidiary grantors party thereto and The Bank of New York, as collateral agent \(filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed November 24, 2006 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.4 — [Pledge Agreement, dated as of November 17, 2006, among HCA Inc., the subsidiary pledgors party thereto and The Bank of New York, as collateral agent \(filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed November 24, 2006 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(a) — [\\$13,550,000,000 — € 1,000,000,000 Credit Agreement, dated as of November 17, 2006, among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Banc of America Securities LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and joint bookrunners, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A. and Citicorp North America, Inc., as co-syndication agents and Merrill Lynch Capital Corporation, as documentation agent \(filed as Exhibit 4.8 to the Company's Current Report on Form 8-K filed November 24, 2006 \(File No. 001-11239\), and incorporated herein by reference\).](#)

## Table of Contents

- 4.5(b) — [Amendment No. 1 to the Credit Agreement, dated as of February 16, 2007, among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and Citicorp North America, Inc., as Co-Syndication Agents, Banc of America Securities, LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche Bank Securities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill Lynch Capital Corporation, as documentation agent \(filed as Exhibit 4.7\(b\) to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2006 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(c) — [Amendment No. 2 to the Credit Agreement, dated as of March 2, 2009, among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and Citicorp North America, Inc., as Co-Syndication Agents, Banc of America Securities, LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche Bank Securities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill Lynch Capital Corporation, as documentation agent \(filed as Exhibit 4.8\(c\) to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2008 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(d) — [Amendment No. 3 to the Credit Agreement, dated as of June 18, 2009, among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and Citicorp North America, Inc., as Co-Syndication Agents, Banc of America Securities, LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche Bank Securities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill Lynch Capital Corporation, as documentation agent \(filed as Exhibit 4.1 to the Company’s Current Report on Form 8-K filed June 22, 2009 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(e) — [Extension Amendment No. 1 to the Credit Agreement, dated as of April 6, 2010, among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Bank of America, N.A., as administrative agent and collateral agent \(filed as Exhibit 10.1 to the Company’s Current Report on Form 8-K filed April 8, 2010 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(f) — [Amended and Restated Joinder Agreement No. 1, dated as of November 8, 2010, by and among each of the financial institutions listed as a “Replacement-1 Revolving Credit Lender” on Schedule A thereto, HCA Inc., Bank of America, N.A., as Administrative Agent and as Collateral Agent, and the other parties listed on the signature pages thereto \(filed as Exhibit 4.1 to the Company’s Quarterly Report on Form 10-Q for the quarter ended September 30, 2010 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(g) — [Restatement Agreement, dated as of May 4, 2011, by and among HCA Inc., HCA UK Capital Limited, the lenders party thereto and Bank of America, N.A., as administrative agent and collateral agent to the Credit Agreement, dated as of November 17, 2006, as amended on February 16, 2007, March 2, 2009, June 18, 2009, April 6, 2010 and November 8, 2010 \(filed as Exhibit 10.1 to the Company’s Current Report on Form 8-K filed May 9, 2011 \(File No. 001-11239\), and incorporated herein by reference\).](#)

## Table of Contents

- 4.5(h) — [Extension Amendment No. 1, dated as of April 25, 2012, by and among HCA Inc., HCA UK Capital Limited, each of the U.S. Guarantors, each of the European Guarantors, the lenders party thereto and Bank of America, N.A., as administrative agent, swingline lender and letter of credit issuer \(filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 26, 2012 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(i) — [Restatement Agreement, dated as of February 26, 2014, to \(i\) the Credit Agreement, dated as of November 17, 2006 and as amended and restated as of May 4, 2011, by and among the HCA Inc., HCA UK Capital Limited, the lenders party thereto and Bank of America, N.A., as administrative agent and collateral agent and \(ii\) the U.S. Guarantee, dated as of November 17, 2006 by and among the guarantors party thereto and Bank of America, N.A., as administrative agent \(filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed February 28, 2014 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(j) — [Supplement No. 14 dated as of November 9, 2015 to the U.S. Guarantee, dated as of November 17, 2006 and amended and restated on February 26, 2014, by and among the guarantors party thereto and Bank of America, N.A., as administrative agent \(filed as Exhibit 4.4\(j\) to the Company's Annual Report on Form 10-K filed February 21, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(k) — [Schedule of Omitted Supplements to the U.S. Guarantee dated as of November 17, 2006 and amended and restated on February 26, 2014, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.](#)
- 4.5(l) — [Restatement Agreement, dated as of June 28, 2017, to the Credit Agreement, dated as of November 17, 2006, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto \(filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed June 30, 2017 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(m) — [Joinder Agreement No. 8, dated as of July 16, 2019, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto \(filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed July 22, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(n) — [Joinder Agreement No. 9, dated as of October 8, 2019, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto \(filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed October 10, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.5(o) — [Joinder Agreement No. 10, dated as of November 20, 2019, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto \(filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed November 21, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.6(a) — [Security Agreement, dated as November 17, 2006, and amended and restated as of March 2, 2009, among the Company, the Subsidiary Grantors named therein and Bank of America, N.A., as Collateral Agent \(filed as Exhibit 4.10 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2008 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.6(b) — [Supplement No. 2 dated as of October 27, 2011, to the Amended and Restated Security Agreement dated as of March 2, 2009, as supplemented, by and among the subsidiary grantor named therein and Bank of America, N.A., as collateral agent \(filed as Exhibit 4.5\(b\) to the Company's Annual Report on Form 10-K filed February 21, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)

## Table of Contents

- 4.6(c) — [Schedule of Omitted Supplements to the Security Agreement dated as of November 17, 2006 and amended and restated as of March 2, 2009, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.](#)
- 4.7(a) — [Pledge Agreement, dated as of November 17, 2006, and amended and restated as of March 2, 2009, among the Company, the Subsidiary Pledgors named therein and Bank of America, N.A., as Collateral Agent \(filed as Exhibit 4.11 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2008 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.7(b) — [Supplement No. 1 dated as of October 27, 2011 to the Amended and Restated Pledge Agreement dated as of March 2, 2009, by and among the subsidiary pledgors named therein and Bank of America, N.A., as collateral agent \(filed as Exhibit 4.6\(b\) to the Company's Annual Report on Form 10-K filed February 21, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.7(c) — [Schedule of Omitted Supplements to the Pledge Agreement dated as of November 6, 2006 and amended and restated as of March 2, 2009, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.](#)
- 4.8(a) — [\\$2,500,000,000 Credit Agreement, dated as of September 30, 2011, by and among HCA Inc., the subsidiary borrowers party thereto, the lenders from time to time party thereto and Bank of America, N.A., as administrative agent \(filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed October 3, 2011 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.8(b) — [Restatement Agreement, dated as of March 7, 2014, to the Credit Agreement, dated as of September 30, 2011, by and among HCA Inc., the subsidiary borrowers party thereto, the lenders party thereto and Bank of America, N.A. as administrative agent and collateral agent \(filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed March 11, 2014 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.8(c) — [Joinder Agreement and Amendment No. 1, dated as of October 30, 2014, to the Credit Agreement, dated as of September 30, 2011 and amended and restated as of March 7, 2014, by and among HCA Inc., the subsidiary borrowers party thereto, the lenders party thereto and Bank of America, N.A. as administrative agent and collateral agent. \(filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed October 31, 2014 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.8(d) — [Restatement Agreement dated as of June 28, 2017, to the Credit Agreement, dated as of September 30, 2011 by and among HCA Inc., as borrower, the subsidiary borrowers party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto \(filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed June 30, 2017 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.8(e) — [Joinder Agreement dated as of January 3, 2018 to the Credit Agreement dated as of September 30, 2011 \(as amended and restated on March 7, 2014, as further amended on October 30, 2014, and as further amended and restated on June 28, 2017\), by and among the subsidiary borrowers party thereto and Bank of America, N.A., as administrative agent \(filed as Exhibit 4.7\(e\) to the Company's Annual Report on Form 10-K filed February 21, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.9(a) — [Security Agreement, dated as of September 30, 2011, by and among HCA Inc., the subsidiary borrowers party thereto and Bank of America, N.A., as collateral agent \(filed as Exhibit 4.5 to the Company's Current Report on Form 8-K filed October 3, 2011 \(File No. 001-11239\), and incorporated herein by reference\).](#)

## Table of Contents

- 4.9(b) — [Supplement No. 1 dated as of October 27, 2011 to the Security Agreement dated as of September 30, 2011, by and among the subsidiary borrower party thereto and Bank of America, N.A., as collateral agent \(filed as Exhibit 4.8\(b\) to the Company's Annual Report on Form 10-K filed February 21, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.9(c) — [Schedule of Omitted Supplements to the Security Agreement dated as of September 30, 2011, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.](#)
- 4.10(a) — [General Intercreditor Agreement, dated as of November 17, 2006, between Bank of America, N.A., as First Lien Collateral Agent, and The Bank of New York, as Junior Lien Collateral Agent \(filed as Exhibit 4.13\(a\) to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.10(b) — [Receivables Intercreditor Agreement, dated as of November 17, 2006, among Bank of America, N.A., as ABL Collateral Agent, Bank of America, N.A., as CF Collateral Agent and The Bank of New York, as Bonds Collateral Agent \(filed as Exhibit 4.13\(b\) to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.10(c) — [First Lien Intercreditor Agreement, dated as of April 22, 2009, among Bank of America, N.A. as Collateral Agent, Bank of America, N.A. as Authorized Representative under the Credit Agreement and Law Debenture Trust Company of New York as the Initial Additional Authorized Representative \(filed as Exhibit 4.5 to the Company's Current Report on Form 8-K filed April 28, 2009, and incorporated herein by reference\).](#)
- 4.10(d) — [Additional General Intercreditor Agreement, dated as of August 1, 2011, by and among Bank of America, N.A., in its capacity as First Lien Collateral Agent, The Bank of New York Mellon, in its capacity as Junior Lien Collateral Agent and in its capacity as trustee for the Second Lien Notes issued on November 17, 2006, and The Bank of New York Mellon Trust Company, N.A., in its capacity as trustee for the Second Lien Notes issued on February 19, 2009 \(filed as Exhibit 4.9 to the Company's Current Report on Form 8-K filed August 1, 2011 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.10(e) — [Additional Receivables Intercreditor Agreement, dated as of August 1, 2011 by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent \(filed as Exhibit 4.10 to the Company's Current Report on Form 8-K filed August 1, 2011 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.10(f) — [Additional General Intercreditor Agreement, dated as of February 16, 2012, by and among Bank of America, N.A., in its capacity as First Lien Collateral Agent, The Bank of New York Mellon, in its capacity as Junior Lien Collateral Agent and in its capacity as trustee for the Second Lien Notes issued on November 17, 2006, and The Bank of New York Mellon Trust Company, N.A., in its capacity as trustee for the Second Lien Notes issued on February 19, 2009 \(filed as Exhibit 4.9 to the Company's Current Report on Form 8-K filed February 16, 2012 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.10(g) — [Additional Receivables Intercreditor Agreement, dated as of February 16, 2012, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent \(filed as Exhibit 4.10 to the Company's Current Report on Form 8-K filed February 16, 2012 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.10(h) — [Additional General Intercreditor Agreement, dated as of October 23, 2012, by and among Bank of America, N.A., in its capacity as First Lien Collateral Agent, The Bank of New York Mellon, in its capacity as Junior Lien Collateral Agent and in its capacity as trustee for the Second Lien Notes issued on November 17, 2006, and The Bank of New York Mellon Trust Company, N.A., in its capacity as trustee for the Second Lien Notes issued on February 19, 2009 \(filed as Exhibit 4.10 to the Company's Current Report on Form 8-K filed October 23, 2012 \(File No. 001-11239\), and incorporated herein by reference\).](#)

## Table of Contents

- 4.10(i) — [Additional Receivables Intercreditor Agreement, dated as of October 23, 2012, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent \(filed as Exhibit 4.11 to the Company's Current Report on Form 8-K filed October 23, 2012 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.11 — [Registration Rights Agreement, dated as of November 22, 2010, among HCA Holdings, Inc., Hercules Holding II, LLC and certain other parties thereto \(filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed November 24, 2010 \(File No. 000-18406\), and incorporated herein by reference\).](#)
- 4.12 — [Registration Rights Agreement, dated as of March 16, 1989, by and among HCA-Hospital Corporation of America and the persons listed on the signature pages thereto \(filed as Exhibit 4.14 to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.13 — [Assignment and Assumption Agreement, dated as of February 10, 1994, between HCA-Hospital Corporation of America and the Company relating to the Registration Rights Agreement, as amended \(filed as Exhibit 4.15 to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.14(a) — [Indenture, dated as of December 16, 1993 between the Company and The First National Bank of Chicago, as Trustee \(filed as Exhibit 4.16\(a\) to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.14(b) — [First Supplemental Indenture, dated as of May 25, 2000 between the Company and Bank One Trust Company, N.A., as Trustee \(filed as Exhibit 4.16\(b\) to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.14(c) — [Second Supplemental Indenture, dated as of July 1, 2001 between the Company and Bank One Trust Company, N.A., as Trustee \(filed as Exhibit 4.16\(c\) to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.14(d) — [Third Supplemental Indenture, dated as of December 5, 2001 between the Company and The Bank of New York, as Trustee \(filed as Exhibit 4.16\(d\) to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.14(e) — [Fourth Supplemental Indenture, dated as of November 14, 2006, between the Company and The Bank of New York, as Trustee \(filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed November 16, 2006 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.15 — [Form of 7.5% Debentures due 2023 \(filed as Exhibit 4.17 to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.16 — [Form of 8.36% Debenture due 2024 \(filed as Exhibit 4.18 to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.17 — [Form of Fixed Rate Global Medium-Term Note \(filed as Exhibit 4.19 to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.18 — [Form of Floating Rate Global Medium-Term Note \(filed as Exhibit 4.20 to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.19 — [Form of 7.69% Note due 2025 \(filed as Exhibit 4.10 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2004 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.20 — [Form of 7.50% Debenture due 2095 \(filed as Exhibit 4.23 to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)

## Table of Contents

- 4.21 — [Form of 7.05% Debenture due 2027 \(filed as Exhibit 4.24 to the Company's Registration Statement on Form S-4 \(File No. 333-145054\), and incorporated herein by reference\).](#)
- 4.22 — [7.50% Note due 2033 in the principal amount of \\$250,000,000 \(filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed November 6, 2003 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.23 — [Form of Indenture of HCA Inc. \(filed as Exhibit 4.2 to the Registrant's Registration Statement on Form S-3 \(File No. 333-175791\), and incorporated herein by reference\).](#)
- 4.24 — [Indenture dated as of August 1, 2011, among HCA Inc., the guarantors named on Schedule I thereto, Delaware Trust Company \(as successor to Law Debenture Trust Company of New York\), as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.5 to the Company's Registration Statement on Form S-3 \(File No. 333-226709\), and incorporated herein by reference\).](#)
- 4.25 — [Supplemental Indenture No. 1, dated as of August 1, 2011, among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed August 1, 2011 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.26 — [Form of 7.50% Senior Notes due 2022 \(included in Exhibit 4.25\).](#)
- 4.27 — [Supplemental Indenture No. 5, dated as of October 23, 2012, among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(Unsecured Notes\) \(filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed October 23, 2012 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.28(a) — [Supplemental Indenture No. 6, dated as of October 23, 2012, among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(Secured Notes\) \(filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed October 23, 2012 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.28(b) — [Supplemental Indenture dated as of January 3, 2018, among the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.26\(b\) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.28(c) — [Schedule of Omitted Supplemental Indentures to Supplemental Indentures, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.](#)
- 4.29 — [Form of 5.875% Senior Notes due 2023 \(included in Exhibit 4.27\).](#)
- 4.30 — [Form of 4.75% Senior Secured Notes due 2023 \(included in Exhibit 4.28\(a\)\).](#)
- 4.31 — [Indenture, dated as of December 6, 2012, among HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as registrar, paying agent and transfer agent \(filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed December 6, 2012 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.32 — [Supplemental Indenture No. 1, dated as of December 6, 2012, among HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as registrar, paying agent and transfer agent \(filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed December 6, 2012 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.33 — [Form of 6.25% Senior Notes due 2021 \(included in Exhibit 4.32\).](#)

## Table of Contents

- 4.34 — [Supplemental Indenture No. 8, dated as of March 17, 2014, among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed March 21, 2014 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.35 — [Form of 5.00% Senior Secured Notes due 2024 \(included in Exhibit 4.34\).](#)
- 4.36 — [Additional Receivables Intercreditor Agreement, dated as of March 17, 2014, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent \(filed as Exhibit 4.9 to the Company's Current Report on Form 8-K filed March 21, 2014 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.37 — [Supplemental Indenture No. 10, dated as of October 17, 2014, among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed October 17, 2014 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.38 — [Form of 5.25% Senior Secured Notes due 2025 \(included in Exhibit 4.37\).](#)
- 4.39 — [Additional Receivables Intercreditor Agreement, dated as of October 17, 2014, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent \(filed as Exhibit 4.9 to the Company's Current Report on Form 8-K filed October 17, 2014 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.40 — [Supplemental Indenture No. 11, dated as of January 16, 2015, among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed January 16, 2015 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.41 — [Form of 5.375% Senior Notes due 2025 \(included in Exhibit 4.40\).](#)
- 4.42 — [Supplemental Indenture No. 12, dated as of May 20, 2015, among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed May 20, 2015 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.43 — [Supplemental Indenture No. 13, dated as of November 13, 2015, among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed November 13, 2015 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.44 — [Form of 5.875% Senior Notes due 2026 \(included in Exhibit 4.43\).](#)
- 4.45 — [Supplemental Indenture No. 14, dated as of December 8, 2015, among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed December 8, 2015 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.46 — [Supplemental Indenture No. 15, dated as of March 15, 2016, among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed March 15, 2016 \(File No. 001-11239\), and incorporated herein by reference\).](#)

## Table of Contents

- 4.47 — [Form of 5.250% Senior Secured Notes due 2026 \(included in Exhibit 4.46\).](#)
- 4.48 — [Additional Receivables Intercreditor Agreement, dated as of March 15, 2016, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as First Lien Collateral Agent \(filed as Exhibit 4.7 to the Company’s Current Report on Form 8-K filed March 15, 2016 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.49 — [Supplemental Indenture No. 16, dated as of August 15, 2016, among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.3 to the Company’s Current Report on Form 8-K filed August 15, 2016 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.50 — [Form of 4.500% Senior Secured Notes due 2027 \(included in Exhibit 4.49\).](#)
- 4.51 — [Additional Receivables Intercreditor Agreement, dated as of August 15, 2016, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as First Lien Collateral Agent \(filed as Exhibit 4.8 to the Company’s Current Report on Form 8-K filed August 15, 2016 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.52 — [Supplemental Indenture No. 17, dated as of December 9, 2016, among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.1 to the Company’s Current Report on Form 8-K filed December 9, 2016 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.53 — [Supplemental Indenture No. 18, dated as of June 22, 2017, among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.2 to the Company’s Current Report on Form 8-K filed on June 22, 2017 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.54 — [Form of 5.500% Senior Secured Notes due 2047 \(included in Exhibit 4.53\).](#)
- 4.55 — [Additional Receivables Intercreditor Agreement, dated as of June 22, 2017, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as First Lien Collateral Agent \(filed as Exhibit 4.7 to the Company’s Current Report on Form 8-K filed on June 22, 2017 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.56 — [Supplemental Indenture No. 19, dated as of August 23, 2018, among HCA Inc., HCA Healthcare, Inc., Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.2 to the Company’s Current Report on Form 8-K filed on August 23, 2018 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.57 — [Form of 5.375% Senior Notes Due 2026 \(included in Exhibit 4.56\).](#)
- 4.58 — [Supplemental Indenture No. 20, dated as of August 23, 2018, among HCA Inc., HCA Healthcare, Inc., Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.3 to the Company’s Current Report on Form 8-K filed on August 23, 2018 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.59 — [Form of 5.625% Senior Notes Due 2028 \(included in Exhibit 4.58\).](#)
- 4.60 — [Supplemental Indenture No. 21, dated as of January 22, 2019, among HCA Inc., HCA Healthcare, Inc., Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.4 to the Company’s Current Report on Form 8-K filed on January 22, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)

## Table of Contents

- 4.61 — [Supplemental Indenture No. 22, dated as of January 30, 2019, among HCA Inc., HCA Healthcare, Inc., Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed on January 30, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.62 — [Form of 5.875% Senior Notes Due 2029 \(included in Exhibit 4.61\).](#)
- 4.63 — [Supplemental Indenture No. 23, dated as of June 12, 2019, among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed on June 12, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.64 — [Supplemental Indenture No. 24, dated as of June 12, 2019, among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed June 12, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.65 — [Supplemental Indenture No. 25, dated as of June 12, 2019, among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent \(filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed June 12, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 4.66 — [Form of 4 1/8% Senior Secured Notes due 2029 \(included in Exhibit 4.63\).](#)
- 4.67 — [Form of 5 1/8% Senior Secured Notes due 2039 \(included in Exhibit 4.64\).](#)
- 4.68 — [Form of 5 1/4% Senior Secured Notes due 2049 \(included in Exhibit 4.65\).](#)
- 4.69 — [Additional Receivables Intercreditor Agreement, dated as of June 12, 2019, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as First Lien Collateral Agent \(filed as Exhibit 4.11 to the Company's Current Report on Form 8-K filed on June 12, 2019 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 10.1 — [Form of Indemnity Agreement with certain officers and directors \(filed as Exhibit 10.3 to the Company's Registration Statement on Form S-4 \(File No. 333-145054\) and incorporated herein by reference\).](#)
- 10.2(a) — [2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates as Amended and Restated \(filed as Exhibit 10.11\(b\) to the Company's Registration Statement on Form S-1 \(File No. 333-171369\), and incorporated herein by reference\).\\*](#)
- 10.2(b) — [First Amendment to 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as amended and restated \(filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.2(c) — [Second Amendment to the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as amended and restated \(filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.3(a) — [Management Stockholder's Agreement dated November 17, 2006 \(filed as Exhibit 10.12 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2006 \(File No. 001-11239\), and incorporated herein by reference\).](#)

## Table of Contents

- 10.3(b) — [Form of Omnibus Amendment to HCA Holdings, Inc.'s Management Stockholder's Agreements \(filed as Exhibit 10.39 to the Company's Registration Statement on Form S-1 \(File No. 333-171369\), and incorporated herein by reference\).](#)
- 10.4 — [Form of Stock Option Agreement \(2011\) \(filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.5(a) — [Form of Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed February 14, 2012 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.5(b) — [Form of 2014 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.17\(b\) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2013 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.6 — [Retirement Agreement between the Company and Thomas F. Frist, Jr., M.D. dated as of January 1, 2002 \(filed as Exhibit 10.30 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2001 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.7 — [Amended and Restated HCA Supplemental Executive Retirement Plan, effective December 22, 2010, except as provided therein \(filed as Exhibit 10.26 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2010 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.8 — [Amended and Restated HCA Restoration Plan, effective December 22, 2010 \(filed as Exhibit 10.27 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2010 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.9(a) — [Amended and Restated Employment Agreement dated September 10, 2018 \(R. Milton Johnson\) \(filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed September 12, 2018 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.9(b) — [Employment Agreement dated November 16, 2006 \(Samuel N. Hazen\) \(filed as Exhibit 10.27\(d\) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2006 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.9(c) — [Employment Agreement dated November 16, 2006 \(Charles J. Hall\) \(filed as Exhibit 10.28\(d\) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2012 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.9(d) — [Amendment to Employment Agreement effective February 9, 2011 \(Samuel N. Hazen\) \(filed as Exhibit 10.29\(j\) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2010 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.9(e) — [Second Amendment to Employment Agreement effective January 29, 2015 \(Samuel N. Hazen\) \(filed as Exhibit 10.23\(i\) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2014 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.9(f) — [Third Amendment to Employment Agreement effective January 27, 2016 \(Samuel N. Hazen\) \(filed as Exhibit 10.23\(j\) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2015 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.9(g) — [Amendment to Employment Agreement effective January 27, 2016 \(Charles J. Hall\) \(filed as Exhibit 10.23\(k\) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2015 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)

## Table of Contents

- 10.9(h) — [Fourth Amendment to Employment Agreement effective November 14, 2016 \(Samuel N. Hazen\) \(filed as Exhibit 10.16\(l\) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2016 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.9(i) — [Fifth Amendment to Employment Agreement effective January 1, 2019 \(Samuel N. Hazen\) \(filed as Exhibit 10.14\(i\) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.10 — [Indemnification Priority and Information Sharing Agreement, dated as of November 1, 2009, between HCA Inc. and certain other parties thereto \(filed as Exhibit 10.35 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2009 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 10.11 — [Assignment and Assumption Agreement, dated November 22, 2010, by and among HCA Inc., HCA Holdings, Inc. and HCA Merger Sub LLC \(filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed November 24, 2010 \(File No. 000-18406\), and incorporated herein by reference\).](#)
- 10.12 — [Omnibus Amendment to Various Stock and Option Plans and the Management Stockholders' Agreement, dated November 22, 2010 \(filed as Exhibit 10.2 to the Company's Current Report on Form 8-K filed November 24, 2010 \(File No. 000-18406\), and incorporated herein by reference\).\\*](#)
- 10.13 — [Omnibus Amendment to Stock Option Agreements Issued Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as amended, effective February 16, 2011 \(filed as Exhibit 10.38 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2010 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.14 — [Stockholders' Agreement, dated as of March 9, 2011, by and among the Company, Hercules Holding II, LLC and the other signatories thereto \(filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed March 16, 2011 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 10.15 — [Amendment, dated as of September 21, 2011, to the Stockholders' Agreement, dated as of March 9, 2011 \(filed as Exhibit 10.2 to the Company's Current Report on Form 8-K filed September 21, 2011 \(File No. 001-11239\), and incorporated herein by reference\).](#)
- 10.16 — [Form of Director Restricted Share Unit Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2011 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.17 — [Executive Severance Policy \(filed as Exhibit 10.46 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2013 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.18 — [HCA Holdings, Inc. Employee Stock Purchase Plan \(filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 25, 2014 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.19 — [Form of 2015 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed February 4, 2015 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.20 — [Form of 2016 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.50 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2015 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)

## Table of Contents

- 10.21 — [Form of Director Restricted Share Unit Agreement \(Annual Award\) Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.22 — [Form of 2017 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.42 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2016 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.23 — [Form of 2017 Performance Share Unit Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.43 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2016 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.24 — [HCA Holdings, Inc. 2017 Senior Officer Performance Excellence Program \(filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 3, 2017 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.25 — [Form of 2018 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.40 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2017 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.26 — [Form of 2018 Performance Share Unit Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.41 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2017 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.27 — [HCA Holdings, Inc. 2018 Senior Officer Performance Excellence Program \(filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 5, 2018 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.28 — [Form of 2019 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.41 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.29 — [Form of 2019 Performance Share Unit Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated \(filed as Exhibit 10.42 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.30 — [Form of Restricted Share Unit Agreement \(R. Milton Johnson\) \(filed as Exhibit 10.43 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.31 — [HCA Healthcare, Inc. 2019 Senior Officer Performance Excellence Program \(filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 2, 2019 \(File No. 001-11239\), and incorporated herein by reference\).\\*](#)
- 10.32 — [Form of 2020 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated.\\*](#)
- 10.33 — [Form of 2020 Performance Share Unit Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated.\\*](#)
- 21 — [List of Subsidiaries.](#)

---

## Table of Contents

23	—	<a href="#">Consent of Ernst &amp; Young LLP.</a>
31.1	—	<a href="#">Certification of Chief Executive Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.</a>
31.2	—	<a href="#">Certification of Chief Financial Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.</a>
32	—	<a href="#">Certification Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.</a>
101	—	The following financial information from our annual report on Form 10-K for the year ended December 31, 2019, filed with the SEC on February 20, 2020, formatted in Extensible Business Reporting Language (XBRL): (i) the consolidated balance sheets at December 31, 2019 and 2018, (ii) the consolidated income statements for the years ended December 31, 2019, 2018 and 2017, (iii) the consolidated comprehensive income statements for the years ended December 31, 2019, 2018 and 2017, (iv) the consolidated statements of stockholders' deficit for the years ended December 31, 2019, 2018 and 2017, (v) the consolidated statements of cash flows for the years ended December 31, 2019, 2018 and 2017, and (vi) the notes to consolidated financial statements.
104	—	The cover page from the Company's Annual Report on Form 10-K for the year ended December 31, 2019, formatted in Inline XBRL (included in Exhibit 101).

\* Management compensatory plan or arrangement.

### **Item 16. Form 10-K Summary**

None.



HCA HEALTHCARE, INC.

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

	<u>Page</u>
<a href="#">Report of Independent Registered Public Accounting Firm</a>	F- 2
Consolidated Financial Statements:	
<a href="#">Consolidated Income Statements for the years ended December 31, 2019, 2018 and 2017</a>	F- 5
<a href="#">Consolidated Comprehensive Income Statements for the years ended December 31, 2019, 2018 and 2017</a>	F- 6
<a href="#">Consolidated Balance Sheets, December 31, 2019 and 2018</a>	F- 7
<a href="#">Consolidated Statements of Stockholders' Deficit for the years ended December 31, 2019, 2018 and 2017</a>	F- 8
<a href="#">Consolidated Statements of Cash Flows for the years ended December 31, 2019, 2018 and 2017</a>	F- 9
<a href="#">Notes to Consolidated Financial Statements</a>	F- 10
<a href="#">Quarterly Consolidated Financial Information (Unaudited)</a>	F- 46

## Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders  
HCA Healthcare, Inc.

### Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of HCA Healthcare, Inc. (the Company) as of December 31, 2019 and 2018, the related consolidated statements of income, comprehensive income, stockholders' deficit and cash flows for each of the three years in the period ended December 31, 2019, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2019, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 20, 2020 expressed an unqualified opinion thereon.

### Adoption of New Accounting Standard

As discussed in Note 1 to the consolidated financial statements, effective January 1, 2019, the Company adopted ASU No. 2016-02, Leases (Topic 842), on a modified retrospective basis.

### Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

### Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the financial statements that were communicated or required to be communicated to the audit committee and that: (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

**Revenue Recognition**

*Description of the Matter*

For the year ended December 31, 2019, the Company's revenues were \$51.336 billion. As discussed in Note 1 to the consolidated financial statements, revenues are based upon the estimated amounts the Company expects to be entitled to receive from patients and third-party payers. Estimates of contractual allowances under managed care, commercial, and governmental insurance plans are based upon the payment terms specified in the related contractual agreements or as mandated under government payer programs. Management continually reviews the contractual allowances estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals. Revenues related to uninsured patients and uninsured copayment and deductible amounts for patients who have health care insurance coverage may have discounts applied (uninsured discounts and contractual discounts). The Company also records estimated implicit price concessions (based primarily on historical collection experience) related to uninsured accounts to record these revenues and accounts receivable at the estimated amounts the Company expects to collect. The primary collection risks relate to uninsured patient accounts, including amounts owed from patients after insurance has paid the amounts covered by the applicable agreement. Implicit price concessions relate primarily to amounts due directly from patients and are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators.

Auditing management's estimates of contractual allowances and implicit price concessions was complex and judgmental due to the significant data inputs and subjective assumptions utilized in determining related amounts.

*How We Addressed the Matter in Our Audit*

We tested internal controls that address the risks of material misstatement related to the measurement and valuation of revenues, including estimation of contractual allowances and implicit price concessions. For example, we tested management's internal controls over the key data inputs to the contractual allowances and implicit price concessions models, significant assumptions underlying management's models, and management's internal controls over retrospective hindsight reviews of historical reserve accuracy.

To test the estimated contractual allowances and implicit price concessions, we performed audit procedures that included, among others, assessing methodologies and evaluating the significant assumptions discussed above and testing the completeness and accuracy of the underlying data used by the Company in its estimates. We compared the significant assumptions used by management to current industry and economic trends and considered changes, if any, to the Company's business and other relevant factors. We also assessed the historical accuracy of management's estimates as a source of potential corroborative or contrary evidence.

**Professional Liability Claims**

*Description of the Matter*

At December 31, 2019, the Company's reserves for professional liability risks were \$1.827 billion and the Company's related provision for losses for the year ended December 31, 2019 was \$497 million. As discussed in Note 1 to the consolidated financial statements, reserves for professional liability risks represent the estimated ultimate cost of all reported and unreported losses incurred and unpaid as of the

---

[Table of Contents](#)

consolidated balance sheet date. Management determines professional liability reserves and provisions for losses using individual case-basis valuations and actuarial analyses. Trends in the average frequency (number of claims) and ultimate average severity (cost per claim) of claims are significant assumptions in estimating the reserves.

Auditing management's professional liability claims reserves was complex and judgmental due to the significant estimations required in determining the reserves, particularly the actuarial methodology and assumptions related to the severity and frequency of claims.

*How We Addressed the Matter  
in Our Audit*

We tested management's internal controls that address the risks of material misstatement over the Company's professional liability claims reserve estimation process. For example, we tested internal controls over management's review of the actuarial methodology and significant assumptions, and the completeness and accuracy of claims data supporting the recorded reserves.

To test the Company's determination of the estimated professional liability expense and reserves, we performed audit procedures that included, among others, testing the completeness and accuracy of underlying claims data used by the Company and its actuaries in its determination of reserves and reviewing the Company's insurance contracts to assess self-insured limits, deductibles and coverage limits. Additionally, with the involvement of our actuarial specialists, we performed audit procedures that included, among others, assessing the actuarial valuation methodologies utilized by management and its actuaries, testing the significant assumptions, including consideration of Company-specific claim reporting and payment data, assessing the accuracy of management's historical reserve estimates, and developing an independent range of reserves for comparison to the Company's recorded amounts.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 1994.

Nashville, Tennessee  
February 20, 2020

[Table of Contents](#)

**HCA HEALTHCARE, INC.**  
**CONSOLIDATED INCOME STATEMENTS**  
**FOR THE YEARS ENDED DECEMBER 31, 2019, 2018 AND 2017**  
**(Dollars in millions, except per share amounts)**

	<u>2019</u>	<u>2018</u>	<u>2017</u>
Revenues	<b>\$ 51,336</b>	\$ 46,677	\$ 43,614
Salaries and benefits	<b>23,560</b>	21,425	20,059
Supplies	<b>8,481</b>	7,724	7,316
Other operating expenses	<b>9,481</b>	8,608	8,051
Equity in earnings of affiliates	<b>(43)</b>	(29)	(45)
Depreciation and amortization	<b>2,596</b>	2,278	2,131
Interest expense	<b>1,824</b>	1,755	1,690
Gains on sales of facilities	<b>(18)</b>	(428)	(8)
Losses on retirement of debt	<b>211</b>	9	39
	<b>46,092</b>	41,342	39,233
Income before income taxes	<b>5,244</b>	5,335	4,381
Provision for income taxes	<b>1,099</b>	946	1,638
Net income	<b>4,145</b>	4,389	2,743
Net income attributable to noncontrolling interests	<b>640</b>	602	527
Net income attributable to HCA Healthcare, Inc.	<b>\$ 3,505</b>	\$ 3,787	\$ 2,216
Per share data:			
Basic earnings per share	<b>\$ 10.27</b>	\$ 10.90	\$ 6.12
Diluted earnings per share	<b>\$ 10.07</b>	\$ 10.66	\$ 5.95
Shares used in earnings per share calculations (in millions):			
Basic	<b>341.210</b>	347.297	362.305
Diluted	<b>348.226</b>	355.303	372.221

The accompanying notes are an integral part of the consolidated financial statements.

[Table of Contents](#)

**HCA HEALTHCARE, INC.**  
**CONSOLIDATED COMPREHENSIVE INCOME STATEMENTS**  
**FOR THE YEARS ENDED DECEMBER 31, 2019, 2018 AND 2017**  
**(Dollars in millions)**

	<u>2019</u>	<u>2018</u>	<u>2017</u>
Net income	<b>\$4,145</b>	\$4,389	\$2,743
Other comprehensive income (loss) before taxes:			
Foreign currency translation	5	(71)	97
Unrealized gains (losses) on available-for-sale securities	15	(7)	1
Realized gains included in other operating expenses	—	—	(2)
	<u>15</u>	<u>(7)</u>	<u>(1)</u>
Defined benefit plans	(63)	44	(43)
Pension costs included in salaries and benefits	13	21	18
	<u>(50)</u>	<u>65</u>	<u>(25)</u>
Change in fair value of derivative financial instruments	(50)	23	11
Interest (benefits) costs included in interest expense	(17)	(10)	20
	<u>(67)</u>	<u>13</u>	<u>31</u>
Other comprehensive (loss) income before taxes	<u>(97)</u>	—	102
Income taxes (benefits) related to other comprehensive income items	(18)	8	42
Other comprehensive (loss) income	<u>(79)</u>	<u>(8)</u>	<u>60</u>
Comprehensive income	<b>4,066</b>	4,381	2,803
Comprehensive income attributable to noncontrolling interests	640	602	527
Comprehensive income attributable to HCA Healthcare, Inc.	<u><b>\$3,426</b></u>	<u>\$3,779</u>	<u>\$2,276</u>

The accompanying notes are an integral part of the consolidated financial statements.

[Table of Contents](#)

**HCA HEALTHCARE, INC.**  
**CONSOLIDATED BALANCE SHEETS**  
**DECEMBER 31, 2019 AND 2018**  
**(Dollars in millions)**

	<u>2019</u>	<u>2018</u>
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents	\$ 621	\$ 502
Accounts receivable	7,380	6,789
Inventories	1,849	1,732
Other	1,346	1,190
	<u>11,196</u>	<u>10,213</u>
Property and equipment, at cost:		
Land	2,178	1,944
Buildings	17,669	15,659
Equipment	25,756	23,577
Construction in progress	1,632	1,785
	<u>47,235</u>	<u>42,965</u>
Accumulated depreciation	<u>(24,520)</u>	<u>(23,208)</u>
	22,715	19,757
Investments of insurance subsidiaries	315	362
Investments in and advances to affiliates	249	232
Goodwill and other intangible assets	8,269	7,953
Right-of-use operating lease assets	1,834	—
Other	480	690
	<u>\$ 45,058</u>	<u>\$ 39,207</u>
<b>LIABILITIES AND STOCKHOLDERS' DEFICIT</b>		
Current liabilities:		
Accounts payable	\$ 2,905	\$ 2,577
Accrued salaries	1,775	1,580
Other accrued expenses	2,932	2,624
Long-term debt due within one year	145	788
	<u>7,757</u>	<u>7,569</u>
Long-term debt, less debt issuance costs and discounts of \$ 239 and \$ 157	33,577	32,033
Professional liability risks	1,370	1,275
Right-of-use operating lease obligations	1,499	—
Income taxes and other liabilities	1,420	1,248
Stockholders' deficit:		
Common stock \$ 0.01 par; authorized 1,800,000,000 shares; outstanding 338,445,600 shares — 2019 and 342,895,200 shares — 2018	3	3
Accumulated other comprehensive loss	(460)	(381)
Retained deficit	(2,351)	(4,572)
Stockholders' deficit attributable to HCA Healthcare, Inc.	<u>(2,808)</u>	<u>(4,950)</u>
Noncontrolling interests	2,243	2,032
	<u>(565)</u>	<u>(2,918)</u>
	<u>\$ 45,058</u>	<u>\$ 39,207</u>

The accompanying notes are an integral part of the consolidated financial statements.

**HCA HEALTHCARE, INC.**  
**CONSOLIDATED STATEMENTS OF STOCKHOLDERS' DEFICIT**  
**FOR THE YEARS ENDED DECEMBER 31, 2019, 2018 AND 2017**  
**(Dollars in millions)**

	Equity (Deficit) Attributable to HCA Healthcare, Inc.					Equity Attributable to Noncontrolling Interests	Total
	Common Stock		Capital in Excess of Par Value	Accumulated Other Comprehensive Loss	Retained Deficit		
	Shares (in millions)	Par Value					
Balances, December 31, 2016	370.536	\$ 4	\$ —	\$ (338)	\$ (6,968)	\$ 1,669	\$(5,633)
Comprehensive income				60	2,216	527	2,803
Repurchase of common stock	(25.092)		(271)		(1,780)		(2,051)
Share-based benefit plans	4.648		281				281
Distributions						(448)	(448)
Other			(10)			63	53
Balances, December 31, 2017	350.092	4	—	(278)	(6,532)	1,811	(4,995)
Comprehensive income (loss)				(8)	3,787	602	4,381
Repurchase of common stock	(14.070)	(1)	(103)		(1,426)		(1,530)
Share-based benefit plans	6.873		115				115
Cash dividends declared (\$ 1.40 share)					(496)		(496)
Distributions						(441)	(441)
Reclassification of stranded tax effects				(95)	95		—
Other			(12)			60	48
Balances, December 31, 2018	342.895	3	—	(381)	(4,572)	2,032	(2,918)
Comprehensive income (loss)				(79)	3,505	640	4,066
Repurchase of common stock	(7.949)		(302)		(729)		(1,031)
Share-based benefit plans	3.500		313				313
Cash dividends declared (\$ 1.60 share)					(555)		(555)
Distributions						(542)	(542)
Other			(11)			113	102
Balances, December 31, 2019	<u>338.446</u>	<u>\$ 3</u>	<u>\$ —</u>	<u>\$ (460)</u>	<u>\$ (2,351)</u>	<u>\$ 2,243</u>	<u>\$ (565)</u>

The accompanying notes are an integral part of the consolidated financial statements.

[Table of Contents](#)

**HCA HEALTHCARE, INC.**  
**CONSOLIDATED STATEMENTS OF CASH FLOWS**  
**FOR THE YEARS ENDED DECEMBER 31, 2019, 2018 AND 2017**  
(Dollars in millions)

	2019	2018	2017
<b>Cash flows from operating activities:</b>			
Net income	\$ 4,145	\$ 4,389	\$ 2,743
Adjustments to reconcile net income to net cash provided by operating activities:			
Increase (decrease) in cash from operating assets and liabilities:			
Accounts receivable	(326)	(423)	(601)
Inventories and other assets	(158)	(242)	(69)
Accounts payable and accrued expenses	396	698	374
Depreciation and amortization	2,596	2,278	2,131
Income taxes	250	74	433
Gains on sales of facilities	(18)	(428)	(8)
Losses on retirement of debt	211	9	39
Amortization of debt issuance costs	30	31	31
Share-based compensation	347	268	270
Other	129	107	83
Net cash provided by operating activities	<u>7,602</u>	<u>6,761</u>	<u>5,426</u>
<b>Cash flows from investing activities:</b>			
Purchase of property and equipment	(4,158)	(3,573)	(3,015)
Acquisition of hospitals and health care entities	(1,682)	(1,253)	(1,212)
Sales of hospitals and health care entities	61	808	25
Change in investments	25	57	(73)
Other	34	60	(4)
Net cash used in investing activities	<u>(5,720)</u>	<u>(3,901)</u>	<u>(4,279)</u>
<b>Cash flows from financing activities:</b>			
Issuances of long-term debt	6,451	2,000	1,502
Net change in revolving bank credit facilities	(560)	(640)	760
Repayment of long-term debt	(5,324)	(1,704)	(753)
Distributions to noncontrolling interests	(542)	(441)	(448)
Payment of debt issuance costs	(73)	(25)	(26)
Payment of dividends	(550)	(487)	—
Repurchases of common stock	(1,031)	(1,530)	(2,051)
Other	(142)	(248)	(45)
Net cash used in financing activities	<u>(1,771)</u>	<u>(3,075)</u>	<u>(1,061)</u>
Effect of exchange rate changes on cash and cash equivalents	8	(15)	—
Change in cash and cash equivalents	119	(230)	86
Cash and cash equivalents at beginning of period	502	732	646
Cash and cash equivalents at end of period	<u>\$ 621</u>	<u>\$ 502</u>	<u>\$ 732</u>
Interest payments	<u>\$ 1,914</u>	<u>\$ 1,744</u>	<u>\$ 1,700</u>
Income tax payments, net	<u>\$ 849</u>	<u>\$ 872</u>	<u>\$ 1,205</u>

The accompanying notes are an integral part of the consolidated financial statements.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 — ACCOUNTING POLICIES

*Reporting Entity*

HCA Healthcare, Inc. is a holding company whose affiliates own and operate hospitals and related health care entities. The term “affiliates” includes direct and indirect subsidiaries of HCA Healthcare, Inc. and partnerships and joint ventures in which such subsidiaries are partners. At December 31, 2019, these affiliates owned and operated 184 hospitals, 123 freestanding surgery centers and provided extensive outpatient and ancillary services. HCA Healthcare, Inc.’s facilities are located in 21 states and England. The terms “Company,” “HCA,” “we,” “our” or “us,” as used herein and unless otherwise stated or indicated by context, refer to HCA Healthcare, Inc. and its affiliates. The terms “facilities” or “hospitals” refer to entities owned and operated by affiliates of HCA and the term “employees” refers to employees of affiliates of HCA.

*Basis of Presentation*

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

The consolidated financial statements include all subsidiaries and entities controlled by HCA. We generally define “control” as ownership of a majority of the voting interest of an entity. The consolidated financial statements include entities in which we absorb a majority of the entity’s expected losses, receive a majority of the entity’s expected residual returns, or both, as a result of ownership, contractual or other financial interests in the entity. The accounts of acquired entities are included in our consolidated financial statements for periods subsequent to our acquisition of controlling interests. Significant intercompany transactions have been eliminated. Investments in entities we do not control, but in which we have a substantial ownership interest and can exercise significant influence, are accounted for using the equity method.

The majority of our expenses are “cost of revenue” items. Costs that could be classified as general and administrative include our corporate office costs, which were \$370 million, \$344 million and \$340 million for the years ended December 31, 2019, 2018 and 2017, respectively.

*Revenues*

Our revenues generally relate to contracts with patients in which our performance obligations are to provide health care services to the patients. Revenues are recorded during the period our obligations to provide health care services are satisfied. Our performance obligations for inpatient services are generally satisfied over periods that average approximately five days, and revenues are recognized based on charges incurred in relation to total expected charges. Our performance obligations for outpatient services are generally satisfied over a period of less than one day. The contractual relationships with patients, in most cases, also involve a third-party payer (Medicare, Medicaid, managed care health plans and commercial insurance companies, including plans offered through the health insurance exchanges) and the transaction prices for the services provided are dependent upon the terms provided by (Medicare and Medicaid) or negotiated with (managed care health plans and commercial insurance companies) the third-party payers. The payment arrangements with third-party payers for the services we provide to the related patients typically specify payments at amounts less than our standard charges. Medicare generally pays for inpatient and outpatient services at prospectively determined rates based on clinical, diagnostic and other factors. Services provided to patients having Medicaid coverage are generally paid at prospectively determined rates per discharge, per identified service or per covered member. Agreements with commercial insurance carriers, managed care and preferred provider organizations generally provide for payments based

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 — ACCOUNTING POLICIES (continued)

*Revenues (continued)*

upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals.

Our revenues are based upon the estimated amounts we expect to be entitled to receive from patients and third-party payers. Estimates of contractual adjustments under managed care and commercial insurance plans are based upon the payment terms specified in the related contractual agreements. Revenues related to uninsured patients and uninsured copayment and deductible amounts for patients who have health care coverage may have discounts applied (uninsured discounts and contractual discounts). We also record estimated implicit price concessions (based primarily on historical collection experience) related to uninsured accounts to record these revenues at the estimated amounts we expect to collect. Our revenues by primary third-party payer classification and other (including uninsured patients) for the years ended December 31, are summarized in the following table (dollars in millions):

	Years Ended December 31,					
	2019	Ratio	2018	Ratio	2017	Ratio
Medicare	\$10,798	21.0%	\$ 9,831	21.1%	\$ 9,285	21.3%
Managed Medicare	6,452	12.6	5,497	11.8	4,680	10.7
Medicaid	1,572	3.1	1,358	2.9	1,316	3.0
Managed Medicaid	2,450	4.8	2,403	5.1	2,165	5.0
Managed care and other insurers	26,544	51.6	24,467	52.4	23,342	53.5
International (managed care and other insurers)	1,162	2.3	1,156	2.5	1,097	2.5
Other	2,358	4.6	1,965	4.2	1,729	4.0
Revenues	<u>\$51,336</u>	<u>100.0%</u>	<u>\$46,677</u>	<u>100.0%</u>	<u>\$43,614</u>	<u>100.0%</u>

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Estimated reimbursement amounts are adjusted in subsequent periods as cost reports are prepared and filed and as final settlements are determined (in relation to certain government programs, primarily Medicare, this is generally referred to as the “cost report” filing and settlement process). The adjustments to estimated Medicare and Medicaid reimbursement amounts and disproportionate-share funds related primarily to cost reports filed during the respective year resulted in net increases to revenues of \$51 million, \$29 million and \$41 million in 2019, 2018 and 2017, respectively. The adjustments to estimated reimbursement amounts related primarily to cost reports filed during previous years resulted in net increases to revenues of \$13 million, \$51 million and \$56 million in 2019, 2018 and 2017, respectively.

The Emergency Medical Treatment and Labor Act (“EMTALA”) requires any hospital participating in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital’s emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize the condition or make an appropriate transfer of the individual to a facility able to handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual’s ability to pay for treatment. Federal and state laws and regulations require, and our commitment to providing quality patient care encourages, us to provide services to patients who are financially unable to pay for the health care services they receive.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**NOTE 1 — ACCOUNTING POLICIES (continued)**

*Revenues (continued)*

Prior to November 2017, patients treated at hospitals for non-elective care, who have income at or below 200% of the federal poverty level, were eligible for charity care. During November 2017, we expanded our charity policy to include patients who have income above 200%, but at or below 400%, of the federal poverty level and we limit the patient responsibility amounts for these patients to a percentage of their annual household income, computed on a sliding scale based upon their annual income and the applicable percentage of the federal poverty level. The federal poverty level is established by the federal government and is based on income and family size. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in revenues. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care. We may attempt to provide assistance to uninsured patients to help determine whether they may qualify for Medicaid, other federal or state assistance, or charity care. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

The collection of outstanding receivables for Medicare, Medicaid, managed care payers, other third-party payers and patients is our primary source of cash and is critical to our operating performance. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. Implicit price concessions relate primarily to amounts due directly from patients. Estimated implicit price concessions are recorded for all uninsured accounts, regardless of the age of those accounts. Accounts are written off when all reasonable internal and external collection efforts have been performed.

The estimates for implicit price concessions are based upon management's assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical writeoffs and collections at facilities that represent a majority of our revenues and accounts receivable (the "hindsight analysis") as a primary source of information in estimating the collectability of our accounts receivable. We perform the hindsight analysis quarterly, utilizing rolling twelve-months accounts receivable collection and writeoff data. We believe our quarterly updates to the estimated implicit price concession amounts at each of our hospital facilities provide reasonable estimates of our revenues and valuations of our accounts receivable. These routine, quarterly changes in estimates have not resulted in material adjustments to the valuations of our accounts receivable or period-to-period comparisons of our results of operations. At December 31, 2019 and 2018, estimated implicit price concessions of \$6.953 billion and \$6.280 billion, respectively, had been recorded to adjust our revenues and accounts receivable to the estimated amounts we expect to collect.

## HCA HEALTHCARE, INC.

## NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

## NOTE 1 — ACCOUNTING POLICIES (continued)

*Revenues (continued)*

To quantify the total impact of the trends related to uninsured patient accounts, we believe it is beneficial to view total uncompensated care, which is comprised of charity care, uninsured discounts and implicit price concessions. A summary of the estimated cost of total uncompensated care for the years ended December 31, follows (dollars in millions):

	<u>2019</u>	<u>2018</u>	<u>2017</u>
Patient care costs (salaries and benefits, supplies, other operating expenses and depreciation and amortization)	<u>\$44,118</u>	<u>\$40,035</u>	<u>\$37,557</u>
Cost-to-charges ratio (patient care costs as percentage of gross patient charges)	<u>12.0%</u>	<u>12.4%</u>	<u>12.9%</u>
Total uncompensated care	<u>\$31,105</u>	<u>\$26,757</u>	<u>\$23,420</u>
Multiply by the cost-to-charges ratio	<u>12.0%</u>	<u>12.4%</u>	<u>12.9%</u>
Estimated cost of total uncompensated care	<u>\$ 3,733</u>	<u>\$ 3,318</u>	<u>\$ 3,021</u>

The total uncompensated care amounts include charity care of \$13.260 billion, \$8.611 billion and \$4.861 billion. The estimated costs of charity care were \$1.591 billion, \$1.068 billion and \$627 million for the years ended December 31, 2019, 2018 and 2017, respectively.

*Cash and Cash Equivalents*

Cash and cash equivalents include highly liquid investments with a maturity of three months or less when purchased. Our insurance subsidiaries' cash equivalent investments in excess of the amounts required to pay estimated professional liability claims during the next twelve months are not included in cash and cash equivalents as these funds are not available for general corporate purposes. Carrying values of cash and cash equivalents approximate fair value due to the short-term nature of these instruments.

Our cash management system provides for daily investment of available balances and the funding of outstanding checks when presented for payment. Outstanding, but unrepresented, checks totaling \$486 million and \$449 million at December 31, 2019 and 2018, respectively, have been included in "accounts payable" in the consolidated balance sheets. Upon presentation for payment, these checks are funded through available cash balances or our credit facility.

*Accounts Receivable*

We receive payments for services rendered from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, employers and patients. We recognize that revenues and receivables from government agencies are significant to our operations, but do not believe there are significant credit risks associated with these government agencies. We do not believe there are any other significant concentrations of revenues from any particular payer that would subject us to any significant credit risks in the collection of our accounts receivable. Days revenues in accounts receivable were 50 days, 51 days and 52 days at December 31, 2019, 2018 and 2017, respectively. Changes in general economic conditions, patient accounting service center operations, payer mix, or federal or state governmental health care coverage could affect our collection of accounts receivable, cash flows and results of operations.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**NOTE 1 — ACCOUNTING POLICIES (continued)**

*Inventories*

Inventories are stated at the lower of cost (first-in, first-out) or market.

*Property and Equipment*

Depreciation expense, computed using the straight-line method, was \$2.579 billion in 2019, \$2.262 billion in 2018 and \$2.111 billion in 2017. Buildings and improvements are depreciated over estimated useful lives ranging generally from 10 to 40 years. Estimated useful lives of equipment vary generally from four to 10 years.

When events, circumstances or operating results indicate the carrying values of certain long-lived assets expected to be held and used might be impaired, we prepare projections of the undiscounted future cash flows expected to result from the use of the assets and their eventual disposition. If the projections indicate the recorded amounts are not expected to be recoverable, such amounts are reduced to estimated fair value. Fair value may be estimated based upon internal evaluations that include quantitative analyses of revenues and cash flows, reviews of recent sales of similar assets and independent appraisals.

Long-lived assets to be disposed of are reported at the lower of their carrying amounts or fair value less costs to sell or close. The estimates of fair value are usually based upon recent sales of similar assets and market responses based upon discussions with and offers received from potential buyers.

*Investments of Insurance Subsidiaries*

At December 31, 2019 and 2018, the investments of our 100% owned insurance subsidiaries were classified as “available-for-sale” as defined in Accounting Standards Codification (“ASC”) No. 320, *Investments — Debt Securities* and are recorded at fair value. The investment securities are held for the purpose of providing a funding source to pay liability claims covered by the insurance subsidiaries. We perform quarterly assessments of individual investment securities to determine whether declines in fair value are due to credit-related or noncredit-related factors. Our investment securities evaluation process involves subjective judgments, often involves estimating the outcome of future events, and requires a significant level of professional judgment in determining whether a credit-related impairment has occurred. We evaluate, among other things, the financial position and near term prospects of the issuer, conditions in the issuer’s industry, liquidity of the investment, changes in the amount or timing of expected future cash flows from the investment, and recent downgrades of the issuer by a rating agency, to determine if, and when, a decline in the fair value of an investment below amortized cost is considered to be a credit-related impairment. The extent to which the fair value of the investment is less than amortized cost and our ability and intent to retain the investment, to allow for any anticipated recovery of the investment’s fair value, are important components of our investment securities evaluation process.

*Goodwill and Intangible Assets*

Goodwill is not amortized but is subject to annual impairment tests. In addition to the annual impairment review, impairment reviews are performed whenever circumstances indicate a possible impairment may exist. Impairment testing for goodwill is done at the reporting unit level. Reporting units are one level below the business segment level, and our impairment testing is performed at the operating division level. We compare the fair value of the reporting unit assets to the carrying amount, on at least an annual basis, to determine if there is potential impairment. If the fair value of the reporting unit assets is less than their carrying value, an impairment loss is recognized. Fair value is estimated based upon internal evaluations of each reporting unit that include

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**NOTE 1 — ACCOUNTING POLICIES (continued)**

*Goodwill and Intangible Assets (continued)*

quantitative analyses of market multiples, revenues and cash flows and reviews of recent sales of similar facilities. No goodwill impairments were recognized during 2019, 2018 or 2017.

During 2019, goodwill increased by \$332 million related to acquisitions and declined by \$4 million related to foreign currency translation and other adjustments. During 2018, goodwill increased by \$636 million related to acquisitions and declined by \$60 million related to foreign currency translation and other adjustments.

During 2019, identifiable intangible assets declined by \$12 million due to amortization, foreign currency translation and other adjustments. During 2018, identifiable intangible assets declined by \$17 million due to amortization, foreign currency translation and other adjustments. Identifiable intangible assets are amortized over estimated lives ranging generally from three to 10 years. The gross carrying amount of identifiable intangible assets at both December 31, 2019 and 2018 was \$184 million and accumulated amortization was \$123 million and \$111 million, respectively. The gross carrying amount of indefinite-lived identifiable intangible assets at both December 31, 2019 and 2018 was \$269 million. Indefinite-lived identifiable intangible assets are not amortized but are subject to annual impairment tests, and impairment reviews are performed whenever circumstances indicate a possible impairment may exist.

*Debt Issuance Costs and Discounts*

Debt issuance costs and discounts are amortized based upon the terms of the respective debt obligations. The gross carrying amount of debt issuance costs and discounts at December 31, 2019 and 2018 was \$413 million and \$360 million, respectively, and accumulated amortization was \$174 million and \$203 million, respectively. Amortization of debt issuance costs and discounts is included in interest expense and was \$30 million, \$31 million and \$31 million for 2019, 2018 and 2017, respectively.

*Professional Liability Claims*

Reserves for professional liability risks were \$1.827 billion and \$1.741 billion at December 31, 2019 and 2018, respectively. The current portion of the reserves, \$457 million and \$466 million at December 31, 2019 and 2018, respectively, is included in “other accrued expenses” in the consolidated balance sheets. Provisions for losses related to professional liability risks were \$497 million, \$447 million and \$466 million for 2019, 2018 and 2017, respectively, and are included in “other operating expenses” in our consolidated income statements. Provisions for losses related to professional liability risks are based upon actuarially determined estimates. During 2019 and 2018, we recorded reductions to the provision for professional liability risks of \$50 million and \$70 million, respectively, due to the receipt of updated actuarial information. Loss and loss expense reserves represent the estimated ultimate net cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves for unpaid losses and loss expenses are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. Adjustments to the estimated reserve amounts are included in current operating results. The reserves for professional liability risks cover approximately 2,300 and 2,200 individual claims at December 31, 2019 and 2018, respectively, and estimates for unreported potential claims. The time period required to resolve these claims can vary depending upon the jurisdiction and whether the claim is settled or litigated. During 2019 and 2018, \$408 million and \$358 million, respectively, of net payments were made for professional and general liability claims. The estimation of the timing of payments beyond a year can vary.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**NOTE 1 — ACCOUNTING POLICIES (continued)**

*Professional Liability Claims (continued)*

significantly. Although considerable variability is inherent in professional liability reserve estimates, we believe the reserves for losses and loss expenses are adequate; however, there can be no assurance the ultimate liability will not exceed our estimates.

A portion of our professional liability risks is insured through a 100% owned insurance subsidiary. Subject, in most cases, to a \$ 15 million per occurrence self-insured retention, our facilities are insured by our 100% owned insurance subsidiary for losses up to \$ 50 million per occurrence. The insurance subsidiary has obtained reinsurance for professional liability risks generally above a retention level of \$25 million per occurrence. We also maintain professional liability insurance with unrelated commercial carriers for losses in excess of amounts insured by our insurance subsidiary.

The obligations covered by reinsurance and excess insurance contracts are included in the reserves for professional liability risks, as we remain liable to the extent the reinsurers and excess insurance carriers do not meet their obligations under the reinsurance and excess insurance contracts. The amounts receivable under the reinsurance contracts include \$37 million and \$40 million at December 31, 2019 and 2018, respectively, recorded in “other assets,” and \$9 million and \$10 million at December 31, 2019 and 2018, respectively, recorded in “other current assets.”

*Financial Instruments*

Derivative financial instruments are employed to manage interest rate risks, and are not used for trading or speculative purposes. We recognize our interest rate swap derivative instruments in the consolidated balance sheets at fair value. Changes in the fair value of derivatives are recognized periodically in stockholders’ equity, as a component of other comprehensive income (loss), provided the derivative financial instrument qualifies for hedge accounting. Gains and losses on derivatives designated as cash flow hedges, to the extent they are effective, are recorded in other comprehensive income (loss), and subsequently reclassified to earnings to offset the impact of the forecasted transactions when they occur. In the event the forecasted transaction to which a cash flow hedge relates is no longer likely, the amount in other comprehensive income is recognized in earnings and generally the derivative is terminated.

The net interest paid or received on interest rate swaps is recognized as adjustments to interest expense. Gains and losses resulting from the early termination of interest rate swap agreements are deferred and amortized as adjustments to interest expense over the remaining term of the debt originally associated with the terminated swap.

*Noncontrolling Interests in Consolidated Entities*

The consolidated financial statements include all assets, liabilities, revenues and expenses of less than 100% owned entities that we control. Accordingly, we have recorded noncontrolling interests in the earnings and equity of such entities.

*Reclassifications*

Certain prior year amounts have been reclassified to conform to the 2019 presentation.

## HCA HEALTHCARE, INC.

## NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

## NOTE 2 — SHARE-BASED COMPENSATION

*Stock Incentive Plan*

Our stock incentive plan is designed to promote the long term financial interests and growth of the Company by attracting and retaining management and other personnel, motivating them to achieve long range goals and aligning their interests with those of our stockholders through opportunities for stock-based compensation and stock ownership in the Company. Stock option, stock appreciation right (“SARs”) and restricted share unit (“RSUs”) grants vest solely based upon continued employment over a specific period of time, and performance share unit (“PSUs”) grants vest based upon both continued employment over a specific period of time and the achievement of predetermined financial targets over time. At December 31, 2019, there were 20.328 million shares available for future grants under the stock incentive plan.

*Employee Stock Purchase Plan*

Our employee stock purchase plan (“ESPP”) provides our participating employees an opportunity to obtain shares of our common stock at a discount (through payroll deductions over three-month periods). At December 31, 2019, 6.883 million shares of common stock were reserved for issuance under the ESPP provisions. During 2019, 2018 and 2017, the Company recognized \$12 million, \$10 million and \$9 million, respectively, of compensation expense related to the ESPP.

*Stock Option, SAR, RSU and PSU Activity*

The fair value of each stock option and SAR award is estimated on the grant date, using valuation models and the weighted average assumptions indicated in the following table. Awards under our stock incentive plan generally vest based on continued employment (“Time Stock Options and SARs” and “Time RSUs”) and based upon continued employment and the achievement of certain financial targets (“Performance Stock Options and SARs”, “Performance RSUs” and “PSUs”). PSUs have a three-year cumulative earnings per share target, and the number of PSUs earned can vary from zero (for actual performance of less than 90% of target for 2019 grants and 80% of target for 2018 and prior grants) to two times the original PSU grant (for actual performance of 110% or more of target for 2019 grants and 120% or more of target for 2018 and prior grants). Each grant is valued as a single award with an expected term equal to the average expected term of the component vesting tranches. The expected term of the share-based award is limited by the contractual term. We use historical exercise behavior data and other factors to estimate the expected term of the options and SARs.

Compensation cost is recognized on the straight-line attribution method. The straight-line attribution method requires that total compensation expense recognized must at least equal the vested portion of the grant-date fair value. The expected volatility is derived using historical stock price information for our common stock and the volatility implied by the trading of options to purchase our stock on open-market exchanges. The risk-free interest rate is the approximate yield on United States Treasury Strips having a life equal to the expected share-based award life on the date of grant. The expected life is an estimate of the number of years a share-based award will be held before it is exercised. The expected dividend yield is estimated based on the assumption that the dividend yield at date of grant will be maintained over the expected life of the grant.

	<u>2019</u>	<u>2018</u>	<u>2017</u>
Risk-free interest rate	2.50%	2.62%	2.13%
Expected volatility	27%	29%	31%
Expected life, in years	6.18	6.15	6.17
Expected dividend yield	1.16%	1.37%	—

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 2 — SHARE-BASED COMPENSATION (continued)

*Stock Option, SAR, RSU and PSU Activity (continued)*

Information regarding Time Stock Options and SARs and Performance Stock Options and SARs activity during 2019, 2018 and 2017 is summarized below (share amounts in thousands):

	Time Stock Options and SARs	Performance Stock Options and SARs	Total Stock Options and SARs	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value (dollars in millions)
Options and SARs outstanding, December 31, 2016	10,936	6,130	17,066	\$ 35.65		
Granted	1,879	—	1,879	81.83		
Exercised	(1,549)	(1,366)	(2,915)	21.49		
Cancelled	(110)	(178)	(288)	52.92		
Options and SARs outstanding, December 31, 2017	11,156	4,586	15,742	43.47		
Granted	2,342	—	2,342	101.96		
Exercised	(3,917)	(1,774)	(5,691)	27.86		
Cancelled	(221)	(145)	(366)	68.43		
Options and SARs outstanding, December 31, 2018	9,360	2,667	12,027	61.49		
Granted	1,349	—	1,349	138.31		
Exercised	(1,137)	(523)	(1,660)	44.45		
Cancelled	(522)	—	(522)	93.26		
Options and SARs outstanding, December 31, 2019	<b>9,050</b>	<b>2,144</b>	<b>11,194</b>	<b>\$ 71.79</b>	<b>5.7 years</b>	<b>\$ 851</b>
Options and SARs exercisable, December 31, 2019	<b>5,273</b>	<b>2,144</b>	<b>7,417</b>	<b>\$ 53.09</b>	<b>4.4 years</b>	<b>\$ 703</b>

The weighted average fair values of stock options and SARs granted during 2019, 2018 and 2017 were \$38.21, \$28.90 and \$28.47 per share, respectively. The total intrinsic value of stock options and SARs exercised during 2019, 2018 and 2017 was \$153 million, \$456 million and \$177 million, respectively. The total fair value of RSUs and PSUs that vested during 2019, 2018 and 2017 was \$346 million, \$413 million and \$188 million, respectively. As of December 31, 2019, the unrecognized compensation cost related to nonvested stock options and SARs was \$73 million.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 2 — SHARE-BASED COMPENSATION (continued)

*Stock Option, SAR, RSU and PSU Activity (continued)*

Information regarding Time RSUs, Performance RSUs and PSUs activity during 2019, 2018 and 2017 is summarized below (share amounts in thousands):

	Time RSUs	Performance RSUs	PSUs	Total RSUs and PSUs	Weighted Average Grant Date Fair Value
RSUs and PSUs outstanding, December 31, 2016	4,111	790	2,386	7,287	\$ 61.21
Granted	1,484	—	1,304	2,788	81.90
Vested	(1,824)	(430)	—	(2,254)	51.20
Cancelled	(306)	(133)	(128)	(567)	64.06
RSUs and PSUs outstanding, December 31, 2017	3,465	227	3,562	7,254	72.05
Granted	1,464	—	1,261	2,725	101.85
Performance adjustment	—	—	1,250	1,250	69.27
Vested	(1,487)	(136)	(2,500)	(4,123)	67.33
Cancelled	(319)	(91)	(151)	(561)	78.82
RSUs and PSUs outstanding, December 31, 2018	3,123	—	3,422	6,545	86.32
Granted	973	—	796	1,769	138.45
Performance adjustment	—	—	227	227	69.94
Vested	(1,216)	—	(1,251)	(2,467)	75.97
Cancelled	(260)	—	(159)	(419)	103.27
RSUs and PSUs outstanding, December 31, 2019	<u>2,620</u>	<u>—</u>	<u>3,035</u>	<u>5,655</u>	<u>\$ 105.23</u>

As of December 31, 2019, the unrecognized compensation cost related to RSUs and PSUs was \$338 million.

NOTE 3 — ACQUISITIONS AND DISPOSITIONS

During 2019, we paid \$1.384 billion to acquire a seven-hospital health system in North Carolina and \$298 million to acquire nonhospital health care entities. During 2018, we paid \$792 million to acquire two hospital facilities and \$461 million to acquire nonhospital health care entities. During 2017, we paid \$1.000 billion to acquire eight hospital facilities and \$212 million to acquire nonhospital health care entities. Purchase price amounts have been allocated to the related assets acquired and liabilities assumed based upon their respective fair values. The purchase price paid in excess of the fair value of identifiable net assets of these acquired entities aggregated \$332 million, \$636 million and \$693 million in 2019, 2018 and 2017, respectively. The consolidated financial statements include the accounts and operations of the acquired entities subsequent to the respective acquisition dates. The pro forma effects of these acquired entities on our results of operations for periods prior to the respective acquisition dates were not significant.

During 2019, we received proceeds of \$25 million and recognized a pretax loss of \$1 million (\$1 million after tax) related to the sale of a hospital facility from our American Group (a Louisiana market). During 2019, we also received proceeds of \$36 million and recognized pretax gain s of \$19 million (\$14 million after tax) related to sales of real estate and other investments. During 2018, we received proceeds of \$758 million and recognized a pretax gain of \$353 million (\$265 million after tax) related to the sale of two hospital facilities from our American Group (Oklahoma market). During 2018, we also received proceeds of \$50 million and recognized

## HCA HEALTHCARE, INC.

## NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

## NOTE 3 — ACQUISITIONS AND DISPOSITIONS ( continued )

pretax gains of \$75 million (\$59 million after tax) related to sales of real estate and other investments. During 2017, we received proceeds of \$25 million and recognized pretax gains of \$8 million (\$5 million after tax) related to sales of real estate and other investments.

## NOTE 4 — INCOME TAXES

The provision for income taxes consists of the following (dollars in millions):

	<u>2019</u>	<u>2018</u>	<u>2017</u>
Current:			
Federal	\$ 670	\$759	\$1,067
State	134	149	120
Foreign	17	23	19
Deferred:			
Federal	254	9	423
State	29	13	3
Foreign	(5)	(7)	6
	<u>\$1,099</u>	<u>\$946</u>	<u>\$1,638</u>

The 2017 Tax Cuts and Jobs Act (“Tax Act”) significantly revised U.S. corporate income taxes, including lowering the statutory corporate tax rate from 35% to 21% beginning in 2018, imposing a mandatory one-time transition tax on undistributed foreign earnings and creating a new U.S. minimum tax on earnings of foreign subsidiaries. Our provision for income taxes for the year ended December 31, 2018 included tax benefits of \$613 million (including \$67 million related to the remeasurement of certain deferred tax assets and liabilities) related to the reduction in our effective tax rate under the Tax Act. We completed our analysis of the impact of the Tax Act during the fourth quarter of 2018, reducing our provision for income taxes for the year ended December 31, 2018 by \$67 million related to a remeasurement of certain deferred tax assets and liabilities for which we were unable to make reasonable estimates in 2017. For the year ended, December 31, 2017, a provisional amount of \$301 million related to the remeasurement of our deferred tax assets and liabilities for which we were then able to make reasonable estimates was recorded as a component of our provision for income taxes. During 2017 we also reclassified a provisional amount of \$127 million from our deferred tax liabilities for the one-time transition tax, based on our estimated undistributed post-1986 foreign earnings and profits. Because we had previously recorded U.S. taxes on these earnings, the transition tax liability, which is payable over an 8-year period, did not affect our 2017 provision for income taxes. Adjustments during 2018 to the provisional amounts recorded in 2017 were not significant.

During 2018, we recorded a reduction to our provision for income taxes of \$28 million for tax credits related to certain 2017 hurricane-related expenses. Our provision for income taxes for the years ended December 31, 2019, 2018 and 2017 included tax benefits of \$65 million, \$124 million and \$82 million, respectively, related to the settlement of employee equity awards. Our foreign pretax income was \$50 million, \$86 million and \$91 million for the years ended December 31, 2019, 2018 and 2017, respectively.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 — INCOME TAXES (continued)

A reconciliation of the federal statutory rate to the effective income tax rate follows:

	2019	2018	2017
Federal statutory rate	21.0%	21.0%	35.0%
State income taxes, net of federal tax benefit	2.7	2.9	2.2
Change in liability for uncertain tax positions	0.4	(0.1)	—
Tax benefit from settlements of employee equity awards	(1.3)	(2.4)	(2.0)
Impact of Tax Act on deferred tax balances	—	(1.6)	7.8
Other items, net	1.1	0.2	(0.5)
Effective income tax rate on income attributable to HCA Healthcare, Inc.	23.9	20.0	42.5
Income attributable to noncontrolling interests from consolidated partnerships	(2.9)	(2.3)	(5.1)
Effective income tax rate on income before income taxes	<u>21.0%</u>	<u>17.7%</u>	<u>37.4%</u>

A summary of the items comprising the deferred tax assets and liabilities at December 31 follows (dollars in millions):

	2019		2018	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed asset basis differences	\$ —	\$ 601	\$ —	\$ 340
Allowances for professional liability and other risks	376	—	355	—
Accounts receivable	307	—	274	—
Compensation	292	—	256	—
Right-of-use lease assets and obligations	369	366	—	—
Other	461	538	424	491
	<u>\$ 1,805</u>	<u>\$ 1,505</u>	<u>\$ 1,309</u>	<u>\$ 831</u>

At December 31, 2019, federal and state net operating loss carryforwards (expiring in years 2022 through 2038) available to offset future taxable income approximated \$ 60 million and \$ 128 million, respectively. Utilization of net operating loss carryforwards in any one year may be limited.

The following table summarizes the activity related to our unrecognized tax benefits (dollars in millions):

	2019	2018
Balance at January 1	\$ 390	\$ 399
Additions based on tax positions related to the current year	29	22
Additions for tax positions of prior years	119	10
Reductions for tax positions of prior years	(3)	(14)
Settlements	—	(2)
Lapse of applicable statutes of limitations	(13)	(25)
Balance at December 31	<u>\$ 522</u>	<u>\$ 390</u>

Our liability for unrecognized tax benefits was \$550 million, including accrued interest of \$62 million and excluding \$34 million that was recorded as reductions of the related deferred tax assets, as of December 31, 2019 (\$435 million, \$48 million and \$3 million, respectively, as of December 31, 2018). Unrecognized tax benefits of \$160 million (\$137 million as of December 31, 2018) would affect the effective rate, if recognized. The increase in our liability for unrecognized tax benefits relates primarily to the effect of certain federal and state legislative and regulatory developments during 2019.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 — INCOME TAXES (continued)

The Internal Revenue Service began an examination of the Company's 2016 and 2017 federal income tax returns during 2019. We are also subject to examination by state and foreign taxing authorities. Depending on the resolution of any federal, state and foreign tax disputes, the completion of examinations by federal, state or foreign taxing authorities, or the expiration of statutes of limitation for specific taxing jurisdictions, we believe it is reasonably possible that our liability for unrecognized tax benefits may significantly increase or decrease within the next 12 months. However, we are currently unable to estimate the range of any possible change.

NOTE 5 — EARNINGS PER SHARE

We compute basic earnings per share using the weighted average number of common shares outstanding. We compute diluted earnings per share using the weighted average number of common shares outstanding plus the dilutive effect of outstanding stock options, SARs, RSUs and PSUs, computed using the treasury stock method. During 2019, 2018 and 2017, we repurchased 7.949 million shares, 14.070 million shares and 25.092 million shares, respectively, of our common stock. The following table sets forth the computations of basic and diluted earnings per share for the years ended December 31, 2019, 2018 and 2017 (dollars and shares in millions, except per share amounts):

	<u>2019</u>	<u>2018</u>	<u>2017</u>
Net income attributable to HCA Healthcare, Inc.	\$ 3,505	\$ 3,787	\$ 2,216
Weighted average common shares outstanding	341.210	347.297	362.305
Effect of dilutive incremental shares	7.016	8.006	9.916
Shares used for diluted earnings per share	<u>348.226</u>	<u>355.303</u>	<u>372.221</u>
Earnings per share:			
Basic earnings per share	\$ 10.27	\$ 10.90	\$ 6.12
Diluted earnings per share	\$ 10.07	\$ 10.66	\$ 5.95

NOTE 6 — INVESTMENTS OF INSURANCE SUBSIDIARIES

A summary of the insurance subsidiaries' investments at December 31 follows (dollars in millions):

	<u>Amortized Cost</u>	<u>2019 Unrealized Amounts</u>		<u>Fair Value</u>
		<u>Gains</u>	<u>Losses</u>	
Debt securities	\$ 359	\$ 18	\$ —	\$ 377
Money market funds and other	85	—	—	85
	<u>\$ 444</u>	<u>\$ 18</u>	<u>\$ —</u>	<u>462</u>
Amounts classified as current assets				(147)
Investment carrying value				<u>\$ 315</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 — INVESTMENTS OF INSURANCE SUBSIDIARIES (continued)

	Amortized Cost	2018 Unrealized Amounts		Fair Value
		Gains	Losses	
Debt securities	\$ 338	\$ 5	\$ (2)	\$ 341
Money market funds and other	68	—	—	68
	<u>\$ 406</u>	<u>\$ 5</u>	<u>\$ (2)</u>	<u>409</u>
Amounts classified as current assets				(47)
Investment carrying value				<u>\$ 362</u>

At December 31, 2019 and 2018, the investments in debt securities of our insurance subsidiaries were classified as “available-for-sale.” Changes in unrealized gains and losses are recorded as adjustments to other comprehensive income (loss).

Scheduled maturities of investments in debt securities at December 31, 2019 were as follows (dollars in millions):

	Amortized Cost	Fair Value
Due in one year or less	\$ 9	\$ 9
Due after one year through five years	85	88
Due after five years through ten years	190	202
Due after ten years	75	78
	<u>\$ 359</u>	<u>\$ 377</u>

The average expected maturity of the investments in debt securities at December 31, 2019 was 5.6 years, compared to the average scheduled maturity of 10.5 years. Expected and scheduled maturities may differ because the issuers of certain securities have the right to call, prepay or otherwise redeem such obligations prior to their scheduled maturity date.

NOTE 7 — FINANCIAL INSTRUMENTS

*Interest Rate Swap Agreements*

We have entered into interest rate swap agreements to manage our exposure to fluctuations in interest rates. These swap agreements involve the exchange of fixed and variable rate interest payments between us and our counterparties based on common notional principal amounts and maturity dates. Pay-fixed interest rate swaps effectively convert variable rate obligations to fixed interest rate obligations. The interest payments under these agreements are settled on a net basis. The net interest payments, based on the notional amounts in these agreements, generally match the timing of the related liabilities, for the interest rate swap agreements which have been designated as cash flow hedges. The notional amounts of the swap agreements represent amounts used to calculate the exchange of cash flows and are not our assets or liabilities. Our credit risk related to these agreements is considered low because the swap agreements are with creditworthy financial institutions.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 — FINANCIAL INSTRUMENTS (continued)

*Interest Rate Swap Agreements (continued)*

The following table sets forth our interest rate swap agreements, which have been designated as cash flow hedges, at December 31, 2019 (dollars in millions):

	<u>Notional Amount</u>	<u>Maturity Date</u>	<u>Fair Value</u>
Pay-fixed interest rate swaps	\$ 2,000	December 2021	\$ 3
Pay-fixed interest rate swaps	500	December 2022	(7)

During the next 12 months, we estimate \$1 million will be reclassified from accumulated other comprehensive income (“OCI”) and will be included in interest expense.

*Derivatives — Results of Operations*

The following table presents the effect of our interest rate swaps on our results of operations for the year ended December 31, 2019 (dollars in millions):

<u>Derivatives in Cash Flow Hedging Relationships</u>	<u>Amount of Loss Recognized in OCI on Derivatives, Net of Tax</u>	<u>Location of Gain Reclassified from Accumulated OCI into Operations</u>	<u>Amount of Gain Reclassified from Accumulated OCI into Operations</u>
Interest rate swaps	\$ 37	Interest expense	\$ 17

*Credit-risk-related Contingent Features*

We have agreements with each of our derivative counterparties that contain a provision where we could be declared in default on our derivative obligations if repayment of the underlying indebtedness is accelerated by the lender due to our default on the indebtedness. As of December 31, 2019, we have not been required to post any collateral related to these agreements. If we had breached these provisions at December 31, 2019, we would have been required to settle our obligations under the agreements at their aggregate, estimated termination value of \$4 million.

NOTE 8 — ASSETS AND LIABILITIES MEASURED AT FAIR VALUE

Accounting Standards Codification 820, *Fair Value Measurements and Disclosures* (“ASC 820”) emphasizes fair value is a market-based measurement, and fair value measurements should be determined based on the assumptions market participants would use in pricing assets or liabilities. ASC 820 utilizes a fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs classified within Levels 1 and 2 of the hierarchy) and the reporting entity’s own assumptions about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities. Level 2 inputs are inputs other than quoted prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. Level 2 inputs may include quoted prices for similar assets and liabilities in active markets, as well as inputs observable for the asset or liability (other than quoted prices), such as interest rates, foreign exchange rates, and yield curves observable at commonly quoted intervals. Level 3 inputs are unobservable inputs for the asset or liability, which are typically based on an entity’s own assumptions, as there is little, if any,

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 8 — ASSETS AND LIABILITIES MEASURED AT FAIR VALUE (continued)

related market activity. In instances where the determination of the fair value measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input significant to the fair value measurement in its entirety. Our assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment.

*Cash Traded Investments*

Our cash traded investments are generally classified within Level 1 or Level 2 of the fair value hierarchy because they are valued using quoted market prices, broker or dealer quotations, or alternative pricing sources with reasonable levels of price transparency.

*Derivative Financial Instruments*

We have entered into interest rate swap agreements to manage our exposure to fluctuations in interest rates. The valuation of these instruments is determined using widely accepted valuation techniques, including discounted cash flow analysis on the expected cash flows of each derivative. This analysis reflects the contractual terms of the derivatives, including the period to maturity, and uses observable market-based inputs, including interest rate curves and implied volatilities. We incorporate credit valuation adjustments to reflect both our own nonperformance risk and the respective counterparty's nonperformance risk in the fair value measurements of these instruments.

The following tables summarize our assets and liabilities measured at fair value on a recurring basis as of December 31, 2019 and 2018, aggregated by the level in the fair value hierarchy within which those measurements fall (dollars in millions):

	December 31, 2019			
	Fair Value	Fair Value Measurements Using		
		Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<b>Assets:</b>				
Investments of insurance subsidiaries:				
Debt securities	\$ 377	\$ —	\$ 377	\$ —
Money market funds and other	85	85	—	—
Investments of insurance subsidiaries	462	85	377	—
Less amounts classified as current assets	(147)	(83)	(64)	—
	<u>\$ 315</u>	<u>2</u>	<u>\$ 313</u>	<u>\$ —</u>
Interest rate swaps (Other)	\$ 3	\$ —	\$ 3	\$ —
<b>Liabilities:</b>				
Interest rate swaps (Income taxes and other liabilities)	\$ 7	\$ —	\$ 7	\$ —

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 8 — ASSETS AND LIABILITIES MEASURED AT FAIR VALUE (continued)

Derivative Financial Instruments (continued)

	December 31, 2018			
	Fair Value	Fair Value Measurements Using		
		Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<b>Assets:</b>				
Investments of insurance subsidiaries:				
Debt securities	\$ 341	\$ —	\$ 341	\$ —
Money market funds and other	68	68	—	—
Investments of insurance subsidiaries	409	68	341	—
Less amounts classified as current assets	(47)	(47)	—	—
	<u>\$ 362</u>	<u>\$ 21</u>	<u>\$ 341</u>	<u>\$ —</u>
Interest rate swaps (Other)	\$ 63	\$ —	\$ 63	\$ —

The estimated fair value of our long-term debt was \$37.026 billion and \$32.887 billion at December 31, 2019 and 2018, respectively, compared to carrying amounts, excluding debt issuance costs and discounts, aggregating \$33.961 billion and \$32.978 billion, respectively. The estimates of fair value are generally based upon the quoted market prices or quoted market prices for similar issues of long-term debt with the same maturities.

NOTE 9 — LONG-TERM DEBT

A summary of long-term debt at December 31, including related interest rates at December 31, 2019, follows (dollars in millions):

	2019	2018
Senior secured asset-based revolving credit facility (effective interest rate of 3.0%)	\$ 2,480	\$ 3,040
Senior secured revolving credit facility	—	—
Senior secured term loan facilities (effective interest rate of 3.3%)	3,725	3,801
Senior secured notes (effective interest rate of 5.1%)	13,850	13,800
Other senior secured debt (effective interest rate of 5.4%)	654	585
Senior secured debt	<u>20,709</u>	<u>21,226</u>
Senior unsecured notes (effective interest rate of 6.3%)	13,252	11,752
Net debt issuance costs	(239)	(157)
Total debt (average life of 8.6 years, rates averaging 5.2 %)	<u>33,722</u>	<u>32,821</u>
Less amounts due within one year	145	788
	<u>\$33,577</u>	<u>\$32,033</u>

During January 2019, we issued \$ 1.500 billion aggregate principal amount of senior unsecured notes comprised of \$ 1.000 billion aggregate principal amount of 5.875 % notes due 2029 and \$ 500 million aggregate principal amount of 5.625 % notes due 2028. We used the net proceeds to fund the purchase of a seven-hospital health system located in western North Carolina.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**NOTE 9 — LONG-TERM DEBT (continued)**

During June 2019, we issued \$5.000 billion aggregate principal amount of senior secured notes comprised of \$2.000 billion aggregate principal amount of 4 1/8% notes due 2029, \$1.000 billion aggregate principal amount of 5 1/8% notes due 2039 and \$2.000 billion aggregate principal amount of 5 1/4% notes due 2049. During July 2019, we redeemed all \$600 million outstanding aggregate principal amount of 4.25% senior secured notes due 2019, all \$3.000 billion outstanding aggregate principal amount of 6.50% senior secured notes due 2020 and all \$1.350 billion outstanding aggregate principal amount of 5.875% senior secured notes due 2022. The pretax loss on retirement of debt for these redemptions was \$211 million.

*Senior Secured Credit Facilities And Other Senior Secured Debt*

We have entered into the following senior secured credit facilities: (i) a \$3.750 billion asset-based revolving credit facility maturing on June 28, 2022 with a borrowing base of 85 % of eligible accounts receivable, subject to customary reserves and eligibility criteria (\$2.480 billion outstanding at December 31, 2019) (the “ABL credit facility”); (ii) a \$2.000 billion senior secured revolving credit facility maturing on June 28, 2022 (none outstanding at December 31, 2019 without giving effect to certain outstanding letters of credit); (iii) a \$1.106 billion senior secured term loan A-6 facility maturing on July 16, 2024 ; (iv) a \$1.474 billion senior secured term loan B-12 facility maturing on March 13, 2025 ; and (v) a \$1.145 billion senior secured term loan B-13 facility maturing on March 18, 2026 . We refer to the facilities described under (ii) through (v) above, collectively, as the “cash flow credit facility” and, together with the ABL credit facility, the “senior secured credit facilities.”

Borrowings under the senior secured credit facilities bear interest at a rate equal to, at our option, either (a) a base rate determined by reference to the higher of (1) the federal funds rate plus 0.50% or (2) the prime rate of Bank of America or (b) a LIBOR rate for the currency of such borrowing for the relevant interest period, plus, in each case, an applicable margin. The applicable margin for borrowings under the senior secured credit facilities may be reduced subject to attaining certain leverage ratios.

The senior secured credit facilities contain a number of covenants that restrict, subject to certain exceptions, our (and some or all of our subsidiaries’) ability to incur additional indebtedness, repay subordinated indebtedness, create liens on assets, sell assets, make investments, loans or advances, engage in certain transactions with affiliates, pay dividends and distributions, and enter into sale and leaseback transactions. In addition, we are required to satisfy and maintain a maximum total leverage ratio covenant under the cash flow credit facility and, in certain situations under the ABL credit facility, a minimum interest coverage ratio covenant.

Senior secured notes consists of (i) \$ 1.250 billion aggregate principal amount of 4.75% first lien notes due 2023; (ii) \$2.000 billion aggregate principal amount of 5.00% first lien notes due 2024; (iii) \$1.400 billion aggregate principal amount of 5.25% first lien notes due 2025; (iv) \$1.500 billion aggregate principal amount of 5.25% first lien notes due 2026; (v) \$1.200 billion aggregate principal amount of 4.50% first lien notes due 2027; (vi) \$ 2.000 billion aggregate principal amount of 4 1/8% first lien notes due 2029; (vii) \$ 1.000 billion aggregate principal amount of 5 1/8% first lien notes due 2039; (viii) \$1.500 billion aggregate principal amount of 5.50% first lien notes due 2047; and (ix) \$ 2.000 billion aggregate principal amount of 5 1/4% first lien notes due 2049. Finance leases and other secured debt totaled \$654 million at December 31, 2019.

We use interest rate swap agreements to manage the variable rate exposure of our debt portfolio. At December 31, 2019, we had entered into effective interest rate swap agreements, in a total notional amount of \$2.500 billion, in order to hedge a portion of our exposure to variable rate interest payments associated with the

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**NOTE 9 — LONG-TERM DEBT (continued)**

*Senior Secured Credit Facilities And Other Senior Secured Debt (continued)*

senior secured credit facilities. The effect of the interest rate swaps is reflected in the effective interest rates for the senior secured credit facilities.

*Senior Unsecured Notes*

Senior unsecured notes consist of (i) \$12.391 billion aggregate principal amount of senior notes with maturities ranging from 2021 to 2033; (ii) an aggregate principal amount of \$125 million medium-term notes maturing 2025; and (iii) an aggregate principal amount of \$736 million debentures with maturities ranging from 2023 to 2095.

*General Debt Information*

The senior secured credit facilities and senior secured notes are fully and unconditionally guaranteed by substantially all existing and future, direct and indirect, 100% owned material domestic subsidiaries that are “Unrestricted Subsidiaries” under our Indenture (the “1993 Indenture”) dated December 16, 1993 (except for certain special purpose subsidiaries that only guarantee and pledge their assets under our ABL credit facility).

All obligations under the ABL credit facility, and the guarantees of those obligations, are secured, subject to permitted liens and other exceptions, by a first-priority lien on substantially all of the receivables of the borrowers and each guarantor under such ABL credit facility (the “Receivables Collateral”).

All obligations under the cash flow credit facility and the guarantees of such obligations are secured, subject to permitted liens and other exceptions, by:

- a first-priority lien on the capital stock owned by HCA Inc., or by any U.S. guarantor, in each of their respective first-tier subsidiaries;
- a first-priority lien on substantially all present and future assets of HCA Inc. and of each U.S. guarantor other than (i) “Principal Properties” (as defined in the 1993 Indenture), (ii) certain other real properties and (iii) deposit accounts, other bank or securities accounts, cash, leaseholds, motor-vehicles and certain other exceptions; and
- a second-priority lien on certain of the Receivables Collateral.

Our senior secured notes and the related guarantees are secured by first-priority liens, subject to permitted liens, on our and our subsidiary guarantors’ assets, subject to certain exceptions, that secure our cash flow credit facility on a first-priority basis and are secured by second-priority liens, subject to permitted liens, on our and our subsidiary guarantors’ assets that secure our ABL credit facility on a first-priority basis and our other cash flow credit facility on a second-priority basis.

Maturities of long-term debt in years 2021 through 2024, excluding amounts under the ABL credit facility, are \$1.156 billion, \$2.177 billion, \$2.770 billion and \$3.137 billion, respectively.

**NOTE 10 — LEASES**

We adopted ASU No. 2016-02, *Leases (Topic 842)*, which requires leases with durations greater than 12 months to be recognized on the balance sheet, effective January 1, 2019, using the modified retrospective approach. Prior period financial statement amounts and disclosures have not been adjusted to reflect the

## HCA HEALTHCARE, INC.

## NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**NOTE 10 — LEASES (continued)**

provisions of the new standard. We elected the package of transition provisions available which allowed us to carry forward our historical assessments of whether contracts are or contain leases, the lease classification and the treatment of initial direct costs.

We lease property and equipment under finance and operating leases. For leases with terms greater than 12 months, we record the related assets and obligations at the present value of lease payments over the term. Many of our leases include rental escalation clauses and renewal options that are factored into our determination of lease payments, when appropriate. We do not separate lease and nonlease components of contracts. Generally, we use our estimated incremental borrowing rate to discount the lease payments, as most of our leases do not provide a readily determinable implicit interest rate.

The following table presents our lease-related assets and liabilities at December 31, 2019 (dollars in millions):

	<u>Balance Sheet Classification</u>	<u>December 31, 2019</u>
<b>Assets:</b>		
Operating leases	Right-of-use operating lease assets	\$ 1,834
Finance leases	Property and equipment	520
Total lease assets		<u>\$ 2,354</u>
<b>Liabilities:</b>		
Current:		
Operating leases	Other accrued expenses	\$ 350
Finance leases	Long-term debt due within one year	87
Noncurrent:		
Operating leases	Right-of-use operating lease obligations	1,499
Finance leases	Long-term debt	470
Total lease liabilities		<u>\$ 2,406</u>
<b>Weighted-average remaining term:</b>		
Operating leases		10.8 years
Finance leases		12.0 years
<b>Weighted-average discount rate:</b>		
Operating leases(1)		5.3%
Finance leases		6.0%

(1) Upon adoption of the new lease standard, discount rates used for existing leases were established at January 1, 2019.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 — LEASES (continued)

The following table presents certain information related to lease expense for finance and operating leases for the year ended December 31, 2019 (dollars in millions):

	Year Ended December 31, 2019
Finance lease expense:	
Amortization of leased assets	\$ 93
Interest on lease liabilities	32
Operating leases(2)	389
Short-term lease expense(2)	316
Variable lease expense(2)	150
	<u>\$ 980</u>

(2) Expenses are included in “other operating expenses” in our consolidated income statements.

The following table presents supplemental cash flow information for the year ended December 31, 2019 (dollars in millions):

	2019
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows for operating leases	\$404
Operating cash flows for finance leases	32
Financing cash flows for finance leases	79

*Maturities of Lease Liabilities*

The following table reconciles the undiscounted minimum lease payment amounts to the operating and finance lease liabilities recorded on the balance sheet at December 31, 2019 (dollars in millions):

	Operating Leases	Finance Leases
Year 1	\$ 411	\$ 110
Year 2	350	105
Year 3	285	99
Year 4	228	58
Year 5	182	60
Thereafter	1,074	368
Total minimum lease payments	2,530	800
Less: amount of lease payments representing interest	(681)	(243)
Present value of future minimum lease payments	1,849	557
Less: current lease obligations	(350)	(87)
Long-term lease obligations	<u>\$ 1,499</u>	<u>\$ 470</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**NOTE 11 — CONTINGENCIES**

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. We are also subject to claims and suits arising in the ordinary course of business, including claims for personal injuries or wrongful restriction of, or interference with, physicians' staff privileges. In certain of these actions the claimants may seek punitive damages against us which may not be covered by insurance. We are also subject to claims by various taxing authorities for additional taxes and related interest and penalties. The resolution of any such lawsuits, claims or legal and regulatory proceedings could have a material, adverse effect on our results of operations, financial position or liquidity.

*Government Investigations, Claims and Litigation*

Health care companies are subject to numerous investigations by various governmental agencies. Under the federal False Claims Act ("FCA"), private parties have the right to bring *qui tam*, or "whistleblower," suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions. Certain of our individual facilities have received, and from time to time, other facilities may receive, government inquiries from, and may be subject to investigation by, federal and state agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material, adverse effect on our results of operations, financial position or liquidity.

Texas operates a state Medicaid program pursuant to a waiver from CMS under Section 1115 of the Social Security Act ("Program"). The Program includes uncompensated-care pools; payments from these pools are intended to defray the uncompensated costs of services provided by our and other hospitals to Medicaid eligible or uninsured individuals. Separately, we and other hospitals provide charity care services in several communities in the state. In 2018, the Civil Division of the U.S. Department of Justice and the U.S. Attorney's Office for the Southern District of Texas requested information about whether the Program, as operated in Harris County, complied with the laws and regulations applicable to provider related donations, and the Company cooperated with that request. On May 21, 2019, a *qui tam* lawsuit asserting violations of the FCA and the Texas Medicaid Fraud Prevention Act related to the Program, as operated in Harris County, was unsealed by the U.S. District Court for the Southern District of Texas. Both the federal and state governments declined to intervene in the *qui tam* lawsuit. The Company believes that our participation is and has been consistent with the requirements of the Program and is vigorously defending against the lawsuit being pursued by the relator. We cannot predict what effect, if any, the *qui tam* lawsuit could have on the Company.

**NOTE 12 — CAPITAL STOCK**

The amended and restated certificate of incorporation authorizes the Company to issue up to 1,800,000,000 shares of common stock, and our amended and restated by-laws set the number of directors constituting the board of directors of the Company at not less than three members, the exact number to be determined from time to time by resolution adopted by the affirmative vote of a majority of the total number of directors then in office.

*Share Repurchase Transactions*

During January 2020, January 2019, October 2017 and November 2016, our Board of Directors authorized share repurchase programs for up to \$8 billion (\$2 billion for each authorization) of our outstanding common stock. During 2019, we repurchased 7.949 million shares of our common stock at an average price of \$129.71 per

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**NOTE 12 — CAPITAL STOCK (continued)**

*Share Repurchase Transactions (continued)*

share through market purchases pursuant to the October 2017 authorization (which was completed during the first quarter of 2019) and the January 2019 authorization. At December 31, 2019, we had \$1.241 billion of repurchase authorization available under the January 2019 authorization.

During 2018, we repurchased 14.070 million shares of our common stock at an average price of \$108.74 per share through market purchases pursuant to the October 2017 authorization. During 2017, we repurchased 25.092 million shares of our common stock at an average price of \$81.73 per share through market purchases pursuant to the November 2016 authorization (which was completed during the fourth quarter of 2017) and the October 2017 authorization.

**NOTE 13 — EMPLOYEE BENEFIT PLANS**

We maintain defined contribution benefit plans that are available to employees who meet certain minimum requirements. Certain of the plans require that we match specified percentages of participant contributions up to certain maximum levels (generally, 100% of the first 3% to 9%, depending upon years of vesting service, of compensation deferred by participants). The cost of these plans totaled \$532 million for 2019, \$499 million for 2018 and \$471 million for 2017. Our contributions are funded during the applicable or following year.

We maintain the noncontributory, nonqualified Restoration Plan to provide certain retirement benefits for eligible employees. Eligibility for the Restoration Plan is based upon earning eligible compensation in excess of the Social Security Wage Base and attaining 1,000 or more hours of service during the plan year. Company credits to participants' account balances (the Restoration Plan is not funded) depend upon participants' compensation, years of vesting service and certain IRS limitations. Benefits expense under this plan was \$44 million for 2019, \$22 million for 2018 and \$40 million for 2017. Accrued benefits liabilities under this plan totaled \$227 million at December 31, 2019 and \$205 million at December 31, 2018.

We maintain a Supplemental Executive Retirement Plan ("SERP") for certain executives (the SERP is not funded). The plan is designed to ensure that upon retirement the participant receives the value of a prescribed life annuity from the combination of the SERP and our other benefit plans. Benefits expense under the plan was \$19 million for 2019, \$26 million for 2018 and \$28 million for 2017. Accrued benefits liabilities under this plan totaled \$192 million at December 31, 2019 and \$195 million at December 31, 2018.

We maintain defined benefit pension plans which resulted from certain hospital acquisitions in prior years. Benefits expense under these plans was \$11 million for 2019, \$9 million for 2018, and \$14 million for 2017. Accrued benefits liabilities under these plans totaled \$63 million at December 31, 2019 and \$68 million at December 31, 2018.

**NOTE 14 — SEGMENT AND GEOGRAPHIC INFORMATION**

We operate in one line of business, which is operating hospitals and related health care entities. We operate in two geographically organized groups: the National and American Groups. At December 31, 2019, the National Group included 95 hospitals located in Alaska, California, Florida, southern Georgia, Idaho, Indiana, northern Kentucky, Nevada, New Hampshire, North Carolina, South Carolina, Utah and Virginia, and the American Group included 83 hospitals located in Colorado, northern Georgia, Kansas, southern Kentucky, Louisiana, Mississippi, Missouri, Tennessee and Texas. We also operate six hospitals in England, and these facilities are included in the Corporate and other group.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 — SEGMENT AND GEOGRAPHIC INFORMATION (continued)

Adjusted segment EBITDA is defined as income before depreciation and amortization, interest expense, gains on sales of facilities, losses on retirement of debt, income taxes and net income attributable to noncontrolling interests. We use adjusted segment EBITDA as an analytical indicator for purposes of allocating resources to geographic areas and assessing their performance. Adjusted segment EBITDA is commonly used as an analytical indicator within the health care industry, and also serves as a measure of leverage capacity and debt service ability. Adjusted segment EBITDA should not be considered as a measure of financial performance under generally accepted accounting principles, and the items excluded from adjusted segment EBITDA are significant components in understanding and assessing financial performance. Because adjusted segment EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, adjusted segment EBITDA, as presented, may not be comparable to other similarly titled measures of other companies. The geographic distributions of our revenues, equity in earnings of affiliates, adjusted segment EBITDA, depreciation and amortization, assets and goodwill and other intangible assets are summarized in the following table (dollars in millions):

	<u>For the Years Ended December 31,</u>		
	<u>2019</u>	<u>2018</u>	<u>2017</u>
<b>Revenues:</b>			
National Group	\$ 25,913	\$ 22,581	\$ 20,772
American Group	23,173	21,959	20,912
Corporate and other	2,250	2,137	1,930
	<u>\$ 51,336</u>	<u>\$ 46,677</u>	<u>\$ 43,614</u>
<b>Equity in earnings of affiliates:</b>			
National Group	\$ (2)	\$ (4)	\$ (21)
American Group	(44)	(40)	(37)
Corporate and other	3	15	13
	<u>\$ (43)</u>	<u>\$ (29)</u>	<u>\$ (45)</u>
<b>Adjusted segment EBITDA:</b>			
National Group	\$ 5,634	\$ 4,980	\$ 4,600
American Group	4,904	4,593	4,231
Corporate and other	(681)	(624)	(598)
	<u>\$ 9,857</u>	<u>\$ 8,949</u>	<u>\$ 8,233</u>
<b>Depreciation and amortization:</b>			
National Group	\$ 1,161	\$ 946	\$ 867
American Group	1,117	1,027	986
Corporate and other	318	305	278
	<u>\$ 2,596</u>	<u>\$ 2,278</u>	<u>\$ 2,131</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 — SEGMENT AND GEOGRAPHIC INFORMATION (continued)

	For the Years Ended December 31,		
	2019	2018	2017
Adjusted segment EBITDA	\$ 9,857	\$ 8,949	\$ 8,233
Depreciation and amortization	2,596	2,278	2,131
Interest expense	1,824	1,755	1,690
Gains on sales of facilities	(18)	(428)	(8)
Losses on retirement of debt	211	9	39
Income before income taxes	<u>\$ 5,244</u>	<u>\$ 5,335</u>	<u>\$ 4,381</u>

	December 31,		
	2019	2018	2017
Assets:			
National Group	\$18,290	\$14,839	\$13,097
American Group	20,608	19,122	18,136
Corporate and other	6,160	5,246	5,360
	<u>\$45,058</u>	<u>\$39,207</u>	<u>\$36,593</u>

	National Group	American Group	Corporate and Other	Total
Goodwill and other intangible assets:				
Balance at December 31, 2016	\$ 1,458	\$ 4,661	\$ 585	\$ 6,704
Acquisitions	19	612	62	693
Foreign currency translation, amortization and other	(3)	(8)	8	(3)
Balance at December 31, 2017	1,474	5,265	655	7,394
Acquisitions	132	504	—	636
Foreign currency translation, amortization and other	(9)	(40)	(28)	(77)
Balance at December 31, 2018	1,597	5,729	627	7,953
Acquisitions	155	39	138	332
Foreign currency translation, amortization and other	(13)	(3)	—	(16)
Balance at December 31, 2019	<u>\$ 1,739</u>	<u>\$ 5,765</u>	<u>\$ 765</u>	<u>\$8,269</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 15 — OTHER COMPREHENSIVE LOSS

The components of accumulated other comprehensive loss are as follows (dollars in millions):

	Unrealized Gains on Available- for-Sale Securities	Foreign Currency Translation Adjustments	Defined Benefit Plans	Change in Fair Value of Derivative Instruments	Total
Balances at December 31, 2016	\$ 7	\$ (211)	\$ (146)	\$ 12	\$(338)
Unrealized gains on available-for-sale securities	1	—	—	—	1
Foreign currency translation adjustments, net of \$35 of income taxes	—	62	—	—	62
Defined benefit plans, net of \$10 income tax benefit	—	—	(33)	—	(33)
Change in fair value of derivative instruments, net of \$4 of income taxes	—	—	—	7	7
Expense (income) reclassified into operations from other comprehensive income, net of \$1 of income taxes and \$7 and \$7 income tax benefits, respectively	(1)	—	11	13	23
Balances at December 31, 2017	7	(149)	(168)	32	(278)
Unrealized losses on available-for-sale securities, net of \$2 income tax benefit	(5)	—	—	—	(5)
Foreign currency translation adjustments, net of \$8 income tax benefit	—	(63)	—	—	(63)
Defined benefit plans, net of \$10 of income taxes	—	—	34	—	34
Change in fair value of derivative instruments, net of \$5 of income taxes	—	—	—	18	18
Expense (income) reclassified into operations from other comprehensive income, net of \$5 income tax benefit and \$2 of income taxes, respectively	—	—	16	(8)	8
Reclassification of stranded tax effects	1	(71)	(30)	5	(95)
Balances at December 31, 2018	3	(283)	(148)	47	(381)
Unrealized gains on available-for-sale securities, net of \$4 of income taxes	11	—	—	—	11
Foreign currency translation adjustments, net of \$5 of income taxes	—	—	—	—	—
Defined benefit plans, net of \$14 income tax benefit	—	—	(49)	—	(49)
Change in fair value of derivative instruments, net of \$13 income tax benefit	—	—	—	(37)	(37)
Expense (income) reclassified into operations from other comprehensive income, net of \$3 income tax benefit and \$3 of income taxes, respectively	—	—	10	(14)	(4)
Balances at December 31, 2019	\$ 14	\$ (283)	\$ (187)	\$ (4)	\$(460)

**HCA HEALTHCARE, INC.****NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)****NOTE 16 — ACCRUED EXPENSES**

A summary of other accrued expenses at December 31 follows (dollars in millions):

	<u>2019</u>	<u>2018</u>
Professional liability risks	\$ 457	\$ 466
Defined contribution benefit plan	528	459
Interest	368	429
Right-of-use operating lease	350	—
Taxes other than income	325	308
Other	904	962
	<u>\$2,932</u>	<u>\$2,624</u>

**NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION**

HCA Inc. is a 100% owned direct subsidiary of HCA Healthcare, Inc. HCA Healthcare, Inc. has \$1.000 billion aggregate principal amount of 6.25% senior unsecured notes due 2021 outstanding. These notes are senior unsecured obligations and are not guaranteed by any of our subsidiaries.

The senior secured credit facilities and senior secured notes described in Note 9 are jointly and severally, and fully and unconditionally guaranteed by substantially all existing and future, direct and indirect, 100% owned material domestic subsidiaries that are “Unrestricted Subsidiaries” under our Indenture dated December 16, 1993 (except for certain special purpose subsidiaries that only guarantee and pledge their assets under our ABL credit facility).

Our condensed consolidating balance sheets at December 31, 2019 and 2018 and condensed consolidating statements of comprehensive income and cash flows for each of the three years in the period ended December 31, 2019, segregating HCA Healthcare, Inc. issuer, HCA Inc. issuer, the subsidiary guarantors, the subsidiary non-guarantors and eliminations, follow.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (continued)

HCA HEALTHCARE, INC.  
CONDENSED CONSOLIDATING COMPREHENSIVE INCOME STATEMENT  
FOR THE YEAR ENDED DECEMBER 31, 2019  
(Dollars in millions)

	HCA Healthcare, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non- Guarantors	Eliminations	Condensed Consolidated
Revenues	\$ —	\$ —	\$ 29,220	\$ 22,116	\$ —	\$ 51,336
Salaries and benefits	—	—	12,898	10,662	—	23,560
Supplies	—	—	4,802	3,679	—	8,481
Other operating expenses	7	—	4,643	4,831	—	9,481
Equity in earnings of affiliates	(3,597)	—	(6)	(37)	3,597	(43)
Depreciation and amortization	—	—	1,447	1,149	—	2,596
Interest expense (income)	64	4,025	(2,001)	(264)	—	1,824
Gains on sales of facilities	—	—	(14)	(4)	—	(18)
Losses on retirement of debt	—	211	—	—	—	211
Management fees	—	—	(768)	768	—	—
	<u>(3,526)</u>	<u>4,236</u>	<u>21,001</u>	<u>20,784</u>	<u>3,597</u>	<u>46,092</u>
Income (loss) before income taxes	3,526	(4,236)	8,219	1,332	(3,597)	5,244
Provision (benefit) for income taxes	21	(976)	1,874	180	—	1,099
Net income (loss)	<u>3,505</u>	<u>(3,260)</u>	<u>6,345</u>	<u>1,152</u>	<u>(3,597)</u>	<u>4,145</u>
Net income attributable to noncontrolling interests	—	—	91	549	—	640
Net income (loss) attributable to HCA Healthcare, Inc.	<u>\$ 3,505</u>	<u>\$ (3,260)</u>	<u>\$ 6,254</u>	<u>\$ 603</u>	<u>\$ (3,597)</u>	<u>\$ 3,505</u>
Comprehensive income (loss) attributable to HCA Healthcare, Inc.	<u>\$ 3,426</u>	<u>\$ (3,311)</u>	<u>\$ 6,215</u>	<u>\$ 614</u>	<u>\$ (3,518)</u>	<u>\$ 3,426</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (continued)

HCA HEALTHCARE, INC.  
CONDENSED CONSOLIDATING COMPREHENSIVE INCOME STATEMENT  
FOR THE YEAR ENDED DECEMBER 31, 2018  
(Dollars in millions)

	HCA Healthcare, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non- Guarantors	Eliminations	Condensed Consolidated
Revenues	\$ —	\$ —	\$ 27,482	\$ 19,195	\$ —	\$ 46,677
Salaries and benefits	—	—	12,287	9,138	—	21,425
Supplies	—	—	4,560	3,164	—	7,724
Other operating expenses	8	—	4,463	4,137	—	8,608
Equity in earnings of affiliates	(3,688)	—	(7)	(22)	3,688	(29)
Depreciation and amortization	—	—	1,335	943	—	2,278
Interest expense (income)	64	3,580	(1,635)	(254)	—	1,755
Gains on sales of facilities	—	—	(357)	(71)	—	(428)
Losses on retirement of debt	—	9	—	—	—	9
Management fees	—	—	(639)	639	—	—
	<u>(3,616)</u>	<u>3,589</u>	<u>20,007</u>	<u>17,674</u>	<u>3,688</u>	<u>41,342</u>
Income (loss) before income taxes	3,616	(3,589)	7,475	1,521	(3,688)	5,335
Provision (benefit) for income taxes	(171)	(834)	1,714	237	—	946
Net income (loss)	<u>3,787</u>	<u>(2,755)</u>	<u>5,761</u>	<u>1,284</u>	<u>(3,688)</u>	<u>4,389</u>
Net income attributable to noncontrolling interests	—	—	99	503	—	602
Net income (loss) attributable to HCA Healthcare, Inc.	<u>\$ 3,787</u>	<u>\$ (2,755)</u>	<u>\$ 5,662</u>	<u>\$ 781</u>	<u>\$ (3,688)</u>	<u>\$ 3,787</u>
Comprehensive income (loss) attributable to HCA Healthcare, Inc.	<u>\$ 3,779</u>	<u>\$ (2,745)</u>	<u>\$ 5,712</u>	<u>\$ 713</u>	<u>\$ (3,680)</u>	<u>\$ 3,779</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (continued)

HCA HEALTHCARE, INC.  
CONDENSED CONSOLIDATING COMPREHENSIVE INCOME STATEMENT  
FOR THE YEAR ENDED DECEMBER 31, 2017  
(Dollars in millions)

	HCA Healthcare, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non- Guarantors	Eliminations	Condensed Consolidated
Revenues	\$ —	\$ —	\$ 25,774	\$ 17,840	\$ —	\$ 43,614
Salaries and benefits	—	—	11,619	8,440	—	20,059
Supplies	—	—	4,286	3,030	—	7,316
Other operating expenses	6	—	4,249	3,796	—	8,051
Equity in earnings of affiliates	(2,476)	—	(6)	(39)	2,476	(45)
Depreciation and amortization	—	—	1,237	894	—	2,131
Interest expense (income)	64	3,088	(1,309)	(153)	—	1,690
Gains on sales of facilities	—	—	(2)	(6)	—	(8)
Losses on retirement of debt	—	39	—	—	—	39
Management fees	—	—	(621)	621	—	—
	<u>(2,406)</u>	<u>3,127</u>	<u>19,453</u>	<u>16,583</u>	<u>2,476</u>	<u>39,233</u>
Income (loss) before income taxes	2,406	(3,127)	6,321	1,257	(2,476)	4,381
Provision (benefit) for income taxes	190	(1,154)	2,293	309	—	1,638
Net income (loss)	2,216	(1,973)	4,028	948	(2,476)	2,743
Net income attributable to noncontrolling interests	—	—	108	419	—	527
Net income (loss) attributable to HCA Healthcare, Inc.	<u>\$ 2,216</u>	<u>\$ (1,973)</u>	<u>\$ 3,920</u>	<u>\$ 529</u>	<u>\$ (2,476)</u>	<u>\$ 2,216</u>
Comprehensive income (loss) attributable to HCA Healthcare, Inc.	<u>\$ 2,276</u>	<u>\$ (1,953)</u>	<u>\$ 3,898</u>	<u>\$ 591</u>	<u>\$ (2,536)</u>	<u>\$ 2,276</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (continued)

HCA HEALTHCARE, INC.  
CONDENSED CONSOLIDATING BALANCE SHEET  
DECEMBER 31, 2019  
(Dollars in millions)

	HCA Healthcare, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non- Guarantors	Eliminations	Condensed Consolidated
<b>ASSETS</b>						
Current assets:						
Cash and cash equivalents	\$ —	\$ —	\$ 118	\$ 503	\$ —	\$ 621
Accounts receivable, net	—	—	4,037	3,343	—	7,380
Inventories	—	—	1,208	641	—	1,849
Other	—	—	727	619	—	1,346
	—	—	6,090	5,106	—	11,196
Property and equipment, net	—	—	13,418	9,297	—	22,715
Investments of insurance subsidiaries	—	—	—	315	—	315
Investments in and advances to affiliates	36,684	—	29	220	(36,684)	249
Goodwill and other intangible assets	—	—	5,743	2,526	—	8,269
Right-of-use operating lease assets	—	—	455	1,379	—	1,834
Other	300	3	29	148	—	480
	<u>\$ 36,984</u>	<u>\$ 3</u>	<u>\$ 25,764</u>	<u>\$ 18,991</u>	<u>\$ (36,684)</u>	<u>\$ 45,058</u>
<b>LIABILITIES AND STOCKHOLDERS' (DEFICIT) EQUITY</b>						
Current liabilities:						
Accounts payable	\$ —	\$ —	\$ 1,903	\$ 1,002	\$ —	\$ 2,905
Accrued salaries	—	—	1,070	705	—	1,775
Other accrued expenses	85	341	1,001	1,505	—	2,932
Long-term debt due within one year	—	54	50	41	—	145
	85	395	4,024	3,253	—	7,757
Long-term debt, net	998	32,016	213	350	—	33,577
Intercompany balances	38,089	(4,314)	(33,828)	53	—	—
Professional liability risks	—	—	—	1,370	—	1,370
Right-of-use operating lease obligations	—	—	345	1,154	—	1,499
Income taxes and other liabilities	620	7	252	541	—	1,420
	39,792	28,104	(28,994)	6,721	—	45,623
Stockholders' (deficit) equity attributable to HCA Healthcare, Inc.	(2,808)	(28,101)	54,652	10,133	(36,684)	(2,808)
Noncontrolling interests	—	—	106	2,137	—	2,243
	<u>(2,808)</u>	<u>(28,101)</u>	<u>54,758</u>	<u>12,270</u>	<u>(36,684)</u>	<u>(565)</u>
	<u>\$ 36,984</u>	<u>\$ 3</u>	<u>\$ 25,764</u>	<u>\$ 18,991</u>	<u>\$ (36,684)</u>	<u>\$ 45,058</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL- RELATED INFORMATION (continued)

HCA HEALTHCARE, INC.  
CONDENSED CONSOLIDATING BALANCE SHEET  
DECEMBER 31, 2018  
(Dollars in millions)

	HCA Healthcare, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non- Guarantors	Eliminations	Condensed Consolidated
<b>ASSETS</b>						
Current assets:						
Cash and cash equivalents	\$ —	\$ —	\$ 174	\$ 328	\$ —	\$ 502
Accounts receivable, net	—	—	3,964	2,825	—	6,789
Inventories	—	—	1,178	554	—	1,732
Other	—	—	669	521	—	1,190
	—	—	5,985	4,228	—	10,213
Property and equipment, net	—	—	12,450	7,307	—	19,757
Investments of insurance subsidiaries	—	—	—	362	—	362
Investments in and advances to affiliates	33,166	—	29	203	(33,166)	232
Goodwill and other intangible assets	—	—	5,724	2,229	—	7,953
Other	478	64	35	113	—	690
	<u>\$ 33,644</u>	<u>\$ 64</u>	<u>\$ 24,223</u>	<u>\$ 14,442</u>	<u>\$ (33,166)</u>	<u>\$ 39,207</u>
<b>LIABILITIES AND STOCKHOLDERS' (DEFICIT) EQUITY</b>						
Current liabilities:						
Accounts payable	\$ —	\$ —	\$ 1,721	\$ 856	\$ —	\$ 2,577
Accrued salaries	—	—	998	582	—	1,580
Other accrued expenses	142	403	905	1,174	—	2,624
Long-term debt due within one year	—	696	55	37	—	788
	142	1,099	3,679	2,649	—	7,569
Long-term debt, net	996	30,544	212	281	—	32,033
Intercompany balances	36,951	(6,789)	(28,415)	(1,747)	—	—
Professional liability risks	—	—	—	1,275	—	1,275
Income taxes and other liabilities	505	—	223	520	—	1,248
	38,594	24,854	(24,301)	2,978	—	42,125
Stockholders' (deficit) equity attributable to HCA Healthcare, Inc.	(4,950)	(24,790)	48,437	9,519	(33,166)	(4,950)
Noncontrolling interests	—	—	87	1,945	—	2,032
	<u>(4,950)</u>	<u>(24,790)</u>	<u>48,524</u>	<u>11,464</u>	<u>(33,166)</u>	<u>(2,918)</u>
	<u>\$ 33,644</u>	<u>\$ 64</u>	<u>\$ 24,223</u>	<u>\$ 14,442</u>	<u>\$ (33,166)</u>	<u>\$ 39,207</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (continued)

HCA HEALTHCARE, INC.  
CONDENSED CONSOLIDATING STATEMENT OF CASH FLOWS  
FOR THE YEAR ENDED DECEMBER 31, 2019  
(Dollars in millions)

	HCA Healthcare, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non- Guarantors	Eliminations	Condensed Consolidated
<b>Cash flows from operating activities:</b>						
Net income (loss)	\$ 3,505	\$ (3,260)	\$ 6,345	\$ 1,152	\$ (3,597)	\$ 4,145
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:						
Change in operating assets and liabilities	—	(62)	17	(43)	—	(88)
Depreciation and amortization	—	—	1,447	1,149	—	2,596
Income taxes	250	—	—	—	—	250
Gains on sales of facilities	—	—	(14)	(4)	—	(18)
Losses on retirement of debt	—	211	—	—	—	211
Amortization of debt issuance costs	—	30	—	—	—	30
Share-based compensation	—	—	347	—	—	347
Equity in earnings of affiliates	(3,597)	—	—	—	3,597	—
Other	109	—	23	(3)	—	129
Net cash provided by (used in) operating activities	267	(3,081)	8,165	2,251	—	7,602
<b>Cash flows from investing activities:</b>						
Purchase of property and equipment	—	—	(2,342)	(1,816)	—	(4,158)
Acquisition of hospitals and health care entities	—	—	(43)	(1,639)	—	(1,682)
Sales of hospitals and health care entities	—	—	42	19	—	61
Change in investments	—	—	6	19	—	25
Other	—	—	(7)	41	—	34
Net cash used in investing activities	—	—	(2,344)	(3,376)	—	(5,720)
<b>Cash flows from financing activities:</b>						
Issuance of long-term debt	—	6,451	—	—	—	6,451
Net change in revolving bank credit facilities	—	(560)	—	—	—	(560)
Repayment of long-term debt	—	(5,227)	(59)	(38)	—	(5,324)
Distributions to noncontrolling interests	—	—	(104)	(438)	—	(542)
Payment of debt issuance costs	—	(73)	—	—	—	(73)
Payment of dividends	(550)	—	—	—	—	(550)
Repurchases of common stock	(1,031)	—	—	—	—	(1,031)
Changes in intercompany balances with affiliates, net	1,457	2,490	(5,714)	1,767	—	—
Other	(143)	—	—	1	—	(142)
Net cash (used in) provided by financing activities	(267)	3,081	(5,877)	1,292	—	(1,771)
Effect of exchange rate changes on cash and cash equivalents	—	—	—	8	—	8
Change in cash and cash equivalents	—	—	(56)	175	—	119
Cash and cash equivalents at beginning of period	—	—	174	328	—	502
Cash and cash equivalents at end of period	\$ —	\$ —	\$ 118	\$ 503	\$ —	\$ 621

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (continued)

HCA HEALTHCARE, INC.  
CONDENSED CONSOLIDATING STATEMENT OF CASH FLOWS  
FOR THE YEAR ENDED DECEMBER 31, 2018  
(Dollars in millions)

	HCA Healthcare, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non- Guarantors	Eliminations	Condensed Consolidated
<b>Cash flows from operating activities:</b>						
Net income (loss)	\$ 3,787	\$ (2,755)	\$ 5,761	\$ 1,284	\$ (3,688)	\$ 4,389
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:						
Change in operating assets and liabilities	—	23	(178)	188	—	33
Depreciation and amortization	—	—	1,335	943	—	2,278
Income taxes	74	—	—	—	—	74
Gains on sales of facilities	—	—	(357)	(71)	—	(428)
Losses on retirement of debt	—	9	—	—	—	9
Amortization of debt issuance costs	—	31	—	—	—	31
Share-based compensation	—	—	268	—	—	268
Equity in earnings of affiliates	(3,688)	—	—	—	3,688	—
Other	91	—	25	(9)	—	107
Net cash provided by (used in) operating activities	264	(2,692)	6,854	2,335	—	6,761
<b>Cash flows from investing activities:</b>						
Purchase of property and equipment	—	—	(2,008)	(1,565)	—	(3,573)
Acquisition of hospitals and health care entities	—	—	(897)	(356)	—	(1,253)
Sales of hospitals and health care entities	—	—	770	38	—	808
Change in investments	—	—	12	45	—	57
Other	—	—	(9)	69	—	60
Net cash used in investing activities	—	—	(2,132)	(1,769)	—	(3,901)
<b>Cash flows from financing activities:</b>						
Issuance of long-term debt	—	2,000	—	—	—	2,000
Net change in revolving bank credit facilities	—	(640)	—	—	—	(640)
Repayment of long-term debt	—	(1,590)	(72)	(42)	—	(1,704)
Distributions to noncontrolling interests	—	—	(83)	(358)	—	(441)
Payment of debt issuance costs	—	(25)	—	—	—	(25)
Payment of dividends	(487)	—	—	—	—	(487)
Repurchases of common stock	(1,530)	—	—	—	—	(1,530)
Changes in intercompany balances with affiliates, net	2,004	2,947	(4,505)	(446)	—	—
Other	(252)	—	—	4	—	(248)
Net cash (used in) provided by financing activities	(265)	2,692	(4,660)	(842)	—	(3,075)
Effect of exchange rate changes on cash and cash equivalents	—	—	—	(15)	—	(15)
Change in cash and cash equivalents	(1)	—	62	(291)	—	(230)
Cash and cash equivalents at beginning of period	1	—	112	619	—	732
Cash and cash equivalents at end of period	\$ —	\$ —	\$ 174	\$ 328	\$ —	\$ 502

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (continued)

HCA HEALTHCARE, INC.  
CONDENSED CONSOLIDATING STATEMENT OF CASH FLOWS  
FOR THE YEAR ENDED DECEMBER 31, 2017  
(Dollars in millions)

	HCA Healthcare, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non- Guarantors	Eliminations	Condensed Consolidated
<b>Cash flows from operating activities:</b>						
Net income (loss)	\$ 2,216	\$ (1,973)	\$ 4,028	\$ 948	\$ (2,476)	\$ 2,743
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:						
Change in operating assets and liabilities	—	(193)	(219)	116	—	(296)
Depreciation and amortization	—	—	1,237	894	—	2,131
Income taxes	433	—	—	—	—	433
Gains on sales of facilities	—	—	(2)	(6)	—	(8)
Losses on retirement of debt	—	39	—	—	—	39
Amortization of debt issuance costs	—	31	—	—	—	31
Share-based compensation	—	—	270	—	—	270
Equity in earnings of affiliates	(2,476)	—	—	—	2,476	—
Other	78	—	—	5	—	83
Net cash provided by (used in) operating activities	251	(2,096)	5,314	1,957	—	5,426
<b>Cash flows from investing activities:</b>						
Purchase of property and equipment	—	—	(1,681)	(1,334)	—	(3,015)
Acquisition of hospitals and health care entities	—	—	(26)	(1,186)	—	(1,212)
Sales of hospitals and health care entities	—	—	14	11	—	25
Change in investments	—	—	(1)	(72)	—	(73)
Other	—	—	—	(4)	—	(4)
Net cash used in investing activities	—	—	(1,694)	(2,585)	—	(4,279)
<b>Cash flows from financing activities:</b>						
Issuance of long-term debt	—	1,500	—	2	—	1,502
Net change in revolving bank credit facilities	—	760	—	—	—	760
Repayment of long-term debt	—	(628)	(77)	(48)	—	(753)
Distributions to noncontrolling interests	—	—	(140)	(308)	—	(448)
Payment of debt issuance costs	—	(26)	—	—	—	(26)
Repurchases of common stock	(2,051)	—	—	—	—	(2,051)
Changes in intercompany balances with affiliates, net	1,867	490	(3,404)	1,047	—	—
Other	(66)	—	—	21	—	(45)
Net cash (used in) provided by financing activities	(250)	2,096	(3,621)	714	—	(1,061)
Change in cash and cash equivalents	1	—	(1)	86	—	86
Cash and cash equivalents at beginning of period	—	—	113	533	—	646
Cash and cash equivalents at end of period	\$ 1	\$ —	\$ 112	\$ 619	\$ —	\$ 732

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

**NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (continued)**

Healthtrust, Inc. — The Hospital Company (“Healthtrust”) is the first-tier subsidiary of HCA Inc. The common stock of Healthtrust has been pledged as collateral for the senior secured credit facilities and senior secured notes described in Note 9. Rule 3-16 of Regulation S-X under the Securities Act requires the filing of separate financial statements for any affiliate of the registrant whose securities constitute a substantial portion of the collateral for any class of securities registered or being registered. We believe the separate financial statements requirement applies to Healthtrust due to the pledge of its common stock as collateral for the senior secured notes. Due to the corporate structure relationship of HCA and Healthtrust, HCA’s operating subsidiaries are also the operating subsidiaries of Healthtrust. The corporate structure relationship, combined with the application of push-down accounting in Healthtrust’s consolidated financial statements related to HCA’s debt and financial instruments, results in the consolidated financial statements of Healthtrust being substantially identical to the consolidated financial statements of HCA. The consolidated financial statements of HCA and Healthtrust present the identical amounts for revenues, expenses, net income, assets, liabilities, total stockholders’ deficit, net cash provided by operating activities, net cash used in investing activities and net cash used in financing activities. Certain individual line items in the HCA consolidated statements of stockholders’ deficit and cash flows are combined into one line item in the Healthtrust consolidated statements of stockholder’s deficit and cash flows.

Reconciliations of the HCA Healthcare, Inc. Consolidated Statements of Stockholders’ Deficit and Consolidated Statements of Cash Flows presentations to the Healthtrust, Inc. — The Hospital Company Consolidated Statements of Stockholder’s Deficit and Consolidated Statements of Cash Flows presentations for the years ended December 31, are as follows (dollars in millions):

	<u>2019</u>	<u>2018</u>	<u>2017</u>
Presentation in HCA Healthcare, Inc. Consolidated Statements of Stockholders’ Deficit:			
Repurchases of common stock	\$(1,031)	\$(1,530)	\$(2,051)
Share-based benefit plans	313	115	281
Cash dividends declared (\$1.60 per share — 2019 and \$1.40 per share — 2018)	(555)	(496)	—
Other	(11)	(12)	(10)
Presentation in Healthtrust, Inc. — The Hospital Company Consolidated Statements of Stockholder’s Deficit:			
Distributions to HCA Healthcare, Inc., net of contributions from HCA Healthcare, Inc.	<u>\$(1,284)</u>	<u>\$(1,923)</u>	<u>\$(1,780)</u>
Presentation in HCA Healthcare, Inc. Consolidated Statements of Cash Flows (cash flows from financing activities):			
Repurchases of common stock	\$(1,031)	\$(1,530)	\$(2,051)
Payment of dividends	(550)	(487)	—
Presentation in Healthtrust, Inc. — The Hospital Company Consolidated Statements of Cash Flows (cash flows from financing activities):			
Cash distributions to HCA Healthcare, Inc.	<u>\$(1,581)</u>	<u>\$(2,017)</u>	<u>\$(2,051)</u>

Due to the consolidated financial statements of Healthtrust being substantially identical to the consolidated financial statements of HCA, except for the items presented in the table above, the separate consolidated financial statements of Healthtrust are not presented.

**HCA HEALTHCARE, INC.**  
**QUARTERLY CONSOLIDATED FINANCIAL INFORMATION**  
**(UNAUDITED)**  
**(Dollars in millions, except per share amounts)**

	2019			
	First	Second	Third	Fourth
Revenues	\$12,517	\$12,602	\$12,694	\$13,523
Net income	\$ 1,181(a)	\$ 927(b)	\$ 764(c)	\$ 1,273
Net income attributable to HCA Healthcare, Inc.	\$ 1,039(a)	\$ 783(b)	\$ 612(c)	\$ 1,071
Basic earnings per share	\$ 3.03	\$ 2.29	\$ 1.80	\$ 3.16
Diluted earnings per share	\$ 2.97	\$ 2.25	\$ 1.76	\$ 3.09

	2018			
	First	Second	Third	Fourth
Revenues	\$11,423	\$11,529	\$11,451	\$12,274
Net income	\$ 1,282( d )	\$ 966( e )	\$ 896( f )	\$ 1,245( g )
Net income attributable to HCA Healthcare, Inc.	\$ 1,144( d )	\$ 820( e )	\$ 759( f )	\$ 1,064( g )
Basic earnings per share	\$ 3.26	\$ 2.35	\$ 2.20	\$ 3.09
Diluted earnings per share	\$ 3.18	\$ 2.31	\$ 2.15	\$ 3.01

- (a) First quarter results include \$1 million of losses on sales of facilities (See Note 3 of the notes to consolidated financial statements).
- (b) Second quarter results include \$14 million of gains on sales of facilities (See Note 3 of the notes to consolidated financial statements).
- (c) Third quarter results include \$ 162 million of losses on retirement of debt (See Note 9 of the notes to consolidated financial statements).
- (d) First quarter results include \$305 million of gains on sales of facilities (See Note 3 of the notes to consolidated financial statements).
- (e) Second quarter results include \$8 million of gains on sales of facilities (See Note 3 of the notes to consolidated financial statements).
- (f) Third quarter results include \$ 5 million of gains on sales of facilities (See Note 3 of the notes to consolidated financial statements) and \$7 million of losses on retirement of debt (See Note 9 of the notes to consolidated financial statements).
- (g) Fourth quarter results include \$6 million of gains on sales of facilities (See Note 3 of the notes to consolidated financial statements).

**DESCRIPTION OF THE REGISTRANT'S SECURITIES  
REGISTERED PURSUANT TO SECTION 12 OF THE  
SECURITIES EXCHANGE ACT OF 1934**

As of December 31, 2019, HCA Healthcare, Inc. had one class of securities registered under Section 12 of the Securities Exchange Act of 1934, as amended: our common stock.

In this Exhibit 4.1, when we refer to the “Company,” “we,” “us” or “our” or when we otherwise refer to ourselves, we mean HCA Healthcare, Inc., excluding, unless otherwise expressly stated, our subsidiaries and affiliates.

The following description is a summary of the material terms of our Certificate of Incorporation, as amended (the “Certificate of Incorporation”), and our Bylaws, as amended (the “Bylaws”), as currently in effect. This description is subject to, and qualified in its entirety by reference to, our Certificate of Incorporation and our Bylaws, each of which are incorporated by reference as an exhibit to the Annual Report on Form 10-K of which this Exhibit 4.1 is a part. We encourage you to read our Certificate of Incorporation, our Bylaws and the applicable provisions of the Delaware General Corporation Law (“DGCL”), for additional information.

#### **Authorized Capital**

As of December 31, 2019, our authorized capital stock consisted of 1,800,000,000 shares of common stock, par value \$.01 per share and 200,000,000 shares of preferred stock.

#### **Common Stock**

*Voting Rights.* Under the terms of the Certificate of Incorporation, each holder of common stock is entitled to one vote for each share on all matters submitted to a vote of the stockholders, including the election of directors. Our stockholders do not have cumulative voting rights. Because of this, the holders of a majority of the shares of common stock entitled to vote and present in person or by proxy at any annual meeting of stockholders are able to elect all of the directors standing for election, if they should so choose.

*Dividends.* Subject to preferences that may be applicable to any then outstanding preferred stock, holders of common stock are entitled to receive ratably those dividends, if any, as may be declared from time to time by the Board of Directors out of legally available assets or funds.

*Liquidation.* In the event of our liquidation, dissolution, or winding up, holders of common stock are entitled to share ratably in the net assets legally available for distribution to stockholders after the payment of all of our debts and other liabilities and the satisfaction of any liquidation preference granted to the holders of any outstanding shares of preferred stock.

*Rights and Preferences.* Holders of common stock have no preemptive or conversion rights, and there are no redemption or sinking fund provisions applicable to the common stock. The rights, preferences, and privileges of the holders of common stock are subject to, and may be adversely affected by, the rights of the holders of shares of any series of preferred stock, which we may designate in the future.

#### **Board of Directors**

The Certificate of Incorporation provides for a Board of Directors of not less than three members, the exact number to be determined from time to time by resolution adopted by the affirmative vote of a majority of the total number of directors then in office. The Certificate of Incorporation provides that directors will be elected to hold office for a term expiring at the next annual meeting of stockholders and until a successor is duly elected and qualified or until his or her earlier death, resignation, disqualification or removal. In uncontested director elections each director is elected by the vote of the majority of the votes cast. An incumbent nominee not receiving a majority of the votes cast in an uncontested election shall continue to serve until (i) the director's successor is elected and qualifies or (ii) the Board of Directors accepts the director's resignation. Newly created directorships and vacancies may be filled, so long as there is at least one remaining director, only by the Board of Directors.

---

### **Amendment to Bylaws**

The Certificate of Incorporation and Bylaws provide that the Board of Directors is expressly authorized to make, alter, amend, change, add to or repeal the Bylaws of the Company by the affirmative vote of a majority of the total number of directors then in office. Any amendment, alteration, change, addition or repeal of the Bylaws of the Company by the stockholders of the Company shall require the affirmative vote of the holders of at least a majority of the outstanding shares of the Company, voting together as a class, entitled to vote on such amendment, alteration, change, addition or repeal.

### **Amendment to Certificate of Incorporation**

The Certificate of Incorporation provides that the affirmative vote of the holders of at least a majority of the voting power of all outstanding shares of the Company entitled to vote generally in the election of directors, voting together in a single class, is required to adopt any provision inconsistent with, to amend or repeal any provision of, or to adopt a bylaw inconsistent with certain specified provisions of the Certificate of Incorporation.

### **Special Meetings of Stockholders**

The Certificate of Incorporation provides that special meetings of stockholders of the Company may be called only by either the Board of Directors, pursuant to a resolution adopted by the affirmative vote of the majority of the total number of directors then in office, or by the Chairman of the Board or the Chief Executive Officer of the Company.

### **Action on Written Consent**

Pursuant to the Certificate of Incorporation and Bylaws, any action required or permitted to be taken at an annual or special meeting of stockholders of the Company may be taken only upon the vote of the stockholders at an annual or special meeting duly called and may not be taken by written consent of the stockholders.

### **Corporate Opportunities**

The Certificate of Incorporation provides that we renounce any interest or expectancy of the Company in the business opportunities of certain of our current and prior investors and of their officers, directors, agents, shareholders, members, partners, affiliates and subsidiaries and each such party shall not have any obligation to offer us those opportunities unless presented to a director or officer of the Company in his or her capacity as a director or officer of the Company.

### **Advance Notice Requirements for Stockholder Proposals and Director Nominations**

Our Bylaws provide that stockholders seeking to nominate candidates for election as directors or to bring business before an annual or special meeting of stockholders must provide timely notice of their proposal in writing to the secretary of the Company. Generally, to be timely, a stockholder's notice must be delivered to, mailed or received at our principal executive offices, addressed to the secretary of the Company, and within the following time periods:

- in the case of an annual meeting, no earlier than 120 days and no later than 90 days prior to the first anniversary of the date of the preceding year's annual meeting; provided, however, that if (A) the annual meeting is advanced by more than 30 days, or delayed by more than 60 days, from the first anniversary of the preceding year's annual meeting, or (B) no annual meeting was held during the preceding year, to be timely the stockholder notice must be received no earlier than 120 days before such annual meeting and no later than the later of 90 days before such annual meeting or the tenth day after the day on which public disclosure of the date of such meeting is first made; and

- in the case of a nomination of a person or persons for election to the Board of Directors at a special meeting of the stockholders called for the purpose of electing directors, no earlier than 120 days before such special meeting and no later than the later of 90 days before such annual or special meeting or the tenth day after the day on which public disclosure of the date of such meeting is first made.

In no event shall an adjournment, postponement or deferral, or public disclosure of an adjournment, postponement or deferral, of a meeting of the stockholders commence a new time period (or extend any time period) for the giving of the stockholder's notice.

We have also adopted a proxy access right that permits a stockholder, or a group of up to 20 stockholders, owning continuously for at least three years shares of our stock representing an aggregate of at least 3% of the voting power entitled to vote in the election of directors, to nominate and include in our proxy materials director nominees, provided that the stockholder(s) and the nominee(s) satisfy the requirements in our Bylaws. Under our Bylaws, to be considered timely, compliant notice of proxy access director nominations for next year's proxy statement and form of proxy must be submitted to the Corporate Secretary at the address specified in our proxy statement no earlier than 150 days and no later than 120 days prior to the first anniversary of the date the Company mailed its proxy statement for the preceding year's annual meeting; provided, however, that if (A) the annual meeting is not within 30 days before or after the anniversary date of the preceding year's annual meeting, or (B) no annual meeting was held during the preceding year, to be timely the stockholder notice must be received no later than 90 days prior to such annual meeting or, if later, the tenth day after the day on which notice of the date of the meeting was mailed or public disclosure of the date of such meeting is first made, whichever occurs first.

#### **Authorized but Unissued Capital Stock**

Our Certificate of Incorporation authorizes our Board of Directors, without further action by the stockholders, to issue up to 200,000,000 shares of preferred stock, par value \$.01 per share, in one or more classes or series, to establish from time to time the number of shares to be included in each such class or series, to fix the rights, powers and preferences of the shares of each such class or series and any qualifications, limitations, or restrictions thereon.

Delaware law does not require stockholder approval for any issuance of authorized shares. However, the listing requirements of the New York Stock Exchange, which would apply as long as our common stock is listed on the New York Stock Exchange, require stockholder approval of certain issuances equal to or exceeding 20% of the then outstanding voting power or then outstanding number of shares of common stock. These additional shares may be used for a variety of corporate purposes, including future public offerings, to raise additional capital or to facilitate acquisitions.

One of the effects of the existence of unissued and unreserved common stock or preferred stock may be to enable our Board of Directors to issue shares to persons friendly to current management, which issuance could render more difficult or discourage an attempt to obtain control of our company by means of a merger, tender offer, proxy contest or otherwise, and thereby protect the continuity of our management and possibly deprive the stockholder of opportunities to sell their shares of common stock at prices higher than prevailing market prices.

#### **Limitation on Directors' Liability and Indemnification**

Section 145(a) of the DGCL grants each corporation organized thereunder the power to indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative (other than an action by or in the right of the corporation) by reason of the fact that the person is or was a director, officer, employee or agent of the corporation, or is or was serving at the request of the corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise, against expenses (including attorneys' fees), judgments, fines and amounts paid in settlement that were actually and reasonably incurred by the person in connection with such action, suit or proceeding if the person acted in good faith and in a manner the person reasonably believed to be in or not opposed to the best interests of the corporation, and, with respect to any criminal action or proceeding, had no reasonable cause to believe the person's conduct was unlawful. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which the person reasonably believed to be in or not opposed to the best interests of the corporation, and, with respect to any criminal action or proceeding, had reasonable cause to believe that the person's conduct was unlawful.

---

Section 145(b) of the DGCL grants each corporation organized thereunder the power to indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action or suit by or in the right of the corporation to procure a judgment in its favor by reason of the fact that the person is or was a director, officer, employee or agent of the corporation, or is or was serving at the request of the corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise against expenses (including attorneys' fees) actually and reasonably incurred by the person in connection with the defense or settlement of such action or suit if the person acted in good faith and in a manner the person reasonably believed to be in or not opposed to the best interests of the corporation and except that no indemnification shall be made pursuant to Section 145(b) of the DGCL in respect of any claim, issue or matter as to which such person shall have been adjudged to be liable to the corporation unless and only to the extent that the Delaware Court of Chancery or the court in which such action or suit was brought shall determine upon application that, despite the adjudication of liability but in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for such expenses which the Court of Chancery or such other court shall deem proper.

Section 145(c) of the DGCL provides that to the extent that a present or former director or officer of a corporation has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in Sections 145(a) and (b) of the DGCL, as described in the preceding paragraphs, or in defense of any claim, issue or matter therein, such person shall be indemnified against expenses (including attorneys' fees) actually and reasonably incurred by such person in connection therewith.

Section 145(g) of the DGCL provides, in general, that a corporation shall have the power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the corporation against any liability asserted against the person in any such capacity, or arising out of the person's status as such, regardless of whether the corporation would have the power to indemnify the person against such liability under the provisions of the DGCL. We maintain a directors' and officers' insurance policy that insures our directors and officers against liabilities incurred in their capacity as such for which they are not otherwise indemnified, subject to certain exclusions.

Section 102(b)(7) of the DGCL enables a corporation in its certificate of incorporation, or an amendment thereto, to eliminate or limit the personal liability of a director to the corporation or its stockholders of monetary damages for violations of the directors' fiduciary duty of care as a director, except (i) for any breach of the director's duty of loyalty to the corporation or its stockholders, (ii) for acts or omissions not in good faith or that involve intentional misconduct or a knowing violation of law, (iii) pursuant to Section 174 of the DGCL (providing for director liability in the event of unlawful payment of dividends or unlawful stock purchases or redemptions) or (iv) for any transaction from which a director derived an improper personal benefit. Our Certificate of Incorporation indemnifies the directors and officers to the full extent of the DGCL and also allows the Board of Directors to indemnify all other employees. Such right of indemnification is not exclusive of any right to which such officer or director may be entitled as a matter of law and shall extend and apply to the estates, heirs, executors and administrators of such persons.

We maintain a directors' and officers' insurance policy. The policy insures directors and officers against unindemnified losses arising from certain wrongful acts in their capacities as directors and officers and reimburses us for those losses for which we have lawfully indemnified the directors and officers. The policy contains various exclusions that are normal and customary for policies of this type.

Our employment agreements with certain of our officers provide indemnification for adverse tax consequences they may suffer pursuant to their employment agreements.

We have entered into an indemnification priority and information sharing agreement with certain of our current and prior investors and certain of their affiliated funds to clarify the priority of advancement and indemnification obligations among us and any of our directors appointed by such investors and other related matters.

---

We believe that our Certificate of Incorporation, Bylaws and insurance policies are necessary to attract and retain qualified persons to serve as directors and officers of the Company.

The limitation of liability and indemnification provisions in our Certificate of Incorporation and Bylaws may discourage stockholders from bringing a lawsuit against directors for breach of their fiduciary duty. They may also reduce the likelihood of derivative litigation against directors and officers, even though an action, if successful, might benefit us and other stockholders. Furthermore, a stockholder's investment may be adversely affected to the extent we pay the costs of settlement and damage awards against directors and officers as required or allowed by these indemnification provisions.

Insofar as indemnification for liabilities arising under the Securities Act may be permitted to directors, officers or persons controlling us pursuant to the foregoing provisions or any other provisions described in this prospectus, we have been informed that in the opinion of the Securities and Exchange Commission such indemnification is against public policy as expressed in the Securities Act and is therefore unenforceable.

### **Delaware Anti-Takeover Statutes**

Certain Delaware law provisions may make it more difficult for someone to acquire us through a tender offer, proxy contest or otherwise.

Section 203 of the DGCL provides that, subject to certain stated exceptions, an "interested stockholder" is any person (other than the corporation and any direct or indirect majority-owned subsidiary) who owns 15% or more of the outstanding voting stock of the corporation or is an affiliate or associate of the corporation and was the owner of 15% or more of the outstanding voting stock of the corporation at any time within the three-year period immediately prior to the date of determination, and the affiliates and associates of such person. A corporation may not engage in a business combination with any interested stockholder for a period of three years following the time that such stockholder became an interested stockholder unless:

- prior to such time the board of directors of the corporation approved either the business combination or transaction which resulted in the stockholder becoming an interested stockholder;
- upon consummation of the transaction which resulted in the stockholder becoming an interested stockholder, the interested stockholder owned at least 85% of the voting stock of the corporation outstanding at the time the transaction commenced, excluding shares owned by (i) persons who are directors and also officers and (ii) employee stock plans in which participants do not have the right to determine confidentially whether shares held subject to the plan will be tendered in a tender or exchange offer; or
- at or subsequent to such time, the business combination is approved by the board of directors and authorized at an annual or special meeting of stockholders, and not by written consent, by the affirmative vote of at least 66 2/3% of the outstanding voting stock which is not owned by the interested stockholder.

The effect of these provisions may make a change in control of our business more difficult by delaying, deferring or preventing a tender offer or other takeover attempt that a stockholder might consider in its best interest. This includes attempts that might result in the payment of a premium to stockholders over the market price for their shares. These provisions also may promote the continuity of our management by making it more difficult for a person to remove or change the incumbent members of the board of directors.

### **Transfer Agent and Registrar**

EQ Shareowner Services is the transfer agent and registrar for our common stock.

### **Listing**

Our common stock is listed on the New York Stock Exchange under the symbol "HCA."

### Schedule of Omitted Supplements to U.S. Guarantee Agreement

The supplements to the U.S. guarantee agreement referenced below are substantially identical in all material respects to the Supplement No. 14 dated as of November 9, 2015 to the U.S. Guarantee dated as of November 17, 2006, as amended and restated as of February 26, 2014, as supplemented (the “U.S. Guarantee Agreement”) and filed as Exhibit 4.5(j) to the Company’s annual report on Form 10-K for the fiscal year ended December 31, 2019 (the “Annual Report”), except as to the names of the additional U.S. guarantors listed on the signature pages thereto and the dates on which such supplements to the U.S. Guarantee Agreement were entered into. These supplements to the U.S. Guarantee Agreement are not being filed as exhibits to the Annual Report in reliance on Instruction 2 to Item 601 of Regulation S-K.

Supplements to the U.S. Guarantee Agreement entered into among HCA Inc., Bank of America, N.A., as administrative agent, and the following subsidiaries as additional U.S. guarantors, as of the dates indicated:

Supplement Number	Date	Additional U.S. Guarantors
No. 13	January 9, 2015	<ul style="list-style-type: none"> <li>• Citrus Memorial Hospital, Inc.</li> <li>• Citrus Memorial Property Management, Inc.</li> <li>• CHCA Pearland, L.P</li> <li>• Columbia Healthcare System of Louisiana, Inc.</li> <li>• HCA Pearland GP, Inc.</li> <li>• Mountain Division – CVH, LLC</li> <li>• Pearland Partner, LLC</li> <li>• Primary Health, Inc.</li> <li>• Sarah Cannon Research Institute, LLC</li> <li>• SCRI Holdings, LLC</li> <li>• Southpoint, LLC</li> <li>• Vision Consulting Group LLC</li> <li>• Vision Holdings, LLC</li> <li>• WCP Properties, LLC</li> </ul>
No. 15	January 10, 2017	<ul style="list-style-type: none"> <li>• East Florida – DMC, Inc.</li> <li>• H2U Wellness Centers, LLC</li> <li>• JPM AA Housing, LLC</li> <li>• MediCredit, Inc.</li> <li>• Oklahoma Holding Company, LLC</li> <li>• Outpatient Services Holdings, Inc.</li> <li>• Oviedo Medical Center, LLC</li> <li>• SSHR Holdco, LLC</li> <li>• The Outsource Group, Inc.</li> </ul>

- Cy-Fair Medical Center Hospital, LLC
- Houston NW Manager, LLC
- Houston – PPH, LLC
- North Houston – TRMC, LLC
- Savannah Health Services, LLC
- Sebring Health Services, LLC
- Southeast Georgia Health Services, LLC
- Weatherford Health Services, LLC

### Schedule of Omitted Supplements to Security Agreement

The supplements to the security agreement referenced below are substantially identical in all material respects to the Supplement No. 2 dated as of October 27, 2011 to the Security Agreement dated as of November 17, 2006, amended and restated as of March 2, 2009, as supplemented (the “Security Agreement”) and filed as Exhibit 4.6(b) to the Company’s annual report on Form 10-K for the fiscal year ended December 31, 2019 (the “Annual Report”), except as to the names of the additional subsidiary grantors listed on the signature pages thereto and the dates on which such supplements to the Security Agreement were entered into. These supplements to the Security Agreement are not being filed as exhibits to the Annual Report in reliance on Instruction 2 to Item 601 of Regulation S-K.

Supplements to the Security Agreement entered into among HCA Inc., Bank of America, N.A., as collateral agent, and the following subsidiaries as additional subsidiary grantors, as of the dates indicated:

<u>Supplement Number</u>	<u>Date</u>	<u>Additional Subsidiary Grantors</u>
No. 3	November 4, 2011	Spalding Rehabilitation L.L.C.
No. 4	January 27, 2012	<ul style="list-style-type: none"> <li>• HealthTrust Workforce Solutions, LLC</li> <li>• Parallon Business Solutions, LLC</li> <li>• Parallon Enterprises, LLC</li> <li>• Parallon Health Information Solutions, LLC</li> <li>• Parallon Payroll Solutions, LLC</li> <li>• Parallon Physician Services, LLC</li> <li>• PTS Solutions, LLC</li> </ul>
No. 5	December 7, 2012	HCA American Finance LLC
No. 7	December 6, 2013	Poinciana Medical Center, Inc.
No. 8	December 6, 2013	U.S. Collections, Inc.
No. 9	December 6, 2013	West Florida – MHT, LLC
No. 10	December 6, 2013	West Florida – PPH, LLC
No. 12	December 6, 2013	North Texas – MCA, LLC
No. 13	January 9, 2015	<ul style="list-style-type: none"> <li>• Citrus Memorial Hospital, Inc.</li> <li>• Citrus Memorial Property Management, Inc.</li> <li>• CHCA Pearland, L.P</li> <li>• Columbia Healthcare System of Louisiana, Inc.</li> <li>• HCA Pearland GP, Inc.</li> <li>• Mountain Division – CVH, LLC</li> <li>• Pearland Partner, LLC</li> <li>• Primary Health, Inc.</li> <li>• Sarah Cannon Research Institute, LLC</li> <li>• SCRI Holdings, LLC</li> <li>• Southpoint, LLC</li> <li>• Vision Consulting Group LLC</li> <li>• Vision Holdings, LLC</li> <li>• WCP Properties, LLC</li> </ul>

No. 14	November 9, 2015	<ul style="list-style-type: none"> <li>• PatientKeeper, Inc.</li> </ul>
No. 15	January 10, 2017	<ul style="list-style-type: none"> <li>• Putnam Community Medical Center of North Florida, LLC</li> <li>• East Florida – DMC, Inc.</li> <li>• H2U Wellness Centers, LLC</li> <li>• JPM AA Housing, LLC</li> <li>• MediCredit, Inc.</li> <li>• Oklahoma Holding Company, LLC</li> <li>• Outpatient Services Holdings, Inc.</li> <li>• Oviedo Medical Center, LLC</li> <li>• SSHR Holdco, LLC</li> </ul>
No. 16	January 3, 2018	<ul style="list-style-type: none"> <li>• Parallon Revenue Cycle Services, Inc.</li> <li>• Cy-Fair Medical Center Hospital, LLC</li> <li>• Houston NW Manager, LLC</li> <li>• Houston – PPH, LLC</li> <li>• North Houston – TRMC, LLC</li> <li>• Savannah Health Services, LLC</li> <li>• Sebring Health Services, LLC</li> <li>• Southeast Georgia Health Services, LLC</li> <li>• Weatherford Health Services, LLC</li> </ul>

### Schedule of Omitted Supplements to Pledge Agreement

The supplements to the pledge agreement referenced below are substantially identical in all material respects to the Supplement No. 1 dated as of October 27, 2011 to the Pledge Agreement dated as of November 6, 2006, and amended and restated as of March 2, 2009, as supplemented (the “Pledge Agreement”) and filed as Exhibit 4.7(b) to the Company’s annual report on Form 10-K for the fiscal year ended December 31, 2019 (the “Annual Report”), except as to the names of the additional pledgors listed on the signature pages thereto and the dates on which such supplements to the Pledge Agreement were entered into. These supplements to the Pledge Agreement are not being filed as exhibits to the Annual Report in reliance on Instruction 2 to Item 601 of Regulation S-K.

Supplements to the Pledge Agreement entered into among HCA Inc., Bank of America, N.A., as collateral agent, and the following subsidiaries as additional pledgors, as of the dates indicated:

<u>Supplement Number</u>	<u>Date</u>	<u>Additional Pledgors</u>
No. 2	November 4, 2011	Spalding Rehabilitation L.L.C.
No. 3	January 27, 2012	<ul style="list-style-type: none"> <li>• HealthTrust Workforce Solutions, LLC</li> <li>• Parallon Business Solutions, LLC</li> <li>• Parallon Enterprises, LLC</li> <li>• Parallon Health Information Solutions, LLC</li> <li>• Parallon Payroll Solutions, LLC</li> <li>• Parallon Physician Services, LLC</li> <li>• PTS Solutions, LLC</li> </ul>
No. 4	December 7, 2012	HCA American Finance LLC
No. 6	December 6, 2013	Poinciana Medical Center, Inc.
No. 7	December 6, 2013	U.S. Collections, Inc.
No. 8	December 6, 2013	West Florida – MHT, LLC
No. 9	December 6, 2013	West Florida – PPH, LLC
No. 11	December 6, 2013	North Texas – MCA, LLC

No. 12	January 9, 2015	<ul style="list-style-type: none"> <li>• Citrus Memorial Hospital, Inc.</li> <li>• Citrus Memorial Property Management, Inc.</li> <li>• CHCA Pearland, L.P</li> <li>• Columbia Healthcare System of Louisiana, Inc.</li> <li>• HCA Pearland GP, Inc.</li> <li>• Mountain Division – CVH, LLC</li> <li>• Pearland Partner, LLC</li> <li>• Primary Health, Inc.</li> <li>• Sarah Cannon Research Institute, LLC</li> <li>• SCRI Holdings, LLC</li> <li>• Southpoint, LLC</li> <li>• Vision Consulting Group LLC</li> <li>• Vision Holdings, LLC</li> <li>• WCP Properties, LLC</li> </ul>
No. 13	November 9, 2015	<ul style="list-style-type: none"> <li>• PatientKeeper, Inc.</li> <li>• Putnam Community Medical Center of North Florida, LLC</li> </ul>
No. 14	January 10, 2017	<ul style="list-style-type: none"> <li>• East Florida – DMC, Inc.</li> <li>• H2U Wellness Centers, LLC</li> <li>• JPM AA Housing, LLC</li> <li>• MediCredit, Inc.</li> <li>• Oklahoma Holding Company, LLC</li> <li>• Outpatient Services Holdings, Inc.</li> <li>• Oviedo Medical Center, LLC</li> <li>• SSHR Holdco, LLC</li> <li>• The Outsource Group, Inc.</li> </ul>
No. 15	January 3, 2018	<ul style="list-style-type: none"> <li>• Cy-Fair Medical Center Hospital, LLC</li> <li>• Houston NW Manager, LLC</li> <li>• Houston – PPH, LLC</li> <li>• North Houston – TRMC, LLC</li> <li>• Savannah Health Services, LLC</li> <li>• Sebring Health Services, LLC</li> <li>• Southeast Georgia Health Services, LLC</li> <li>• Weatherford Health Services, LLC</li> </ul>

### Schedule of Omitted Supplements to Security Agreement

The supplements to the security agreement referenced below are substantially identical in all material respects to the Supplement No. 1 dated as of October 27, 2011 to the Security Agreement dated as of September 30, 2011, as supplemented (the "Security Agreement") and filed as Exhibit 4.9(b) to the Company's annual report on Form 10-K for the fiscal year ended December 31, 2019 (the "Annual Report"), except as to the names of the additional subsidiary grantors listed on the signature pages thereto and the dates on which such supplements to the Security Agreement were entered into. These supplements to the Security Agreement are not being filed as exhibits to the Annual Report in reliance on Instruction 2 to Item 601 of Regulation S-K.

Supplements to the Security Agreement entered into among HCA Inc., Bank of America, N.A., as collateral agent, and the following subsidiaries as additional subsidiary grantors, as of the dates indicated:

<u>Supplement Number</u>	<u>Date</u>	<u>Additional Subsidiary Grantors</u>
No. 2	November 4, 2011	Spalding Rehabilitation L.L.C.
No. 3	January 27, 2012	<ul style="list-style-type: none"> <li>• HealthTrust Workforce Solutions, LLC</li> <li>• Parallon Business Solutions, LLC</li> <li>• Parallon Enterprises, LLC</li> <li>• Parallon Health Information Solutions, LLC</li> <li>• Parallon Payroll Solutions, LLC</li> <li>• Parallon Physician Services, LLC</li> <li>• PTS Solutions, LLC</li> </ul>
No. 4	December 7, 2012	HCA American Finance LLC
No. 6	December 6, 2013	Poinciana Medical Center, Inc.
No. 7	December 6, 2013	U.S. Collections, Inc.
No. 8	December 6, 2013	West Florida – MHT, LLC
No. 9	December 6, 2013	West Florida – PPH, LLC
No. 11	December 6, 2013	North Texas – MCA, LLC
No. 12	March 25, 2014	AR Holding 31, LLC
No. 12	January 9, 2015	<ul style="list-style-type: none"> <li>• Citrus Memorial Hospital, Inc.</li> <li>• Citrus Memorial Property Management, Inc.</li> <li>• CHCA Pearland, L.P</li> <li>• Columbia Healthcare System of Louisiana, Inc.</li> <li>• HCA Pearland GP, Inc.</li> <li>• Mountain Division – CVH, LLC</li> <li>• Pearland Partner, LLC</li> <li>• Primary Health, Inc.</li> <li>• Sarah Cannon Research Institute, LLC</li> <li>• SCRI Holdings, LLC</li> <li>• Southpoint, LLC</li> <li>• Vision Consulting Group LLC</li> <li>• Vision Holdings, LLC</li> <li>• WCP Properties, LLC</li> </ul>

No. 13	November 9, 2015	<ul style="list-style-type: none"> <li>• PatientKeeper, Inc.</li> <li>• Putnam Community Medical Center of North Florida, LLC</li> </ul>
No. 14	January 10, 2017	<ul style="list-style-type: none"> <li>• East Florida – DMC, Inc.</li> <li>• H2U Wellness Centers, LLC</li> <li>• JPM AA Housing, LLC</li> <li>• MediCredit, Inc.</li> <li>• Oklahoma Holding Company, LLC</li> <li>• Outpatient Services Holdings, Inc.</li> <li>• Oviedo Medical Center, LLC</li> <li>• SSHR Holdco, LLC</li> <li>• Parallon Revenue Cycle Services, Inc.</li> </ul>
No. 15	January 3, 2018	<ul style="list-style-type: none"> <li>• Cy-Fair Medical Center Hospital, LLC</li> <li>• Houston NW Manager, LLC</li> <li>• Houston – PPH, LLC</li> <li>• North Houston – TRMC, LLC</li> <li>• Savannah Health Services, LLC</li> <li>• Sebring Health Services, LLC</li> <li>• Southeast Georgia Health Services, LLC</li> <li>• Weatherford Health Services, LLC</li> </ul>

**Schedule of Omitted Supplemental Indentures to Supplemental Indentures relating to the Company's Senior Secured Notes**

*4.75% Senior Secured Notes due 2023 (Sixth Supplemental Indenture)*

The supplemental indentures referenced below are substantially identical in all material respects to the Supplemental Indenture, dated as of January 3, 2018 (the "Supplement to the Sixth Supplemental Indenture"), to the indenture, dated as of August 1, 2011 (the "Base Indenture") and filed as Exhibit 4.28(b) to the Company's annual report on Form 10-K for the fiscal year ended December 31, 2019 (the "Annual Report") as supplemented by the Sixth Supplemental Indenture dated as of October 23, 2012, and filed as Exhibit 4.28(a) to the Annual Report, except as to the names of the subsidiary guarantors listed on the signature pages thereto and the dates on which such supplemental indentures were entered into. These supplemental indentures are not being filed as exhibits to the Annual Report in reliance on Instruction 2 to Item 601 of Regulation S-K.

Supplemental indentures to the Sixth Supplemental Indenture entered into among Delaware Trust Company, as trustee and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent, and the following subsidiary guarantors on the dates indicated:

- January 10, 2017
  - Oviedo Medical Center, LLC
  - East Florida - DMC, LLC
  - Oklahoma Holding Company, LLC
  - Mediacredit, Inc.
  - The Outsource Group, Inc.
  - Outpatient Services Holdings, Inc.
  - H2U Wellness Centers, Inc.
  - SSHR Holdco, LLC
  - JPM AA Housing, LLC
- November 9, 2015
  - Putnam Community Medical Center of North Florida, LLC
  - PatientKeeper, Inc.
- January 9, 2015
  - Mountain Division - CVH, LLC
  - Citrus Memorial Hospital, Inc.
  - Citrus Memorial Property Management, Inc.
  - Primary Health, Inc.
  - Pearland Partner, LLC
  - HCA Pearland GP, Inc.
  - Columbia Healthcare System of Louisiana, Inc.
  - SCRI Holdings LLC
  - Vision Consulting Group, LLC
  - Vision Holdings, LLC
  - Southpoint, LLC
  - WCP Properties, LLC
  - CHCA Pearland, L.P.
  - Sarah Cannon Research Institute, LLC
- December 6, 2013
  - Poinciana Medical Center, Inc.
  - U.S. Collections, Inc.
  - West Florida - MHT, LLC
  - West Florida - PPH, LLC
  - North Texas - MCA, LLC

- December 7, 2012
  - HCA American Finance LLC

*5.00% Senior Secured Notes due 2024 (Eighth Supplemental Indenture)*

The supplemental indentures referenced below are substantially identical in all material respects to the Supplement to the Sixth Supplemental Indenture, except as to the indenture being supplemented, the names of the subsidiary guarantors listed on the signature pages thereto and the dates on which such supplemental indentures were entered into. These supplemental indentures are not being filed as exhibits to the Annual Report in reliance on Instruction 2 to Item 601 of Regulation S-K.

Supplemental indentures to the Base Indenture as supplemented by the Eighth Supplemental Indenture dated as of March 17, 2014 and filed as Exhibit 4.34 to the Annual Report, entered into among Delaware Trust Company, as trustee and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent, and the following subsidiary guarantors on the dates indicated:

- January 3, 2018
  - Southeast Georgia Health Service, LLC
  - Sebring Health Services, LLC
  - Houston - PPH, LLC
  - Cy-Fair Medical Center Hospital, LLC
  - North Houston - TRMC, LLC
  - Savannah Health Services, LLC
  - Houston NW Manager, LLC
  - Weatherford Health Services, LLC
- January 10, 2017
  - Oviedo Medical Center, LLC
  - East Florida - DMC, LLC
  - Oklahoma Holding Company, LLC
  - Medicredit, Inc.
  - The Outsource Group, Inc.
  - Outpatient Services Holdings, Inc.
  - H2U Wellness Centers, Inc.
  - SSHR Holdco, LLC
  - JPM AA Housing, LLC
- November 9, 2015
  - Putnam Community Medical Center of North Florida, LLC
  - PatientKeeper, Inc.
- January 9, 2015
  - Mountain Division - CVH, LLC
  - Citrus Memorial Hospital, Inc.
  - Citrus Memorial Property Management, Inc.
  - Primary Health, Inc.
  - Pearland Partner, LLC
  - HCA Pearland GP, Inc.
  - Columbia Healthcare System of Louisiana, Inc.
  - SCRI Holdings LLC
  - Vision Consulting Group, LLC
  - Vision Holdings, LLC
  - Southpoint, LLC
  - WCP Properties, LLC
  - CHCA Pearland, L.P.
  - Sarah Cannon Research Institute, LLC

*5.25% Senior Secured Notes due 2025 (Tenth Supplemental Indenture)*

The supplemental indentures referenced below are substantially identical in all material respects to the Supplement to the Sixth Supplemental Indenture, except as to the indenture being supplemented, the names of the subsidiary guarantors listed on the signature pages thereto and the dates on which such supplemental indentures were entered into. These supplemental indentures are not being filed as exhibits to the Annual Report in reliance on Instruction 2 to Item 601 of Regulation S-K.

Supplemental indentures to the Base Indenture as supplemented by the Tenth Supplemental Indenture dated as of October 17, 2014 and filed as Exhibit 4.37 to the Annual Report, entered into among Delaware Trust Company, as trustee and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent, and the following subsidiary guarantors on the dates indicated:

- January 3, 2018
  - Southeast Georgia Health Service, LLC
  - Sebring Health Services, LLC
  - Houston - PPH, LLC
  - Cy-Fair Medical Center Hospital, LLC
  - North Houston - TRMC, LLC
  - Savannah Health Services, LLC
  - Houston NW Manager, LLC
  - Weatherford Health Services, LLC
- January 10, 2017
  - Oviedo Medical Center, LLC
  - East Florida - DMC, LLC
  - Oklahoma Holding Company, LLC
  - Medicredit, Inc.
  - The Outsource Group, Inc.
  - Outpatient Services Holdings, Inc.
  - H2U Wellness Centers, Inc.
  - SSHR Holdco, LLC
  - JPM AA Housing, LLC
- November 9, 2015
  - Putnam Community Medical Center of North Florida, LLC
  - PatientKeeper, Inc.
- January 9, 2015
  - Mountain Division - CVH, LLC
  - Citrus Memorial Hospital, Inc.
  - Citrus Memorial Property Management, Inc.
  - Primary Health, Inc.
  - Pearland Partner, LLC
  - HCA Pearland GP, Inc.
  - Columbia Healthcare System of Louisiana, Inc.
  - SCRI Holdings LLC
  - Vision Consulting Group, LLC
  - Vision Holdings, LLC
  - Southpoint, LLC
  - WCP Properties, LLC
  - CHCA Pearland, L.P.
  - Sarah Cannon Research Institute, LLC

*5.25% Senior Secured Notes due 2026 (Fifteenth Supplemental Indenture)*

The supplemental indentures referenced below are substantially identical in all material respects to the Supplement to the Sixth Supplemental Indenture, except as to the indenture being supplemented, the names of the subsidiary

guarantors listed on the signature pages thereto and the dates on which such supplemental indentures were entered into. These supplemental indentures are not being filed as exhibits to the Annual Report in reliance on Instruction 2 to Item 601 of Regulation S-K.

Supplemental indentures to the Base Indenture as supplemented by the Fifteenth Supplemental Indenture dated as of March 15, 2016 and filed as Exhibit 4.46 to the Annual Report, entered into among Delaware Trust Company, as trustee and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent, and the following subsidiary guarantors on the dates indicated:

- January 3, 2018
  - Southeast Georgia Health Service, LLC
  - Sebring Health Services, LLC
  - Houston - PPH, LLC
  - Cy-Fair Medical Center Hospital, LLC
  - North Houston - TRMC, LLC
  - Savannah Health Services, LLC
  - Houston NW Manager, LLC
  - Weatherford Health Services, LLC
- January 10, 2017
  - Oviedo Medical Center, LLC
  - East Florida - DMC, LLC
  - Oklahoma Holding Company, LLC
  - Medicredit, Inc.
  - The Outsource Group, Inc.
  - Outpatient Services Holdings, Inc.
  - H2U Wellness Centers, Inc.
  - SSHR Holdco, LLC
  - JPM AA Housing, LLC

*4.50% Senior Secured Notes due 2027 (Sixteenth Supplemental Indenture)*

The supplemental indentures referenced below are substantially identical in all material respects to the Supplement to the Sixth Supplemental Indenture, except as to the indenture being supplemented, the names of the subsidiary guarantors listed on the signature pages thereto and the dates on which such supplemental indentures were entered into. These supplemental indentures are not being filed as exhibits to the Annual Report in reliance on Instruction 2 to Item 601 of Regulation S-K.

Supplemental indentures to the Base Indenture as supplemented by the Sixteenth Supplemental Indenture dated as of August 15, 2016 and filed as Exhibit 4.49 to the Annual Report, entered into among Delaware Trust Company, as trustee and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent, and the following subsidiary guarantors on the dates indicated:

- January 3, 2018
  - Southeast Georgia Health Service, LLC
  - Sebring Health Services, LLC
  - Houston - PPH, LLC
  - Cy-Fair Medical Center Hospital, LLC
  - North Houston - TRMC, LLC
  - Savannah Health Services, LLC
  - Houston NW Manager, LLC
  - Weatherford Health Services, LLC
- January 10, 2017
  - Oviedo Medical Center, LLC
  - East Florida - DMC, LLC
  - Oklahoma Holding Company, LLC

- 
- Mediacredit, Inc.
  - The Outsource Group, Inc.
  - Outpatient Services Holdings, Inc.
  - H2U Wellness Centers, Inc.
  - SSHR Holdco, LLC
  - JPM AA Housing, LLC

*5.50% Senior Secured Notes due 2047 (Eighteenth Supplemental Indenture)*

The supplemental indentures referenced below are substantially identical in all material respects to the Supplement to the Sixth Supplemental Indenture, except as to the indenture being supplemented, the names of the subsidiary guarantors listed on the signature pages thereto and the dates on which such supplemental indentures were entered into. These supplemental indentures are not being filed as exhibits to the Annual Report in reliance on Instruction 2 to Item 601 of Regulation S-K.

Supplemental indentures to the Base Indenture as supplemented by the Eighteenth Supplemental Indenture dated as of June 22, 2017 and filed as Exhibit 4.53 to the Annual Report, entered into among Delaware Trust Company, as trustee and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent, and the following subsidiary guarantors on the date indicated:

- January 3, 2018
  - Southeast Georgia Health Service, LLC
  - Sebring Health Services, LLC
  - Houston - PPH, LLC
  - Cy-Fair Medical Center Hospital, LLC
  - North Houston - TRMC, LLC
  - Savannah Health Services, LLC
  - Houston NW Manager, LLC
  - Weatherford Health Services, LLC

**Form of HCA Healthcare, Inc.  
Stock Appreciation Rights Agreement**

This STOCK APPRECIATION RIGHTS AGREEMENT (the "Agreement"), dated as of \_\_\_\_\_ (the "Grant Date") is made by and between HCA Healthcare, Inc., a Delaware corporation (together with its Subsidiaries, Successors and other applicable Service Recipients, hereinafter referred to as the "Company"), and the individual whose name is set forth below, who is an employee of the Company and hereinafter referred to as the "Grantee". Any capitalized terms herein not otherwise defined in Article I shall have the meaning set forth in the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as amended and restated (the "Plan").

WHEREAS, the Company wishes to carry out the Plan, the terms of which are hereby incorporated by reference and made a part of this Agreement; and

WHEREAS, the Compensation Committee of the Board of Directors of the Company, including any subcommittee formed pursuant to Section 3(a) of the Plan, (or, if no such committee is appointed, the Board of Directors of the Company) (the "Committee") has determined that it would be to the advantage and best interest of the Company and its shareholders to grant an award of Stock Appreciation Rights ("SARs") as provided for herein to the Grantee as an incentive for increased efforts during his or her term of office, employment or service with the Company, and has advised the Company thereof and instructed the undersigned officers to issue said SARs;

NOW, THEREFORE, in consideration of the mutual covenants herein contained and other good and valuable consideration, receipt of which is hereby acknowledged, the parties hereto do hereby agree as follows:

**STOCK APPRECIATION RIGHTS GRANT**

Grantee:	<b>[Participant Name]</b> <b>[Participant Address]</b>
Aggregate number of SARs granted hereunder:	<b>[SAR Award]</b>
Base Price of all SARs granted hereunder:	<b>[Base Price]</b>
Grant Date of Award (" <u>Grant Date</u> "):	<b>[Grant Date]</b>

ARTICLE I  
DEFINITIONS

Whenever the following terms are used in this Agreement, they shall have the meaning specified below unless the context clearly indicates to the contrary.

**Section 1.1. Cause**

“Cause” shall mean “Cause” as such term may be defined in any employment agreement or change-in-control agreement in effect at the time of termination of employment between the Grantee and the Company or, if there is no such employment or change-in-control agreement, “Cause” shall mean (i) willful and continued failure by Grantee (other than by reason of a Permanent Disability) to perform his or her material duties with respect to the Company which continues beyond ten (10) business days after a written demand for substantial performance is delivered to Grantee by the Company (the “Cure Period”); (ii) willful or intentional engaging by Grantee in material misconduct that causes material and demonstrable injury, monetarily or otherwise, to the Company or its Affiliates; (iii) conviction of, or a plea of nolo contendere to, a crime constituting (x) a felony under the laws of the United States or any state thereof or (y) a misdemeanor for which a sentence of more than six months’ imprisonment is imposed; or (iv) Grantee’s engaging in any action in breach of restrictive covenants made by Grantee under any agreement containing restrictive covenants (e.g., covenants not to disclose confidential information, to compete with the business of the Company or to solicit the employees thereof to terminate their employment) or any employment or change-in-control agreement between the Grantee and the Company, which continues beyond the Cure Period (to the extent that, in the Board’s reasonable judgment, such breach can be cured).

**Section 1.2. Good Reason**

“Good Reason” shall mean “Good Reason” as such term may be defined in any employment agreement or change-in-control agreement in effect at the time of termination of employment between the Grantee and the Company, or, if there is no such employment or change-in-control agreement, “Good Reason” shall mean (i) (A) a reduction in Grantee’s base salary (other than a general reduction in base salary that affects all similarly situated employees (defined as all employees within the same Company pay grade as that of Grantee) in substantially the same proportions that the Board implements in good faith after consultation with the Chief Executive Officer and Chief Operating Officer of the Company, if any); (B) a reduction in Grantee’s annual incentive compensation opportunity; or (C) the reduction of benefits payable to Grantee under the Company’s Supplemental Executive Retirement Plan (if Grantee is a participant in such plan), in each case other than any isolated, insubstantial and

inadvertent failure by the Company that is not in bad faith and is cured within ten (10) business days after Grantee gives the Company written notice of such event; provided that the events described in (i)(A) or (i)(B) above will not be deemed to give rise to Good Reason if employment is terminated, but Grantee declines an offer of employment involving a loss of compensation of less than 15% from a purchaser, transferee, outsourced vendor, new operating entity or affiliated employer; (ii) a substantial diminution in Grantee's title, duties and responsibilities, other than any isolated, insubstantial and inadvertent failure by the Company that is not in bad faith and is cured within ten (10) business days after Grantee gives the Company written notice of such event; or (iii) a transfer of Grantee's primary workplace to a location that is more than twenty (20) miles from his or her workplace as of the date of this Agreement; provided that Good Reason shall not be deemed to occur merely because Grantee's willful decision to change position or status within the Company causes one or more of the occurrences described in (i), (ii), or (iii) to come about.

**Section 1.3. Permanent Disability**

"Permanent Disability" shall mean "Disability" as such term is defined in any employment agreement between Grantee and the Company, or, if there is no such employment agreement, "Disability" as defined in the long-term disability plan of the Company applicable to Grantee or that would apply to the Grantee if the Grantee were employed with the Company at the applicable time.

**Section 1.4. Retirement**

"Retirement" shall mean Grantee's resignation from service with the Company (i) after attaining 65 years of age or (ii) after attaining 60 years of age and completing twenty (20) years of service with the Company.

**Section 1.5. SARs**

"SARs" shall mean the aggregate number of SARs granted under Section 2.1 of this Agreement.

**Section 1.6. Secretary**

"Secretary" shall mean the Secretary of the Company.

ARTICLE II  
GRANT OF SARs

**Section 2.1. Grant of SARs**

For good and valuable consideration, on and as of the date hereof the Company grants to the Grantee an award of SARs (the "Award") on the terms

and conditions set forth in this Agreement. Each SAR represents the right to receive pursuant to this Agreement, upon exercise of the SAR, a payment from the Company in shares of Common Stock having a value equal to the excess of the Fair Market Value of one Share on the exercise date over the Base Price (as defined below).

**Section 2.2. Base Price**

Subject to Section 2.4, the base price of each SAR granted pursuant to this Agreement (the “Base Price”) shall be as set forth on the first page of this Agreement.

**Section 2.3. No Guarantee of Employment**

Nothing in this Agreement or in the Plan shall confer upon the Grantee any right to continue in the employ of the Company nor interfere with or restrict in any way the rights of the Company, which are hereby expressly reserved, to terminate the employment of the Grantee at any time for any reason whatsoever, with or without cause, subject to the applicable provisions of, if any, the Grantee’s employment agreement with the Company or offer letter provided by the Company to the Grantee.

**Section 2.4. Adjustments to SARs**

The SARs shall be subject to the adjustment provisions of Sections 8 and 9 of the Plan, provided, however, that in the event of the payment of an extraordinary dividend by the Company to its stockholders, then: first, the Base Price of each SAR shall be reduced by the amount of the dividend per share paid, but only to the extent the Committee determines it to be permitted under applicable tax laws and it will not have adverse tax consequences to the Grantee; and, if such reduction cannot be fully effected due to such tax laws, second, the Company shall pay to the Grantee a cash payment, on a per SAR basis, equal to the balance of the amount of the dividend not permitted to be applied to reduce the Base Price of the applicable SARs as follows: (a) for each Share with respect to which a vested SAR relates, promptly following the date of such dividend payment; and (b), for each Share with respect to which an unvested SAR relates, on the date on which such SAR becomes vested and exercisable with respect to such Share.

ARTICLE III  
PERIOD OF EXERCISABILITY

**Section 3.1. Commencement of Exercisability**

(a) So long as the Grantee continues to be employed by the

Company, this Award shall become vested and exercisable with respect to 25% of the SARs on each of the first four anniversaries of the Grant Date (each such date, a “Vesting Date”). Except as provided in Section 3.1(b), or as otherwise provided by the Committee, no part of this Award shall become vested as to any additional SARs as of any date following the termination of Grantee’s employment with the Company for any reason and any SAR, which is (or determined to be) unvested as of the Grantee’s termination of employment, shall immediately expire without payment therefor.

(b) Notwithstanding the foregoing, any unvested SARs may become vested prior to the applicable Vesting Date, or continue to vest (and not be forfeited) following Grantee’s termination of employment, under the following circumstances:

(1) Upon the occurrence of a Change in Control (the definition of which is set forth on Schedule A attached hereto):

(A) In the event the entity surviving the Change in Control (the “Successor”) assumes the Award granted hereby, if the Grantee’s employment with the Successor is terminated without Cause by the Successor, or terminates for Good Reason by the Grantee or on account of Grantee’s death, Permanent Disability, or Retirement prior to an applicable Vesting Date, all unvested SARs not previously forfeited shall immediately vest and become exercisable as of the date of such termination of employment for the applicable period set forth in Section 3.2;

(B) In the event the Successor does not assume the Award granted hereby, all SARs not previously forfeited shall vest (if not already vested) immediately prior to the effective date of the Change in Control, and shall be cancelled in exchange for the payment described in Section 9(a)(ii)(A) of the Plan as of the effective date of the Change in Control;

(2) Upon the Grantee’s Retirement on or after the first anniversary of the Grant Date, except as otherwise provided by Section 3.1(b)(1), any unvested SARs shall immediately thereupon vest and shall not be forfeited, but shall become exercisable only at the time such SARs would have become exercisable in accordance with Section 3(a) or this Section 3(b) had the Grantee remained employed with the Company through each applicable Vesting Date or Grantee’s earlier death or Permanent Disability; for the avoidance of doubt, in the event of Grantee’s Retirement prior to such one year anniversary of the Grant Date, unless otherwise provided in Section 3.1(b)(1)(A), no part of this Award shall become vested and all SARs subject to this Award shall immediately expire without payment therefor;

(3) In the event of the Grantee’s termination of employment on account of Grantee’s death or Permanent Disability on or after the first anniversary of the Grant Date, all unexercised SARs not previously forfeited shall vest and become exercisable immediately upon such termination.

---

**Section 3.2. Expiration of SARs**

The Grantee may not exercise any SAR granted pursuant to this Award, and any unexercised SAR shall immediately expire without any payment therefor, after the first to occur of the following events:

- (a) The tenth anniversary of the Grant Date so long as the Grantee remains employed with the Company or a Successor through such date;
- (b) The fourth anniversary of the date of the Grantee's termination of employment with the Company or a Successor, if the Grantee's employment terminates by reason of death or Permanent Disability;
- (c) Immediately upon the date of the Grantee's termination of employment by the Company or a Successor for Cause;
- (d) One hundred and eighty (180) days after the date of the Grantee's termination of employment by the Company or a Successor without Cause (for any reason other than as set forth in Section 3.2(b));
- (e) One hundred and eighty (180) days after the date of the Grantee's termination of employment with the Company or a Successor by the Grantee for Good Reason;
- (f) The fourth anniversary of the date of the Grantee's termination of employment with the Company or a Successor by the Grantee upon Retirement; or
- (g) Sixty (60) days after the date of the Grantee's termination of employment with the Company or a Successor by the Grantee without Good Reason (except due to Retirement, death or Permanent Disability).

For the avoidance of doubt, for purposes of this Agreement, Grantee's employment shall not be deemed to have terminated so long as Grantee remains employed by any Service Recipient.

ARTICLE IV  
EXERCISE

**Section 4.1. Person Eligible to Exercise**

The Grantee may exercise only that portion of this Award that has both vested and become exercisable at the time Grantee desires to exercise this Award and that has not expired pursuant to Section 3.2. During the lifetime of the

---

Grantee, only the Grantee (or his or her duly authorized legal representative) may exercise the SARs granted pursuant to this Award or any portion thereof. After the death of the Grantee, any vested and exercisable portion of this Award may, prior to the time when such portion becomes unexercisable under Section 3.2, be exercised by his personal representative or by any person empowered to do so under the Grantee's will or under the then applicable laws of descent and distribution.

**Section 4.2. Partial Exercise**

Any vested and exercisable portion of this Award, or the entire Award, if then wholly vested and exercisable, may be exercised in whole or in part at any time prior to the time when the Award or portion thereof becomes unexercisable under Section 3.2.

**Section 4.3. Manner of Exercise**

Subject to the Company's code of conduct and securities trading policies as in effect from time to time, this Award, or any exercisable portion thereof, may be exercised solely by delivering to the Company or its designated agent all of the following prior to the time when the Award or such portion expires under Section 3.2:

(a) Notice in writing (or such other medium acceptable to the Company or its designated agent) signed or acknowledged by the Grantee or other person then entitled to exercise the Award, stating the number of SARs subject to the Award in respect of which the Award is thereby being exercised, such notice complying with all applicable rules established by the Committee;

(b) (i) Full payment (in cash or by check or by a combination thereof) to satisfy the minimum withholding tax obligation with respect to which the Award or portion thereof is exercised or (ii) indication that the Grantee elects to satisfy the withholding tax obligation through an arrangement that is compliant with the Sarbanes-Oxley Act of 2002 (and any other applicable laws and exchange rules) and that provides for the delivery of irrevocable instructions to a broker to sell Shares obtained upon the exercise of the Award and to deliver promptly to the Company an amount to satisfy the minimum withholding tax obligation that would otherwise be required to be paid by the Grantee to the Company pursuant to clause (i) of this subsection (b), or (iii) if made available by the Company, indication that the Grantee elects to have the number of Shares that would otherwise be issued to the Grantee upon exercise of such Award (or portion thereof) reduced by a number of Shares having an aggregate Fair Market Value, on the date of such exercise, equal to the payment to satisfy the minimum withholding tax obligation that would otherwise be required to be made by the Grantee to the Company pursuant to clause (i) of this subsection (b).

(c) If required by the Company, a bona fide written

representation and agreement, in a form satisfactory to the Company, signed by the Grantee or other person then entitled to exercise such Award or portion thereof, stating that the shares of Common Stock are being acquired for his own account, for investment and without any present intention of distributing or reselling said shares or any of them except as may be permitted under the Securities Act of 1933, as amended (the "Act"), and then applicable rules and regulations thereunder, and that the Grantee or other person then entitled to exercise such Award or portion thereof will indemnify the Company against and hold it free and harmless from any loss, damage, expense or liability resulting to the Company if any sale or distribution of the shares by such person is contrary to the representation and agreement referred to above; provided, however, that the Company may, in its reasonable discretion, take whatever additional actions it deems reasonably necessary to ensure the observance and performance of such representation and agreement and to effect compliance with the Act and any other federal or state securities laws or regulations; and

(d) In the event the Award or portion thereof shall be exercised pursuant to Section 4.1 by any person or persons other than the Grantee, appropriate proof of the right of such person or persons to exercise the Award.

Without limiting the generality of the foregoing, the Company may require an opinion of counsel acceptable to it to the effect that any subsequent transfer of shares acquired on exercise of this Award (or portion thereof) does not violate the Act, and may issue stop-transfer orders covering such Shares. Share certificates evidencing stock issued on exercise of any portion of this Award shall bear an appropriate legend referring to the provisions of subsection (c) above and the agreements herein. The written representation and agreement referred to in subsection (c) above shall, however, not be required if the shares to be issued pursuant to such exercise have been registered under the Act, and such registration is then effective in respect of such shares.

#### **Section 4.4. Conditions to Issuance of Stock Certificates**

The Shares issuable (whether by certificate or otherwise) upon the exercise of this Award, or any portion thereof, may be either previously authorized but unissued Shares or issued Shares, which have then been reacquired by the Company. Such Shares shall be fully paid and nonassessable. If share certificates are to be issued, the Company shall not be required to issue or deliver any certificate or certificates for Shares purchased upon the exercise of this Award or portion thereof prior to fulfillment of all of the following conditions:

(a) The obtaining of approval or other clearance from any state or federal governmental agency which the Committee shall, in its reasonable and good faith discretion, determine to be necessary or advisable; and

(b) The lapse of such reasonable period of time following the exercise of the Award as the Committee may from time to time establish for reasons of administrative convenience or as may otherwise be required by applicable law.

---

**Section 4.5. Rights as Stockholder**

Except as otherwise provided in Section 2.4 of this Agreement, the holder of any SARs subject to this Award shall not be, nor have any of the rights or privileges of, a stockholder of the Company in respect of any Shares issuable upon the exercise of this Award or any portion thereof unless and until certificates representing such Shares shall have been issued by the Company to such holder, or the Company or its designated agent has otherwise recorded the appropriate book entries evidencing Grantee's ownership of the Shares.

ARTICLE V  
MISCELLANEOUS

**Section 5.1. Administration**

The Committee shall have the power to interpret the Plan and this Agreement and to adopt such rules for the administration, interpretation and application of the Plan as are consistent therewith and to interpret or revoke any such rules. All actions taken and all interpretations and determinations made by the Committee shall be final and binding upon the Grantee, the Company and all other interested persons. No member of the Committee shall be personally liable for any action, determination or interpretation made in good faith with respect to the Plan or this Award. In its absolute discretion, the Board may at any time and from time to time exercise any and all rights and duties of the Committee under the Plan and this Agreement.

**Section 5.2. Award Not Transferable**

No part of, or interest in, this Award shall be liable for the debts, contracts or engagements of the Grantee or his successors in interest or shall be subject to disposition by transfer, alienation, anticipation, pledge, encumbrance, assignment or any other means whether such disposition be voluntary or involuntary or by operation of law by judgment, levy, attachment, garnishment or any other legal or equitable proceedings (including bankruptcy), and any attempted disposition thereof shall be null and void and of no effect; provided, however, that this Section 5.2 shall not prevent transfers by will or by the applicable laws of descent and distribution.

**Section 5.3. Notices**

Any notice to be given under the terms of this Agreement to the Company shall be addressed to the Company in care of its Secretary or its designee, and any notice to be given to the Grantee shall be addressed to him at

---

the address (including an electronic address) reflected in the Company's books and records. By a notice given pursuant to this Section 5.3, either party may hereafter designate a different address for notices to be given to him. Any notice, which is required to be given to the Grantee, shall, if the Grantee is then deceased, be given to the Grantee's personal representative if such representative has previously informed the Company of his status and address by written notice under this Section 5.3. Any notice shall have been deemed duly given when (i) delivered in person, (ii) delivered in an electronic form approved by the Company, (iii) enclosed in a properly sealed envelope or wrapper addressed as aforesaid, deposited (with postage prepaid) in a post office or branch post office regularly maintained by the United States Postal Service, or (iv) enclosed in a properly sealed envelope or wrapper addressed as aforesaid, deposited (with fees prepaid) in an office regularly maintained by FedEx, UPS, or comparable non-public mail carrier.

**Section 5.4. Titles; Pronouns**

Titles are provided herein for convenience only and are not to serve as a basis for interpretation or construction of this Agreement. The masculine pronoun shall include the feminine and neuter, and the singular the plural, where the context so indicates.

**Section 5.5. Applicability of Plan**

The Grantee hereby acknowledges receipt of a copy of the Plan and agrees to be bound by all the terms and provisions thereof. The terms of this Agreement are governed by the terms of the Plan, and in the case of any inconsistency between the terms of this Agreement and the terms of the Plan, the terms of the Plan shall govern.

**Section 5.6. Amendment**

Subject to Section 10 of the Plan, this Agreement may be amended only by a writing executed by the parties hereto, which specifically states that it is amending this Agreement.

**Section 5.7 Governing Law**

The laws of the State of Delaware shall govern the interpretation, validity and performance of the terms of this Agreement regardless of the law that might be applied under principles of conflicts of laws.

**Section 5.8 Arbitration**

In the event of any controversy among the parties hereto arising out of, or relating to, this Agreement which cannot be settled amicably by the parties,

such controversy shall be finally, exclusively and conclusively settled by mandatory arbitration conducted expeditiously in accordance with the American Arbitration Association rules, by a single independent arbitrator. Such arbitration process shall take place within the Nashville, Tennessee metropolitan area. The decision of the arbitrator shall be final and binding upon all parties hereto and shall be rendered pursuant to a written decision, which contains a detailed recital of the arbitrator's reasoning. Judgment upon the award rendered may be entered in any court having jurisdiction thereof. Each party shall bear its own legal fees and expenses, unless otherwise determined by the arbitrator. If the Grantee substantially prevails on any of his or her substantive legal claims, then the Company shall reimburse all legal fees and arbitration fees incurred by the Grantee to arbitrate the dispute.

IN WITNESS WHEREOF, this Agreement has been executed and delivered by the parties hereto.

HCA HEALTHCARE, INC.

By: \_\_\_\_\_

Its: \_\_\_\_\_

Grantee:

(electronically accepted)

---

**Schedule A**

**Definition of Change in Control**

For purposes of this Agreement, the term “Change in Control” shall mean, in lieu of any definition contained in the Plan:

(i) the sale or disposition, in one or a series of related transactions, of all or substantially all of the assets of the Company to any Person or Group other than an employee benefit plan (or trust forming a part thereof) maintained by (1) the Company or (2) any corporation or other Person of which a majority of its voting power of its voting equity securities or equity interest is owned, directly or indirectly, by the Company (a “Permitted Holder”); or

(ii) any Person or Group, other than a Permitted Holder, becomes the Beneficial Owner (as such term is defined in Rule 13d-3 under the Exchange Act (or any successor rule thereto) (except that a Person shall be deemed to have “beneficial ownership” of all shares that any such Person has the right to acquire, whether such right is exercisable immediately or only after the passage of time)), directly or indirectly, of more than 50% of the total voting power of the voting stock of the Company (or any entity which controls the Company), including by way of merger, consolidation, tender or exchange offer or otherwise; or

(iii) a reorganization, recapitalization, merger or consolidation (a “Corporate Transaction”) involving the Company, unless securities representing more than 50% of the combined voting power of the then outstanding voting securities entitled to vote generally in the election of directors of the Company or the corporation resulting from such Corporate Transaction (or the parent of such corporation) are Beneficially Owned subsequent to such transaction by the Person or Persons who were the Beneficial Owners of the outstanding voting securities entitled to vote generally in the election of directors of the Company immediately prior to such Corporate Transaction, in substantially the same proportions as their ownership immediately prior to such Corporate Transaction; or

(iv) during any period of 12 months, individuals who at the beginning of such period constituted the Board (together with any new directors whose election by such Board or whose nomination for election by the shareholders of the Company was approved by a vote of a majority of the directors of the Company, then still in office, who were either directors at the beginning of such period or whose election or nomination for election was previously so approved) cease for any reason to constitute a majority of the Board then in office.

**Form of HCA Healthcare, Inc.  
Performance Share Unit Agreement**

This PERFORMANCE SHARE UNIT AGREEMENT (this "Agreement") is made and entered into as of the \_\_\_\_ day of \_\_\_\_\_, 20\_\_ (the "Grant Date"), between HCA Healthcare, Inc., a Delaware corporation (together with its Subsidiaries and Affiliates, as applicable, the "Company"), and **[Participant Name]**, (the "Grantee"). Capitalized terms not otherwise defined herein shall have the meaning ascribed to such terms in the Company's 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (the "Plan").

WHEREAS, the Company has adopted the Plan, which permits the issuance of Other Stock-Based Awards, including an award that provides the right to receive Shares upon the completion of the attainment of performance objectives (a "Performance Share Unit"); and

WHEREAS, the Compensation Committee of the Board of Directors of the Company or a subcommittee thereof (or if no such committee is appointed, the Board of Directors of the Company) (each, the "Committee") has determined that Grantee is entitled to an award thereunder, a portion of which is payable as a Performance Share Unit award under the Plan;

NOW, THEREFORE, the parties hereto agree as follows:

**PERFORMANCE SHARE UNIT GRANT**

Grantee:	<b>[Participant Name]</b> <b>[Participant Address]</b>
Target Number of Performance Share Units Granted Hereunder ("Target Award"):	<b>[Award]</b>
Grant Date:	<b>[Grant Date]</b>

**1. Grant of Performance Share Unit Award.**

1.1 The Company hereby grants to the Grantee the award ("Award") of Performance Share Units ("PSUs") set forth above on the terms and conditions set forth in this Agreement and as otherwise provided in the Plan. A bookkeeping account will be maintained by the Company to keep track of the PSUs and any dividend equivalent units that may accrue as provided in Section 3.

1.2 The Grantee's rights with respect to the Award shall remain forfeitable at all times prior to the dates on which the PSUs shall vest in accordance

---

with Section 2 hereof. This Award may not be assigned, alienated, pledged, attached, sold or otherwise transferred or encumbered by Grantee other than by will or the laws of descent and distribution. Any sale, assignment, transfer, pledge, hypothecation, loan or other disposition other than in accordance with this Section 1.2 shall be null and void.

## 2. Vesting and Payment.

2.1 General. Except as provided in Section 2.2, Section 2.3 or Section 2.4, the Award shall vest as of the end of the Performance Period (as defined in this Section 2.1(a)) (the “Normal Vesting Date”), but only if (a) and to the extent the Company has achieved the performance targets over the period (the “Performance Period”) set forth on Exhibit A attached hereto as certified by the Committee, and (b) the Grantee has remained in service with the Company continuously until the Normal Vesting Date. The number of PSUs that vest may be greater than or less than the Target Award, as more specifically set forth on Exhibit A.

### 2.2 Death; Disability; Retirement; Involuntary Termination Without Cause.

(a) Notwithstanding Section 2.1, in the event the Grantee’s employment with the Company terminates prior to the Normal Vesting Date on account of Grantee’s death, Grantee shall immediately vest in a number of PSUs equal to the Target Award, multiplied by a fraction, the numerator of which is the number of days during the Performance Period during which Grantee was employed by the Company, and the denominator of which is the total number of days in the Performance Period (such fraction, the “Proration Factor”); provided, that this Section 2.2(a) shall not apply if Grantee’s death occurs prior to the first anniversary of the Grant Date.

(b) Notwithstanding Section 2.1, in the event of the Grantee’s employment with the Company terminates prior to the Normal Vesting Date on account of Grantee’s Permanent Disability, Grantee shall vest on the Normal Vesting Date in a number of PSUs equal to the number of PSUs that would have vested if the Grantee had remained employed with the Company until the Normal Vesting Date (based on the attainment of the performance targets determined by the Committee in accordance with Exhibit A hereto), multiplied by the Proration Factor; provided, that this Section 2.2(b) shall not apply if Grantee’s employment terminates prior to the first anniversary of the Grant Date. Any such PSUs shall settle at the time set forth in Section 2.5 as if they had vested on the Normal Vesting Date, or if earlier, upon the determination of the number of PSUs that shall be eligible to vest in connection with a Change in Control as described in Section 2.4. For purposes of this Agreement, “Permanent Disability” shall have the meaning as set forth in any employment agreement between Grantee and the Company, or if there is no such employment agreement, as defined in the long-term disability plan of the Company applicable to Grantee or that would apply to the Grantee if the Grantee were employed with the Company at the applicable time.

---

(c) Notwithstanding Section 2.1, in the event Grantee's employment terminates on account of Retirement or as a result of an involuntary termination without Cause by the Company, Grantee shall vest on the Normal Vesting Date in a number of PSUs equal to the number of PSUs that would have vested if the Grantee had remained employed with the Company until the Normal Vesting Date (based on the attainment of the performance targets determined by the Committee in accordance with Exhibit A hereto), multiplied by the Proration Factor; provided, that this Section 2.2(c) shall not apply if Grantee's employment terminates prior to the first anniversary of the Grant Date. Any such PSUs shall settle at the time set forth in Section 2.5 as if they had vested on the Normal Vesting Date, or if earlier, upon the determination of the number of PSUs that shall be eligible to vest in connection with a Change in Control as described in Section 2.4.

For purposes of this Agreement, unless otherwise defined in any other contractual agreement between Grantee and the Successor, (1) "Retirement" means Grantee's resignation from service with the Company (i) after attaining 65 years of age, or (ii) after attaining 60 years of age and completing twenty years of service with the Company; and (2) "Cause" means "Cause" as such term may be defined in any employment agreement or change-in-control agreement in effect at the time of termination of employment between the Grantee and the Company, or, if there is no such employment or change-in-control agreement, "Cause" shall mean (i) willful and continued failure by Grantee (other than by reason of a Permanent Disability) to perform his or her material duties with respect to the Company which continues beyond ten (10) business days after a written demand for substantial performance is delivered to Grantee by the Company (the "Cure Period"); (ii) willful or intentional engaging by Grantee in material misconduct that causes material and demonstrable injury, monetarily or otherwise, to the Company; (iii) conviction of, or a plea of nolo contendere to, a crime constituting (x) a felony under the laws of the United States or any state thereof or (y) a misdemeanor for which a sentence of more than six months' imprisonment is imposed; or (iv) Grantee's engaging in any action in breach of restrictive covenants made by Grantee under any agreement containing restrictive covenants (e.g., covenants not to disclose confidential information, to compete with the business of the Company or to solicit the employees thereof to terminate their employment) or any employment or change-in-control agreement between the Grantee and the Company, which continues beyond the Cure Period (to the extent that, in the Company reasonable judgment, such breach can be cured).

(d) In the event Grantee's employment has terminated as described in Section 2.2(b) or Section 2.2(c), and Grantee subsequently dies more than six months prior to the Normal Vesting Date, the provisions of Section 2.2(b) or Section 2.2(c) shall be applied as if the performance targets had been achieved at the 100% Target Award level, and the applicable number of PSUs (after applying the applicable proration) shall immediately thereupon vest.

**2.3 Termination of Employment.** Except as provided in Section 2.2, Section 2.4 or as otherwise provided by the Committee, if the Grantee's service as an employee of the Company terminates for any reason prior to the Normal Vesting Date, the Grantee shall forfeit all rights with respect to all PSUs that are not vested on such date of termination.

---

2.4 Change in Control. Upon the occurrence of a Change in Control (the definition of which is set forth on Schedule A attached hereto),

(a) Subject to Section 2.4(c), in the event the entity surviving the Change in Control (together with its Affiliates, the “Successor”) assumes the Award granted hereby, (1) any in process Performance Periods shall end upon the date immediately preceding the Change in Control, (2) the number of PSUs that shall be eligible to vest shall be the Target Award, (3) such Target Award shall vest on the Normal Vesting Date, provided that Grantee remains employed with the Successor through the Normal Vesting Date and (4) notwithstanding Section 2.3 and the previous clause, in the event the Grantee’s employment with the Successor is terminated without Cause by the Successor, or terminates for Good Reason by the Grantee or on account of Grantee’s death or Permanent Disability prior to the Normal Vesting Date, the Target Award shall immediately vest and the applicable Shares shall be released to the Grantee (or Grantee’s estate or other legal representative) upon the Grantee’s termination of employment.

(b) In the event the Successor does not assume the Award granted hereby, a number of PSUs equal to the Target Award shall vest as of the effective date of the Change in Control and the appropriate number of Shares shall be released in accordance with Section 2.5.

(c) In the event Grantee is Retirement eligible at the time of a Change in Control and the Successor assumes the Award granted hereby, a number of PSUs equal to the Target Award, multiplied by the Proration Factor applied as if the Grantee’s employment terminated on account of Retirement on the effective date of the Change in Control, shall vest as of the effective date of the Change in Control and the appropriate number of Shares shall be released in accordance with Section 2.5. In addition, a number of PSUs equal to the difference between the Target Award and the number of PSUs settled on the effective date of the Change in Control shall remain unvested but shall become eligible to vest under terms and conditions similar to those set forth in Section 2.4(a)(3) and Section 2.4(a)(4).

(d) For purposes of this Agreement, unless otherwise defined in any other contractual agreement between Grantee and the Successor, “Good Reason” shall mean “Good Reason” as such term may be defined in any employment agreement or change-in-control agreement in effect at the time of termination of employment between the Grantee and the Successor, or, if there is no such employment or change-in-control agreement, “Good Reason” shall mean (i) (A) a reduction in Grantee’s base salary (other than a general reduction in base salary that affects all similarly situated employees (defined as all employees within the same Successor pay grade as that of Grantee) in substantially the same proportions that the Successor implements in good faith, if any); (B) a reduction in

---

Grantee's annual incentive compensation opportunity; or (C) the reduction of benefits payable to Grantee under the Company's Supplemental Executive Retirement Plan (if Grantee is a participant in such plan), in each case other than any isolated, insubstantial and inadvertent failure by the Successor that is not in bad faith and is cured within ten (10) business days after Grantee gives the Successor written notice of such event; provided that the events described in (i)(A) or (i)(B) above will not be deemed to give rise to Good Reason if employment is terminated, but Grantee declines an offer of employment involving a loss of compensation of less than 15% from the Successor; (ii) a substantial diminution in Grantee's title, duties and responsibilities, other than any isolated, insubstantial and inadvertent failure by the Successor that is not in bad faith and is cured within ten (10) business days after Grantee gives the Successor written notice of such event; or (iii) a transfer of Grantee's primary workplace to a location that is more than twenty (20) miles from his or her workplace as of the date of this Agreement; provided that Good Reason shall not be deemed to occur merely because Grantee's willful decision to change position or status within the Successor causes one or more of the occurrences described in (i), (ii), or (iii) to come about. For purposes of this Section 2.4, the definitions of "Cause" and "Permanent Disability" shall be applied with respect to the Successor as well as the Company.

2.5 Settlement. The Grantee shall be entitled to settlement of the PSUs covered by this Agreement at the time that such PSUs vest pursuant to Section 2.1, Section 2.2 or Section 2.4, as applicable, or if applicable, the date on which the Committee provides the certification set forth in Section 2.1(a) (any such date, the "Settlement Date"). Such settlement shall be made as promptly as practicable thereafter (but in no event after the earlier of the thirtieth day following the Settlement Date or the date that is two months and fifteen days following the Normal Vesting Date), through the issuance to the Grantee (or to the executors or administrators of Grantee's estate in the event of the Grantee's death) of a stock certificate (or evidence such Shares have been registered in the name of the Grantee with the relevant stock agent) for a number of Shares equal to the number of such vested PSUs and any Dividend Equivalent Units that may have accrued pursuant to Section 3 hereof; provided, that any cash-based dividend equivalent rights granted pursuant to Section 3 hereof and any fractional Dividend Equivalent Units shall be paid in cash when (and only if) the PSUs to which they relate settle to the Grantee.

2.6 Withholding Obligations. Except as otherwise provided by the Committee, upon the settlement of any PSUs subject to this Award, the Company shall reduce the number of Shares (and the amount of cash, in the case of cash-based dividend equivalent rights) that would otherwise be issued to the Grantee upon settlement of the Award by a number of Shares (and cash, if applicable) having an aggregate Fair Market Value on the date of such issuance equal to the payment to satisfy the minimum withholding tax obligation of the Company with respect to which the Award is being settled.

---

### 3. Dividend Rights.

The Grantee shall receive dividend equivalent rights in respect of the PSUs covered by this Award at the time of any payment of dividends to stockholders on Shares. At the Company's option, the PSUs will be credited with either (a) additional Performance Share Units (the "Dividend Equivalent Units") (including fractional units) for cash dividends paid on shares of the Company's Common Stock by (i) multiplying the cash dividend paid per Share by the number of PSUs (and previously credited Dividend Equivalent Units) outstanding and unpaid, and (ii) dividing the product determined above by the Fair Market Value of a Share, in each case, on the date the dividend record date, or (b) a cash amount equal to the amount that would be payable to the Grantee as a stockholder in respect of a number of Shares equal to the number of PSUs (and previously credited Dividend Equivalent Units) outstanding and unpaid as of the dividend record date; provided, that cash-based dividend equivalents shall be credited unless the Committee affirmatively elects to credit Dividend Equivalent Units. The PSUs will be credited with Dividend Equivalent Units for stock dividends paid on shares of the Company's Common Stock by multiplying the stock dividend paid per Share by the number of PSUs (and previously credited Dividend Equivalent Units) outstanding and unpaid on the dividend record date. Each Dividend Equivalent Unit shall have a value equal to one Share. Each Dividend Equivalent Unit or cash dividend equivalent right will vest and be settled or payable at the same time as the PSU to which the dividend equivalent right relates. For the avoidance of doubt, no dividend equivalent rights shall accrue under this Section 3 in the event that any dividend equivalent rights or other applicable adjustments pursuant to Section 5 hereof provide similar benefits.

### 4. No Right to Continued Service.

Nothing in this Agreement or the Plan shall be interpreted or construed to confer upon the Grantee any right to continue service as an officer or employee of the Company.

### 5. Adjustments.

The provisions of Section 8 and Section 9 of the Plan are hereby incorporated by reference, and the PSUs (and any Dividend Equivalent Units) are subject to such provisions. Any determination made by the Committee or the Board pursuant to such provisions shall be made in accordance with the provisions of the Plan and shall be final and binding for all purposes of the Plan and this Agreement.

### 6. Administration Subject to Plan.

The Grantee hereby acknowledges receipt of a copy of the Plan and agrees to be bound by all the terms and provisions thereof. The terms of this Agreement are governed by the terms of the Plan, and in the case of any inconsistency between the terms of this Agreement and the terms of the Plan, the terms of the Plan shall govern. The Committee shall have the power to interpret the Plan and

---

this Agreement and to adopt such rules for the administration, interpretation and application of the Plan as are consistent therewith and to interpret or revoke any such rules. All actions taken and all interpretations and determinations made by the Committee shall be final and binding upon the Grantee, the Company and all other interested persons. No member of the Committee shall be personally liable for any action, determination or interpretation made in good faith with respect to the Plan or this Award.

7. Modification of Agreement.

Subject to the restrictions contained in Sections 6 and 10 of the Plan, the Committee may waive any conditions or rights under, amend any terms of, or alter, suspend, discontinue, cancel or terminate, the Award, prospectively or retroactively; provided that any such waiver, amendment, alteration, suspension, discontinuance, cancellation or termination that would adversely affect the rights of the Grantee or any holder or beneficiary of the Award in more than a *de minimis* way shall not to that extent be effective without the consent of the Grantee, holder or beneficiary affected.

8. Section 409A.

Notwithstanding anything herein to the contrary, to the maximum extent permitted by applicable law, the settlement of the PSUs (including any dividend equivalent rights related thereto) to be made to the Grantee pursuant to this Agreement is intended to qualify as a "short-term deferral" pursuant to Section 1.409A-1(b)(4) of the Regulations and this Agreement shall be interpreted consistently therewith. However, under certain circumstances, settlement of the PSUs or any dividend equivalent rights may not so qualify, and in that case, the Committee shall administer the grant and settlement of such PSUs and any dividend equivalent rights in strict compliance with Section 409A of the Code. Further, notwithstanding anything herein to the contrary, if at the time of a Participant's termination of employment with the Company and all Service Recipients, the Participant is a "specified employee" as defined in Section 409A of the Code, and the deferral of the commencement of any payments or benefits otherwise payable hereunder as a result of such termination of service is necessary in order to prevent the imposition of any accelerated or additional tax under Section 409A of the Code, then the Company will defer the commencement of the payment of any such payments or benefits hereunder (without any reduction in such payments or benefits ultimately paid or provided to the Participant) to the minimum extent necessary to satisfy Section 409A of the Code until the date that is six months and one day following the Participant's termination of employment with the Company (or the earliest date as is permitted under Section 409A of the Code), if such payment or benefit is payable upon a termination of employment. For purposes of this Agreement, a "termination of employment" shall have the same meaning as "separation from service" under Section 409A of the Code and Grantee shall be deemed to have remained employed so long as Grantee has not "separated from service" with the Company or Successor. Each payment of PSUs (and related dividend equivalent units) constitutes a "separate payment" for purposes of Section 409A of the Code.

---

9. Severability.

If any provision of this Agreement is, or becomes, or is deemed to be invalid, illegal, or unenforceable in any jurisdiction or as to any Person or the Award, or would disqualify the Plan or Award under any laws deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to the applicable laws, or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan or the Award, such provision shall be stricken as to such jurisdiction, Person or Award, and the remainder of the Plan and Award shall remain in full force and effect.

10. Governing Law.

The validity, interpretation, construction and performance of this Agreement shall be governed by the laws of the State of Delaware without giving effect to the conflicts of law principles thereof, except to the extent that such laws are preempted by Federal law.

11. Successors in Interest.

This Agreement shall inure to the benefit of and be binding upon any successor to the Company. This Agreement shall inure to the benefit of the Grantee's legal representatives. All obligations imposed upon the Grantee and all rights granted to the Company under this Agreement shall be binding upon the Grantee's heirs, executors, administrators and successors.

12. Resolution of Disputes.

Any dispute or disagreement which may arise under, or as a result of, or in any way related to, the interpretation, construction or application of this Agreement shall be determined by the Committee. Any determination made hereunder shall be final, binding and conclusive on the Grantee and the Company for all purposes.

13. Notices.

Any notice to be given under the terms of this Agreement to the Company shall be addressed to the Company in care of its Secretary or its designee, and any notice to be given to the Grantee shall be addressed to him at the address (including an electronic address) then reflected in the Company's books and records. By a notice given pursuant to this Section 13, either party may hereafter designate a different address for notices to be given to him. Any notice, which is required to be given to the Grantee, shall, if the Grantee is then deceased, be given to the Grantee's personal representative if such representative has previously informed the Company of his status and address by written notice under this Section 13. Any notice shall have been deemed duly given when (i) delivered in person, (ii) delivered in an electronic form approved by the Company, (iii) enclosed in a properly sealed envelope or wrapper addressed as aforesaid, deposited (with postage prepaid) in a post office or branch post office regularly maintained by the United States Postal Service, or (iv) enclosed in a properly sealed envelope or wrapper addressed as aforesaid, deposited (with fees prepaid) in an office regularly maintained by FedEx, UPS, or comparable non-public mail carrier.

---

IN WITNESS WHEREOF, the parties have caused this Performance Share Unit Agreement to be duly executed effective as of the day and year first above written.

HCA Healthcare, Inc.

By: \_\_\_\_\_

Grantee:

(electronically accepted)

---

**Schedule A**  
**Definition of Change in Control**

For purposes of this Agreement, the term “Change in Control” shall mean, in lieu of any definition contained in the Plan:

(i) the sale or disposition, in one or a series of related transactions, of all or substantially all of the assets of the Company to any Person or Group other than an employee benefit plan (or trust forming a part thereof) maintained by (1) the Company or (2) any corporation or other Person of which a majority of its voting power of its voting equity securities or equity interest is owned, directly or indirectly, by the Company (a “Permitted Holder”); or

(ii) any Person or Group, other than a Permitted Holder, becomes the Beneficial Owner (as such term is defined in Rule 13d-3 under the Exchange Act (or any successor rule thereto) (except that a Person shall be deemed to have “beneficial ownership” of all shares that any such Person has the right to acquire, whether such right is exercisable immediately or only after the passage of time)), directly or indirectly, of more than 50% of the total voting power of the voting stock of the Company (or any entity which controls the Company), including by way of merger, consolidation, tender or exchange offer or otherwise; or

(iii) a reorganization, recapitalization, merger or consolidation (a “Corporate Transaction”) involving the Company, unless securities representing more than 50% of the combined voting power of the then outstanding voting securities entitled to vote generally in the election of directors of the Company or the corporation resulting from such Corporate Transaction (or the parent of such corporation) are Beneficially Owned subsequent to such transaction by the Person or Persons who were the Beneficial Owners of the outstanding voting securities entitled to vote generally in the election of directors of the Company immediately prior to such Corporate Transaction, in substantially the same proportions as their ownership immediately prior to such Corporate Transaction; or

(iv) during any period of 12 months, individuals who at the beginning of such period constituted the Board (together with any new directors whose election by such Board or whose nomination for election by the shareholders of the Company was approved by a vote of a majority of the directors of the Company, then still in office, who were either directors at the beginning of such period or whose election or nomination for election was previously so approved) cease for any reason to constitute a majority of the Board then in office.

**HCA Healthcare, Inc.  
2020 Performance Share Unit Award  
Performance Targets**

1. Target Award. The target number of PSUs for the Grantee is as set forth on the first page of the Award Agreement. For the avoidance of doubt, all percentages associated with the Award shall be of the Target Award.

2. Performance Period. The Performance Period for this Award shall begin on January 1, 2020 and end on December 31, 2022.

3. Performance Goal. The “Performance Goal” for this Award is Cumulative EPS over the Performance Period. For purposes of this Exhibit A, Cumulative EPS means the sum of the Company’s “diluted earnings per share” of each of the three fiscal years of the Company within the Performance Period as reported in the Company’s audited financial statements for each such year, adjusted to exclude the effects of: (a) gains or losses on sales of facilities, (b) gains or losses on extinguishment of debt, (c) asset or investment impairment charges, (d) legal claim costs (disclosed as separate line item in consolidated income statement), (e) expenses, or adjustments to expenses, for share-based compensation recognized under ASC Topic 718 related to the Performance Share Units that results from EPS performance above or below the Target EPS during the Performance Period, (f) gains or losses on acquisition or disposition of controlling interest in equity investment or consolidated entity, and (g) any other gains, expenses or losses resulting from significant, unusual and/or nonrecurring events, as described in management’s discussion and analysis of financial condition and results of operations appearing in the Company’s annual report for the applicable fiscal year, as determined in good faith by the Board or the Committee.

4. Percentage of PSUs Earned. Following the end of the Performance Period, the Committee will determine the extent to which PSUs have become earned and shall vest according to the following schedule:

<u>Cumulative EPS</u>	<u>Percentage of Target PSUs Earned</u>
Greater than or equal to 110% of Target EPS	200%
100% of Target EPS	100%
90% of Target EPS	25%
Less than 90% of Target EPS	0%

Thus, up to 200% of the Target Award may be earned if maximum performance is achieved for the Performance Period. Vesting related to performance between the percentages of Target EPS listed above will be determined by straight line interpolation. Any PSUs not earned and vested as provided above on the applicable determination date shall be forfeited.

ALABAMA

CareOne Home Health Services, Inc.  
Four Rivers Medical Center PHO, Inc.  
Selma Medical Center Hospital, Inc.

ALASKA

Alaska Regional Medical Group, LLC  
Anchorage Surgicenter, LLC  
Chugach PT, Inc.  
Columbia Behavioral Healthcare, Inc.  
Columbia North Alaska Healthcare, Inc.  
Surgicare of Anchorage, LLC

ARIZONA

DS Real Estate Holdings, LLC  
Urgent Care Extra - Ann & Simmons, LLC  
Urgent Care Extra - Cactus & Southern Highlands, LLC  
Urgent Care Extra - Charleston & Decatur, LLC  
Urgent Care Extra - Charleston/Sloan, LLC  
Urgent Care Extra - Craig & Clayton, LLC  
Urgent Care Extra - Craig & Decatur, LLC  
Urgent Care Extra - Durango & Cheyenne, LLC  
Urgent Care Extra - Durango & Flamingo, LLC  
Urgent Care Extra - Eastern & Horizon Ridge, LLC  
Urgent Care Extra - Rainbow/Mardon, LLC  
Urgent Care Extra - Warm Springs & Green Valley, LLC  
Urgent Care Extra-Tropicana & Jones, LLC

ARKANSAS

Columbia Health System of Arkansas, Inc.

BERMUDA

Parthenon Insurance Company, Limited

CALIFORNIA

Center for Advanced Imaging, LLC  
CFC Investments, Inc.  
CH Systems

---

Chino Community Hospital Corporation, Inc.  
Columbia ASC Management, L.P.  
Columbia Good Samaritan Health System Limited Partnership  
Columbia Riverside, Inc.  
Columbia/HCA San Clemente, Inc.  
Encino Hospital Corporation, Inc.  
Far West Division, Inc.  
Galen-Soch, Inc.  
Good Samaritan Surgery Center, L.P.  
HCA Health Services of California, Inc.  
Healdsburg General Hospital, Inc.  
L E Corporation  
Las Encinas Hospital  
Los Gatos Surgical Center, a California Limited Partnership  
Los Robles Regional Medical Center  
Los Robles Regional Medical Center MOB, LLC  
Los Robles SurgiCenter, LLC  
MCA Investment Company  
Mission Bay Memorial Hospital, Inc.  
Neuro Affiliates Company  
Pacific Partners Management Services, Inc.  
Riverside Healthcare System, L.P.  
Riverside Holdings, Inc.  
San Joaquin Surgical Center, Inc.  
San Jose Pathology Outreach, LLC  
Silicon Valley Health Holdings, LLC  
Southwest Surgical Clinic, Inc.  
Surgicare of Good Samaritan, LLC  
Surgicare of Los Gatos, Inc.  
Surgicare of Los Robles, LLC  
Surgicare of Riverside, LLC  
Surgicare of West Hills, Inc.  
West Hills Hospital  
West Hills Surgical Center, Ltd.  
West Los Angeles Physicians' Hospital, Inc.  
Westminster Community Hospital

#### COLORADO

Altitude Mid Level Providers, LLC  
Arapahoe Surgicenter, LLC  
Center for Advanced Diagnostics LLC  
Centrum Surgery Center, Ltd.  
Clear Creek Surgery Center, LLC

---

Colorado Health Systems, Inc.  
Columbine Psychiatric Center, Inc.  
Continental Division I, Inc.  
Denver Mid-Town Surgery Center, Ltd.  
Denver Surgicenter, LLC  
Diagnostic Mammography Services, G.P.  
Galen of Aurora, Inc.  
HCA-HealthONE LLC  
Health Care Indemnity, Inc.  
HealthONE at Breckenridge, LLC  
HealthONE Aurora Investment, LLC  
HealthONE CareNow Urgent Care, LLC  
HealthONE Clear Creek, LLC  
HealthONE Clinic Services - Bariatric Medicine, LLC  
HealthONE Clinic Services - Behavioral Health, LLC  
HealthONE Clinic Services - Cancer Care LLC  
HealthONE Clinic Services - Cancer Specialties, LLC  
HealthONE Clinic Services - Cardiovascular, LLC  
HealthONE Clinic Services - Medical Specialties, LLC  
HealthONE Clinic Services - Neurosciences, LLC  
HealthONE Clinic Services - Obstetrics and Gynecology, LLC  
HealthONE Clinic Services - Occupational Medicine, LLC  
HealthONE Clinic Services - Oncology Hematology, LLC  
HealthONE Clinic Services - Orthopedic Specialists, LLC  
HealthONE Clinic Services - Otolaryngology Specialists, LLC  
HealthONE Clinic Services - Pediatric Cardiovascular Surgery, LLC  
HealthONE Clinic Services - Pediatric Specialties, LLC  
HealthONE Clinic Services - Primary Care, LLC  
HealthONE Clinic Services - Spine Specialists, LLC  
HealthONE Clinic Services - Spine Surgeons LLC  
HealthONE Clinic Services - Surgery Neurological, LLC  
HealthONE Clinic Services - Surgical Specialties, LLC  
HealthONE Clinic Services - Transplant Services, LLC  
HealthONE Clinic Services - Women's Services, LLC  
HealthONE Clinic Services - Youth Rehabilitation LLC  
HealthONE Clinic Services LLC  
HealthOne Heart Care LLC  
HealthONE High Street Primary Care Center, LLC  
HealthONE Institutes for Clinical Research, LLC  
HealthONE IRL Pathology Services, LLC  
HealthOne Lincoln Investment, LLC  
HealthONE Lowry, LLC  
HealthONE of Denver, Inc.  
HealthONE Radiation Therapy at Red Rocks, LLC

---

HealthONE Radiation Therapy at Thornton, LLC  
HealthONE Ridge View Endoscopy Center, LLC  
HealthONE Surgicare of Ridge View, LLC  
HealthONE Urologic, LLC  
HealthOne Westside Investment, LLC  
Hospital-Based CRNA Services, Inc.  
Lakewood Surgicare, Inc.  
Lincoln Surgery Center, LLC  
Medical Care America Colorado, LLC  
Medical Imaging of Colorado LLC  
Mountain View MRI Associates, Ltd.  
MOVCO, Inc.  
New Rose Holding Company, Inc.  
North Suburban Spine Center, L.P.  
P/SL Hyperbaric Partnership  
Park Ridge Surgery Center, LLC  
Proaxis Therapy HealthOne LLC  
Red Rocks Surgery Center, LLC  
Rocky Mountain Pediatric Hematology Oncology, LLC  
Rocky Mountain Surgery Center, LLC  
Rose Ambulatory Surgery Center, L.P.  
Rose Health Partners, LLC  
Rose Medical Plaza, Ltd.  
Rose POB, Inc.  
Sky Ridge Spine Manager, LLC  
Sky Ridge Surgery Center, L.P.  
Southwest Medpro, Ltd.  
Surgery Center of the Rockies, LLC  
Surgicare of Arapahoe, LLC  
Surgicare of Denver Mid-Town, Inc.  
Surgicare of Denver, LLC  
Surgicare of Park Ridge, LLC  
Surgicare of Rose, LLC  
Surgicare of Sky Ridge Women's Center, LLC  
Surgicare of Sky Ridge, LLC  
Surgicare of Southeast Denver, Inc.  
Surgicare of Swedish, LLC  
Surgicare of Thornton, LLC  
Swedish Medpro, Inc.  
Swedish MOB I, Ltd.  
Swedish MOB II, Inc.  
Swedish MOB III, Inc.  
Swedish MOB IV, Inc.  
Swedish MOB, LLC  
Urology Surgery Center of Colorado, LLC

---

DELAWARE

AC Med, LLC  
ADC Surgicenter, LLC  
Aligned Business Consortium Group, L.P.  
Alliance Surgicare, LLC  
Alpine Surgicenter, LLC  
Alternaco, LLC  
American Medicorp Development Co.  
AOGN, LLC  
Appledore Medical Group, Inc.  
AR Holding 1, LLC  
AR Holding 10, LLC  
AR Holding 11, LLC  
AR Holding 12, LLC  
AR Holding 13, LLC  
AR Holding 14, LLC  
AR Holding 15, LLC  
AR Holding 16, LLC  
AR Holding 17, LLC  
AR Holding 18, LLC  
AR Holding 19, LLC  
AR Holding 2, LLC  
AR Holding 20, LLC  
AR Holding 21, LLC  
AR Holding 22, LLC  
AR Holding 23, LLC  
AR Holding 24, LLC  
AR Holding 25, LLC  
AR Holding 26, LLC  
AR Holding 27, LLC  
AR Holding 28, LLC  
AR Holding 29, LLC  
AR Holding 30, LLC  
AR Holding 31, LLC  
AR Holding 4, LLC  
AR Holding 5, LLC  
AR Holding 6, LLC  
AR Holding 7, LLC  
AR Holding 8, LLC  
AR Holding 9, LLC  
ASD Shared Services, LLC

---

Atlanta Healthcare Management, L.P.  
Atlanta Market GP, Inc.  
Augusta CyberKnife, LLC  
Augusta Management Services, LLC  
Aurora Endoscopy Surgicenter, LLC  
Austin GI Surgicenter, LLC  
Aventura Cancer Center Manager, LLC  
Bay Area Surgicenter, LLC  
Bayshore Partner, LLC  
Belton Family Practice Clinic, LLC  
Boynton Beach EFL Imaging Center, LLC  
Bradenton Outpatient Services, LLC  
Brandon Imaging Manager, LLC  
Brandon Regional Cancer Center, LLC  
Brentwood ASC, LLC  
Brighton Surgicenter, LLC  
Brownsville Surgicenter, LLC  
C/HCA Capital, Inc.  
C/HCA, Inc.  
California Imaging Center Manager, LLC  
California Urgent Care, LLC  
Cancer Centers of North Florida, LLC  
Cancer Services of Aventura, LLC  
Capital Division - CCA, Inc.  
CAREOS, Surgicenter, LLC  
CarePartners HHA Holdings, LLLP  
CarePartners HHA, LLLP  
CarePartners Rehabilitation Hospital, LLLP  
CareSpot of Brentwood (210 Franklin Road), LLC  
CareSpot of Cool Springs (100 International Drive), LLC  
CareSpot of Donelson (2372 Lebanon Road), LLC  
CareSpot of Hendersonville (280 Indian Lake Boulevard), LLC  
CareSpot of Hermitage (5225 Old Hickory Boulevard), LLC  
CareSpot of Lebanon (1705 West Main Street), LLC  
CareSpot of Mt. Juliet (S. Mt. Juliet Road), LLC  
CareSpot of Murfreesboro (1340 Broad Street), LLC  
CareSpot of Nashville (2001 Glen Echo Road), LLC  
CareSpot of Nashville (West End Avenue), LLC  
CareSpot Professional Services of Middle Tennessee, LLC  
Carolina Forest Imaging Manager, LLC  
Centennial CyberKnife Center, LLC  
Centennial CyberKnife Manager, LLC  
Centerpoint Medical Center of Independence, LLC  
Central Florida Imaging Services, LLC

---

Central Florida Management Services, LLC  
Central Health Holding Company, Inc.  
Charleston CareNow Urgent Care, LLC  
CHC Finance Co.  
CHC Payroll Agent, Inc.  
CHCA Bayshore, L.P.  
CHCA Clear Lake, L.P.  
CHCA Conroe, L.P.  
CHCA Mainland, L.P.  
CHCA West Houston, L.P.  
CHCA Woman's Hospital, L.P.  
Clear Lake Cardiac Catheterization Center, L.P.  
Clear Lake Cardiac GP, LLC  
Clear Lake Merger, LLC  
Clear Lake Regional Partner, LLC  
ClinicServ, LLC  
Coastal Bend Hospital, Inc.  
Coastal Healthcare Services, Inc.  
Coliseum Health Group, LLC  
Coliseum Medical Center, LLC  
Coliseum Surgery Center, L.L.C.  
Columbia Hospital Corporation of Fort Worth  
Columbia Hospital Corporation of Houston  
Columbia Hospital Corporation-Delaware  
Columbia Palm Beach GP, LLC  
Columbia Rio Grande Healthcare, L.P.  
Columbia Valley Healthcare System, L.P.  
Columbia Westbank Healthcare, L.P.  
Columbia/HCA Middle East Management Company  
Columbia-SDH Holdings, Inc.  
Columbus Cath Lab, Inc.  
Columbus Cath Lab, LLC  
Concept EFL Imaging Center, LLC  
Concept West EFL Imaging Center, LLC  
Conroe Partner, LLC  
CoralStone Management, Inc.  
Corpus Christi Surgicenter, LLC  
COSCORP, LLC  
CPS TN Processor 1, Inc.  
CRMC-M, LLC  
Cy-Fair Medical Center Hospital, LLC  
Dallas/Ft. Worth Physician, LLC  
Delray EFL Imaging Center, LLC  
Denver Clinic Surgicenter, LLC

---

Doctors Hospital of Augusta, LLC  
East Florida CareNow Urgent Care, LLC  
East Florida Imaging Holdings, LLC  
Eastern Idaho Brachytherapy Equipment Manager, LLC  
Eastern Idaho Brachytherapy Equipment, LLC  
Eastern Idaho Care Partners ACO, LLC  
Eastern Idaho Care Partners Holdings, LLC  
Eastern Idaho Care Partners, LLC  
EASTSIDE URGENT CARE LLC  
EMMC, LLC  
EP Health, LLC  
EP Holdco, LLC  
EPIC Development, Inc.  
EPIC Diagnostic Centers, Inc.  
EPIC Healthcare Management Company  
EPIC Surgery Centers, Inc.  
Fairview Park GP, LLC  
Fairview Partner, LLC  
Family Care of E. Jackson County, LLC  
FHAL, LLC  
FMH Health Services, LLC  
Focus Hand Surgicenter, LLC  
Forest Park Surgery Pavilion, Inc.  
Forest Park Surgery Pavilion, L.P.  
Fort Bend Hospital, Inc.  
Frisco Surgicare, LLC  
GA PHYSICIAN SERVICES LLC  
GA Urgentcare Holding LLC  
Galen (Kansas) Merger, LLC  
Galen BH, Inc.  
Galen Global Finance, Inc.  
Galen GOK, LLC  
Galen Health Institutes, Inc.  
Galen Holdco, LLC  
Galen Hospital Alaska, Inc.  
Galen International Holdings, Inc.  
Galen KY, LLC  
Galen MCS, LLC  
Galen Medical Corporation  
Galen MRMC, LLC  
Galen NMC, LLC  
Galen NSH, LLC  
Galen SOM, LLC  
Galen SSH, LLC

---

Galendeco, Inc.  
GalTex, LLC  
Garden Park Community Hospital Limited Partnership  
Gardens EFL Imaging Center, LLC  
GenoSpace, LLC  
Georgia Health Holdings, Inc.  
Georgia, L.P.  
GHC-Galen Health Care, LLC  
Good Samaritan Hospital, L.P.  
Good Samaritan Hospital, LLC  
Goppert-Trinity Family Care, LLC  
GPCH-GP, Inc.  
Gramercy Eye Surgicenter, LLC  
Grand Strand Regional Medical Center, LLC  
Grandview Health Care Clinic, LLC  
HCA - IT&S Field Operations, Inc.  
HCA - IT&S Inventory Management, Inc.  
HCA - IT&S TN Field Operations, Inc.  
HCA American Finance LLC  
HCA Health Services of Midwest, Inc.  
HCA Healthcare Mission Fund, LLC  
HCA Holdco, LLC  
HCA Imaging Services of North Florida, Inc.  
HCA Inc.  
HCA Management Services, L.P.  
HCA Outpatient Imaging Services Group, Inc.  
HCA Property GP, LLC  
HCA Psychiatric Company  
HCA SF LLC  
HCA SFB 1 LLC  
HCA Squared, LLC  
HCA Wesley Rehabilitation Hospital, Inc.  
HCA-Access Healthcare Holdings, LLC  
HCA-Access Healthcare Partner, Inc.  
HCA-California Urgent Care Holdings, LLC  
HCA-EmCare Holdings, LLC  
HCA-EMS Holdings, LLC  
HCA-Georgia Urgent Care Holdings, LLC  
HCA-HBPS Holdings, LLC  
HCAPS Anesthesia Manager, LLC  
HCA-Solis Holdings, Inc.  
HCA-Solis Mammography Service Holdings of Continental, LLC  
HCA-Solis Mammography Service Holdings of Gulf Coast, LLC  
HCA-Solis Mammography Service Holdings of North Texas, LLC

---

HCA-Solis Mammography Service Holdings of TriStar, LLC  
HCA-Solis Mammography Services, LLC  
HCA-Solis Master, LLC  
HCA-Urgent Care Holdings, LLC  
Health Insight Capital, LLC  
Health Services (Delaware), Inc.  
Health Services Merger, Inc.  
Healthcare Purchasing Alliance, LLC  
Healthcare Technology Assessment Corporation  
Healthco, LLC  
Healthnet of Kentucky, LLC  
HealthONE Care Partners, LLC  
Healthserv Acquisition, LLC  
Healthtrust MOB Tennessee, LLC  
Healthtrust Purchasing Group, L.P.  
Healthtrust, Inc. - The Hospital Company  
Hearthstone Home Health, Inc.  
Heathrow Imaging, LLC  
Hendersonville ODC, LLC  
Henrico Doctors Hospital - Forest Campus Property, LLC  
HHBY Holdings, LLC  
HHNC, LLC  
HICCH-SCL, LLC  
hInsight-Airstrip Holdings, LLC  
hInsight-BMA Holdings, LLC  
hInsight-Customer Care Holdings, LLC  
hInsight-Digital Reasoning Holdings, LLC  
hInsight-Healthbox Holdings, LLC  
hInsight-I2 Holdings, LLC  
hInsight-InVivoLink Holdings, LLC  
hInsight-Loyale Healthcare Holdings, LLC  
hInsight-LS Holdings, LLC  
hInsight-Mobile Heartbeat Holdings, LLC  
hInsight-NX, LLC  
hInsight-Procured Holdings, LLC  
hInsight-PWS I Holdings, LLC  
hInsight-VAI Holdings, LLC  
HM OMCOS, LLC  
Hospital Corp., LLC  
Hospital Development Properties, Inc.  
Hospital Partners Merger, LLC  
Houston - PPH, LLC  
Houston Healthcare Holdings, Inc.  
Houston NW Manager, LLC

---

Houston Urologic Surgicenter, LLC  
Houston Woman's Hospital Partner, LLC  
HPG Enterprises, LLC  
HPG Solutions, LLC  
HSS Holdco, LLC  
HSS Systems, LLC  
HTI Hospital Holdings, Inc.  
HTI MOB, LLC  
HTI MSO, LLC  
Imaging Services of Appomattox, LLC  
Imaging Services of Jacksonville, LLC  
Imaging Services of Louisiana Manager, LLC  
Imaging Services of Louisiana, LLC  
Imaging Services of Orlando, LLC  
Imaging Services of Richmond, LLC  
Imaging Services of Roanoke, LLC  
Imaging Services of West Boynton, LLC  
IMX Holdings, LLC  
Independence Regional Medical Group, LLC  
Indianapolis Hospital Partner, LLC  
Integrated Regional Laboratories, LLP  
InVivoLink, Inc.  
Jackson County Medical Group, LLC  
JCSH, LLC  
JFK Medical Center Limited Partnership  
Jupiter EFL Imaging Center, LLC  
Kansas Healthserv, LLC  
Kendall Regional Medical Center, LLC  
Kingwood Surgicenter, LLC  
Lake City Imaging, LLC  
Lakeside Radiology, LLC  
Lakeview Medical Center, LLC  
Laredo Medco, LLC  
Lee's Summit Family Care, LLC  
Lewis-Gale Medical Center, LLC  
Lewisville Surgicare, LLC  
Loveland Surgicenter, LLC  
Low Country Health Services, Inc. of the Southeast  
Lowry Surgicenter, LLC  
Macon Healthcare, LLC  
Macon Northside Health Group, LLC  
Macon Northside Hospital, LLC  
Management Services Holdings, Inc.  
Maury County Behavioral Health, LLC

---

Mayhill Cancer Center, LLC  
MCA-CTMC Holdings, LLC  
Medical Arts Hospital of Texarkana, Inc.  
Medical Care America, LLC  
Medical Care Financial Services Corp.  
Medical Care Real Estate Finance, Inc.  
Medical Center of Plano Partner, LLC  
Medical Centers of Oklahoma, LLC  
Medical City Dallas Partner, LLC  
Medical City Specialty Surgicenter of Dallas, LLC  
Medical City Surgery Center of Alliance, LLC  
Medical City Surgery Center of Frisco, LLC  
Medical City Surgery Center of Lewisville, LLC  
Medical Corporation of America  
Medical Office Buildings of Kansas, LLC  
Medical Specialties, Inc.  
MediStone Healthcare Ventures, Inc.  
MediVision of Mecklenburg County, Inc.  
MediVision of Tampa, Inc.  
MediVision, Inc.  
Methodist Ambulatory Surgery Center of Boerne, LLC  
Methodist Ambulatory Surgery Center of Landmark, LLC  
MH Anesthesiology Physicians, LLC  
MH Angel Medical Center, LLLP  
MH Asheville Specialty Hospital, LLC  
MH Blue Ridge Medical Center, LLLP  
MH Eckerd Living Center, LLLP  
MH Highlands-Cashiers Medical Center, LLLP  
MH Hospital Holdings, Inc.  
MH Hospital Manager, LLC  
MH Master Holdings, LLLP  
MH Master, LLC  
MH McDowell Imaging, LLLP  
MH Mission Hospital McDowell, LLLP  
MH Mission Hospital, LLLP  
MH Mission Imaging, LLLP  
MH Physician Services, LLC  
MH Transylvania Imaging, LLLP  
MH Transylvania Regional Hospital, LLLP  
Miami Beach EFL Imaging Center, LLC  
MidAmerica Oncology, LLC  
Mid-Continent Health Services, Inc.  
Middle Georgia Hospital, LLC  
Midtown Diagnostics, LLC

---

Midwest Division - ACH, LLC  
Midwest Division - CMC, LLC  
Midwest Division - LRHC, LLC  
Midwest Division - LSH, LLC  
Midwest Division - MCI, LLC  
Midwest Division - MMC, LLC  
Midwest Division - OPRMC, LLC  
Midwest Division - RMC, LLC  
Midwest Holdings, Inc.  
Midwest Medicine Associates, LLC  
Midwest Metropolitan Physicians Group, LLC  
Mobile Corps., Inc.  
Mobile Heartbeat, LLC  
MRT&C, Inc.  
Nashville Shared Services General Partnership  
NeighborMD Management, LLC  
Nevada Urgent Care Holdings, Inc.  
New Iberia Holdings, Inc.  
North Augusta Imaging Management, LLC  
North Augusta Imaging Services, LLC  
North Brandon Imaging, LLC  
North Florida Cancer Center Lake City, LLC  
North Florida Cancer Center Live Oak, LLC  
North Florida Cancer Center Tallahassee, LLC  
North Florida Radiation Oncology, LLC  
North Houston - TRMC, LLC  
North Miami Beach Surgery Center Limited Partnership  
North Miami Beach Surgical Center, LLC  
North Tampa Imaging, LLC  
North Texas Medical Center, Inc.  
Northeast Florida Cancer Services, LLC  
Northern Virginia Surgicenter, LLC  
Northwest Fla. Home Health Agency, Inc.  
Notami Hospitals, LLC  
Notami, LLC  
Notco, LLC  
NTGP, LLC  
NTMC Management Company  
NTMC Venture, Inc.  
Ocala Stereotactic Radiosurgery Partner, LLC  
Ocala Stereotactic Radiosurgery, LLC  
ODP Holdings, LLC  
ODP Manager, LLC  
ODP Properties, LLC

---

Ogden Tomotherapy Manager, LLC  
Ogden Tomotherapy, LLC  
OHH Imaging Services, LLC  
Oklahoma Holding Company, LLC  
Oncology Services of Corpus Christi Manager, LLC  
Oncology Services of Corpus Christi, LLC  
Orlando Outpatient Surgical Center, Inc.  
Outpatient Cardiovascular Center of Central Florida, LLC  
Outpatient GP, LLC  
Outpatient Services - LAD, LLC  
Outpatient Services Holdings, Inc.  
Palm Beach EFL Imaging Center, LLC  
Palms West Hospital Limited Partnership  
Paragon SDS, Inc.  
Paragon WSC, Inc.  
Parallon Holdings, LLC  
Parkland Physician Services, Inc.  
Parkway Hospital, Inc.  
PatientKeeper, Inc.  
Pavilion Surgicenter, LLC  
Pearland Partner, LLC  
Physicians West Surgicenter, LLC  
Pinellas Medical, LLC  
Pioneer Medical, LLC  
Plano Heart Institute, L.P.  
Plano Heart Management, LLC  
Plantation General Hospital, L.P.  
PMM, Inc.  
POH Holdings, LLC  
Portsmouth Regional Ambulatory Surgery Center, LLC  
Portsmouth Surgicenter, LLC  
Preferred Works WC, LLC  
Primary Medical Management, Inc.  
Putnam Radiation Oncology Manager, LLC  
Putnam Radiation Oncology, LLC  
Radiation Oncology Center of Thornton, LLC  
Radiation Oncology Manager, LLC  
RCH, LLC  
Red Rock at Smoke Ranch, LLC  
Red Rock Holdco, LLC  
Reston Hospital Center, LLC  
Riverside CyberKnife Manager, LLC  
Riverside Hospital, Inc.  
Riverside Imaging, LLC

---

ROi CPS, LLC  
Round Rock Hospital, Inc.  
Samaritan, LLC  
San Bernardino Imaging, LLC  
San Jose Healthcare System, LP  
San Jose Hospital, L.P.  
San Jose Medical Center, LLC  
San Jose, LLC  
San Marcos ASC, LLC  
San Marcos Surgicenter, LLC  
Sarah Cannon Research Institute, LLC  
Savannah Health Network, LLC  
Savannah Health Services, LLC  
SCRI Holdings, LLC  
Sebring Health Services, LLC  
Silicon Valley Surgery Center, L.P.  
Silicon Valley Surgicenter, LLC  
SJMC, LLC  
Solis Mammography at Bayshore Medical Center, LLC  
Solis Mammography at Clear Lake Regional Medical Center, LLC  
Solis Mammography at Conroe Regional Medical Center, LLC  
Solis Mammography at Denton Regional Medical Center, LLC  
Solis Mammography at HCA Houston Tomball, LLC  
Solis Mammography at Kingwood Medical Center, LLC  
Solis Mammography at Las Colinas Medical Center, LLC  
Solis Mammography at Medical Center Alliance, LLC  
Solis Mammography at Medical Center Arlington, LLC  
Solis Mammography at Medical Center of Lewisville, LLC  
Solis Mammography at Medical Center of McKinney, LLC  
Solis Mammography at Medical Center of Plano, LLC  
Solis Mammography at Medical City Dallas, LLC  
Solis Mammography at Pearland Medical Center, LLC  
Solis Mammography at Rose Medical Center, LLC  
Solis Mammography at Skyline Medical Center, LLC  
Solis Mammography at StoneCrest Medical Center, LLC  
Solis Mammography at West Houston Medical Center, LLC  
Solis Mammography at Woman's Hospital of Texas, LLC  
Solis Mammography of Cedar Hill, LLC  
Solis Mammography of CyFair, LLC  
Solis Mammography of Dallas, LLC  
Solis Mammography of Flower Mound, LLC  
Solis Mammography of Frisco, LLC  
Solis Mammography of Garland, LLC  
Solis Mammography of Grand Prairie, LLC

---

Solis Mammography of Houston NW, LLC  
Solis Mammography of Katy, LLC  
Solis Mammography of Louetta/249, LLC  
Solis Mammography of Mainland, LLC  
Solis Mammography of Mansfield, LLC  
Solis Mammography of Mesquite, LLC  
Solis Mammography of Montgomery, LLC  
Solis Mammography of North Cypress, LLC  
Solis Mammography of North Loop, LLC  
Solis Mammography of Sugar Land, LLC  
Solis Mammography of West Plano, LLC  
Solis Mammography of Woman's Place, LLC  
South Austin Surgical Management, LLC  
South Austin Surgicenter, LLC  
South Brandon Imaging, LLC  
South Valley Hospital, L.P.  
Southeast Georgia Health Services, LLC  
Southern Kentucky Surgicenter, LLC  
Southtown Women's Clinic, LLC  
Spalding Rehabilitation L.L.C.  
Spring Hill Imaging, LLC  
Springview KY, LLC  
SSHR Holdco, LLC  
SSJ St. Petersburg Holdings, Inc.  
Steamboat Springs Surgicenter, LLC  
Stiles Road Imaging LLC  
StoneCrest Surgery Center, LLC  
Stones River Hospital, LLC  
StoneSprings Surgicenter, LLC  
Suburban Medical Center at Hoffman Estates, Inc.  
Summit General Partner, Inc.  
Summit Outpatient Diagnostic Center, LLC  
Sun Bay Medical Office Building, Inc.  
Sun City Imaging, LLC  
Sun-Med, LLC  
Sunrise Hospital and Medical Center, LLC  
Surgicare of ADC, LLC  
Surgicare of AGI, LLC  
Surgicare of Alpine, LLC  
Surgicare of Aurora Endoscopy, LLC  
Surgicare of Bay Area, LLC  
Surgicare of Brentwood, LLC  
Surgicare of Brighton, LLC  
Surgicare of Brownsville, LLC

---

Surgicare of CAREOS, LLC  
Surgicare of Corpus Christi, LLC  
Surgicare of Dallas Specialty, LLC  
Surgicare of Denton, Inc.  
Surgicare of Denver Clinic, LLC  
Surgicare of Focus Hand, LLC  
Surgicare of Houston Kingwood, LLC  
Surgicare of Houston, LLC  
Surgicare of Loveland, LLC  
Surgicare of Nashville, LLC  
Surgicare of Pavilion, LLC  
Surgicare of Physicians West El Paso, LLC  
Surgicare of Plano, Inc.  
Surgicare of Portsmouth, LLC  
Surgicare of Silicon Valley, LLC  
Surgicare of Southern Kentucky, LLC  
Surgicare of Steamboat Springs, LLC  
Surgicare of StoneCrest, LLC  
Surgicare of StoneSprings, LLC  
Surgicare of Willis, LLC  
Surgico, LLC  
Swedish MOB Acquisition, Inc.  
TBHI Outpatient Services, LLC  
Terre Haute Hospital GP, Inc.  
Terre Haute Hospital Holdings, Inc.  
Terre Haute Regional Hospital, L.P.  
The Cancer Care Center of North Florida, LLC  
Total Imaging - Parsons, LLC  
Town Plaza Family Practice, LLC  
Trident Medical Center, LLC  
TriStar Maury Behavioral Healthcare, LLC  
U.S. Collections, Inc.  
Ultra Imaging Management Services, LLC  
Ultra Imaging of Tampa, LLC  
Urgent Care Enterprise, LLC  
Utah CareNow Urgent Care, LLC  
Utah Medco, LLC  
Valify, Inc.  
Value Health Management, Inc.  
VHSC Plantation, LLC  
Vision Consulting Group LLC  
Washington Holdco, LLC  
Weatherford Health Services, LLC  
Weatherford Mammography JV, LLC

---

Wesley Cath Lab, LLC  
Wesley Manager, LLC  
Wesley Medical Center, LLC  
West Boynton Beach Open Imaging Center, LLC  
West Florida Imaging Services, LLC  
West Florida PET Services, LLC  
West Houston, LLC  
Westbury Hospital, Inc.  
WHG Medical, LLC  
Willis Surgicenter, LLC  
WJHC, LLC  
Woman's Hospital Merger, LLC  
Women's Hospital Indianapolis GP, Inc.  
Women's Hospital Indianapolis, L.P.

FLORIDA

Access 2 Health Care Physicians, LLC  
Access Health Care Physicians, LLC  
Access Management Co., LLC  
Ace Leasing II, LLC  
All About Staffing, Inc.  
Ambulatory Laser Associates, GP  
Ambulatory Surgery Center Group, Ltd.  
Atlantis Surgicare, LLC  
Aventura Comprehensive Cancer Research Group of Florida, Inc.  
Aventura Healthcare Specialists LLC  
Aventura Neurosurgery, LLC  
BAMI Property, LLC  
Bannerman Family Care, LLC  
Bay Hospital, Inc.  
Bayonet Point Surgery Center, Ltd.  
Bayside Ambulatory Center, LLC  
Behavioral Health Sciences of West Florida, LLC  
Belleair Surgery Center, Ltd.  
Big Cypress Medical Center, Inc.  
Bonita Bay Surgery Center, Inc.  
Bonita Bay Surgery Center, Ltd.  
Bradenton Cardiology Physician Network, LLC  
Broward Cardiovascular Surgeons, LLC  
Broward Healthcare System, Inc.  
Broward Neurosurgeons, LLC  
Capital Regional Healthcare, LLC  
Capital Regional Heart Associates LLC

---

Capital Regional Psychiatry Associates, LLC  
CCH-GP, Inc.  
Cedars International Cardiology Consultants, LLC  
Cedars Medical Center Hospitalists, LLC  
Central Florida Cardiology Interpretations, LLC  
Central Florida Division Practice, Inc.  
Central Florida Health Services, LLC  
Central Florida Obstetrics & Gynecology Associates, LLC  
Central Florida Physician Network, LLC  
Central Florida Regional Hospital, Inc.  
Central Pasco, LLC  
Citrus Memorial Hospital, Inc.  
Citrus Memorial Property Management, Inc.  
Citrus Primary Care, Inc.  
Citrus Specialty Group, Inc.  
Citrus Surgicenter, LLC  
Collier County Home Health Agency, Inc.  
Columbia Behavioral Health, Ltd.  
Columbia Behavioral Healthcare of South Florida, Inc.  
Columbia Central Florida Division, Inc.  
Columbia Development of Florida, Inc.  
Columbia Eye and Specialty Surgery Center, Ltd.  
Columbia Florida Group, Inc.  
Columbia Hospital Corporation of Central Miami  
Columbia Hospital Corporation of Kendall  
Columbia Hospital Corporation of Miami  
Columbia Hospital Corporation of Miami Beach  
Columbia Hospital Corporation of North Miami Beach  
Columbia Hospital Corporation of South Broward  
Columbia Hospital Corporation of South Dade  
Columbia Hospital Corporation of South Florida  
Columbia Hospital Corporation of South Miami  
Columbia Hospital Corporation of Tamarac  
Columbia Hospital Corporation-SMM  
Columbia Jacksonville Healthcare System, Inc.  
Columbia Lake Worth Surgical Center Limited Partnership  
Columbia Midtown Joint Venture  
Columbia North Central Florida Health System Limited Partnership  
Columbia North Florida Regional Medical Center Limited Partnership  
Columbia Ocala Regional Medical Center Physician Group, Inc.  
Columbia Palm Beach Healthcare System Limited Partnership  
Columbia Park Healthcare System, Inc.  
Columbia Park Medical Center, Inc.  
Columbia Physician Services - Florida Group, Inc.

---

Columbia Primary Care, LLC  
Columbia Resource Network, Inc.  
Columbia Tampa Bay Division, Inc.  
Columbia-Osceola Imaging Center, Inc.  
Community Hospital Family Practice, LLC  
Comprehensive Radiation Oncology, LLC  
Coral Springs Surgi-Center, Ltd.  
Countryside Surgery Center, Ltd.  
Davie Medical Center, LLC  
Daytona Medical Center, Inc.  
Dean 4641, LLC  
Diagnostic Breast Center, Inc.  
Doctors Osteopathic Medical Center, Inc.  
Doctors Same Day Surgery Center, Inc.  
Doctors Same Day Surgery Center, Ltd.  
DOMC Property, LLC  
East Florida - DMC, Inc.  
East Florida Behavioral Health Network, LLC  
East Florida Cardiology Network, LLC  
East Florida Division, Inc.  
East Florida Emergency Physician Group, LLC  
East Florida Healthcare, LLC  
East Florida Hospitalists, LLC  
East Florida Primary Care, LLC  
East Pointe Hospital, Inc.  
Edward White Hospital, Inc.  
Emergency Providers Group LLC  
Englewood Community Hospital Auxiliary, Inc.  
Englewood Community Hospital, Inc.  
Family Care Partners, LLC  
Fawcett Memorial Hospital, Inc.  
Florida Care Partners Orlando, LLC  
Florida Care Partners, LLC  
Florida Home Health Services-Private Care, Inc.  
Florida Outpatient Surgery Center, Ltd.  
Fort Myers Market, Inc.  
Fort Pierce Immediate Care Center, Inc.  
Fort Pierce Orthopaedics, LLC  
Fort Pierce Surgery Center, Ltd.  
Fort Walton Beach Medical Center, Inc.  
Freeport Family Medicine, LLC  
Ft. Pierce Surgicare, LLC  
Ft. Walton Beach Anesthesia Services, LLC  
Gainesville GYN Oncology of North Florida Regional Medical Center, LLC

---

Gainesville Physicians, LLC  
Galen Diagnostic Multicenter, Ltd.  
Galen Hospital-Pembroke Pines, Inc.  
Galen of Florida, Inc.  
Galencare, Inc.  
GME Services of Osceola, LLC  
Grant Center Hospital of Ocala, Inc.  
Greater Tampa Bay Physician Network, LLC  
Greater Tampa Bay Physician Specialists, LLC  
Greater Tampa Bay Physicians - Pinellas, LLC  
Gulf Coast Inpatient Specialists, LLC  
Gulf Coast Medical Center Primary Care, LLC  
Gulf Coast Multispecialty Services, LLC  
Hamilton Memorial Hospital, Inc.  
HCA - Viera ALF, LLC  
HCA - WHS Progressive, LLC  
HCA - WHS Services, LLC  
HCA Health Services of Florida, Inc.  
HCA Health Services of Miami, Inc.  
HCA Outpatient Clinic Services of Miami, Inc.  
HCA Sarasota Orthopedic and Spine Clinical Co-Management Company, LLC  
HD&S Corp. Successor, Inc.  
HealthCoast Physician Group, LLC  
Heathrow Internal Medicine, LLC  
Heritage Family Care, LLC  
HMMG 1226, LLC  
Homecare North, Inc.  
Hospital Corporation of Lake Worth  
Institute for Women's Health and Body, LLC  
Integrated Regional Lab, LLC  
Integrated Regional Laboratories Pathology Services, LLC  
Intensive Care Consortium, Inc.  
Jacksonville CareNow Urgent Care, LLC  
Jacksonville Multispecialty Services, LLC  
Jacksonville Surgery Center, Ltd.  
JFK Internal Medicine Faculty Practice, LLC  
JPM AA Housing, LLC  
Kendall Healthcare Group, Ltd.  
Kendall Regional Urgent Care, LLC  
Kissimmee Surgicare, Ltd.  
LAD Imaging, LLC  
Lake City Regional Medical Group, LLC  
Largo Medical Center, Inc.  
Largo Physician Group, LLC

---

Lawnwood Cardiovascular Surgery, LLC  
Lawnwood Healthcare Specialists, LLC  
Lawnwood Medical Center, Inc.  
Live Oak Immediate Care Center, LLC  
Manatee Surgicare, Ltd.  
Marion Community Hospital, Inc.  
Medical Associates of Ocala, LLC  
Medical Center of Port St. Lucie, Inc.  
Medical Center of Santa Rosa, Inc.  
Medical Center of Southwest Florida, LLC  
Medical Partners of North Florida, LLC  
Memorial Family Practice Associates, LLC  
Memorial Health Primary Care at St. Johns Bluff, LLC  
Memorial Healthcare Group, Inc.  
Memorial Neurosurgery Group, LLC  
Mercy ASC, LLC  
MHS Partnership Holdings JSC, Inc.  
MHS Partnership Holdings SDS, Inc.  
Miami Beach Healthcare Group, Ltd.  
Miami Dade Surgical Specialists, LLC  
Miami Lakes Surgery Center, Ltd.  
Miami-Dade Cardiology Consultants, LLC  
MSL Acquisition, LLC  
Network MS of Florida, Inc.  
New Port Richey Hospital, Inc.  
New Port Richey Surgery Center, Ltd.  
Niceville Family Practice, LLC  
North Central Florida Health System, Inc.  
North Florida Division I, Inc.  
North Florida Division Practice, Inc.  
North Florida GI Center GP, Inc.  
North Florida GI Center, Ltd.  
North Florida Immediate Care Center, Inc.  
North Florida Neurosurgery, LLC  
North Florida Outpatient Imaging Center, Ltd.  
North Florida Physician Services, Inc.  
North Florida Physicians, LLC  
North Florida Regional Company Care, LLC  
North Florida Regional Investments, Inc.  
North Florida Regional Medical Center, Inc.  
North Florida Regional Psychiatry, LLC  
North Florida Regional Trauma, LLC  
North Florida Rehab Investments, LLC  
North Florida Surgical Associates, LLC

---

North Palm Beach County Surgery Center, LLC  
North River Physician Network, LLC  
North Transfer Center, LLC  
Northside MRI, Inc.  
Northwest Florida Healthcare Systems, Inc.  
Northwest Florida Multispecialty Physicians, LLC  
Northwest Florida Primary Care, LLC  
Northwest Medical Center, Inc.  
Notami Hospitals of Florida, Inc.  
Oak Hill Acquisition, Inc.  
Oak Hill Family Care, LLC  
Oak Hill Hospitalists, LLC  
Ocala Health Company Care, LLC  
Ocala Health Imaging Services, LLC  
Ocala Health Primary Care, LLC  
Ocala Health Surgical Group, LLC  
Ocala Health Trauma, LLC  
Ocala Regional Outpatient Services, Inc.  
Okaloosa Hospital, Inc.  
Okeechobee Hospital, Inc.  
Orange County Healthcare, LLC  
Orange Park Hospitalists, LLC  
Orange Park Medical Center, Inc.  
Orlando CareNow Urgent Care, LLC  
Orlando Surgicare, Ltd.  
Osceola Neurological Associates, LLC  
Osceola Physician Network, LLC  
Osceola Regional Hospital, Inc.  
Osceola Regional Hospitalists, LLC  
Osceola Surgical Associates, LLC  
Outpatient Surgical Services, Ltd.  
Oviedo Medical Center, LLC  
P&L Associates  
Palm Beach General Surgery, LLC  
Palm Beach Healthcare System, Inc.  
Palm Beach Hospitalists Program, LLC  
Palms West Gastroenterology, LLC  
Palms West Surgery Center, Ltd.  
Park South Imaging Center, Ltd.  
Pediatric Intensivist Group, LLC  
Pensacola Primary Care, Inc.  
Pinnacle Physician Network, LLC  
Poinciana Medical Center, Inc.  
Port St. Lucie Surgery Center, Ltd.

---

Premier Medical Management, Ltd.  
Primary Care Medical Associates, Inc.  
Primary Care Services of Orlando, LLC  
Psychiatry Services of Osceola, LLC  
Pulmonary Renal Intensivist Group, LLC  
Putnam Community Medical Center of North Florida, LLC  
Putnam Hospital, Inc.  
Putnam Surgical Group, LLC  
Raulerson Gastroenterology, LLC  
Raulerson GYN, LLC  
Raulerson Primary Care, LLC  
Riverwalk ASC, LLC  
Sarasota Doctors Hospital, Inc.  
South Florida Division Practice, Inc.  
South Transfer Center, LLC  
Southwest Florida Health System, Inc.  
Southwest Florida Regional Medical Center, Inc.  
St. Lucie Hospitalists, LLC  
St. Lucie Medical Center Hyperbarics, LLC  
St. Lucie Medical Center Walk-In Clinic, LLC  
St. Lucie Medical Specialists, LLC  
St. Lucie West Primary Care, LLC  
St. Petersburg General Surgery, LLC  
Sun City Hospital, Inc.  
Surgery Center of Atlantis, LLC  
Surgery Center of Aventura, Ltd.  
Surgery Center of Port Charlotte, Ltd.  
Surgical Park Center, Ltd.  
Surgicare America - Winter Park, Inc.  
Surgicare of Altamonte Springs, Inc.  
Surgicare of Aventura, LLC  
Surgicare of Bayonet Point, Inc.  
Surgicare of Bayside, LLC  
Surgicare of Brandon, Inc.  
Surgicare of Brooksville, LLC  
Surgicare of Central Florida, Inc.  
Surgicare of Citrus, LLC  
Surgicare of Countryside, Inc.  
Surgicare of Florida, Inc.  
Surgicare of Ft. Pierce, Inc.  
Surgicare of Kissimmee, Inc.  
Surgicare of Laurel Grove, LLC  
Surgicare of Manatee, Inc.  
Surgicare of Merritt Island, Inc.

---

Surgicare of Miami Lakes, LLC  
Surgicare of Newport Richey, Inc.  
Surgicare of Orange Park II, LLC  
Surgicare of Orange Park, Inc.  
Surgicare of Orange Park, Ltd.  
Surgicare of Orlando, Inc.  
Surgicare of Palms West, LLC  
Surgicare of Pinellas, Inc.  
Surgicare of Plantation, Inc.  
Surgicare of Port Charlotte, LLC  
Surgicare of Port St. Lucie, Inc.  
Surgicare of Riverwalk, LLC  
Surgicare of St. Andrews, Inc.  
Surgicare of St. Andrews, Ltd.  
Surgicare of Stuart, Inc.  
Surgicare of Tallahassee, Inc.  
Tallahassee Community Network, Inc.  
Tallahassee Medical Center, Inc.  
Tallahassee Orthopaedic Surgery Partners, Ltd.  
Tampa Bay Health System, Inc.  
Tampa Surgi-Centre, Inc.  
Telehealth Physician Services, LLC  
The Neurohealth Sciences Center, LLC  
Total Imaging - Hudson, LLC  
Total Imaging - North St. Petersburg, LLC  
Travel Medicine and Infections, LLC  
University Healthcare Specialists, LLC  
University Hospital, Ltd.  
Venture Ambulatory Surgery Center, LLC  
Venture Medical Management, LLC  
West Florida - MHT, LLC  
West Florida - PPH, LLC  
West Florida Behavioral Health, Inc.  
West Florida Cardiology Network, LLC  
West Florida Cardiology Physicians, LLC  
West Florida CareNow Urgent Care, LLC  
West Florida Division, Inc.  
West Florida Gulf Coast Primary Care, LLC  
West Florida HealthWorks, LLC  
West Florida Internal Medicine, LLC  
West Florida Physician Network, LLC  
West Florida Professional Billing, LLC  
West Florida Regional Medical Center, Inc.  
West Florida Specialty Physicians, LLC

---

West Florida Trauma Network, LLC  
West Florida Urgent Care Network, LLC  
West Jacksonville Medical Center, Inc.  
Westside Surgery Center, Ltd.  
Wildwood Medical Center, Inc.  
Women's Health Center of Central Florida, LLC

GEORGIA

4600 Waters Avenue Professional Building Condominium Association, Inc.  
Acworth Immediate Care, LLC  
Albany Family Practice, LLC  
AOSC Sports Medicine, Inc.  
AppleCare/Memorial Immediate Care Joint Venture, LLC  
Atlanta Home Care, L.P.  
Atlanta Outpatient Surgery Center, Inc.  
Atlanta Surgery Center, Ltd.  
Augusta Inpatient Services, LLC  
Augusta Multispecialty Services, LLC  
Augusta Primary Care Services, LLC  
Augusta Specialty Hospitalists, LLC  
Augusta Urgent Care Services, LLC  
Byron Family Practice, LLC  
Cartersville Medical Center, LLC  
Cartersville Occupational Medicine Center, LLC  
Cartersville Physician Practice I, LLC  
CCBH Psychiatric Hospitalists, LLC  
Center for Occupational Medicine, LLC  
Chatsworth Hospital Corp.  
Church Street Partners  
Coliseum Health Group, Inc.  
Coliseum Park Hospital, Inc.  
Coliseum Primary Care Services, LLC  
Coliseum Primary Healthcare - Macon, LLC  
Coliseum Primary Healthcare - Riverside, LLC  
Coliseum Professional Associates, LLC  
Coliseum Same Day Surgery Center, L.P.  
Columbia Coliseum Same Day Surgery Center, Inc.  
Columbia Surgicare of Augusta, Ltd.  
Columbia-Georgia PT, Inc.  
Columbus Cardiology, Inc.  
Columbus Doctors Hospital, Inc.  
Diagnostic Services, G.P.  
Doctors Hospital Columbus GA-Joint Venture

---

Doctors Hospital of Augusta Neurology, LLC  
Doctors Hospital Surgery Center, L.P.  
Doctors-I, Inc.  
Doctors-II, Inc.  
Doctors-III, Inc.  
Doctors-IV, Inc.  
Doctors-IX, Inc.  
Doctors-V, Inc.  
Doctors-VI, Inc.  
Doctors-VII, Inc.  
Doctors-VIII, Inc.  
Doctors-X, Inc.  
Dublin Community Hospital, LLC  
Dublin Heart Specialists, LLC  
Dublin Multispecialty, LLC  
Eastside Behavioral Health Associates, LLC  
Eastside General Surgery, LLC  
Eastside Heart and Vascular, LLC  
Eastside Medical Center, LLC  
Eastside Surgery Center, LLC  
EHCA Diagnostics, LLC  
EHCA Eastside Occupational Medicine Center, LLC  
EHCA Metropolitan, LLC  
EHCA Parkway, LLC  
EHCA Peachtree, LLC  
EHCA West Paces, LLC  
EHCA, LLC  
Fairview Medical Services, LLC  
Fairview Park, Limited Partnership  
Georgia Psychiatric Company, Inc.  
Grace Family Practice, LLC  
Grayson Primary Care, LLC  
Greater Gwinnett Internal Medicine Associates, LLC  
Greater Gwinnett Physician Corporation  
Gwinnett Community Hospital, Inc.  
HCA Health Services of Georgia, Inc.  
HCOL, Inc.  
Heritage Medical Care, LLC  
Hospitalists at Fairview Park, LLC  
JDGC Management, LLC  
Macon Psychiatric Hospitalists, LLC  
Marietta Outpatient Medical Building, Inc.  
Marietta Outpatient Surgery, Ltd.  
Marietta Surgical Center, Inc.

---

Med Corp., Inc.  
Medical Center - West, Inc.  
Medical Oncology Associates, LLC  
Memorial Satilla Specialists, LLC  
Middle Georgia Urgent Care Services, LLC  
MOSC Sports Medicine, Inc.  
Neurosurgery Atlanta, LLC  
North Georgia Primary Care Group, LLC  
Northlake Medical Center, LLC  
Northlake Physician Practice Network, Inc.  
Northlake Surgical Center, L.P.  
Northlake Surgicare, Inc.  
Orthopaedic Specialty Associates, L.P.  
Orthopaedic Sports Specialty Associates, Inc.  
Peach State Anesthesia Partners, LLC  
Provident Professional Building Condominium Association, Inc.  
Redmond Anesthesia Services, LLC  
Redmond Hospital Services, LLC  
Redmond Neurosurgery, LLC  
Redmond Park Health Services, Inc.  
Redmond Park Hospital, LLC  
Redmond Physician Practice Company  
Redmond Specialty Services, LLC  
Rome Imaging Center Limited Partnership  
Savannah Behavioral Health Associates, LLC  
Savannah Inpatient Services, LLC  
Savannah Multispecialty Associates, LLC  
Savannah Pediatric Care, LLC  
Savannah Primary Care Associates, LLC  
Surgery Center of Rome, L.P.  
Surgicare of Augusta, Inc.  
Surgicare of Buckhead, LLC  
Surgicare of Eastside, LLC  
Surgicare of Evans, Inc.  
Surgicare of Rome, Inc.  
The Rankin Foundation  
Urology Center of North Georgia, LLC  
West Paces Services, Inc.

IDAHO

East Falls Cardiovascular and Thoracic Surgery, LLC  
East Falls Family Medicine, LLC  
East Falls Plastic Surgery, LLC

---

Eastern Idaho Health Services, Inc.  
Eastern Idaho Regional Medical Center Inpatient Services, LLC  
EIRMC Hospitalist Services, LLC  
Idaho Behavioral Health Services, LLC  
Idaho Physician Services, Inc.  
Patients First Neurology, LLC  
West Valley Medical Center, Inc.  
West Valley Medical Group Specialty Services LLC  
West Valley Medical Group, LLC  
West Valley Therapy Services, LLC

ILLINOIS

Chicago Grant Hospital, Inc.  
Columbia Chicago Division, Inc.  
Columbia LaGrange Hospital, LLC  
Galen of Illinois, Inc.  
Illinois Psychiatric Hospital Company, Inc.  
Smith Laboratories, Inc.

INDIA

All About Staffing (India) Ltd.

INDIANA

Advanced Plastic Surgery Center of Terre Haute, LLC  
Basic American Medical, Inc.  
Hospitalists of the Wabash Valley, LLC  
Regional Hospital Healthcare Partners, LLC  
Surgicare of Indianapolis, Inc.  
Surgicare of Terre Haute, LLC  
Terre Haute MOB, L.P.  
Terre Haute Obstetrics and Gynecology, LLC

KANSAS

Care for Women, LLC  
Centerpoint Medical Specialists, LLC  
College Park Ancillary, LLC  
College Park Endoscopy Center, LLC  
College Park Radiology, LLC  
Emergency Physicians at Wesley Medical Center, LLC  
Family Health Medical Group of Overland Park, LLC  
Galichia Anesthesia Services, LLC

---

Galichia Emergency Physicians, LLC  
Health Partners of Kansas, Inc.  
Heart of America ASC, LLC  
Heart of America Surgicenter, LLC  
Heartland Women's Group at Wesley, LLC  
Hospitalists at Wesley Medical Center, LLC  
IRL Pathology Services MidAmerica, LLC  
Johnson County Neurology, LLC  
Johnson County Surgery Center, L.P.  
Johnson County Surgicenter, L.L.C.  
Kansas CareNow Urgent Care, LLC  
Kansas City Cardiac Arrhythmia Research LLC  
Kansas City Gastroenterology & Hepatology Physicians Group, LLC  
Kansas City Vascular & General Surgery Group, LLC  
Kansas City Women's Clinic Group, LLC  
Kansas Pulmonary and Sleep Specialists, LLC  
Kansas Trauma and Critical Care Specialists, LLC  
Menorah Medical Group, LLC  
Menorah Urgent Care, LLC  
MidAmerica Division, Inc.  
Mid-America Surgery Center, LLC  
Mid-America Surgery Institute, LLC  
Midwest Cardiology Specialists, LLC  
Midwest Cardiovascular and Thoracic Surgeons of Kansas, LLC  
Midwest Heart & Vascular Specialists, LLC  
Midwest Oncology Associates, LLC  
Mill Creek Outpatient Services, LLC  
MMC Sleep Lab Management, LLC  
Neurology Associates of Kansas, LLC  
OPRMC-HBP, LLC  
Overland Park Cardiovascular, Inc.  
Overland Park Medical Specialists, LLC  
Overland Park Orthopedics, LLC  
Overland Park Surgical Specialties, LLC  
Pediatric Specialty Clinic LLC  
Physician Associates of Corporate Woods, LLC  
Quivira Internal Medicine, Inc.  
Research Neurology Associates, LLC  
Research Neuroscience Institute, LLC  
Statland Medical Group, LLC  
Surgery Center of Overland Park, L.P.  
Surgicare of Overland Park, LLC  
Surgicare of Wichita, Inc.  
Surgicare of Wichita, LLC

---

Surgicenter of Johnson County, Ltd., a Kansas limited partnership  
The Medical Group of Kansas City, LLC  
Wesley Physician Services, LLC  
Wesley Physicians - Anesthesiologist, LLC  
Wesley Physicians - Cardiovascular, LLC  
Wesley Physicians - Medical Specialties LLC  
Wesley Physicians - Obstetrics and Gynecology LLC  
Wesley Physicians - Primary Care LLC  
Wesley Select Network, LLC  
Wesley Urgent Care, LLC  
Wichita CareNow Urgent Care, LLC

#### KENTUCKY

CHCK, Inc.  
Commonwealth Specialists of Kentucky, LLC  
Frankfort Hospital, Inc.  
Frankfort Wound Care, LLC  
Galen Center for Professional Development, Inc.  
Galen of Kentucky, Inc.  
Greenview Hospital, Inc.  
Greenview PrimeCare, LLC  
Greenview Specialty Associates, LLC  
Hospitalists at Greenview Regional Hospital, LLC  
Isleworth Partners, Inc.  
Mikrod Services, Inc.  
Southern Kentucky Medicine Associates, LLC  
Surgery Center of Greenview, L.P.  
Surgicare of Greenview, Inc.  
Tri-County Community Hospital, Inc.  
Warren County Ambulance Service, LLC

#### LOUISIANA

Acadiana Care Center, Inc.  
Acadiana Practice Management, Inc.  
Acadiana Regional Pharmacy, Inc.  
Center for Digestive Diseases, LLC  
Children's Multi-Specialty Group, LLC  
CLASC Manager, LLC  
Columbia Healthcare System of Louisiana, Inc.  
Columbia West Bank Hospital, Inc.  
Columbia/HCA of Baton Rouge, Inc.  
Columbia/HCA of New Orleans, Inc.

---

HCA Health Services of Louisiana, Inc.  
Lafayette OB Hospitalists, LLC  
Lafayette Urogynecology & Urology Center, LLC  
Lakeside Women's Services, LLC  
Lakeview Cardiology Specialists, LLC  
Lakeview Regional Physician Group, LLC  
Louisiana Psychiatric Company, Inc.  
Medical Center of Baton Rouge, Inc.  
Metairie Primary Care Associates, LLC  
New Iberia Healthcare, LLC  
Notami (Opelousas), Inc.  
Notami Hospitals of Louisiana, Inc.  
Rapides After Hours Clinic, L.L.C.  
Rapides Healthcare System, L.L.C.  
Rapides Regional Physician Group Primary Care, LLC  
Rapides Regional Physician Group Specialty Care, LLC  
Rapides Regional Physician Group, LLC  
Rapides Surgery Center, LLC  
RMCA Professionals Mgmt, LLC  
Southwest Medical Center Family Practice, LLC  
Southwest Medical Center Multi-Specialty Group, LLC  
Southwest Medical Center Surgical Group, LLC  
Surgicare Merger Company of Louisiana  
Surgicare of Lakeview, Inc.  
Surgicare Outpatient Center of Baton Rouge, Inc.  
Surgicenter of East Jefferson, Inc.  
Tchefuncte Cardiology Associates - Lakeview, LLC  
The Regional Health System of Acadiana, LLC  
TUHC Anesthesiology Group, LLC  
TUHC Hospitalist Group, LLC  
TUHC Physician Group, LLC  
TUHC Primary Care and Pediatrics Group, LLC  
TUHC Radiology Group, LLC  
Tulane Clinic, LLC  
Tulane Professionals Management, L.L.C.  
University Healthcare System, L.C.  
Uptown Primary Care Associates, LLC  
Women's & Children's Pediatric Hematology/Oncology Center, LLC  
Women's & Children's Pulmonology Clinic, LLC  
Women's and Children's Professional Management, L.L.C.  
Women's Multi-Specialty Group, LLC

---

LUXEMBOURG

HCA Luxembourg 1 Sarl  
HCA Luxembourg 2 Sarl  
HCA Luxembourg Equities Sarl  
HCA Luxembourg Investments Sarl  
HCA Switzerland Limited

MASSACHUSETTS

Columbia Hospital Corporation of Massachusetts, Inc.  
Orlando Outpatient Surgical Center, Ltd.

MISSISSIPPI

Brookwood Medical Center of Gulfport, Inc.  
Coastal Imaging Center of Gulfport, Inc.  
Coastal Imaging Center, L.P.  
Galen of Mississippi, Inc.  
Garden Park Hospitalist Program, LLC  
Garden Park Investments, L.P.  
Garden Park Physician Group - Specialty Care, LLC  
Garden Park Physician Group, Inc.  
Gulf Coast Medical Ventures, Inc.  
VIP, Inc.

MISSOURI

Bone & Joint Specialists Physician Group, LLC  
Cardiology Associates Medical Group, LLC  
Cedar Creek Medical Group, LLC  
Centerpoint Cardiology Services, LLC  
Centerpoint Clinic of Blue Springs, LLC  
Centerpoint Hospital Based Physicians, LLC  
Centerpoint Orthopedics, LLC  
Centerpoint Physicians Group, LLC  
Centerpoint Women's Services, LLC  
Clinishare, Inc.  
Endocrinology Associates of Lee's Summit, LLC  
Eye Care Surgicare, Ltd., a Missouri limited partnership  
Family Health Specialists of Lee's Summit, LLC  
Foot & Ankle Specialty Services, LLC  
HCA Midwest Comprehensive Care, Inc.  
Health Midwest Medical Group, Inc.  
Health Midwest Office Facilities Corporation  
Health Midwest Ventures Group, Inc.

---

HM Acquisition, LLC  
Independence Neurosurgery Services, LLC  
Independence Surgicare, Inc.  
Jackson County Pulmonary Medical Group, LLC  
Kansas City Neurology Associates, LLC  
Kansas City Pulmonology Practice, LLC  
Kansas City Surgery Center Properties, LLC  
KC Pain ASC, LLC  
KC Surgicare, LLC  
Medical Center Imaging, Inc.  
MediCredit, Inc.  
Metropolitan Multispecialty Physicians Group, Inc.  
Midwest Cardiovascular & Thoracic Surgery, LLC  
Midwest Division - RBH, LLC  
Midwest Division Spine Care, LLC  
Midwest Doctor's Group, LLC  
Midwest Infectious Disease Specialists, LLC  
Midwest Trauma Services, LLC  
Midwest Women's Healthcare Specialists, LLC  
Missouri Healthcare System, L.P.  
National Association of Senior Friends  
Notami Hospitals of Missouri, Inc.  
Nuclear Diagnosis, Inc.  
Ozarks Medical Services, Inc.  
Parallon Revenue Cycle Services, Inc.  
Raymore Medical Group, LLC  
Research Cardiology Associates, LLC  
Research Family Physicians, LLC  
Research Internal Medicine, LLC  
Resource Optimization & Innovation, L.L.C.  
RMC - Pulmonary, LLC  
RMC Transplant Physicians, LLC  
Senior Health Associates, LLC  
Surgery Center of Independence, L.P.  
Surgical Care Medical Group, LLC  
Surgicare of Kansas City, LLC  
Surgicenter of Kansas City, L.L.C.  
Women's Center at Brookside, LLC

NEVADA

CHC Holdings, Inc.  
CHC Venture Co.  
Columbia Hospital Corporation of West Houston

---

Fremont Women's Health, LLC  
Health Service Partners, Inc.  
Las Vegas ASC, LLC  
Las Vegas Surgicare, Inc.  
Las Vegas Surgicare, Ltd., a Nevada Limited Partnership  
MountainView GME Primary Care, LLC  
Nevada Surgery Center of Southern Hills, L.P.  
Nevada Surgicare of Southern Hills, LLC  
Rhodes Limited-Liability Company  
Sahara Outpatient Surgery Center, Ltd.  
Southern Hills Medical Center, LLC  
Specialty Surgicare of Las Vegas, LP  
Sunrise Flamingo Holdings, LLC  
Sunrise Flamingo Surgery Center, Limited Partnership  
Sunrise Mountainview Hospital, Inc.  
Sunrise Mountainview Multi-Specialty Clinics, LLC  
Sunrise Outpatient Services, Inc.  
Sunrise Physician Services, LLC  
Sunrise Trauma Services, LLC  
Surgicare of Las Vegas, Inc.  
Urgent Care Extra Silverado & Maryland LLC  
Urgent Care Nevada LLC  
Value Health Holdings, Inc.  
VH Holdco, Inc.  
VH Holdings, Inc.  
Western Plains Capital, Inc.

#### NEW HAMPSHIRE

Appledore Medical Group II, Inc.  
Derry ASC, Inc.  
HCA Health Services of New Hampshire, Inc.  
Med-Point of New Hampshire, Inc.  
Occupational Health Services of PRH, LLC  
Parkland Hospitalists Program, LLC  
Parkland Oncology, LLC  
Salem Surgery Center, Limited Partnership  
Surgicare of Salem, LLC

#### NORTH CAROLINA

Blue Ridge-TKC, LLC  
CareOne Home Health Services, Inc.  
Cumberland Medical Center, Inc.

---

HCA - Raleigh Community Hospital, Inc.  
Healthy State, Inc.  
Heritage Hospital, Inc.  
HTI Health Services of North Carolina, Inc.  
Imaging Realty, LLC  
Mecklenburg Surgical Land Development, Ltd.  
Mission Community Anesthesiology Specialists, LLC  
Mission Employer Solutions, LLC  
Mission Health Partners, Inc.  
Raleigh Community Medical Office Building, Ltd.  
Spruce Pine Healthcare, LLC

OHIO

Columbia/HCA Healthcare Corporation of Northern Ohio  
Columbia-CSA/HS Greater Canton Area Healthcare System, L.P.  
Columbia-CSA/HS Greater Cleveland Area Healthcare System, L.P.  
Lorain County Surgery Center, Ltd.  
Surgicare of Lorain County, Inc.  
Surgicare of Westlake, Inc.  
Westlake Surgicare, L.P.

OKLAHOMA

Columbia Doctors Hospital of Tulsa, Inc.  
Columbia Oklahoma Division, Inc.  
Edmond General Surgery, LLC  
Edmond Hospitalists, LLC  
Edmond Physician Hospital Organization, Inc.  
Healthcare Oklahoma, Inc.  
Medi Flight of Oklahoma, LLC  
Medical Imaging, Inc.  
Millenium Health Care of Oklahoma, Inc.  
Oklahoma Outpatient Surgery Limited Partnership  
Oklahoma Physicians - Medical Specialties LLC  
Oklahoma Physicians - Obstetrics and Gynecology LLC  
Oklahoma Physicians - Primary Care LLC  
Oklahoma Physicians - Surgical Specialties LLC  
Oklahoma Surgicare, Inc.  
Plains Healthcare System, Inc.  
Surgicare of Tulsa, Inc.  
SWMC, Inc.

---

PHILIPPINES

All About Staffing Philippines, Inc.  
Career Staffing USA, Inc.

SOUTH CAROLINA

C/HCA Development, Inc.  
Carolina Regional Surgery Center, Inc.  
Carolina Regional Surgery Center, Ltd.  
Coastal Carolina Home Care, Inc.  
Coastal Carolina Multispecialty Associates, LLC  
Coastal Carolina Primary Care, LLC  
Coastal Inpatient Physicians, LLC  
Colleton Ambulatory Care, LLC  
Colleton Diagnostic Center, LLC  
Colleton Medical Anesthesia, LLC  
Colleton Medical Hospitalists, LLC  
Colleton Otolaryngology, Head and Neck Surgery, LLC  
Columbia/HCA Healthcare Corporation of South Carolina  
Doctor's Memorial Hospital of Spartanburg Limited Partnership  
Grand Strand Senior Health Center, LLC  
Grand Strand Specialty Associates, LLC  
Grand Strand Surgical Specialists, LLC  
North Augusta Rehab Health Center, LLC  
North Charleston Diagnostic Imaging Center, LLC  
South Atlantic Division, Inc.  
Tri-County Surgical Specialists, LLC  
Trident Behavioral Health Services, LLC  
Trident Eye Surgery Center, L.P.  
Trident Medical Services, Inc.  
Trident Neonatology Services, LLC  
Walterboro Community Hospital, Inc.  
Waterway Primary Care, LLC

SWITZERLAND

HCA Switzerland Holding GmbH  
Glemm SA  
HCA Switzerland Finance GmbH

TENNESSEE

2490 Church, LLC  
Advanced Bundle Convener, LLC

---

Arthritis Specialists of Nashville, Inc.  
Athens Community Hospital, Inc.  
Centennial Cardiovascular Consultants, LLC  
Centennial Heart, LLC  
Centennial Hospitalists, LLC  
Centennial Neuroscience, LLC  
Centennial Psychiatric Associates, LLC  
Centennial Surgery Center, L.P.  
Centennial Surgical Associates, LLC  
Centennial Surgical Clinic, LLC  
Centennial Women's Group, LLC  
Central Tennessee Hospital Corporation  
Chattanooga ASC Acquisition, Inc.  
Chattanooga Diagnostic Associates, LLC  
Chattanooga Healthcare Network Partner, Inc.  
Chattanooga Healthcare Network, L.P.  
Clarksville Surgicenter, LLC  
Clinical Education Shared Services, LLC  
Columbia Integrated Health Systems, Inc.  
Columbia Medical Group - Centennial, Inc.  
Columbia Medical Group - Daystar, Inc.  
Columbia Medical Group - Parkridge, Inc.  
Columbia Medical Group - Southern Hills, Inc.  
Columbia Medical Group - The Frist Clinic, Inc.  
Dickson Surgery Center, L.P.  
Envision Stakes, LLC  
Frist Clinic Express, LLC  
Gastroenterology Specialists of Middle Tennessee, LLC  
H2U Wellness Centers, LLC  
HCA - Information Technology & Services, Inc.  
HCA - IT&S PBS Field Operations, Inc.  
HCA ASD Financial Operations, LLC  
HCA ASD Sales Services, LLC  
HCA Central Group, Inc.  
HCA Chattanooga Market, Inc.  
HCA Development Company, Inc.  
HCA Eastern Group, Inc.  
HCA Health Services of Tennessee, Inc.  
HCA Human Resources, LLC  
HCA Long Term Health Services of Miami, Inc.  
HCA Medical Services, Inc.  
HCA Patient Safety Organization, LLC  
HCA Physician Services, Inc.  
HCA Realty, Inc.

---

Health to You, LLC  
Healthcare Sales National Management Services Group, LLC  
HealthTrust Workforce Solutions, LLC  
Healthtrust, Inc. - The Hospital Company  
Hendersonville Hospital Corporation  
Hendersonville Hospitalist Services, Inc.  
Hendersonville OB/GYN, LLC  
Hendersonville Primary Care, LLC  
Hermitage Primary Care, LLC  
Hometruster Management Services, Inc.  
Horizon Orthopedics, LLC  
Horizon Surgical, LLC  
Hospital Corporation of Tennessee  
Hospital Realty Corporation  
Hospitalists at Centennial Medical Center, LLC  
Hospitalists at Horizon Medical Center, LLC  
Hospitalists at Parkridge, LLC  
Hospitalists at StoneCrest, LLC  
HTI Memorial Hospital Corporation  
Indian Path Hospital, Inc.  
Internal Medicine Associates of Southern Hills, LLC  
Madison Behavioral Health, LLC  
Med Group - Southern Hills Hospitalists, LLC  
Medical Center Surgery Associates, L.P.  
Medical Group - Dickson, Inc.  
Medical Group - Southern Hills of Brentwood, LLC  
Medical Group - Southern Hills of Nolensville, LLC  
Medical Group - StoneCrest FP, Inc.  
Medical Group - Stonecrest Pulmonology, LLC  
Medical Group - StoneCrest, Inc.  
Medical Group - Summit, Inc.  
Medical Plaza Ambulatory Surgery Center Associates, L.P.  
Middle Tennessee Neurology LLC  
MP Management, LLC  
Nashville Psychiatric Company, Inc.  
Nashville Surgicenter, LLC  
Natchez Medical Associates, LLC  
Natchez Surgery Center, LLC  
National Contact Center Management Group, LLC  
National Transfer Center Management Services, LLC  
Network Management Services, Inc.  
Neurology Associates of Hendersonville, LLC  
North Florida Regional Freestanding Surgery Center, L.P.  
NPAS Solutions, LLC

---

NPAS, Inc.  
Old Fort Village, LLC  
OneSourceMed, Inc.  
Palmer Medical Center, LLC  
Parallon Business Solutions, LLC  
Parallon Enterprises, LLC  
Parallon Health Information Solutions, LLC  
Parallon Payroll Solutions, LLC  
Parallon Physician Services, LLC  
Park View Insurance Company  
Parkridge East Specialty Associates, LLC  
Parkridge Hospitalists, Inc.  
Parkridge Medical Associates, LLC  
Parkridge Medical Center, Inc.  
Parkridge Professionals, Inc.  
Parkside Surgery Center, Inc.  
Plano Ambulatory Surgery Associates, L.P.  
Portland Primary Care, LLC  
Premier ASC, LLC  
PSG Delegated Services, LLC  
PTS Solutions, LLC  
Sarah Cannon Development Innovations, LLC  
SCRI Scientifics, LLC  
Skyline Medical Group, LLC  
Skyline Neuroscience Associates, LLC  
Skyline Rehab Associates, LLC  
Skyline Specialty Associates, LLC  
Southern Hills Neurology Consultants, LLC  
Southpoint, LLC  
Spring Hill Hospital, Inc.  
Spring Hill Physicians, LLC  
St. Mark's Ambulatory Surgery Associates, L.P.  
Sterling Primary Care Associates, LLC  
Stonecrest Medical Group - Family Practice of Murfreesboro, LLC  
Stonecrest Medical Group - SC Murfreesboro Family Practice, LLC  
Sullins Surgical Center, Inc.  
Summit Convenient Care at Lebanon, LLC  
Summit Heart, LLC  
Summit Research Solutions, LLC  
Summit Surgery Center, L.P.  
Summit Surgical Associates, LLC  
Summit Walk-in Clinic, LLC  
Surgicare of Chattanooga, LLC  
Surgicare of Clarksville, LLC

---

Surgicare of Dickson, LLC  
Surgicare of Madison, Inc.  
Surgicare of Natchez, LLC  
Surgicare of Premier Orthopaedic, LLC  
Surgicare of Southern Hills, Inc.  
Surgicare of Wilson County, LLC  
Surgicare Outpatient Center of Jackson, Inc.  
TCMC Madison-Portland, Inc.  
Tennessee Healthcare Management, Inc.  
Tennessee Valley Outpatient Diagnostic Center, LLC  
The Charter Cypress Behavioral Health System, L.L.C.  
Trident Ambulatory Surgery Center, L.P.  
TriStar Bone Marrow Transplant, LLC  
TriStar Cardiovascular Surgery, LLC  
TriStar Family Care, LLC  
TriStar Gynecology Oncology, LLC  
TriStar Health System, Inc.  
TriStar Joint Replacement Institute, LLC  
TriStar Medical Group - Centennial Primary Care, LLC  
TriStar Medical Group - Legacy Health, LLC  
TriStar Medical Network, LLC  
TriStar OB/GYN, LLC  
TriStar Orthopedics, LLC  
TriStar Physicians, LLC  
TriStar Radiation Oncology, LLC  
Vascular and Endovascular Specialists, LLC  
Vision Holdings, LLC  
WCP Properties, LLC  
Wilson County Outpatient Surgery Center, L.P.  
Women's and Children's Specialists, LLC

#### TEXAS

360 Community Alliance, LLC  
Acute Kids Urgent Care of Medical City Children's Hospital, PLLC  
Administrative Physicians of North Texas, PLLC  
Advanced Practice Providers of Gulf Coast, PLLC  
Ambulatory Endoscopy Clinic of Dallas, Ltd.  
Ambulatory Endoscopy Holdco, LLC  
Arlington Diagnostic South, Inc.  
Arlington Neurosurgeons, PLLC  
Arlington Primary Care, PLLC  
Arlington Primary Medicine, PLLC  
Austin Heart Cardiology MSO, LLC

---

Austin Medical Center, Inc.  
Austin Physicians Management, LLC  
Austin Urogynecology, PLLC  
Bailey Square Ambulatory Surgical Center, Ltd.  
Bailey Square Outpatient Surgical Center, Inc.  
Barrow Medical Center CT Services, Ltd.  
Bay Area Healthcare Group, Ltd.  
Bay Area Surgical Center Investors, Ltd.  
Bay Area Surgicare Center, Inc.  
Bayshore Family Practitioners, PLLC  
Bayshore Multi-Specialty Group, PLLC  
Bayshore Occupational and Family Medicine, PLLC  
Bayshore Radiation Oncology Services, PLLC  
Bayshore Surgery Center, Ltd.  
Bedford-Northeast Community Hospital, Inc.  
Bellaire Imaging, Inc.  
Brownsville Specialists of Texas, PLLC  
Brownsville Surgery, PLLC  
Brownsville Surgical Specialists, PLLC  
Brownsville-Valley Regional Medical Center, Inc.  
C. Medrano, M.D., PLLC  
Calder Immediate Care, PLLC  
Calloway Creek Surgery Center, L.P.  
Calloway Creek Surgicare, LLC  
Capital Area Cardiology  
Capital Area CareNow Physician Associates  
Capital Area Multispecialty Providers  
Capital Area Neurosurgeons  
Capital Area Occupational Medicine, PLLC  
Capital Area Primary Care Providers  
Capital Area Primary Care, PLLC  
Capital Area Providers  
Capital Area Specialists, PLLC  
Capital Area Specialty Providers  
Capital Area Surgeons, PLLC  
Cardio Vascular Surgeons of North Texas, PLLC  
Cardiology Clinic of San Antonio, PLLC  
Cardiology Specialists of North Texas, PLLC  
Cardiovascular and Thoracic Surgeons of Texas, PLLC  
CC Clinic, PLLC  
Central San Antonio Surgical Center Investors, Ltd.  
Central Texas Cardiac Arrhythmia Physicians, PLLC  
CHC Management, Ltd.  
CHC Payroll Company

---

CHC Realty Company  
CHCA Pearland, L.P.  
CHC-El Paso Corp.  
CHC-Miami Corp.  
Christina Cano-Gonzalez, M.D., PLLC  
City of San Antonio H2U Employee Health and Wellness Center, PLLC  
Clear Lake Family Physicians, PLLC  
Clear Lake Medical Tower Owners Association, Inc.  
Clear Lake Multi-Specialty Group, PLLC  
Clear Lake Regional Medical Center, Inc.  
Clear Lake Surgicare, Ltd.  
Coastal Bend Hospital CT Services, Ltd.  
Collin County Diagnostic Associates, PLLC  
COL-NAMC Holdings, Inc.  
Columbia Ambulatory Surgery Division, Inc.  
Columbia Bay Area Realty, Ltd.  
Columbia Call Center, Inc.  
Columbia Central Group, Inc.  
Columbia Champions Treatment Center, Inc.  
Columbia GP of Mesquite, Inc.  
Columbia Greater Houston Division Healthcare Network, Inc.  
Columbia Hospital at Medical City Dallas Subsidiary, L.P.  
Columbia Hospital Corporation at the Medical Center  
Columbia Hospital Corporation of Arlington  
Columbia Hospital Corporation of Bay Area  
Columbia Hospital Corporation of Corpus Christi  
Columbia Hospital-El Paso, Ltd.  
Columbia Medical Arts Hospital Subsidiary, L.P.  
Columbia Medical Center at Lancaster Subsidiary, L.P.  
Columbia Medical Center Dallas Southwest Subsidiary, L.P.  
Columbia Medical Center of Arlington Subsidiary, L.P.  
Columbia Medical Center of Denton Subsidiary, L.P.  
Columbia Medical Center of Las Colinas, Inc.  
Columbia Medical Center of Lewisville Subsidiary, L.P.  
Columbia Medical Center of McKinney Subsidiary, L.P.  
Columbia Medical Center of Plano Subsidiary, L.P.  
Columbia North Hills Hospital Subsidiary, L.P.  
Columbia North Texas Healthcare System, L.P.  
Columbia North Texas Subsidiary GP, LLC  
Columbia North Texas Surgery Center Subsidiary, L.P.  
Columbia Northwest Medical Center Partners, Ltd.  
Columbia Northwest Medical Center, Inc.  
Columbia Plaza Medical Center of Fort Worth Subsidiary, L.P.  
Columbia Psychiatric Management Co.

---

Columbia South Texas Division, Inc.  
Columbia Specialty Hospital of Dallas Subsidiary, L.P.  
Columbia Specialty Hospitals, Inc.  
Columbia Surgery Group, Inc.  
Columbia/HCA Healthcare Corporation of Central Texas  
Columbia/HCA Heartcare of Corpus Christi, Inc.  
Columbia/HCA International Group, Inc.  
Columbia/HCA of Houston, Inc.  
Columbia/HCA of North Texas, Inc.  
Columbia/HCA Physician Hospital Organization Medical Center Hospital  
Columbia-Quantum, Inc.  
Comprehensive Radiology Management Services, Ltd.  
Congenital Heart Surgery Center, PLLC  
Conroe Hospital Corporation  
Conroe Montgomery Physicians Group, PLLC  
Conroe Orthopedic Specialists, PLLC  
Conroe Specialists of Texas, PLLC  
Corpus Christi Healthcare Group, Ltd.  
Corpus Christi Heart Clinic, PLLC  
Corpus Christi Primary Care Associates, PLLC  
Corpus Christi Psychiatric Specialists, PLLC  
Corpus Christi Radiation Oncology, PLLC  
Corpus Christi Surgery Center, L.P.  
Corpus Christi Surgery, Ltd.  
Corpus Surgicare, Inc.  
CP Surgery Center, LLC  
CUC, PLLC  
Dallas Cardiology Specialists, PLLC  
Dallas CardioThoracic Surgery Consultants, PLLC  
Dallas Hand Surgery Center, PLLC  
Dallas Medical Specialists, PLLC  
Dallas Neuro-Stroke Affiliates, PLLC  
Dallas Pediatric Neurosurgery Specialists, PLLC  
Deep Purple Investments, LLC  
Del Sol Bariatric Clinic, PLLC  
Denton Cancer Center, PLLC  
Denton County Hospitalist Program, PLLC  
Denton Pediatric Physicians, PLLC  
Denton Regional Ambulatory Surgery Center, L.P.  
DFW Physicians Group, PLLC  
Doctors Bay Area Physician Hospital Organization  
Doctors Hospital (Conroe), Inc.  
Dura Medical, Inc.  
E.P. Physical Therapy Centers, Inc.

---

East Houston Primary Care, PLLC  
East Houston Specialists, PLLC  
East Orthopedics, PLLC  
El Paso CareNow Urgent Care, PLLC  
El Paso Healthcare Provider Network  
El Paso Healthcare System Physician Services, LLC  
El Paso Healthcare System, Ltd.  
El Paso Nurses Unlimited, Inc.  
El Paso Primary Care, PLLC  
El Paso Surgery Centers, L.P.  
El Paso Surgicenter, Inc.  
Eldridge Family Practitioners, PLLC  
Elite Family Health of Plano, PLLC  
Elite OB-GYN Services of El Paso, PLLC  
Elite Orthopaedics of El Paso, PLLC  
Elite Orthopaedics of Irving, PLLC  
Elite Orthopaedics of Plano, PLLC  
Emergency Psychiatric Medicine, PLLC  
Endoscopy of Plano, L.P.  
Endoscopy Surgicare of Plano, LLC  
EPIC Properties, Inc.  
EPSC, L.P.  
Family First Medicine in Brownsville, PLLC  
Family Practitioners of Montgomery, PLLC  
Family Practitioners of Pearland, PLLC  
Fannin MOB Property Management, LLC  
Fannin MOB, LLC  
Flower Mound Surgery Center, Ltd.  
Fort Worth Investments, Inc.  
Frisco Warren Parkway 91, Inc.  
G. Rowe, M.D., PLLC  
G. Schnider, M.D., PLLC  
G. Voorhees, M.D., PLLC  
G.P. Martin Fletcher & Associates, LLC  
Galen Hospital of Baytown, Inc.  
General and Cardiovascular Surgeons of Conroe, PLLC  
General Surgeons of Houston, PLLC  
General Surgeons of North Richland Hills, PLLC  
General Surgeons of Pasadena, PLLC  
GI Associates of Denton, PLLC  
GI Associates of Lewisville, PLLC  
Gramercy Surgery Center, Ltd.  
Greater Houston Preferred Provider Option, Inc.  
Green Oaks Hospital Subsidiary, L.P.

---

Gulf Coast Division, Inc.  
Gulf Coast Electrophysiology Associates, PLLC  
Gulf Coast Physician Administrators, Inc.  
Gulf Coast Provider Network, Inc.  
H2U Wellness Centers — Conroe ISD, PLLC  
H2U Wellness Centers — Corpus Christi, PLLC  
H2U Wellness Centers — Clear Lake Regional Medical Center, PLLC  
H2U Wellness Centers — Conroe Regional Medical Center, PLLC  
H2U Wellness Centers - Del Sol Medical Center, PLLC  
H2U Wellness Centers — El Paso, PLLC  
H2U Wellness Centers - Las Palmas Medical Center, PLLC  
H2U Wellness Centers - Medical City Dallas, PLLC  
H2U Wellness Centers — PISD, PLLC  
H2U Wellness Centers — San Benito CISD, PLLC  
H2U Wellness Centers - St. David's Medical Center, PLLC  
HBP Lone Star, Inc.  
HCA Central/West Texas Physicians Management, LLC  
HCA Gulf Coast GME, PLLC  
HCA Health Services of Texas, Inc.  
HCA Pearland GP, Inc.  
HCA Plano Imaging, Inc.  
HCA Western Group, Inc.  
HCAPS Conroe Affiliation, Inc.  
HealthTrust Locums, Inc.  
Heart Specialist of North Texas, PLLC  
Heartcare of Texas, Ltd.  
Hidalgo County Family Practitioners, PLLC  
Hidden Lakes Health Center, PLLC  
Hip & Joint Specialists of North Texas, PLLC  
Houston CareNow Urgent Care, PLLC  
Houston Northwest Concessions, L.L.C.  
Houston Northwest Operating Company, L.L.C.  
Houston Northwest Surgical Partners, Inc.  
Houston Obstetrics and Gynecology for Women, PLLC  
Houston Pediatric Specialty Group, PLLC  
HPG Energy, L.P.  
HPG GP, LLC  
HTI Gulf Coast, Inc.  
HWCA, PLLC  
ICU Associates of West Houston, PLLC  
Internal Medicine Associates of Huntsville, PLLC  
Internal Medicine of Pasadena, PLLC  
Internist Associates of Houston, PLLC  
J. M. Garcia, M.D., PLLC

---

Kathy L. Summers, M.D., PLLC  
Kennedale Primary Care PLLC  
Kingwood Multi-Specialty Group, PLLC  
Kingwood Surgery Center, LLC  
KPH-Consolidation, Inc.  
Kyle Primary Care, PLLC  
Lake Forest Family Health, PLLC  
Las Colinas Primary Care, PLLC  
Las Colinas Surgery Center, Ltd.  
Las Palmas Del Sol Cardiology, PLLC  
Las Palmas Del Sol Internal Medicine, PLLC  
Las Palmas Del Sol Urgent Care, PLLC  
Leadership Healthcare Holdings II L.P., L.L.P.  
Leadership Healthcare Holdings L.P., L.L.P.  
Leslie Cohan, M.D., PLLC  
Lewisville Primary Care, PLLC  
Lone Star Intensivists at Gulf Coast, PLLC  
Lonestar Provider Network  
Longview Regional Physician Hospital Organization, Inc.  
LPN TeleBehavioral Health, PLLC  
M. Jamshidi, D.O., PLLC  
Mainland Family Medicine, PLLC  
Mainland Multi-Specialty Group, PLLC  
Mainland Primary Care Physicians, PLLC  
Mark Gottesman, M.D., PLLC  
Martin Fletcher Associates Holdings, Inc.  
Martin, Fletcher & Associates, L.P.  
Mary Alice Cowan, M.D., PLLC  
Maternal Fetal Medicine Specialists of Corpus Christi, PLLC  
McAllen Comprehensive Upper Extremity Center, PLLC  
McKinney Surgeons, PLLC  
MEC Endoscopy, LLC  
Med City Dallas Outpatient Surgery Center, L.P.  
Med-Center Hosp./Houston, Inc.  
Medical Care Surgery Center, Inc.  
Medical City Dallas Hospital, Inc.  
Medical City Dallas Primary Care, PLLC  
Medical City OB-GYN, PLLC  
Medical City Pediatrics, PLLC  
Medical City Transplant, PLLC  
MediPurchase, Inc.  
Methodist Cardiology Physicians  
Methodist CareNow Physician Associates  
Methodist CareNow Urgent Care, PLLC

---

Methodist Healthcare System of San Antonio, Ltd., L.L.P.  
Methodist Inpatient Management Group  
Methodist Medical Center ASC, L.P.  
Methodist Physician Alliance  
Methodist Physician Practice Services, LLC  
Methodist Physician Practices, PLLC  
Metroplex Surgicenters, Inc.  
MFA G.P., LLC  
MFM Fact, PLLC  
MGH Medical, Inc.  
MHS SC Partner, L.L.C.  
MHS Surgery Centers, L.P.  
Michael Mann, M.D., PLLC  
Mid-Cities Surgi-Center, Inc.  
Movement Disorders of North Texas, PLLC  
National Patient Account Services, Inc.  
Navarro Memorial Hospital, Inc.  
Neuro-Hospitalist of Clear Lake, PLLC  
NeuroHospitalist of McAllen, PLLC  
Neurological Eye Specialists of North Texas, PLLC  
Neurological Specialists of McKinney, PLLC  
Neurological Specialists, PLLC  
Neurosurgery of Kingwood, PLLC  
Neurosurgical Associates of North Texas, PLLC  
Neurosurgical Specialists of El Paso, PLLC  
Neurosurgical Specialists of North Texas, PLLC  
North Austin Plastic Surgery Associates, PLLC  
North Austin Surgery Center, L.P.  
North Central Methodist ASC, L.P.  
North Hills Cardiac Catheterization Center, L.P.  
North Hills Catheterization Lab, LLC  
North Hills Orthopaedic Surgeons, PLLC  
North Hills Surgicare, L.P.  
North Shore Specialists of Texas, PLLC  
North Texas - MCA, LLC  
North Texas Cardiology, PLLC  
North Texas Craniofacial Fellowship Program, PLLC  
North Texas Division, Inc.  
North Texas General, L.P.  
North Texas Geriatrics, PLLC  
North Texas Heart Surgery Center, PLLC  
North Texas Internal Medicine Specialists, PLLC  
North Texas Neuro Stroke OP, PLLC  
North Texas of Hope, PLLC

---

North Texas Pulmonary Critical Care, PLLC  
North Texas Sports and Orthopedics Center, PLLC  
North Texas Stroke Center, PLLC  
Northeast Methodist Surgicare, Ltd.  
Northeast PHO, Inc.  
NT Urgent Care, PLLC  
NTX Pathology Program, PLLC  
Oakwood Surgery Center, Ltd., LLP  
OB Hospitalists of Woman's Hospital, PLLC  
OB/Gyn Associates of Denton, PLLC  
OB/GYN of Brownsville, PLLC  
Occupational and Family Medicine of South Texas  
On-Site Primary Care, PLLC  
Orthopedic Hospital, Ltd.  
Outpatient Women's and Children's Surgery Center, Ltd.  
Paragon of Texas Health Properties, Inc.  
Paragon Physicians Hospital Organization of South Texas, Inc.  
Paragon Surgery Centers of Texas, Inc.  
Park Central Surgical Center, Ltd.  
Parkway Cardiac Center, Ltd.  
Parkway Surgery Services, Ltd.  
Pasadena Bayshore Hospital, Inc.  
Pearland Institute for Women's Health, PLLC  
Pediatric Anesthesia Consultants of San Antonio, PLLC  
Pediatric Cardiac Intensivists of North Texas, PLLC  
Pediatric Critical Care of Clear Lake, PLLC  
Pediatric Hospitalists of Conroe, PLLC  
Pediatric Intensivists of El Paso, PLLC  
Pediatric Intensivists of North Texas, PLLC  
Pediatric Specialists of Clear Lake, PLLC  
Pediatric Surgicare, Inc.  
Pediatrics of Greater Houston, PLLC  
Physicians Ambulatory Surgery Center, LLC  
Plano Surgery Center - GP, LLC  
Plano Surgery Center Real Estate, LLC  
Plano Surgicenter Real Estate Manager, LLC  
Plano Urology, PLLC  
Plaza Medical Specialists, PLLC  
Plaza Primary Care, PLLC  
Plaza Transplant Center, PLLC  
Podiatry of Clear Lake, PLLC  
Primary Care Plano, PLLC  
Primary Care South, PLLC  
Primary Care West, PLLC

---

Primary Health Asset Holdings, Ltd.  
Primary Health Network of South Texas  
Primary Health Physicians, PLLC  
Primary Health, Inc.  
Quantum/Bellaire Imaging, Ltd.  
Rim Building Partners, L.P.  
Rio Grande Healthcare MSO, Inc.  
Rio Grande NP, Inc.  
Rio Grande Regional Hospital, Inc.  
Rio Grande Valley Cardiology, PLLC  
Rio Grande Valley CareNow Urgent Care, PLLC  
Rio Grande Valley Urology, PLLC  
Rosewood Medical Center, Inc.  
Rosewood Professional Building, Ltd.  
Round Rock Trauma Surgeons, PLLC  
Royal Oaks Surgery Center, L.P.  
S.A. Medical Center, Inc.  
San Antonio Division, Inc.  
San Antonio Regional Hospital, Inc.  
San Antonio Surgicenter, LLC  
Sante Fe Family Practitioners, PLLC  
SAPN, LLC  
South Austin Surgery Center, Ltd.  
South Texas Surgicare, Inc.  
Southern Texas Physicians' Network  
Specialists in Obstetrics and Gynecology, PLLC  
Specialty Associates of West Houston, PLLC  
Spring Branch Family Practitioners, PLLC  
Spring Branch Medical Center, Inc.  
St. David's Healthcare Partnership, L.P., LLP  
St. David's Austin Area ASC, LLC  
St. David's Cardiology, PLLC  
St. David's CareNow Urgent Care, PLLC  
St. David's Heart & Vascular, PLLC  
St. David's Neurology, PLLC  
St. David's OB Hospitalist, PLLC  
St. David's Ortho, Neuro and Rehab, PLLC  
St. David's Physical Medicine and Rehabilitation, PLLC  
St. David's Quality Alliance, LLC  
St. David's Specialized Women's Services, PLLC  
St. David's Trauma Surgeons, PLLC  
STPN Manager, LLC  
Sugar Land Surgery Center Anesthesia, LLC  
Sugar Land Surgery Center, Ltd.

---

Sun Towers/Vista Hills Holding Co.  
Surgery Associates of NTX, PLLC  
Surgery Center of Bay Area Houston, LLC  
Surgical Center of Irving, Inc.  
Surgical Facility of West Houston, L.P.  
Surgical Specialists of Clear Lake, PLLC  
Surgical Specialists of Conroe, PLLC  
Surgical Specialists of Corpus Christi, PLLC  
Surgicare of Arlington, LLC  
Surgicare of Bay Area Endoscopy, LLC  
Surgicare of Central Park Surgery Center, LLC  
Surgicare of Central San Antonio, Inc.  
Surgicare of Flower Mound, Inc.  
Surgicare of Fort Worth Co-GP, LLC  
Surgicare of Fort Worth, Inc.  
Surgicare of Gramercy, Inc.  
Surgicare of Houston Women's, Inc.  
Surgicare of Kingwood, LLC  
Surgicare of McKinney, Inc.  
Surgicare of Medical City Dallas, LLC  
Surgicare of Memorial Endoscopy, LLC  
Surgicare of North Austin, LLC  
Surgicare of North San Antonio, Inc.  
Surgicare of Northeast San Antonio, Inc.  
Surgicare of Pasadena, Inc.  
Surgicare of Round Rock, Inc.  
Surgicare of Royal Oaks, LLC  
Surgicare of South Austin, Inc.  
Surgicare of Southwest Houston, LLC  
Surgicare of St. David's Austin, LLC  
Surgicare of Sugar Land, Inc.  
Surgicare of Travis Center, Inc.  
Tarrant County Surgery Center, L.P.  
Texas CareNow Physician Associates  
Texas HSS, LLC  
Texas Institute of Medicine and Surgery  
Texas Psychiatric Company, Inc.  
The Austin Diagnostic Clinic, PLLC  
The Cardiovascular Partnership for Quality, LLC  
The West Texas Division of Columbia, Inc.  
THN Physicians Association, Inc.  
Travis Surgery Center, L.P.  
Tuscan Imaging Center at Las Colinas, LLC  
Urological Specialists of Arlington, PLLC

---

Urology Services of El Paso, PLLC  
Urology Specialists of Kingwood, PLLC  
Village Oaks Medical Center, Inc.  
W & C Hospital, Inc.  
West Houston ASC, Inc.  
West Houston Healthcare Group, Ltd.  
West Houston Internal Specialists, PLLC  
West Houston Medical, PLLC  
West Houston Outpatient Medical Facility, Inc.  
West Houston Surgicare, Inc.  
West LPN Fort Worth Oncology, PLLC  
West LPN, Inc.  
West McKinney Imaging Services, LLC  
West Park Surgery Center, L.P.  
WHMC, Inc.  
Woman's Health Group, PLLC  
Woman's Hospital of Texas, Incorporated  
Women Practitioners of Houston, PLLC  
Women Specialists of Bayshore, PLLC  
Women Specialists of Clear Lake, PLLC  
Women Specialists of Mainland, PLLC  
Women's Link Specialty Obstetrical Referral Clinic, PLLC  
Women's Surgical Specialists of Texas, PLLC

UNITED KINGDOM

52 Alderley Road LLP  
Backlogs Limited  
Basil Street Practice Limited  
Blossoms Healthcare LLP  
Catalog360 Limited  
Chelsea Outpatient Centre LLP  
Chiswick Outpatient Centre LLP  
Elstree Outpatient Centre LLP  
Galen Health Partners Limited  
General Medical Clinics Limited  
Hamsard 3160 Limited  
Harley Street Clinic @ The Groves LLP  
Hathor Chelsea, Ltd.  
HCA Carenow Limited  
HCA Global Capital LLP  
HCA Healthcare UK Limited  
HCA International Holdings Limited  
HCA International Limited

---

HCA Luxembourg Finance Limited  
HCA Medical City Limited  
HCA Purchasing Limited  
HCA Staffing Limited  
HCA Swiss Capital 1 LLP  
HCA Swiss Capital 2 LLP  
HCA UK Capital Limited  
HCA UK Holdings Limited  
HCA UK Investments Limited  
HCA UK Limited  
HCA UK Services Limited  
Health International Billing Partners Limited  
HealthTrust Europe Company Limited  
HealthTrust Europe LLP  
Leaders in Oncology Care Limited  
LOC @ The Christie LLP  
LOC @ The London Bridge Hospital LLP  
LOC Partnership LLP  
London Oncology Clinic LLP  
London Pathology Limited  
London Radiography & Radiotherapy Services Limited  
OBS Diagnostic and Treatment Centre LLP  
Online Pathology Services Limited  
PET CT LLP  
Robotic Radiosurgery LLP  
Roodlane Medical Limited  
Sarah Cannon Research Institute UK Limited  
SCRI Global Services Limited  
St. Martins Healthcare Limited  
St. Martins Ltd.  
St. Martins Medical Services Limited  
The Christie Clinic LLP  
The Glynne Medical Practice Limited  
The Harley Street Cancer Clinic Limited  
The Physicians Clinic Limited  
The Prostate Centre Limited  
Urology Associates (London) Limited  
Urology Specialists Devonshire LLP  
Urology Specialists London LLP  
Welbeck Street Diagnostic Centre LLP  
Wellington Diagnostic Services LLP

---

UTAH

Alta Internal Medicine, LLC  
Bountiful Surgery Center, LLC  
Brigham City Community Hospital Physician Services, LLC  
Brigham City Community Hospital, Inc.  
Brigham City Health Plan, Inc.  
Columbia Ogden Medical Center, Inc.  
East Layton Internal Medicine, LLC  
General Hospitals of Galen, Inc.  
Gynecology Specialists of Utah, LLC  
Healthtrust Utah Management Services, Inc.  
Hospital Corporation of Utah  
HTI Physician Services of Utah, Inc.  
Jordan Family Health, L.L.C.  
Lakeview Hospital Physician Services, LLC  
Lakeview Internal Medicine, LLC  
Lakeview Regional Medical Center Inpatient Services, LLC  
Lakeview Urology & General Surgery, LLC  
Layton Family Practice, LLC  
Lone Peak Hospital, Inc.  
Maternal Fetal Services of Utah, LLC  
Mountain Division - CVH, LLC  
Mountain Division, Inc.  
Mountain View Hospital, Inc.  
Mountain West Surgery Center, LLC  
MountainStar Behavioral Health, LLC  
MountainStar Brigham General Surgery, LLC  
Mountainstar Brigham OBGYN, LLC  
MountainStar Canyon Surgical Clinic, LLC  
MountainStar Cardiology Ogden Regional, LLC  
MountainStar Cardiology St. Marks, LLC  
Mountainstar Cardiovascular Services, LLC  
MountainStar Intensivist Services, LLC  
MountainStar Medical Group - Cache Valley, LLC  
MountainStar Medical Group - Ogden Regional Medical Center, LLC  
MountainStar Medical Group - St. Mark's Hospital, LLC  
MountainStar Medical Group Neurosurgery-St. Mark's, LLC  
MountainStar Medical Group Timpanogos Primary Care, LLC  
MountainStar Medical Group Timpanogos Specialty Care, LLC  
Mountainstar Ogden Pediatrics, LLC  
MountainStar Specialty Services, LLC  
MountainStar Urgent Care, LLC  
Mt. Ogden Utah Surgical Center, LLC  
MVH Professional Services, LLC  
Northern Utah Healthcare Corporation

---

Northern Utah Healthcare Imaging Holdco, LLC  
Northern Utah Imaging, LLC  
Ogden Imaging, LLC  
Ogden Internal Medicine & Urology, LLC  
Ogden Regional Health Plan, Inc.  
Ogden Regional Medical Center Professional Billing, LLC  
Ogden Senior Center, LLC  
Ridgeline Surgicenter, LLC  
Salt Lake City Surgicare, Inc.  
St. Mark's Gynecology Oncology Care, LLC  
St. Mark's Investments, Inc.  
St. Mark's Physician Billing, LLC  
St. Mark's Professional Services, LLC  
St. Mark's South Jordan Family Practice, LLC  
Surgicare of Bountiful, LLC  
Surgicare of Mountain West, LLC  
Surgicare of Mt. Ogden, LLC  
Surgicare of Ridgeline, LLC  
Surgicare of Utah, LLC  
Surgicare of Wasatch Front, LLC  
The Wasatch Endoscopy Center, Ltd.  
Timpanogos Pain Specialists, LLC  
Timpanogos Regional Medical Services, Inc.  
Utah Imaging GP, LLC  
Utah Surgery Center, L.P.  
Wasatch Front Surgery Center, LLC  
West Jordan Hospital Corporation  
West Valley Imaging, LLC

#### VIRGIN ISLANDS

The London Breast Institute UK Ltd

#### VIRGINIA

Alleghany General and Bariatric Services, LLC  
Alleghany Hospitalists, LLC  
Alleghany Primary Care, Inc.  
Alleghany Specialists, LLC  
Ambulatory Services Management Corporation of Chesterfield County, Inc.  
Appomattox Imaging, LLC  
Arlington Surgery Center, L.P.  
Arlington Surgicare, LLC  
Ashburn ASC, LLC

---

Ashburn Imaging, LLC  
Atrium Surgery Center, L.P.  
Atrium Surgicare, LLC  
Behavioral Health Wellness Center, LLC  
Blacksburg Family Care, LLC  
Buford Road Imaging, L.L.C.  
Capital Anesthesia Services, LLC  
Capital Division, Inc.  
Capital Professional Billing, LLC  
Cardiac Surgical Associates, LLC  
Carlin Springs Urgent Care, LLC  
Central Shared Services, LLC  
Chesterfield Imaging, LLC  
Chippenham & Johnston-Willis Hospitals, Inc.  
Chippenham & Johnston-Willis Sports Medicine, LLC  
Chippenham Ambulatory Surgery Center, LLC  
Chippenham Pediatric Specialists, LLC  
Christiansburg Family Medicine, LLC  
Christiansburg Internal Medicine, LLC  
CJW Infectious Disease, LLC  
CJW Wound Healing Center, LLC  
Columbia Arlington Healthcare System, L.L.C.  
Columbia Healthcare of Central Virginia, Inc.  
Columbia Medical Group - Southwest Virginia, Inc.  
Columbia Pentagon City Hospital, L.L.C.  
Columbia/Alleghany Regional Hospital, Incorporated  
Columbia/HCA John Randolph, Inc.  
Commonwealth Perinatal Services, LLC  
Crewe Outpatient Imaging, LLC  
CVMC Property, LLC  
Daleville Imaging Manager, LLC  
Daleville Imaging, L.P.  
Dominion Hospital Physicians' Group, LLC  
Fairfax Surgical Center, L.P.  
Family Medicine of Blacksburg, LLC  
Family Practice at Forest Hill, LLC  
Family Practice at Retreat, LLC  
Fort Chiswell Family Practice, LLC  
Forward Pathology Solutions, LLC  
Galen of Virginia, Inc.  
Galen Property, LLC  
Galen Virginia Hospital Corporation  
Generations Family Practice, Inc.  
GYN-Oncology of Southwest Virginia, LLC

---

HCA Health Services of Virginia, Inc.  
HCA LewisGale Regional Cancer Centers Clinical Co-Management Company, LLC  
HCA Richmond Cardiac Clinical Co-Management Company, LLC  
HDH Thoracic Surgeons, LLC  
Henrico Doctors' Neurology Associates, LLC  
Henrico Doctor's OB GYN Specialists, LLC  
Henrico Surgical Specialists, LLC  
HSS Virginia, L.P.  
Institute of Advanced ENT Surgery, LLC  
Internal Medicine of Blacksburg, LLC  
James River Internists, LLC  
John Randolph Family Practice, LLC  
John Randolph OB/GYN, LLC  
John Randolph Surgeons, LLC  
Lewis-Gale Hospital, Incorporated  
Lewis-Gale Physicians, LLC  
LGMC Ambulatory Surgery Center, LLC  
Loudoun Surgery Center, LLC  
Mechanicsville Imaging, LLC  
Montgomery Cancer Center, LLC  
Montgomery Hospitalists, LLC  
Montgomery Regional Hospital, Inc.  
Montgomery Surgery Associates, LLC  
Northern Virginia CareNow Urgent Care, LLC  
Northern Virginia Community Hospital, LLC  
Northern Virginia Hospital Corporation  
Orthopedics Specialists, LLC  
Pavilion 2 Condominium Property, LLC  
Pavilion 2 Medical Office Building Condominium Association, Inc.  
Preferred Hospitals, Inc.  
Primary Care of West End, LLC  
Primary Health Group, Inc.  
Pulaski Community Hospital, Inc.  
Pulaski Urology, LLC  
Quick Care Centers, LLC  
Radford Family Medicine, LLC  
Reston Hospitalists, LLC  
Reston Surgery Center, L.P.  
Retreat Cardiology, LLC  
Retreat Hospital, LLC  
Retreat Internal Medicine, LLC  
Retreat Surgical Associates, LLC  
Richmond Imaging Employer Corp.  
Richmond Multi-Specialty, LLC

---

Richmond Pediatric Surgeon's, LLC  
Roanoke Imaging, LLC  
Roanoke Neurosurgery, LLC  
Roanoke Surgery Center, L.P.  
Roanoke Valley Gynecology, LLC  
Salem Hospitalists, LLC  
Short Pump Imaging, LLC  
Southwest Virginia Orthopedics and Spine, LLC  
Specialty Physicians of Northern Virginia, LLC  
Spotsylvania Condominium Property, LLC  
Spotsylvania Medical Center, Inc.  
Spotsylvania Multi-Specialty Group, LLC  
Spotsylvania Regional Surgery Center, LLC  
Stafford Imaging, LLC  
StoneSprings Medical Office Building Property, LLC  
Surgical Associates of Southwest Virginia, LLC  
Surgicare of Ashburn, LLC  
Surgicare of Chippenham, LLC  
Surgicare of Fairfax, Inc.  
Surgicare of Hanover, Inc.  
Surgicare of Reston, Inc.  
Surgicare of Roanoke, LLC  
Surgicare of Spotsylvania, LLC  
Surgicare of Winchester, LLC  
Tri-City Multi-Specialty, LLC  
Urology Specialists of Richmond, LLC  
Virginia Care Partners ACO LLC  
Virginia Gynecologic Oncology, LLC  
Virginia Hematology & Oncology Associates, Inc.  
Virginia Hospitalists, Inc.  
Virginia Psychiatric Company, Inc.  
Virginia Quality Care Partners, LLC  
West Creek Ambulatory Surgery Center, LLC  
West Creek Medical Center, Inc.  
Women's & Children's Center, LLC  
Women's Health Center of SWVA, LLC

#### WASHINGTON

ACH, Inc.  
Capital Network Services, Inc.

---

WEST VIRGINIA

Columbia Parkersburg Healthcare System, LLC

Galen of West Virginia, Inc.

HCA Health Services of West Virginia, Inc.

Hospital Corporation of America

Parkersburg SJ Holdings, Inc.

Teays Valley Health Services, LLC

Tri Cities Health Services Corp.

## Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

- (1) Registration Statement (Form S-8 No. 333-197656) pertaining to the HCA Healthcare, Inc. Employee Stock Purchase Plan,
- (2) Registration Statement (Form S-8 No. 333-172887) pertaining to the 2006 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates, as Amended and Restated,
- (3) Registration Statement (Form S-8 No. 333-150714) pertaining to the 2006 Stock Incentive Plan for Key Employees of HCA Inc. and its Affiliates, and
- (4) Registration Statement (Form S-3 No. 333- 226709) of HCA Healthcare, Inc.;

of our reports dated February 20, 2020, with respect to the consolidated financial statements of HCA Healthcare, Inc. and the effectiveness of internal control over financial reporting of HCA Healthcare, Inc., included in this Annual Report (Form 10-K) of HCA Healthcare, Inc. for the year ended December 31, 2019.

/s/ Ernst & Young LLP

Nashville, Tennessee  
February 20, 2020

## CERTIFICATIONS

I, Samuel N. Hazen, certify that:

1. I have reviewed this annual report on Form 10-K of HCA Healthcare, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit and compliance committee of the registrant's board of directors (or persons performing the equivalent functions):
  - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

By: /s/ SAMUEL N. HAZEN  
Samuel N. Hazen  
*Chief Executive Officer*

Date: February 20, 2020

## CERTIFICATIONS

I, William B. Rutherford, certify that:

1. I have reviewed this annual report on Form 10-K of HCA Healthcare, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit and compliance committee of the registrant's board of directors (or persons performing the equivalent functions):
  - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

By: /s/ WILLIAM B. RUTHERFORD

William B. Rutherford

*Executive Vice President and Chief Financial Officer*

Date: February 20, 2020

**CERTIFICATION PURSUANT TO  
18 U.S.C. SECTION 1350,  
AS ADOPTED PURSUANT TO  
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of HCA Healthcare, Inc. (the "Company") on Form 10-K for the year ended December 31, 2019, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned certifies, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

By: /s/ SAMUEL N. HAZEN

Samuel N. Hazen  
*Chief Executive Officer*

February 20, 2020

By: /s/ WILLIAM B. RUTHERFORD

William B. Rutherford  
*Executive Vice President and Chief Financial Officer*

February 20, 2020