HCA Healthcare, Inc.
Form 10-K
February 21, 2019
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2018

Or

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

For the transition period from _____ to _____

Commission File Number 1-11239

HCA Healthcare, Inc.

(Exact Name of Registrant as Specified in its Charter)

Delaware	**27-3865930**
(State or Other Jurisdiction of	**(I.R.S. Employer**
Incorporation or Organization)	**Identification No.)**
One Park Plaza	
Nashville, Tennessee	**37203**
(Address of Principal Executive Offices)	**(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	**Name of Each Exchange on Which Registered**
Common Stock, $0.01 Par Value	**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 if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of Registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of large accelerated filer,

accelerated filer, smaller reporting company and emerging growth company in Rule 12b-2 of the Exchange Act.

Large accelerated filer	Accelerated filer
Non-accelerated filer	Smaller reporting company

Emerging growth company

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

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

As of January 31, 2019, there were 342,376,700 outstanding shares of the Registrant s common stock. As of June 30, 2018, the aggregate market value of the common stock held by nonaffiliates was approximately $28.045 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 2019 Annual Meeting of Stockholders are incorporated by reference into Part III hereof.

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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, 2018, we operated 179 hospitals, comprised of 175 general, acute care hospitals; three psychiatric hospitals; and one rehabilitation hospital. In addition, we operated 123 freestanding surgery centers. Our facilities are located in 20 states and England.

The terms Company, HCA, we, our or us, as used herein and unless otherwise stated or indicated by context, r 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. 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.

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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, 2018, we owned and operated 175 general, acute care hospitals with 46,687 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, 2018, we operated three psychiatric hospitals with 412 licensed beds. Our psychiatric hospitals provide therapeutic programs, including child, adolescent and adult psychiatric care, 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. Charges and reimbursement rates for inpatient 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.

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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 from third-party payers and other (including uninsured patients) for the years ended December 31, 2018, 2017 and 2016 are summarized in the following table (dollars in millions):

	Years Ended December 31,					
	2018	**Ratio**	**2017**	**Ratio**	**2016**	**Ratio**
Medicare	**$ 9,831**	**21.1%**	$ 9,285	21.3%	$ 8,719	21.0%
Managed Medicare	**5,497**	**11.8**	4,680	10.7	4,278	10.3
Medicaid	**1,358**	**2.9**	1,316	3.0	1,278	3.1
Managed Medicaid	**2,403**	**5.1**	2,165	5.0	2,317	5.6
Managed care and other insurers	**24,467**	**52.4**	23,342	53.5	22,287	53.7
International (managed care and insurers)	**1,156**	**2.5**	1,097	2.5	1,195	2.9
Other	**1,965**	**4.2**	1,729	4.0	1,416	3.4
Revenues	**$ 46,677**	**100.0%**	$ 43,614	100.0%	$ 41,490	100.0%

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. Patients are generally not responsible for the total difference between established hospital gross charges and amounts reimbursed for such services under Medicare, Medicaid, HMOs, PPOs and other managed care plans, but are responsible to the extent of 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. In implementing our uninsured discount 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. These reductions have

been extended through 2027. In 2013, the Centers for Medicare & Medicaid Services (CMS) began imposing a 2% reduction on Medicare payments.

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

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inpatient discharge are established based on the patient s assigned Medicare severity diagnosis-related group (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 Health Reform Law). 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 2018, CMS increased the MS-DRG rate by approximately 1.2%. This increase reflected a 2.7% market basket increase adjusted by the following percentage points: a 0.75 reduction required by the Health Reform Law, a negative 0.6 productivity adjustment, a further reduction of 0.6 to remove the effects of prior adjustments related to the two midnight rule, and a positive 0.46 adjustment in accordance with the 21st Century Cures Act. Under the two midnight rule, services provided to Medicare beneficiaries are payable as inpatient hospital services only when there is a reasonable expectation that the hospital care is medically necessary and will be required across two midnights, absent unusual circumstances. For federal fiscal year 2019, CMS increased the MS-DRG rate by approximately 1.85%. This increase reflects a market basket update of 2.9%, adjusted by the following percentage points: a 0.75 reduction required by the Health Reform Law, 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). Additional adjustments may apply, depending on patient-specific or hospital-specific factors. Under the post-acute care transfer policy, for example, 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, or 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 0.25% reduction of the market basket update. Hospitals that do not demonstrate meaningful use of electronic health records (EHRs) are subject to a 0.75% 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, pursuant to the Health Reform Law, 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.

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The Health Reform Law also provides for reduced payments to hospitals 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 2019, 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 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, pursuant to the Health Reform Law, 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 Health Reform Law 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 care; efficiency and cost reduction; safety and patient and caregiver experience of care. CMS estimates that $1.9 billion will be available to hospitals as incentive payments in federal fiscal year 2019 under the 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 2018, CMS finalized a rule that will reimburse clinic visit services provided at all off-campus provider-based departments 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. CMS will phase in the expansion of this site-neutral policy over two calendar years, beginning in 2019.

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 Health Reform Law. For calendar year 2018, CMS increased APC payment rates by an estimated 1.4%. The change reflected a market basket increase of 2.7% with a negative 0.6 percentage point productivity adjustment and a negative 0.75 percentage point adjustment required by the Health Reform Law, along with other payment adjustments and policy changes. For calendar year 2019, CMS increased APC

payment rates by an estimated 1.35%. This increase reflects 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 Health Reform Law. 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.

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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 methodology and rates as is applied to non-340B-discounted drugs. In a final rule effective January 1, 2018, CMS reduced the Medicare payments under the outpatient PPS for most drugs obtained at the 340B-discounted rates. CMS also made corresponding increases to the Medicare reimbursement rates to all hospitals for other drugs and services paid under the outpatient PPS. On December 27, 2018, the United States District Court for the District of Columbia held that the adoption of the 2018 rule had exceeded CMS statutory authority. The court has asked the parties to submit briefs on the appropriate remedy to implement the holding. The holding and the court s remedy could potentially be appealed. Depending upon the court s remedy and the outcome of any appeal, this case could result in a decrease to the Company s outpatient Medicare reimbursement.

Rehabilitation

CMS reimburses inpatient rehabilitation facilities (IRFs) on a PPS basis. Under the IRF PPS, patients are classified into case mix groups based upon impairment, age, comorbidities (additional diseases or disorders from which the patient suffers) and functional capability. IRFs are paid a predetermined amount per discharge that reflects the patient s case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. Each federal fiscal 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 Health Reform Law. For federal fiscal year 2018, CMS increased IRF payment rates by an estimated 0.9%. This reflected an increase factor of 1.0%, the figure required by MACRA, with adjustments related to outlier threshold results. 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 adjustment and a 0.75 percentage point reduction required by the Health Reform Law, among other payment adjustments. In addition, CMS requires IRFs to report quality measures to avoid receiving a reduction of 2 percentage points to the market basket update.

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, 2018, we had one rehabilitation hospital and 62 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 payment year, the Health Reform Law provides for the annual market basket update to be further reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For federal fiscal year 2018, CMS increased inpatient psychiatric payment rates by approximately 1.0%, which reflected a 2.6% IPF market basket update, reduced by a 0.6 percentage point productivity adjustment and by a 0.75 percentage point as required by the Health Reform Law, among other payment adjustments.

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 Health Reform Law, and other payment adjustments. Inpatient psychiatric facilities are required to report quality

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measures to CMS to avoid receiving a 2.0 percentage point reduction to the market basket update. As of December 31, 2018, 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 considers expanding 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. Commercial third-party payers may adopt 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. 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 as required by the Health Reform Law. For calendar year 2018, CMS increased ASC payments by 1.2%, which reflected a consumer price index update of 1.7% and a negative 0.5 percentage point productivity adjustment. For calendar year 2019, CMS increased ASC payment rates by 2.1%, which reflects a market basket increase of 2.9%, less a 0.8 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 2019, CMS updated the conversion factor based on the 0.25% increase required by the Bipartisan Budget Act of 2018 and a budget neutrality adjustment.

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 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.

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Alternatively, providers may participate in the MIPS track. Currently, providers electing this option may receive payment incentives or be subject to payment reductions of up to 5% of the provider s Medicare payments 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. The adjustment percentage will increase incrementally to 9% by 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 2019.

Medicare reimburses hospitals for a portion (65%) of bad debts resulting from 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 chain providers 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 flow.

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 assignment of new Medicare appeals to Administrative Law

Judges. 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.

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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 Health Reform Law, as enacted, 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. However, the Health Reform Law requires states to at least maintain Medicaid eligibility standards for children established prior to the enactment of the law until October 1, 2019.

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.

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

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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 the U.S. Department of Health and Human Services (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 (MSSP), which was established pursuant to the Health Reform Law, 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 a voluntary bundled payment program known as the Bundled Payment for Care Improvement (BPCI) initiative. Participation in bundled payment programs is generally voluntary, but CMS requires hospitals in selected geographic areas to participate in bundling programs for specified orthopedic procedures. 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 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) payments are determined annually based on certain statistical information required by HHS and are paid as a percentage addition to MS-DRG payments.

The Health Reform Law reduced Medicare DSH payments to 25% of the amount they otherwise would have been absent the law. The remaining 75% of the amount that would otherwise be paid under Medicare DSH is effectively pooled, and this pool is adjusted each year by a formula that reflects changes in the national level of uninsured who

are under 65 years of age. Thus, the greater the level of coverage for the previously uninsured nationally, the more the Medicare DSH payment pool will be reduced. Each DSH hospital is paid out of the DSH payment pool an amount allocated based upon its estimated cost of providing uncompensated care as a percentage in relation to the cost of providing uncompensated care for all other DSH hospitals.

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Hospitals that provide care to a disproportionately high number of low-income patients may receive Medicaid DSH 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 Health Reform Law and subsequent legislation provide for reductions to the Medicaid DSH hospital program. However, Congress has delayed the implementation of these reductions until 2020. 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.

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%, 28% and 29% of our total admissions for the years ended December 31, 2018, 2017 and 2016, respectively. Managed care contracts are typically negotiated for terms between one and three years. While we generally received contracted annual average increases of 4% to 5% from managed care payers during 2018, there can be no assurance that we will continue to receive increases in the future. 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.

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, 2018, approximately 83% of our admissions of uninsured patients occurred through our

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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 Health Reform Law 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 Health Reform Law. 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.

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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.

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,				
	2018	**2017**	**2016**	**2015**	**2014**
Number of hospitals at end of period	**179**	179	170	168	166
Number of freestanding outpatient surgery centers at end of period	**123**	120	118	116	113
Number of licensed beds at end of period(a)	**47,199**	46,738	44,290	43,771	43,356
Weighted average licensed beds(b)	**46,857**	45,380	44,077	43,620	43,132
Admissions(c)	**2,003,753**	1,936,613	1,891,831	1,868,789	1,795,312
Equivalent admissions(d)	**3,420,406**	3,286,432	3,191,519	3,122,746	2,958,674
Average length of stay (days)(e)	**4.9**	4.9	4.9	4.9	4.8
Average daily census(f)	**26,663**	26,000	25,340	25,084	23,835
Occupancy rate(g)	**57%**	57%	58%	58%	55%
Emergency room visits(h)	**8,764,431**	8,624,137	8,378,340	8,050,159	7,450,748
Outpatient surgeries(i)	**971,537**	941,231*	932,213	909,386	891,633
Inpatient surgeries(j)	**548,220**	540,304*	537,306	529,900	518,881

(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.

* Reclassifications between inpatient surgery cases and outpatient surgery cases for 2017 have been made to conform to the 2018 presentation.

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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 hospitals 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 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.

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, quality and condition of the facilities and prices charged. Hospitals must publish online a list of their standard charges for items and services. We have increased our focus on operating outpatient services with improved accessibility and more convenient service for patients and increased 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. Increasing vertical integration efforts involving third-party payers and health care providers 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,

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such as the Health Reform Law s creation of the Exchanges and 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, including those offered through the Exchanges, 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 Health Reform Law. 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. 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, to 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. 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.

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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 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 Health Reform Law 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

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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 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.

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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.

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 Health Reform Law 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 Health Reform Law 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 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

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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 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 Health Reform Law, 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

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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, 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 a HIPAA compliance plan, which we believe complies with the HIPAA privacy and security regulations and under which a HIPAA compliance group monitors our compliance. 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

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impose additional penalties. For example, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions in response to data breaches.

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 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 or industry practices.

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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 Health Reform Law 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 2019. 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 Health Reform Law. The Health Reform Law 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 Health Reform Law. 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 Health Reform Law, its implementation or interpretation. The 2017 Tax Cuts and Jobs Act (the Tax Act) repealed the penalty associated with the individual mandate to maintain health insurance effective January 1, 2019. Additionally, 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 Health Reform Law. 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. Further, the President of the United States signed an executive order that directs agencies to minimize economic and regulatory burdens of the Health Reform Law, which may result in additional changes in how the law is implemented.

As currently structured, the Health Reform Law expands coverage through a combination of public program expansion and private sector health insurance and other reforms. 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

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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.

The expansion of health coverage through the private sector as a result of the Health Reform Law has been driven by new 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. Health insurers participating in an Exchange must offer a set of minimum benefits, as defined by HHS, and may offer more benefits. For individuals and families below 400% of the federal poverty level, the cost of obtaining health insurance through the Exchanges is subsidized by the federal government. Large employers are required to provide health insurance benefits to their full time employees or pay a penalty if an employee obtains government-subsidized coverage through an Exchange. Although individuals are required to maintain health insurance for a minimum defined set of benefits, elimination of the penalty associated with this mandate may impact the number of individuals who elect to purchase health insurance.

As discussed in Item 1, Business Sources of Revenue, the Health Reform Law provides for spending reductions for Medicare, Medicaid and other federal health care programs. It also increasingly ties payment for services to quality outcomes, provides for the creation of ACOs and creates incentives and other initiatives to better coordinate patient care across settings and over time. The Health Reform Law also makes several significant changes to health care fraud and abuse laws, provides additional enforcement tools to the government, increases cooperation between agencies by establishing mechanisms for the sharing of information and enhances criminal and administrative penalties for non-compliance. For example, the Health Reform Law tightens up the rules for returning overpayments made by governmental health programs and expands FCA liability to include failure to timely repay identified overpayments. The Health Reform Law also prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. As a result, the law effectively prevents the formation of new physician-owned hospitals that participate in Medicare and Medicaid. While the law 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.

The Health Reform Law 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 meaningful contribution to the Company s results of operations. However, in December 2018, the United States District Court for the Northern District of Texas held that, as a result of the repeal of the penalty associated with the individual mandate, the mandate was unconstitutional. In addition, because the court found that the mandate could not be severed from the rest of the law, the court held that the entire Health Reform Law was also unconstitutional, but the law remains in place pending appeal. The Company could be affected by the ultimate outcome of this and other court challenges, and by efforts to change, repeal or replace the Health Reform Law, as 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 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

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that shift financial responsibility to patients and further difficulties in collecting patient receivables for copayment and deductible amounts.

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 a toll-free telephone ethics line.

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, 2018, we had approximately 262,000 employees, including approximately 66,000 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, 2018, certain employees at 39 of our domestic hospitals are represented by various labor unions. While no elections are expected in 2019, it is possible additional hospitals may unionize in the future. We

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consider our employee relations to be good and have not experienced work stoppages that have materially, adversely affected our business or results 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. Recent changes by the National Labor Relations Board (the NLRB) in its election procedures could increase the likelihood of employee unionization attempts. 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.

Executive Officers of the Registrant

As of February 1, 2019, our executive officers were as follows:

Name	Age	Position(s)
R. Milton Johnson	62	Chairman
Samuel N. Hazen	58	Chief Executive Officer and Director
Phillip G. Billington	51	Senior Vice President Internal Audit Services
Victor L. Campbell	72	Senior Vice President Government Affairs
Michael S. Cuffe, M.D.	53	President Physician Services Group
Jane D. Englebright	61	Senior Vice President and Chief Nursing Officer
Jon M. Foster	57	President American Group
Charles J. Hall	65	President National Group
A. Bruce Moore, Jr.	58	President Service Line and Operations Integration
Sandra L. Morgan	56	Senior Vice President Provider Relations
J. William B. Morrow	48	Senior Vice President Finance and Treasurer
P. Martin Paslick	59	Senior Vice President and Chief Information Officer
Jonathan B. Perlin, M.D.	57	President Clinical Services Group and Chief Medical Officer
Deborah M. Reiner	57	Senior Vice President Marketing and Communications

William B. Rutherford	55	Executive Vice President and Chief Financial Officer
Joseph A. Sowell, III	62	Senior Vice President and Chief Development Officer
John M. Steele	63	Senior Vice President and Chief Human Resource Officer
Kathryn A. Torres	55	Senior Vice President Payer Contracting and Alignment
Robert A. Waterman	65	Senior Vice President and General Counsel
Kathleen M. Whalen	55	Senior Vice President and Chief Ethics and Compliance Officer
Christopher F. Wyatt	41	Senior Vice President and Controller

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R. Milton Johnson has served as Chairman since December 31, 2014 and has been a director of the Company since December 2009. Mr. Johnson served as Chairman and Chief Executive Officer from December 31, 2014 through December 2018. He served as President and Chief Executive Officer from January 1, 2014 to December 31, 2014. Mr. Johnson previously served the Company as President and Chief Financial Officer from February 2011 through December 2013 and Executive Vice President and Chief Financial Officer from July 2004 to February 2011. Prior to that time, he served as Senior Vice President and Controller from July 1999 until July 2004 and as Vice President and Controller of the Company from November 1998 to July 1999. From April 1995 to October 1998, Mr. Johnson served as Vice President Tax of the Company. Prior to that time, Mr. Johnson served as Director of Tax for Healthtrust, Inc. The Hospital Company from September 1987 to April 1995.

Samuel N. Hazen was appointed Chief Executive Officer effective January 1, 2019 and was appointed as a director in September 2018. Mr. Hazen served as President and Chief Operating Officer from November 2016 through December 2018. Prior to that time, he had served as Chief Operating Officer since January 2015. Mr. Hazen served as President Operations of the Company from February 2011 to January 2015. Mr. Hazen served as President Western Group from July 2001 to February 2011 and as Chief Financial Officer Western Group of the Company from August 1995 to July 2001. Mr. Hazen served as Chief Financial Officer North Texas Division of the Company from February 1994 to July 1995. Prior to that time, Mr. Hazen served in various hospital and regional Chief Financial Officer positions with Humana Inc. and Galen Health Care, Inc.

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.

Victor L. Campbell has served as Senior Vice President of the Company since February 1994. He is responsible for government relations. Prior to that time, Mr. Campbell served as HCA-Hospital Corporation of America s Vice President for Investor, Corporate and Government Relations. Mr. Campbell joined HCA-Hospital Corporation of America in 1972. Mr. Campbell serves on the board of the Coalition to Protect America s Health Care, as a member of the American Hospital Association s President s Forum, and on the board of trustees of the Federation of American Hospitals.

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 as the At-Large Nursing Representative to 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, Knoxville, Tennessee and The Methodist Hospital System in Houston, Texas.

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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 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 of the Company 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.

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William B. Rutherford has served as the Company s 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 of the Company 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 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.

John M. Steele has served as Senior Vice President and Chief Human Resource Officer since July 2017. Prior to that time, he served as Senior Vice President Human Resources of the Company from November 2003 to July 2017. Mr. Steele served as Vice President Compensation and Recruitment of the Company from November 1997 to October 2003. From March 1995 to November 1997, Mr. Steele served as Assistant Vice President Recruitment.

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 of the Company 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.

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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, 2018, our total indebtedness was $32.821 billion. As of December 31, 2018, we had availability of $1.983 billion under our senior secured revolving credit facility and $710 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;
- 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.

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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;
- 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, 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 can 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

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portion of our 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 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. In addition, 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. Federal law provides for the future expansion of the number of quality measures that must be reported. Additional quality measures and trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes. Further, CMS requires every Medicare-participating hospital to establish and update annually a public listing online of the hospital s standard charges for items and services. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures or on patient satisfaction surveys or if our standard charges are or are perceived to be higher than our competitors, our patient volumes could decline.

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 healthcare 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 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. Further, 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.

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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, 2018, estimated implicit price concessions of $6.280 billion had been recorded as reductions to our accounts receivable to enable us to record our revenues and accounts receivable at the estimated amounts we expect to collect. Total uncompensated care increased from $20.455 billion for 2016 to $23.420 billion for 2017 and to $26.757 billion for 2018.

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 Health Reform Law 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 Health Reform Law. 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 Health Reform Law. Even if the Health Reform Law remains in effect, we will continue to experience collectability issues and provide uninsured discounts and charity care for individuals residing in states that choose not to implement the Medicaid expansion, 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 coverage. Further, 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.

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 40.9% of our revenues from the Medicare and Medicaid programs in 2018. 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 Health Reform Law has made significant changes to Medicare and Medicaid, and future health reform efforts or further efforts to repeal or significantly change the Health Reform Law 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 2027. 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 Health Reform Law and other laws. Further, from time to time, CMS revises the reimbursement systems used to reimburse health care providers,

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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, certain items and 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 over the next two years. CMS is also considering proposals to reduce drug costs. 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, which could result in Medicaid supplemental payments being reduced or eliminated. For example, in December 2017, CMS announced that it will phase out funding for Designated State Health Programs under certain types of Medicaid waivers. 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.

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 results of operations may be adversely affected by health care reform efforts, particularly court challenges to, and efforts to repeal, replace or otherwise significantly change the Health Reform Law. We are unable to predict what, if any, and when such changes will be made in the future.

In recent years, Congress and certain state legislatures have introduced and passed a large number of proposals and legislation designed to make major changes in the health care system, including changes intended to increase access to health insurance. The Health Reform Law is the most prominent of these efforts and represents a significant shift in the way health care services are delivered, covered, and reimbursed. Although it has reduced our Medicare and Medicaid reimbursement, the Health Reform Law has also reduced the number of uninsured patients to whom we provide health care services, primarily through the Exchanges and Medicaid expansion. However, effective January 2019, Congress eliminated the financial penalty associated with the individual mandate. Additionally, 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 Health Reform Law. These developments may impact the number of individuals that elect to obtain public or private health insurance

or the scope of such coverage, if purchased.

In December 2018, as a result of the individual mandate penalty being eliminated, the United States District Court for the Northern District of Texas found that the entire Health Reform Law was unconstitutional, but the law remains in place pending appeal. If the District Court s ruling is upheld on appeal, it could have an adverse effect on the Company s results of operations. In addition, the presidential administration and a number of

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members of Congress continue to attempt to repeal, amend or replace the law, or make significant changes to its implementation, and the law remains subject to court challenges. 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. There is uncertainty regarding whether, when, and how the Health Reform Law may be further changed, what alternative provisions, if any, will be enacted, the timing of enactment and implementation of alternative provisions, the impact of alternative provisions on health care industry participants, 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. Members of Congress have also proposed measures that would expand government-sponsored coverage, including single-payer proposals. 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 Health Reform Law, may have an adverse effect on our business, results of operations, cash flow, capital resources, and liquidity.

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 52.4%, 53.5% and 53.7% of our revenues for 2018, 2017 and 2016, 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 also 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. Cost-reduction strategies by large employer groups 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 Health Reform Law 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.

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

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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 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. Recent changes in federal labor laws and the NLRB s modification of its election procedures could increase the likelihood of employee unionization attempts. 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 raise rates to offset these increased costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. 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.

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.

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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.

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 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.

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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. Many foreign data privacy regulations (including the General Data Protection Regulation (the GDPR), which became effective in the European Union on May 25, 2018) are more stringent than those in the United States. These laws and regulations are rapidly evolving and changing, and could have an adverse effect on our operations. Companies obligations and requirements under these laws and regulations are subject to uncertainty in how they may be interpreted by government authorities and regulators. 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. 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. 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 engage in consumer debt collection for HCA-affiliated hospitals and certain non-affiliated hospitals. The federal Fair Debt Collection Practices Act and Telephone Consumer Protection Act restrict the methods that companies may use to contact and seek payment from consumer debtors regarding past due accounts. Many states impose additional requirements on debt collection 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, we could be subject to liabilities, including civil penalties, 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 and criminal penalties.

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.

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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 assignment of new Medicare appeals to Administrative Law Judges, 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 any of these 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.

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 continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by third-party payers. 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.

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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 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 Health Reform Law 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 will 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 2019 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. 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. 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.

Many large private third-party payers currently require hospitals 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.

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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. CMS has announced aggressive goals for adopting alternative payment models, which may include additional bundled payment programs, and private third-party payers may also transition away from fee-for-service payment models. 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.

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 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.

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

We, independently 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

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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 and malware 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.

If we fail to continue to demonstrate meaningful use of certified electronic health record systems, our operations could be adversely affected.

Eligible hospitals and eligible professionals that fail to demonstrate meaningful use of certified EHR technology in an applicable prior reporting period are subject to reduced payments from Medicare in connection with the CMS Promoting Interoperability Program. Failure to continue to demonstrate meaningful use of certified EHR technology could have a material, adverse effect on our financial position and results of operations.

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. 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

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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 conversion 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 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 179 hospitals at December 31, 2018, and 92 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities combined revenues represented approximately 49% of our consolidated revenues for the year ended December 31, 2018. 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, and the property insurance we obtain may not be adequate to cover losses from future hurricanes or other natural disasters.

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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 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 liability 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.

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 $409 million at December 31, 2018. 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, 2018, we had a net unrealized gain of $3 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 other-than-temporary 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.

The U.K. Financial Conduct Authority announced in 2017 that it intends to phase out LIBOR by the end of 2021. Changes to LIBOR or any other benchmark rate may impact credit markets. As of December 31, 2018, we had $6.841 billion of borrowings under our senior secured credit facilities that bore interest at rates based on LIBOR and $2.693 billion of unfunded commitments under those facilities. The administrative agent for those facilities may approve a comparable or successor rate with respect to LIBOR or, if not feasible, another

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accommodation as reasonably determined by the agent. The replacement of LIBOR with a comparable or successor rate could cause the amount of interest payable on our senior secured credit facilities to be different than expected.

As of December 31, 2018, 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.

Uncertainties in the interpretation and application of the 2017 Tax Cuts and Jobs Act could materially affect our tax obligations and effective tax rate.

The 2017 Tax Cuts and Jobs Act (the Tax Act) was enacted on December 22, 2017. The Tax Act significantly revises 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. Due to the complexity and uncertainty regarding numerous provisions of the Tax Act, we continue to monitor legislative developments and interpretive guidance issued by federal and state taxing authorities or other standard-setting bodies to determine if adjustments to amounts we have recorded for federal, state, and foreign tax assets and liabilities as of December 31, 2018 are appropriate. Any adjustments or additional amounts recorded may materially impact our provision for income taxes and effective tax rate in the periods in which they are made.

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 20% as of January 31, 2019). 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.

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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, 2018:

State	Hospitals	Beds
Alaska	1	250
California	5	1,858
Colorado	7	2,415
Florida	45	12,057
Georgia	9	2,459
Idaho	2	468
Indiana	1	278
Kansas	4	1,374
Kentucky	2	384
Louisiana	4	1,049
Mississippi	1	130
Missouri	5	1,030
Nevada	3	1,283
New Hampshire	2	295
South Carolina	3	941
Tennessee	13	2,544
Texas	47	13,252
Utah	8	1,011
Virginia	11	3,284
International		
England	6	837
	179	47,199

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.

We maintain our headquarters in approximately 2,129,000 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

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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. The Civil Division of the U.S. Department of Justice and the U.S. Attorney s Office for the Southern District of Texas have requested information about whether the Program as operated in Harris County complies with the laws and regulations applicable to provider related donations. The Company is cooperating with this request. We believe that our participation is and has been consistent with the requirements of the Program. However, at this time, we cannot predict what effect, if any, the request or resulting claims under the federal FCA, other statutes, regulations or laws, could have on the Company.

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

None.

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PART II

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

During January 2019, our Board of Directors authorized a share repurchase program for up to $2 billion of our outstanding common stock. During October 2017, our Board of Directors authorized a share repurchase program for up to $2 billion of our outstanding common stock. Repurchases made during the fourth quarter of 2018, as detailed below, were made pursuant to the $2 billion October 2017 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, 2018 through December 31, 2018 (dollars in millions, except per share amounts).

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares That May Yet Be Purchased Under Publicly Announced Plans or Programs
October 1, 2018 through October 31, 2018	952,686	$ 134.40	952,686	$ 479
November 1, 2018 through November 30, 2018	613,685	$ 138.43	613,685	$ 394
December 1, 2018 through December 31, 2018	946,231	$ 128.59	946,231	$ 272
Total for Fourth Quarter 2018	2,512,602	$ 133.20	2,512,602	$ 272

Our common stock is traded on the New York Stock Exchange (NYSE) (symbol HCA). On January 29, 2019, our Board of Directors declared a quarterly dividend of $0.40 per share on our common stock payable on March 29, 2019 to stockholders of record on March 1, 2019. 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 2018, our Board of Directors declared four quarterly dividends of $0.35 per share, or $1.40 per share in the aggregate, on our common stock. There were no dividends or distributions declared during 2017. At the close of business on February 8, 2019, there were approximately 380 holders of record of our common stock.

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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

	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
HCA Healthcare, Inc.	**$ 100.00**	**$ 153.83**	**$ 141.75**	**$ 155.15**	**$ 184.11**	**$ 263.98**
S&P 500	**100.00**	**113.69**	**115.26**	**129.05**	**157.22**	**150.33**
S&P Health Care	**100.00**	**125.34**	**133.97**	**130.37**	**159.15**	**169.44**

The graph shows the cumulative total return to our stockholders beginning as of December 31, 2013 through December 31, 2018, 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, 2013 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.

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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)

	2018	2017	2016	2015	2014
Summary of Operations:					
Revenues	**$ 46,677**	$ 43,614	$ 41,490	$ 39,678	$ 36,918
Salaries and benefits	**21,425**	20,059	18,897	18,115	16,641
Supplies	**7,724**	7,316	6,933	6,638	6,262
Other operating expenses	**8,608**	8,051	7,496	7,056	6,630
Equity in earnings of affiliates	**(29)**	(45)	(54)	(46)	(43)
Depreciation and amortization	**2,278**	2,131	1,966	1,904	1,820
Interest expense	**1,755**	1,690	1,707	1,665	1,743
Losses (gains) on sales of facilities	**(428)**	(8)	(23)	5	(29)
Losses on retirement of debt	**9**	39	4	135	335
Legal claim (benefits) costs			(246)	249	78
	41,342	39,233	36,680	35,721	33,437
Income before income taxes	**5,335**	4,381	4,810	3,957	3,481
Provision for income taxes	**946**	1,638	1,378	1,261	1,108
Net income	**4,389**	2,743	3,432	2,696	2,373
Net income attributable to noncontrolling interests	**602**	527	542	567	498
Net income attributable to HCA Healthcare, Inc.	**$ 3,787**	$ 2,216	$ 2,890	$ 2,129	$ 1,875
Per common share data:					
Basic earnings per share	**$ 10.90**	$ 6.12	$ 7.53	$ 5.14	$ 4.30
Diluted earnings per share	**$ 10.66**	$ 5.95	$ 7.30	$ 4.99	$ 4.16
Cash dividends declared per share	**$ 1.40**				
Financial Position:					
Assets	**$ 39,207**	$ 36,593	$ 33,758	$ 32,744	$ 30,980
Working capital	**2,644**	3,819	3,252	3,716	3,450
Long-term debt, net, including amounts due within one year	**32,821**	33,058	31,376	30,488	29,426
Noncontrolling interests	**2,032**	1,811	1,669	1,553	1,396
Stockholders deficit	**(2,918)**	(4,995)	(5,633)	(6,046)	(6,498)

Cash Flow Data:					
Cash provided by operating activities	**$ 6,761**	$ 5,426	$ 5,653	$ 4,734	$ 4,448
Cash used in investing activities	**(3,901)**	(4,279)	(3,240)	(2,583)	(2,918)
Purchase of property and equipment	**(3,573)**	(3,015)	(2,760)	(2,375)	(2,176)
Cash used in financing activities	**(3,075)**	(1,061)	(2,508)	(1,976)	(1,378)

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	2018	2017	2016	2015	2014
Operating Data:					
Number of hospitals at end of period	**179**	179	170	168	166
Number of freestanding outpatient surgical centers at end of period	**123**	120	118	116	113
Number of licensed beds at end of period(a)	**47,199**	46,738	44,290	43,771	43,356
Weighted average licensed beds(b)	**46,857**	45,380	44,077	43,620	43,132
Admissions(c)	**2,003,753**	1,936,613	1,891,831	1,868,789	1,795,312
Equivalent admissions(d)	**3,420,406**	3,286,432	3,191,519	3,122,746	2,958,674
Average length of stay (days)(e)	**4.9**	4.9	4.9	4.9	4.8
Average daily census(f)	**26,663**	26,000	25,340	25,084	23,835
Occupancy(g)	**57%**	57%	58%	58%	55%
Emergency room visits(h)	**8,764,431**	8,624,137	8,378,340	8,050,159	7,450,748
Outpatient surgeries(i)	**971,537**	941,231*	932,213	909,386	891,633
Inpatient surgeries(j)	**548,220**	540,304*	537,306	529,900	518,881
Days revenues in accounts receivable(k)	**51**	52	50	53	54
Outpatient revenues as a % of patient revenues(l)	**38%**	38%	38%	40%	38%

(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.

* Reclassifications between inpatient surgery cases and outpatient surgery cases for 2017 have been made to conform to the 2018 presentation.

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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 h 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. 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, pro estimate, anticipate, plan, initiative or continue. These forward-looking statements are based on our current pla 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 Health Reform Law), including the effects of court challenges to, any repeal of, or changes to, the Health Reform Law or 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, (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 and effects related to 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 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

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MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (Continued)

Forward-Looking Statements (continued)

cybersecurity incidents or security breaches, (22) our ongoing ability to demonstrate meaningful use of certified electronic health record (EHR) technology, (23) the impact of natural disasters, such as hurricanes and floods, or similar events beyond our control, (24) the effects of the 2017 Tax Cuts and Jobs Act (the Tax Act), including potential legislation or interpretive guidance that may be issued by federal and state 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.

2018 Operations Summary

Net income attributable to HCA Healthcare, Inc. totaled $3.787 billion, or $10.66 per diluted share, for 2018, compared to $2.216 billion, or $5.95 per diluted share, for 2017. The 2018 results include net 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 2017 results include net gains on sales of facilities of $8 million, or $0.01 per diluted share, and losses on retirement of debt of $39 million, or $0.06 per diluted share. The 2018 results include a reduction in our provision for income taxes of $551 million, or $1.55 per diluted share, on net income attributable to HCA Healthcare, Inc., excluding gains on sales of facilities and losses on retirement of debt, related to the impact of the Tax Act, $484 million due to a reduction in the effective tax rate and $67 million for the remeasurement of certain of our deferred tax assets and liabilities for which we were unable to record reasonable estimates in 2017. The 2017 results include an increase in the provision for income taxes of $301 million, or $0.81 per diluted share, related to the remeasurement of our deferred tax assets and liabilities due to the enactment of the Tax Act. During 2018, we recorded a reduction to the provision for professional liability risks of $70 million, or $0.15 per diluted share. 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. During 2017, we recorded additional expenses and losses of revenues estimated at approximately $140 million, or $0.24 per diluted share, associated with the impact of hurricanes Harvey and Irma on our Texas, Florida, Georgia and South Carolina facilities. Both of these amounts are 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 2018 and 2017 included tax benefits of $124 million, or $0.35 per diluted share, and $82 million, or $0.22 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 355.303 million shares and 372.221 million shares for the years ended December 31, 2018 and 2017, respectively. During 2018 and 2017, we repurchased 14.070 million and 25.092 million shares, respectively, of our common stock.

Revenues increased to $46.677 billion for 2018 from $43.614 billion for 2017. Revenues increased 7.0% and 6.5%, respectively, on a consolidated basis and on a same facility basis for 2018, compared to 2017. The consolidated revenues increase 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. The same facility revenues increase resulted primarily from a 3.9% increase in same facility revenue per equivalent admission and a 2.5% increase in same facility equivalent admissions.

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MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (Continued)

2018 Operations Summary (continued)

During 2018, consolidated admissions increased 3.5% and same facility admissions increased 2.5%, compared to 2017. Inpatient surgical volumes increased 1.5% on a consolidated basis and increased 0.8% on a same facility basis during 2018, compared to 2017. Outpatient surgical volumes increased 3.2% on a consolidated basis and increased 1.8% on a same facility basis during 2018, compared to 2017. Emergency room visits increased 1.6% on a consolidated basis and increased 0.1% on a same facility basis during 2018, compared to 2017.

Total uncompensated care increased $3.337 billion for 2018, compared to 2017. Total uncompensated care as a percentage of the sum of revenues and total uncompensated care was 36.4% for 2018, compared to 34.9% for 2017. Same facility uninsured admissions increased 8.5% and same facility uninsured emergency room visits increased 3.8% for 2018, compared to 2017. Same facility uninsured admissions increased 5.9% and same facility uninsured emergency room visits increased 2.4% for 2017, compared to 2016.

Interest expense totaled $1.755 billion for 2018, compared to $1.690 billion for 2017. The $65 million increase in interest expense for 2018 was due to the increase in the average debt balance.

Cash flows from operating activities increased $1.335 billion, from $5.426 billion for 2017 to $6.761 billion for 2018. The increase in cash flows from operating activities was primarily related to the increase in net income, excluding gains on sales of facilities, of $1.226 billion.

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 model. 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

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MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (Continued)

Business Strategy (continued)

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.

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

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MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (Continued)

Critical Accounting Policies and Estimates (continued)

Revenues (continued)

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, 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. In implementing the uninsured discount policy, we may first 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 $29 million, $41 million and $31 million in 2018, 2017 and 2016, respectively. The adjustments to estimated reimbursement amounts, which resulted in net increases to revenues, related primarily to cost reports filed during previous years were $51 million, $56 million and $90 million in 2018, 2017 and 2016, 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 aging of those accounts. Accounts are written off when all reasonable internal and external collection efforts have been performed.

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AND RESULTS OF OPERATIONS (Continued)

Critical Accounting Policies and Estimates (continued)

Revenues (continued)

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, 2018 and December 31, 2017, estimated implicit price concessions of $6.280 billion and $5.488 billion, respectively, had been recorded as reductions to our accounts receivable balances to enable us to record our revenues and accounts receivable at the estimated amounts we expect to collect.

To quantify the total impact of and trends related to uninsured 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):

	2018	2017	2016
Patient care costs (salaries and benefits, supplies, other operating expenses and depreciation and amortization)	**$ 40,035**	$ 37,557	$ 35,304
Cost-to-charges ratio (patient care costs as percentage of gross patient charges)	**12.4%**	12.9%	13.5%
Total uncompensated care	**$ 26,757**	$ 23,420	$ 20,455
Multiply by the cost-to-charges ratio	**12.4%**	12.9%	13.5%
Estimated cost of total uncompensated care	**$ 3,318**	$ 3,021	$ 2,761

Total uncompensated care as a percentage of the sum of revenues and total uncompensated care was 36.4% for 2018, 34.9% for 2017 and 33.0% for 2016. Days revenues in accounts receivable were 51 days, 52 days and 50 days at December 31, 2018, 2017 and 2016, 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

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MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (Continued)

Critical Accounting Policies and Estimates (continued)

Professional Liability Claims (continued)

$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 $447 million, $466 million and $430 million for the years ended December 31, 2018, 2017 and 2016, respectively. During 2018, we recorded a reduction to the provision for professional liability risks of $70 million 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 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 $1.514 billion to $1.814 billion at December 31, 2018 and $1.456 billion to $1.743 billion at December 31, 2017. 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 $31 million or reduce

the reserve estimate by $29 million. A 2.5% change in the expected claim severity trend could be reasonably likely and would increase the reserve estimate by $110 million or reduce the reserve estimate by $101 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 2,200 and 2,500 individual claims at December 31, 2018 and 2017, 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

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Critical Accounting Policies and Estimates (continued)

Professional Liability Claims (continued)

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 $1.741 billion and $1.627 billion at December 31, 2018 and 2017, respectively. The current portion of these reserves, $466 million and $429 million at December 31, 2018 and 2017, 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 $50 million and $24 million receivable under reinsurance and excess insurance contracts at December 31, 2018 and 2017, respectively) were $1.692 billion and $1.603 billion at December 31, 2018 and 2017, respectively. The estimated total net reserves for professional liability risks at December 31, 2018 and 2017 are comprised of $703 million and $751 million, respectively, of case reserves for known claims and $989 million and $852 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):

	2018	2017	2016
Net reserves for professional liability claims, January 1	**$ 1,603**	$ 1,494	$ 1,421
Provision for current year claims	**486**	467	428
Unfavorable (favorable) development related to prior years claims	**(39)**	(1)	2
Total provision	**447**	466	430
Payments for current year claims	**3**	7	9
Payments for prior years claims	**355**	350	348
Total claim payments	**358**	357	357
Net reserves for professional liability claims, December 31	**$ 1,692**	$ 1,603	$ 1,494

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.

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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 7.0% to $46.677 billion for 2018 from $43.614 billion for 2017 and increased 5.1% for 2017 from $41.490 billion for 2016. 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. The increase in revenues in 2017 can be attributed to the combined impact of a 2.1% increase in revenue per equivalent admission and a 3.0% increase in equivalent admissions compared to the prior year.

Same facility revenues increased 6.5% for the year ended December 31, 2018 compared to the year ended December 31, 2017 and increased 3.8% for the year ended December 31, 2017 compared to the year ended December 31, 2016. 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. The 3.8% increase for 2017 can be primarily attributed to the combined impact of a 2.2% increase in same facility revenue per equivalent admission and a 1.5% increase in same facility equivalent admissions.

Consolidated admissions increased 3.5% during 2018 compared to 2017 and increased 2.4% during 2017 compared to 2016. Consolidated surgeries increased 2.6% during 2018 compared to 2017 and increased 0.8% during 2017 compared to 2016. Consolidated emergency room visits increased 1.6% during 2018 compared to 2017 and increased 2.9% during 2017 compared to 2016.

Same facility admissions increased 2.5% during 2018 compared to 2017 and increased 1.1% during 2017 compared to 2016. Same facility surgeries increased 1.4% during 2018 compared to 2017 and declined 0.7% during 2017 compared to 2016. Same facility emergency room visits increased 0.1% during 2018 compared to 2017 and increased 1.4% during 2017 compared to 2016.

Same facility uninsured emergency room visits increased 3.8% and same facility uninsured admissions increased 8.5% during 2018 compared to 2017. Same facility uninsured emergency room visits increased 2.4% and same facility

uninsured admissions increased 5.9% during 2017 compared to 2016.

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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, 2018, 2017 and 2016 are set forth below.

	Years Ended December 31,		
	2018	**2017**	**2016**
Medicare	**30%**	30%	31%
Managed Medicare	**17**	16	15
Medicaid	**5**	6	6
Managed Medicaid	**12**	12	12
Managed care and insurers	**28**	28	29
Uninsured	**8**	8	7
	100%	100%	100%

The approximate percentages of our inpatient revenues related to Medicare, managed Medicare, Medicaid, managed Medicaid, managed care plans and insurers for the years ended December 31, 2018, 2017 and 2016 are set forth below.

	Years Ended December 31,		
	2018	**2017**	**2016**
Medicare	**28%**	28%	28%
Managed Medicare	**14**	13	12
Medicaid	**4**	5	5
Managed Medicaid	**6**	5	6
Managed care and insurers	**48**	49	49
	100%	100%	100%

At December 31, 2018, we owned and operated 45 hospitals and 32 surgery centers in the state of Florida. Our Florida facilities revenues totaled $10.892 billion, $10.168 billion and $9.522 billion for the years ended December 31, 2018, 2017 and 2016, respectively. At December 31, 2018, we owned and operated 47 hospitals and 29 surgery centers in the state of Texas. Our Texas facilities revenues totaled $12.023 billion, $10.634 billion and $9.898 billion for the years ended December 31, 2018, 2017 and 2016, respectively. During 2018, 2017 and 2016, 57%, 56% and 56% of our admissions and 49%, 48% and 47%, respectively, of our revenues were generated by our Florida and Texas facilities. Uninsured admissions in Florida and Texas represented 70%, 70% and 69% of our uninsured admissions during 2018, 2017 and 2016, 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 indicated that it will phase out some of the federal funding. Our Texas Medicaid revenues included Medicaid supplemental waiver payments of $450 million, $351 million and $370 million during 2018, 2017 and 2016, respectively.

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AND RESULTS OF OPERATIONS (Continued)

Results of Operations (continued)

Revenue/Volume Trends (continued)

In addition, we receive supplemental payments in several other states. We are aware these supplemental payment programs are currently being reviewed by certain state agencies and 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.

Operating Results Summary

The following are comparative summaries of operating results for the years ended December 31, 2018, 2017 and 2016 (dollars in millions):

	2018		2017		2016	
	Amount	**Ratio**	**Amount**	**Ratio**	**Amount**	**Ratio**
Revenues	**$ 46,677**	**100.0**	$ 43,614	100.0	$ 41,490	100.0
Salaries and benefits	**21,425**	**45.9**	20,059	46.0	18,897	45.5
Supplies	**7,724**	**16.5**	7,316	16.8	6,933	16.7
Other operating expenses	**8,608**	**18.5**	8,051	18.4	7,496	18.1
Equity in earnings of affiliates	**(29)**	**(0.1)**	(45)	(0.1)	(54)	(0.1)
Depreciation and amortization	**2,278**	**4.9**	2,131	4.9	1,966	4.8
Interest expense	**1,755**	**3.8**	1,690	3.9	1,707	4.1
Gain on sales of facilities	**(428)**	**(0.9)**	(8)		(23)	(0.1)
Losses on retirement of debt	**9**		39	0.1	4	
Legal claim benefits					(246)	(0.6)
	41,342	**88.6**	39,233	90.0	36,680	88.4
Income before income taxes	**5,335**	**11.4**	4,381	10.0	4,810	11.6
Provision for income taxes	**946**	**2.0**	1,638	3.7	1,378	3.3
Net income	**4,389**	**9.4**	2,743	6.3	3,432	8.3

Net income attributable to noncontrolling interests	**602**	**1.3**	527	1.2	542	1.3
Net income attributable to HCA Healthcare, Inc.	**$ 3,787**	**8.1**	$ 2,216	5.1	$ 2,890	7.0
% changes from prior year:						
Revenues	**7.0%**		5.1%		4.6%	
Income before income taxes	**21.8**		(8.9)		21.6	
Net income attributable to HCA Healthcare, Inc.	**70.9**		(23.3)		35.8	
Admissions(a)	**3.5**		2.4		1.2	
Equivalent admissions(b)	**4.1**		3.0		2.2	
Revenue per equivalent admission	**2.8**		2.1		2.3	
Same facility % changes from prior year(c):						
Revenues	**6.5**		3.8		4.1	
Admissions(a)	**2.5**		1.1		1.1	
Equivalent admissions(b)	**2.5**		1.5		1.9	
Revenue per equivalent admission	**3.9**		2.2		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.

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AND RESULTS OF OPERATIONS (Continued)

Results of Operations (continued)

Years Ended December 31, 2018 and 2017

Net income attributable to HCA Healthcare, Inc. totaled $3.787 billion, or $10.66 per diluted share, for 2018, compared to $2.216 billion, or $5.95 per diluted share, for 2017. The 2018 results include net 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 2017 results include net gains on sales of facilities of $8 million, or $0.01 per diluted share, and losses on retirement of debt of $39 million, or $0.06 per diluted share. The 2018 results include a reduction in provision for income taxes of $551 million, or $1.55 per diluted share, on net income attributable to HCA Healthcare, Inc., excluding gains on sales of facilities and losses on retirement of debt, related to the impact of tax rate changes and the remeasurement of certain of our deferred tax assets and liabilities for which we were unable to record reasonable estimates in 2017 related to the Tax Act. The 2017 results include an increase in provision for income taxes of $301 million, or $0.81 per diluted share, related to the remeasurement of our deferred tax assets and liabilities due to the enactment of the Tax Act. During 2018, we recorded a reduction to the provision for professional liability risks of $70 million, or $0.15 per diluted share. 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. During 2017, we recorded additional expenses and losses of revenues estimated at approximately $140 million, or $0.24 per diluted share, associated with the impact of hurricanes Harvey and Irma on our Texas, Florida, Georgia and South Carolina facilities. Both of these amounts are 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 2018 and 2017 included tax benefits of $124 million, or $0.35 per diluted share, and $82 million, or $0.22 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 355.303 million shares and 372.221 million shares for the years ended December 31, 2018 and 2017, respectively. During 2018 and 2017, we repurchased 14.070 million and 25.092 million shares, respectively, of our common stock.

During 2018, consolidated admissions increased 3.5% and same facility admissions increased 2.5% compared to 2017. Consolidated inpatient surgeries increased 1.5% and same facility inpatient surgeries increased 0.8% during 2018 compared to 2017. Consolidated outpatient surgeries increased 3.2%, and same facility outpatient surgeries increased 1.8% during 2018 compared to 2017. Emergency room visits increased 1.6% on a consolidated basis and increased 0.1% on a same facility basis during 2018 compared to 2017.

Revenues increased 7.0% to $46.677 billion for 2018 from $43.614 billion for 2017. The increase in revenues was primarily due to the combined impact of a 2.8% increase in revenue per equivalent admission and a 4.1% increase in

equivalent admissions compared to 2017. Same facility revenues increased 6.5% due primarily 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 compared to 2017.

Salaries and benefits, as a percentage of revenues, were 45.9% in 2018 and 46.0% in 2017. Salaries and benefits per equivalent admission increased 2.6% in 2018 compared to 2017. Same facility labor rate increases averaged 3.4% for 2018 compared to 2017. Share-based compensation expense was $268 million in 2018 and $270 million in 2017.

Supplies, as a percentage of revenues, were 16.5% in 2018 and 16.8% in 2017. Supply costs per equivalent admission increased 1.4% in 2018 compared to 2017. Supply costs per equivalent admission increased 3.6% for

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Results of Operations (continued)

Years Ended December 31, 2018 and 2017 (continued)

medical devices and 1.2% for general medical and surgical items, and declined 1.5% for pharmacy supplies in 2018 compared to 2017.

Other operating expenses, as a percentage of revenues, was 18.5% in 2018 and 18.4% in 2017. 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 $447 million and $466 million for 2018 and 2017, respectively.

Equity in earnings of affiliates was $29 million for 2018 and $45 million for 2017.

Depreciation and amortization, as a percentage of revenues, was 4.9% each in 2018 and 2017. Depreciation expense was $2.262 billion for 2018 and $2.111 billion for 2017.

Interest expense increased to $1.755 billion for 2018 from $1.690 billion for 2017. The increase in interest expense was due to an increase in the average debt balance. Our average debt balance was $33.065 billion for 2018 compared to $32.082 billion for 2017. The average interest rate for our long-term debt was 5.3% for both 2018 and 2017.

Net gains on sales of facilities were $428 million and $8 million, respectively, for 2018 and 2017. The net gains on sales of facilities for 2018 related primarily to the sale of the two hospital facilities in our Oklahoma market. The net gains on sales of facilities for 2017 related to sales of real estate and other investments.

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. During 2017, we issued $1.500 billion aggregate principal amount of 5.500% senior secured notes due 2047. We used the net proceeds for general corporate purposes, including funding the purchase of certain hospital acquisitions, and the redemption of all $500 million aggregate principal amount of our existing 8.000% senior notes maturing in October 2018. The pretax loss on retirement of debt was $39 million.

The effective tax rates were 20.0% and 42.5% for 2018 and 2017, 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 reductions for tax credits related to certain 2017 hurricane-related

expenses. Our provision for income taxes for 2017 included $14 million related to reductions in interest expense (net of tax). Our provisions for income taxes for 2018 and 2017 included benefits of $67 million and increases of $301 million, respectively, 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 2018 and 2017 also included tax benefits of $124 million and $82 million, respectively, related to employee equity award settlements. Excluding the effect of these adjustments, the effective tax rates for 2018 and 2017 would have been 24.6% and 37.2%, respectively.

Net income attributable to noncontrolling interests increased from $527 million for 2017 to $602 million for 2018. The increase in net income attributable to noncontrolling interests related primarily to joint ventures in two Texas markets.

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Results of Operations (continued)

Years Ended December 31, 2017 and 2016

Net income attributable to HCA Healthcare, Inc. totaled $2.216 billion, or $5.95 per diluted share, for 2017, compared to $2.890 billion, or $7.30 per diluted share, for 2016. Financial results for 2017 include additional expenses and losses of revenues estimated at approximately $140 million, or $0.24 per diluted share, associated with the impact of hurricanes Harvey and Irma on our Texas, Florida, Georgia and South Carolina facilities and an increase in provision for income taxes of $301 million, or $0.81 per diluted share, related to the revaluation of our deferred tax assets and liabilities due to the enactment of the Tax Act. The amount associated with the hurricanes is prior to any insurance recoveries. Financial results for 2017 also include tax benefits of $82 million, or $0.22 per diluted share, related to employee equity award settlements, net gains on sales of facilities of $8 million, or $0.01 per diluted share, and losses on retirement of debt of $39 million, or $0.06 per diluted share. Financial results for 2016 include tax benefits of $51 million, or $0.13 per diluted share, related to the resolution of federal income tax issues for our 2011 and 2012 tax years and $162 million, or $0.41 per diluted share, related to employee equity award settlements. Financial results for 2016 also include net gains on sales of facilities of $23 million, or $0.05 per diluted share, losses on retirement of debt of $4 million, or $0.01 per diluted share, and legal claim benefits of $246 million, or $0.39 per diluted share, related to the settlement of the Health Midwest litigation. All per diluted share disclosures are based upon amounts net of the applicable income taxes. Shares used for diluted earnings per share were 372.221 million shares and 395.851 million shares for the years ended December 31, 2017 and 2016, respectively. During 2017 and 2016, we repurchased 25.092 million and 36.325 million shares, respectively, of our common stock.

During 2017, consolidated admissions increased 2.4% and same facility admissions increased 1.1% compared to 2016. Consolidated inpatient surgeries increased 1.7% and same facility inpatient surgeries increased 0.3% during 2017 compared to 2016. Consolidated outpatient surgeries increased 0.3%, and same facility outpatient surgeries declined 1.3% during 2017 compared to 2016. Emergency room visits increased 2.9% on a consolidated basis and increased 1.4% on a same facility basis during 2017 compared to 2016.

Revenues increased 5.1% to $43.614 billion for 2017 from $41.490 billion for 2016. The increase in revenues was due to the combined impact of a 2.1% increase in revenue per equivalent admission and a 3.0% increase in equivalent admissions compared to 2016. Same facility revenues increased 3.8% due primarily to the combined impact of a 2.2% increase in same facility revenue per equivalent admission and a 1.5% increase in same facility equivalent admissions compared to 2016.

Salaries and benefits, as a percentage of revenues, were 46.0% in 2017 and 45.5% in 2016. Salaries and benefits per equivalent admission increased 3.1% in 2017 compared to 2016. Same facility labor rate increases averaged 3.0% for 2017 compared to 2016. Share-based compensation expense increased from $251 million in 2016 to $270 million in 2017.

Supplies, as a percentage of revenues, were 16.8% in 2017 and 16.7% in 2016. Supply costs per equivalent admission increased 2.5% in 2017 compared to 2016. Supply costs per equivalent admission increased 4.9% for medical devices, 0.3% for pharmacy supplies and 1.7% for general medical and surgical items in 2017 compared to 2016.

Other operating expenses, as a percentage of revenues, was 18.4% in 2017 and 18.1% in 2016. 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 $466 million and $430 million for 2017 and 2016, respectively.

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AND RESULTS OF OPERATIONS (Continued)

Results of Operations (continued)

Years Ended December 31, 2017 and 2016 (continued)

Equity in earnings of affiliates was $45 million for 2017 and $54 million for 2016.

Depreciation and amortization, as a percentage of revenues, was 4.9% in 2017 and 4.8% in 2016. Depreciation expense was $2.111 billion for 2017 and $1.946 billion for 2016.

Interest expense declined to $1.690 billion for 2017 from $1.707 billion for 2016. The decline in interest expense was due to a decline in the average interest rate. Our average debt balance was $32.082 billion for 2017 compared to $31.048 billion for 2016. The average interest rate for our long-term debt declined from 5.5% for 2016 to 5.3% for 2017.

Net gains on sales of facilities were $8 million and $23 million, respectively, for 2017 and 2016 and related to sales of real estate and other investments.

During 2017, we issued $1.500 billion aggregate principal amount of 5.500% senior secured notes due 2047. We used the net proceeds for general corporate purposes, including funding the purchase of certain hospitals, and the redemption of all $500 million aggregate principal amount of our existing 8.000% senior notes maturing in October 2018. The pretax loss on retirement of debt was $39 million. During 2016, we issued $1.200 billion aggregate principal amount of 4.500% senior secured notes due 2027. We used the net proceeds for general corporate purposes and to retire a portion of one of our senior secured term loans. We also entered into a joinder agreement to retire the remaining portion of this senior secured term loan using proceeds from a new $1.200 billion senior secured term loan facility maturing in February 2024. The pretax loss on retirement of debt was $4 million.

The effective tax rates were 42.5% and 32.3% for 2017 and 2016, 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 2017 included increases of $301 million related to the remeasurement of our deferred tax assets and liabilities due to the enactment of the Tax Act and $14 million related to reductions in interest expense (net of tax). Our provision for income taxes for 2017 and 2016 also included tax benefits of $82 million and $162 million, respectively, related to employee equity award settlements. Our provision for income taxes for 2016 also included tax benefits of $51 million primarily related to the resolution of federal income tax issues for our 2011 and 2012 tax years. Excluding the effect of these adjustments, the effective tax rates for 2017 and 2016 would have been 37.2% and 37.3%, respectively.

Net income attributable to noncontrolling interests declined from $542 million for 2016 to $527 million for 2017. The decline in net income attributable to noncontrolling interests related primarily to a joint venture in a Texas market.

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.

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Liquidity and Capital Resources (continued)

Cash provided by operating activities totaled $6.761 billion in 2018 compared to $5.426 billion in 2017 and $5.653 billion in 2016. 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 $1.226 billion. The $227 million decline in cash provided by operating activities for 2017, compared to 2016, was primarily related to the $689 million decline in net income, offset by increases related to depreciation and amortization of $165 million and income taxes of $310 million. Working capital totaled $2.644 billion at December 31, 2018 and $3.819 billion at December 31, 2017. The decline in working capital of $1.175 billion is primarily related to increases in other accrued expenses of $641 million and long-term debt due within one year of $588 million. Cash payments for interest and income taxes declined $289 million for 2018 compared to 2017 and declined $16 million for 2017 compared to 2016.

Cash used in investing activities was $3.901 billion, $4.279 billion and $3.240 billion in 2018, 2017 and 2016, respectively. Excluding acquisitions, capital expenditures were $3.573 billion in 2018, $3.015 billion in 2017 and $2.760 billion in 2016. We expended $1.253 billion, $1.212 billion and $576 million for acquisitions of hospitals and health care entities during 2018, 2017 and 2016, respectively. Planned capital expenditures are expected to approximate $3.7 billion in 2019. At December 31, 2018, there were projects under construction which had an estimated additional cost to complete and equip over the next five years of approximately $3.5 billion. We expect to finance capital expenditures with internally generated and borrowed funds. Cash received from disposals of hospitals and health care entities increased $783 million for 2018 compared to 2017 primarily related to the receipt of $758 million from the sale of the two hospitals in our Oklahoma market.

Cash used in financing activities totaled $3.075 billion in 2018, $1.061 billion in 2017 and $2.508 billion in 2016. During 2018, we had a net decline of $344 million in our indebtedness, paid cash dividends of $487 million and paid cash of $1.530 billion for repurchases of common stock. During 2017, we had a net increase of $1.509 billion in our indebtedness and paid cash of $2.051 billion for repurchases of common stock. During 2016, we had a net increase of $815 million in our indebtedness and paid cash of $2.751 billion for repurchases of common stock. During 2018, 2017 and 2016, we made distributions to noncontrolling interests of $441 million, $448 million and $434 million, respectively. We paid debt issuance costs of $25 million, $26 million and $40 million for 2018, 2017 and 2016, 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 2019, our Board of Directors authorized a share repurchase program for up to $2 billion of our outstanding common stock. At December 31, 2018, $272 million of share repurchase authorization remained available under the $2 billion share repurchase program authorized by our board of directors during October 2017. 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 29, 2019, our Board of Directors declared a quarterly dividend of $0.40 per share on our common stock payable on March 29, 2019 to stockholders of record on March 1, 2019. During 2018, our Board of Directors declared four quarterly dividends of $0.35 per share, or $1.40 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.

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AND RESULTS OF OPERATIONS (Continued)

Liquidity and Capital Resources (continued)

In addition to cash flows from operations, available sources of capital include amounts available under our senior secured credit facilities ($2.693 billion as of December 31, 2018 and $2.933 billion as of January 31, 2019) and anticipated access to public and private debt and equity markets.

Investments of our insurance subsidiaries, to maintain statutory equity and pay claims, totaled $409 million and $472 million at December 31, 2018 and 2017, respectively. The insurance subsidiary maintained net reserves for professional liability risks of $183 million and $194 million at December 31, 2018 and 2017, 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 $1.509 billion and $1.409 billion at December 31, 2018 and 2017, respectively. Claims payments, net of reinsurance recoveries, during the next 12 months are expected to approximate $456 million. We estimate that approximately $422 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 $32.821 billion and $33.058 billion at December 31, 2018 and 2017, respectively. Our interest expense was $1.755 billion for 2018 and $1.690 billion for 2017.

During June 2017, we issued $1.500 billion aggregate principal amount of 5.500% senior secured notes due 2047. We used the net proceeds for general corporate purposes, including funding the purchase of certain hospital acquisitions, and the redemption, during July 2017, of all $500 million aggregate principal amount of our existing 8.000% senior notes maturing in October 2018.

During June 2017, we amended our senior secured revolving credit facilities by (i) increasing the commitments under the senior secured asset-based revolving credit facility to $3.750 billion, (ii) extending the maturity date of the revolving credit commitments to June 28, 2022, (iii) amending the incremental facility provisions to permit the incurrence of additional incremental credit facilities in an aggregate principal amount of $1.5 billion and (iv) providing that the commitment fee for unutilized commitments under the senior secured asset-based revolving credit facility shall be 0.250% per annum.

During March 2018, we entered into a joinder agreement to refinance our existing senior secured term B-8 loan credit facility maturing on February 15, 2024, repay a portion of our existing senior secured term B-9 loan credit facility maturing on March 18, 2023 and pay related fees and expenses with a new $1.500 billion senior secured term B-10 loan credit facility maturing on March 13, 2025. The senior secured term B-10 loan credit facility bears

interest at LIBOR plus an applicable margin of 2.00% or a base rate plus an applicable margin of 1.00%, compared to applicable margins of 2.25% and 1.25%, respectively, under the senior secured term B-8 loan credit facility.

During March 2018, we also entered into an additional joinder agreement to refinance a portion of our existing senior secured term B-9 loan credit facility maturing on March 18, 2023 and pay related fees and expenses with a new approximately $1.166 billion senior secured term B-11 loan credit facility maturing on March 18, 2023. The senior secured term B-11 loan credit facility bears interest at LIBOR plus an applicable margin of 1.75% or a base rate plus an applicable margin of 0.75%, compared to applicable margins of 2.00% and 1.00%, respectively, under the senior secured term B-9 loan credit facility.

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AND RESULTS OF OPERATIONS (Continued)

Liquidity and Capital Resources (continued)

Financing Activities (continued)

During August 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.

During January 2019, we issued $1.500 billion aggregate principal amount of senior 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 six-hospital health system located in western North Carolina.

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.

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AND RESULTS OF OPERATIONS (Continued)

Contractual Obligations and Off-Balance Sheet Arrangements

As of December 31, 2018, maturities of contractual obligations and other commercial commitments are presented in the table below (dollars in millions):

		Payments Due by Period			
Contractual Obligations(a)	**Total**	**Current**	**2-3 Years**	**4-5 Years**	**After 5 Years**
Long-term debt including interest, excluding the senior secured credit facilities(b)	$ 36,936	$ 2,215	$ 6,699	$ 8,039	$ 19,983
Loans outstanding under the senior secured credit facilities, including interest(b)	7,333	207	1,342	4,333	1,451
Professional liability claims(c)	1,741	466	711	342	222
Operating leases(d)	2,244	320	560	357	1,007
Purchase and other obligations(d)	28	21	4	2	1
Total contractual obligations	$ 48,282	$ 3,229	$ 9,316	$ 13,073	$ 22,664

		Commitment Expiration by Period			
Other Commercial Commitments Not Recorded on the Consolidated Balance Sheet	**Total**	**Current**	**2-3 Years**	**4-5 Years**	**After 5 Years**
Surety bonds(e)	$ 72	$ 71	$ 1	$	$
Letters of credit(e)	17	17			
Physician commitments(f)	35	25	10		
Total commercial commitments	$ 124	$ 113	$ 11	$	$

(a) We have not included obligations related to unrecognized tax benefits of $435 million at December 31, 2018, 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, 2018, remain constant during the period presented.

(c)

The estimation of the timing of payments for professional liability claims 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 relate to future operating lease obligations, purchase obligations and other obligations and are not recorded in our consolidated balance sheet. Amounts also include physician commitments that are 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, 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, normally over a period of one year, 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, 2018.

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 $409 million at December 31, 2018. These investments are carried at

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HCA HEALTHCARE, INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (Continued)

Market Risk (continued)

fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At December 31, 2018, we had a net unrealized gain of $3 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 other-than-temporary 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 $4.341 billion of long-term debt at December 31, 2018 was subject to variable rates of interest, while the remaining balance in long-term debt of $28.480 billion at December 31, 2018 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 2018 and 2017.

The estimated fair value of our total long-term debt was $32.887 billion at December 31, 2018. 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 $43 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.

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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 21.1%, 21.3% and 21.0% of our revenues for 2018, 2017 and 2016, 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

During 2016, the IRS completed its examination, resolving all outstanding federal income tax issues for our 2011 and 2012 tax years. We are subject to examination by the IRS for tax years after 2014 as well as by state and foreign taxing authorities.

Management believes HCA Healthcare, Inc., its predecessors 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.

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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, 2018.

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.

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(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, 2018, 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, 2018, 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, 2018 and 2017, 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, 2018, and the related notes and our report dated February 21, 2019 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.

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 21, 2019

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(c) Changes in Internal Control Over Financial Reporting

During the fourth quarter of 2018, 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 2019 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 Section 16(a) Beneficial Ownership Reporting Compliance in the definitive proxy materials to be filed in connection with our 2019 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 2019 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. 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 2019 Annual Meeting of Stockholders, which information is incorporated herein by reference.

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 2019 Annual Meeting of Stockholders, which information is incorporated herein by reference.

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This table provides certain information as of December 31, 2018 with respect to our equity compensation plans:

EQUITY COMPENSATION PLAN INFORMATION

(Share and share unit amounts in thousands)

	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) 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	18,572(1)	$ 61.49(1)	28,989(2)
Equity compensation plans not approved by security holders			
Total	18,572	$ 61.49	28,989

(1) Includes 3,123 thousand restricted share units which vest solely based upon continued employment over a specific period of time and 3,422 thousand 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 80% of target) to two times the units granted (for actual performance of 120% or more of target). The weighted average exercise price does not take these restricted share units and performance share units into account.

(2) Includes 21,162 thousand 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 7,827 thousand 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 2019 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 2019 Annual Meeting of Stockholders, which information is incorporated herein by reference.

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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 (filed as Exhibit 3.1 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).
3.2	Second Amended and Restated Bylaws of the Company (filed as Exhibit 3.1 to the Company s Current Report on Form 8-K filed December 21, 2017 (File No. 001-11239), and incorporated herein by reference).
4.1	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).
4.2	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).
4.3	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).
4.4(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).

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4.4(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).
4.4(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).
4.4(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).
4.4(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).
4.4(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).
4.4(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).

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4.4(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).
4.4(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).
4.4(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.
4.4(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.
4.4(l)	Joinder Agreement No. 1, dated as of June 10, 2015, 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 15, 2015 (File No. 001-11239), and incorporated herein by reference).
4.4(m)	Joinder Agreement No. 2, dated as of March 18, 2016, 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 March 18, 2016 (File No. 001-11239), and incorporated herein by reference).
4.4(n)	Joinder Agreement No. 3, dated as of August 15, 2016, 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 August 15, 2016 (File No. 001-11239), and incorporated herein by reference).
4.4(o)	Joinder Agreement No. 4, dated as of February 15, 2017, 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 February 15, 2017 (File No. 001-11239), and incorporated herein by reference).
4.4(p)	Joinder Agreement No. 5, dated as of March 20, 2017, 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 March 20, 2017 (File No. 001-11239), and incorporated herein by reference).
4.4(q)	Restatement Agreement dated as of June 28, 2017, 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).

4.4(r)	Joinder Agreement No. 6, dated as of March 13, 2018, 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 March 13, 2018 (File No. 001-11239), and incorporated herein by reference).

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4.4(s)	Joinder Agreement No. 7, dated as of March 13, 2018, 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 4.2 to the Company s Current Report on Form 8-K filed March 13, 2018 (File No. 001-11239), and incorporated herein by reference).
4.5(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).
4.5(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.
4.5(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.
4.6(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).
4.6(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.
4.6(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.
4.7(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).
4.7(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).
4.7(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).
4.7(d)	Restatement Agreement dated as of June 28, 2017, 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).

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4.7(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.
4.8(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).
4.8(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.
4.8(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.
4.9(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).
4.9(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).
4.9(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).
4.9(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).
4.9(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).
4.9(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).

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4.9(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).
4.9(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).
4.9(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).
4.10	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).
4.11	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).
4.12	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).
4.13(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).
4.13(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).
4.13(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).
4.13(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).
4.13(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).

4.14 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).

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4.15	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).
4.16	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).
4.17	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).
4.18	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).
4.19	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).
4.20	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).
4.21	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).
4.22	Indenture, dated as of November 23, 2010, among HCA Holdings, Inc., Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent, and Law Debenture Trust Company of New York, as trustee (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed November 24, 2010 (File No. 000-18406), 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(a)	Supplemental Indenture No. 2, dated as of August 1, 2011, 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 1, 2011 (File No. 001-11239), and incorporated herein by reference).
4.26(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.
4.26(c)	Schedule of Omitted Supplemental Indentures to Supplemental Indentures, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.

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4.27	Form of 7.50% Senior Notes due 2022 (included in Exhibit 4.25).
4.28	Form of 6.50% Senior Secured Notes due 2020 (included in Exhibit 4.26).
4.29	Supplemental Indenture No. 4, dated as of February 16, 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 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed February 16, 2012 (File No. 001-11239), and incorporated herein by reference).
4.30	Form of 5.875% Senior Secured Notes due 2022 (included in Exhibit 4.29).
4.31	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).
4.32	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).
4.33	Form of 5.875% Senior Notes due 2023 (included in Exhibit 4.31).
4.34	Form of 4.75% Senior Secured Notes due 2023 (included in Exhibit 4.32).
4.35	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).
4.36	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).
4.37	Form of 6.25% Senior Notes due 2021 (included in Exhibit 4.36).
4.38	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).
4.39	Form of 5.00% Senior Secured Notes due 2024 (included in Exhibit 4.38).
4.40	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).

4.41	Supplemental Indenture No. 9, 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 4.2 to the Company s Current Report on Form 8-K filed October 17, 2014 (File No. 001-11239), and incorporated herein by reference).

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4.42	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).
4.43	Form of 4.25% Senior Secured Notes due 2019 (included in Exhibit 4.41).
4.44	Form of 5.25% Senior Secured Notes due 2025 (included in Exhibit 4.42).
4.45	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).
4.46	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).
4.47	Form of 5.375% Senior Notes due 2025 (included in Exhibit 4.46).
4.48	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).
4.49	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).
4.50	Form of 5.875% Senior Notes due 2026 (included in Exhibit 4.49).
4.51	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).
4.52	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).
4.53	Form of 5.250% Senior Secured Notes due 2026 (included in Exhibit 4.52).
4.54	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).

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4.55	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).
4.56	Form of 4.500% Senior Secured Notes due 2027 (included in Exhibit 4.55).
4.57	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).
4.58	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).
4.59	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).
4.60	Form of 5.500% Senior Secured Notes due 2047 (included in Exhibit 4.59).
4.61	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).
4.62	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).
4.63	Form of 5.375% Senior Notes Due 2026 (included in Exhibit 4.62).
4.64	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).
4.65	Form of 5.625% Senior Notes Due 2028 (included in Exhibit 4.64).
4.66	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).
4.67	

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).

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4.68	Form of 5.875% Senior Notes Due 2029 (included in Exhibit 4.67).
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).
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 (2009) (filed as Exhibit 10.17 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).*
10.5	Form of Stock Option Agreement (2010) (filed as Exhibit 10.20 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).*
10.6	Form of 2x Time Stock Option Agreement (filed as Exhibit 10.2 to the Company s Quarterly Report on Form 10-Q for the quarter ended September 30, 2009 (File No. 001-11239), and incorporated herein by reference).*
10.7	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).*
10.8(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).*
10.8(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).*
10.9	Form of Director Restricted Share Unit Agreement (Initial 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 Current Report on Form 8-K filed February 14, 2012 (File No. 001-11239), and incorporated herein by reference).*

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10.10	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 10.3 to the Company s Current Report on Form 8-K filed February 14, 2012 (File No. 001-11239), and incorporated herein by reference).*
10.11	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).*
10.12	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).*
10.13	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).*
10.14(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).*
10.14(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).*
10.14(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).*
10.14(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).*
10.14(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).*
10.14(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).*
10.14(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).*
10.14(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).*
10.14(i)	Fifth Amendment to Employment Agreement effective January 1, 2019 (Samual N. Hazen)*

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10.15	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).
10.16	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).
10.17	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).*
10.18	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).*
10.19	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).
10.20	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).
10.21	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).*
10.22	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).*
10.23	Form of Director Restricted Share Unit Agreement (Initial Award) under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.48 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).*
10.24	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 10.49 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).*
10.25	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).*
10.26	

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).*

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10.27	Form of 2015 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 10.47 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).*
10.28	HCA Holdings, Inc. 2015 Senior Officer Performance Excellence Program (filed as Exhibit 10.1 to the Company s Current Report on Form 8-K filed April 2, 2015 (File No. 001-11239), and incorporated herein by reference).*
10.29	Form of 2015 PEP Restricted Share Unit Agreement (Officers) (filed as Exhibit 10.2 to the Company s Current Report on Form 8-K filed April 2, 2015 (File No. 001-11239), and incorporated herein by reference).*
10.30	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 10.3 to the Company s Quarterly Report on Form 10-Q for the quarter ended March 31, 2015 (File No. 001-11239), and incorporated herein by reference).*
10.31	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).*
10.32	Form of 2016 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 10.51 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).*
10.33	HCA Holdings, Inc. 2016 Senior Officer Performance Excellence Program (filed as Exhibit 10.1 to the Company s Current Report on Form 8-K filed April 1, 2016 (File No. 001-11239), and incorporated herein by reference).*
10.34	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).*
10.35	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).*
10.36	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).*
10.37	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).*

10.38	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).*

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10.39	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).*
10.40	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).*
10.41	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.*
10.42	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.*
10.43	Form of Restricted Share Unit Agreement (R. Milton Johnson) *
21	List of Subsidiaries.
23	Consent of Ernst & Young LLP.
31.1	Certification of Chief Executive Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Chief Financial Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32	Certification Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	The following financial information from our annual report on Form 10-K for the year ended December 31, 2018, filed with the SEC on February 21, 2019, formatted in Extensible Business Reporting Language (XBRL): (i) the consolidated balance sheets at December 31, 2018 and 2017, (ii) the consolidated income statements for the years ended December 31, 2018, 2017 and 2016, (iii) the consolidated comprehensive income statements for the years ended December 31, 2018, 2017 and 2016, (iv) the consolidated statements of stockholders deficit for the years ended December 31, 2018, 2017 and 2016, (v) the consolidated statements of cash flows for the years ended December 31, 2018, 2017 and 2016, and (vi) the notes to consolidated financial statements.

* Management compensatory plan or arrangement.

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

None.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

HCA HEALTHCARE, INC.

By: /s/ SAMUEL N. HAZEN
Samuel N. Hazen
Chief Executive Officer

Dated: February 21, 2019

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ SAMUEL N. HAZEN Samuel N. Hazen	Chief Executive Officer and Director (Principal Executive Officer)	February 21, 2019
/s/ WILLIAM B. RUTHERFORD William B. Rutherford	Executive Vice President and Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer)	February 21, 2019
/s/ R. MILTON JOHNSON R. Milton Johnson	Chairman and Director	February 21, 2019
/s/ ROBERT J. DENNIS Robert J. Dennis	Director	February 21, 2019
/s/ NANCY-ANN DEPARLE Nancy-Ann DeParle	Director	February 21, 2019
/s/ THOMAS F. FRIST III Thomas F. Frist III	Director	February 21, 2019
/s/ WILLIAM R. FRIST William R. Frist	Director	February 21, 2019

/s/ CHARLES O. HOLLIDAY, JR. Charles O. Holliday, Jr.	Director	February 21, 2019
/s/ ANN H. LAMONT Ann H. Lamont	Director	February 21, 2019
/s/ GEOFFREY G. MEYERS Geoffrey G. Meyers	Director	February 21, 2019
/s/ MICHAEL W. MICHELSON Michael W. Michelson	Director	February 21, 2019
/s/ WAYNE J. RILEY Wayne J. Riley	Director	February 21, 2019
/s/ JOHN W. ROWE John W. Rowe	Director	February 21, 2019

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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, 2018 and 2017, 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, 2018, 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, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with 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, 2018, 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 21, 2019 expressed an unqualified opinion thereon.

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.

/s/ Ernst & Young LLP

We have served as the Company s auditor since 1994.

Nashville, Tennessee

February 21, 2019

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HCA HEALTHCARE, INC.

CONSOLIDATED INCOME STATEMENTS

FOR THE YEARS ENDED DECEMBER 31, 2018, 2017 AND 2016

(Dollars in millions, except per share amounts)

	2018	2017	2016
Revenues	**$ 46,677**	$ 43,614	$ 41,490
Salaries and benefits	**21,425**	20,059	18,897
Supplies	**7,724**	7,316	6,933
Other operating expenses	**8,608**	8,051	7,496
Equity in earnings of affiliates	**(29)**	(45)	(54)
Depreciation and amortization	**2,278**	2,131	1,966
Interest expense	**1,755**	1,690	1,707
Gains on sales of facilities	**(428)**	(8)	(23)
Losses on retirement of debt	**9**	39	4
Legal claim benefits			(246)
	41,342	39,233	36,680
Income before income taxes	**5,335**	4,381	4,810
Provision for income taxes	**946**	1,638	1,378
Net income	**4,389**	2,743	3,432
Net income attributable to noncontrolling interests	**602**	527	542
Net income attributable to HCA Healthcare, Inc.	**$ 3,787**	$ 2,216	$ 2,890
Per share data:			
Basic earnings per share	**$ 10.90**	$ 6.12	$ 7.53
Diluted earnings per share	**$ 10.66**	$ 5.95	$ 7.30
Shares used in earnings per share calculations (in millions):			
Basic	**347.297**	362.305	383.591
Diluted	**355.303**	372.221	395.851

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

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HCA HEALTHCARE, INC.

CONSOLIDATED COMPREHENSIVE INCOME STATEMENTS

FOR THE YEARS ENDED DECEMBER 31, 2018, 2017 AND 2016

(Dollars in millions)

	2018	2017	2016
Net income	**$ 4,389**	$ 2,743	$ 3,432
Other comprehensive income (loss) before taxes:			
Foreign currency translation	**(71)**	97	(224)
Unrealized gains (losses) on available-for-sale securities	**(7)**	1	(9)
Realized gains included in other operating expenses		(2)	
	(7)	(1)	(9)
Defined benefit plans	**44**	(43)	(35)
Pension costs included in salaries and benefits	**21**	18	18
	65	(25)	(17)
Change in fair value of derivative financial instruments	**23**	11	20
Interest (benefits) costs included in interest expense	**(10)**	20	109
	13	31	129
Other comprehensive income (loss) before taxes		102	(121)
Income taxes (benefits) related to other comprehensive income items	**8**	42	(48)
Other comprehensive income (loss)	**(8)**	60	(73)
Comprehensive income	**4,381**	2,803	3,359
Comprehensive income attributable to noncontrolling interests	**602**	527	542
Comprehensive income attributable to HCA Healthcare, Inc.	**$ 3,779**	$ 2,276	$ 2,817

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

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HCA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

DECEMBER 31, 2018 AND 2017

(Dollars in millions)

	2018	2017
ASSETS		
Current assets:		
Cash and cash equivalents	**$ 502**	$ 732
Accounts receivable	**6,789**	6,501
Inventories	**1,732**	1,573
Other	**1,190**	1,171
	10,213	9,977
Property and equipment, at cost:		
Land	**1,944**	1,746
Buildings	**15,659**	14,249
Equipment	**23,577**	22,168
Construction in progress	**1,785**	1,921
	42,965	40,084
Accumulated depreciation	**(23,208)**	(22,189)
	19,757	17,895
Investments of insurance subsidiaries	**362**	418
Investments in and advances to affiliates	**232**	199
Goodwill and other intangible assets	**7,953**	7,394
Other	**690**	710
	$ 39,207	$ 36,593
LIABILITIES AND STOCKHOLDERS DEFICIT		
Current liabilities:		
Accounts payable	**$ 2,577**	$ 2,606
Accrued salaries	**1,580**	1,369
Other accrued expenses	**2,624**	1,983
Long-term debt due within one year	**788**	200
	7,569	6,158
Long-term debt, less net debt issuance costs of $157 and $164	**32,033**	32,858

Professional liability risks	**1,275**	1,198
Income taxes and other liabilities	**1,248**	1,374
Stockholders deficit:		
Common stock $0.01 par; authorized 1,800,000,000 shares; outstanding 342,895,200 shares 2018 and 350,091,600 shares 2017	**3**	4
Accumulated other comprehensive loss	**(381)**	(278)
Retained deficit	**(4,572)**	(6,532)
Stockholders deficit attributable to HCA Healthcare, Inc.	**(4,950)**	(6,806)
Noncontrolling interests	**2,032**	1,811
	(2,918)	(4,995)
	$ 39,207	$ 36,593

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

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HCA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS DEFICIT

FOR THE YEARS ENDED DECEMBER 31, 2018, 2017 AND 2016

(Dollars in millions)

	Equity (Deficit) Attributable to HCA Healthcare, Inc.						
	Common Stock		Capital in Excess of Par Value	Accumulated Other Comprehensive Loss	Retained Deficit	Equity Attributable to Noncontrolling Interests	Total
	Shares (in millions)	Par Value					
Balances, December 31, 2015	398.739	$ 4	$	$ (265)	$ (7,338)	$ 1,553	$ (6,046)
Comprehensive income (loss)				(73)	2,890	542	3,359
Repurchase of common stock	(36.325)		(231)		(2,520)		(2,751)
Share-based benefit plans	8.122		233				233
Distributions						(434)	(434)
Other			(2)			8	6
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)
Acquisition of entities with noncontrolling interests						63	63
Other			(10)				(10)
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 ($1.40 share)					**(496)**		**(496)**
Distributions						**(441)**	**(441)**
Net acquisition of entities with noncontrolling interests						**60**	**60**
Reclassification of stranded tax effects				**(95)**	**95**		
Other			**(12)**				**(12)**
Balances, December 31, 2018	**342.895**	**$ 3**	**$**	**$ (381)**	**$ (4,572)**	**$ 2,032**	**$ (2,918)**

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

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HCA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED DECEMBER 31, 2018, 2017 AND 2016

(Dollars in millions)

	2018	2017	2016
Cash flows from operating activities:			
Net income	**$ 4,389**	$ 2,743	$ 3,432
Adjustments to reconcile net income to net cash provided by operating activities:			
Increase (decrease) in cash from operating assets and liabilities:			
Accounts receivable	**(423)**	(601)	10
Inventories and other assets	**(242)**	(69)	(112)
Accounts payable and accrued expenses	**698**	374	144
Depreciation and amortization	**2,278**	2,131	1,966
Income taxes	**74**	433	123
Gains on sales of facilities	**(428)**	(8)	(23)
Losses on retirement of debt	**9**	39	4
Legal claim benefits			(246)
Amortization of debt issuance costs	**31**	31	34
Share-based compensation	**268**	270	251
Other	**107**	83	70
Net cash provided by operating activities	**6,761**	5,426	5,653
Cash flows from investing activities:			
Purchase of property and equipment	**(3,573)**	(3,015)	(2,760)
Acquisition of hospitals and health care entities	**(1,253)**	(1,212)	(576)
Disposal of hospitals and health care entities	**808**	25	26
Change in investments	**57**	(73)	64
Other	**60**	(4)	6
Net cash used in investing activities	**(3,901)**	(4,279)	(3,240)
Cash flows from financing activities:			
Issuances of long-term debt	**2,000**	1,502	5,400
Net change in revolving bank credit facilities	**(640)**	760	(110)
Repayment of long-term debt	**(1,704)**	(753)	(4,475)
Distributions to noncontrolling interests	**(441)**	(448)	(434)
Payment of debt issuance costs	**(25)**	(26)	(40)
Payment of cash dividends	**(487)**		

Repurchases of common stock	**(1,530)**	(2,051)	(2,751)
Other	**(248)**	(45)	(98)
Net cash used in financing activities	**(3,075)**	(1,061)	(2,508)
Effect on exchange rate changes in cash and cash equivalents	**(15)**		
Change in cash and cash equivalents	**(230)**	86	(95)
Cash and cash equivalents at beginning of period	**732**	646	741
Cash and cash equivalents at end of period	**$ 502**	$ 732	$ 646
Interest payments	**$ 1,744**	$ 1,700	$ 1,666
Income tax payments, net	**$ 872**	$ 1,205	$ 1,255

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

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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, 2018, these affiliates owned and operated 179 hospitals, 123 freestanding surgery centers and provided extensive outpatient and ancillary services. HCA Healthcare, Inc. s facilities are located in 20 states and England. The terms Company, HCA, we, our or us, as used her 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 $344 million, $340 million and $343 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Revenues

In May 2014, the Financial Accounting Standards Board (FASB) issued a new standard related to revenue recognition. We adopted the new standard effective January 1, 2018, using the full retrospective method. The adoption of the new standard did not have an impact on our recognition of net revenues for any periods prior to adoption. The most significant impact of adopting the new standard is to the presentation of our consolidated income statements, where we no longer present the Provision for doubtful accounts as a separate line item and our Revenues are presented net of estimated implicit price concession revenue deductions. We also have eliminated the related presentation of allowances for doubtful accounts on our consolidated balance sheets as a result of the adoption of the new standard.

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

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (continued)

Revenues (continued)

(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 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 allowances 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 self-pay revenues at the estimated amounts we expect to collect. Our revenues from third-party payers and others (including uninsured patients) for the years ended December 31, are summarized in the following table (dollars in millions):

	Years Ended December 31,					
	2018	**Ratio**	**2017**	**Ratio**	**2016**	**Ratio**
Medicare	**$ 9,831**	**21.1%**	$ 9,285	21.3%	$ 8,719	21.0%
Managed Medicare	**5,497**	**11.8**	4,680	10.7	4,278	10.3
Medicaid	**1,358**	**2.9**	1,316	3.0	1,278	3.1
Managed Medicaid	**2,403**	**5.1**	2,165	5.0	2,317	5.6
Managed care and other insurers	**24,467**	**52.4**	23,342	53.5	22,287	53.7
International (managed care and insurers)	**1,156**	**2.5**	1,097	2.5	1,195	2.9
Other	**1,965**	**4.2**	1,729	4.0	1,416	3.4
Revenues	**$ 46,677**	**100.0%**	$ 43,614	100.0%	$ 41,490	100.0%

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 $29 million, $41 million and $31 million in 2018, 2017 and 2016, respectively. The adjustments to estimated reimbursement amounts related primarily to cost reports filed during previous years resulted in net increases to revenues of $51 million, $56 million and $90 million in 2018, 2017 and 2016, respectively.

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (continued)

Revenues (continued)

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. 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. In implementing the uninsured discount policy, we may first 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 aging 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, 2018 and 2017, estimated implicit price concessions of $6.280 billion and $5.488 billion, respectively, had been recorded as reductions to our accounts receivable balances to enable us to record our revenues and accounts receivable at the estimated amounts we expect to collect.

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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 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):

	2018	2017	2016
Patient care costs (salaries and benefits, supplies, other operating expenses and depreciation and amortization)	**$ 40,035**	$ 37,557	$ 35,304
Cost-to-charges ratio (patient care costs as percentage of gross patient charges)	**12.4%**	12.9%	13.5%
Total uncompensated care	**$ 26,757**	$ 23,420	$ 20,455
Multiply by the cost-to-charges ratio	**12.4%**	12.9%	13.5%
Estimated cost of total uncompensated care	**$ 3,318**	$ 3,021	$ 2,761

Total uncompensated care as a percentage of the sum of revenues and total uncompensated care was 36.4% for 2018, 34.9% for 2017 and 33.0% for 2016. The total uncompensated care amounts include charity care of $8.611 billion, $4.861 billion and $4.151 billion, and the related estimated costs of charity care were $1.068 billion, $627 million and $560 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Recent Pronouncements

In February 2016, the FASB issued Accounting Standards Update 2016-02, *Leases* (ASU 2016-02), which requires lessees to recognize assets and liabilities for most leases. ASU 2016-02 is effective for public business entities for annual and interim periods beginning after December 15, 2018. We plan to adopt ASU 2016-02 effective January 1, 2019 applying a modified retrospective approach in which we will not adjust comparable prior period information and disclosures. We expect to utilize the practical expedients being made available, including the package of practical expedients to not reassess whether a contract is or contains a lease, the lease classification and initial direct costs. We believe the primary effect of adopting the new standard will be to record right-of-use assets and obligations for our leases currently classified as operating leases, and we expect the amount of right-of-use assets and obligations resulting from the adoption of ASU 2016-02 to be approximately $1.6 billion.

In February 2018, the FASB issued Accounting Standards Update 2018-02, *Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income* (ASU 2018-02). In implementing the provisions of the Tax Cuts and Jobs Act of 2017 (the Tax Act), the remeasurement of our deferred tax assets and liabilities was recorded as a component of our provision for income taxes. For deferred tax amounts that were originally recorded through accumulated other comprehensive income (AOCI), the remeasurement of deferred tax assets and liabilities through the provision for income taxes resulted in these amounts becoming stranded in AOCI. ASU 2018-02 permits companies to reclassify the stranded tax amounts recorded in AOCI to retained earnings, and we reclassified $95 million of stranded tax effects from AOCI to retained earnings effective October 1, 2018.

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

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (continued)

Cash and Cash Equivalents (continued)

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 unpresented, checks totaling $449 million and $480 million at December 31, 2018 and 2017, 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 51 days, 52 days and 50 days at December 31, 2018, 2017 and 2016, 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.

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 $2.262 billion in 2018, $2.111 billion in 2017 and $1.946 billion in 2016. 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, 2018 and 2017, 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*

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (continued)

Investments of Insurance Subsidiaries (continued)

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 market value are temporary or other-than-temporary. 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 an 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 other-than-temporary. The length of time and 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 quantitative analyses of market multiples, revenues and cash flows and reviews of recent sales of similar facilities. No goodwill impairments were recognized during 2018, 2017 or 2016.

During 2018, goodwill increased by $636 million related to acquisitions and declined by $60 million related to foreign currency translation and other adjustments. During 2017, goodwill increased by $693 million related to acquisitions and by $12 million related to foreign currency translation and other adjustments.

During 2018, identifiable intangible assets declined by $17 million due to amortization, foreign currency translation and other adjustments. During 2017, identifiable intangible assets declined by $15 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, 2018 and 2017 was $184 million and accumulated amortization was $111 million and $94 million, respectively. The gross carrying amount of indefinite-lived identifiable intangible assets at both December 31, 2018 and 2017 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

Debt issuance costs are amortized based upon the terms of the respective debt obligations. The gross carrying amount of debt issuance costs at December 31, 2018 and 2017 was $360 million and $353 million, respectively, and accumulated amortization was $203 million and $189 million, respectively. Amortization of debt issuance costs is included in interest expense and was $31 million, $31 million and $34 million for 2018, 2017 and 2016, respectively.

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (continued)

Professional Liability Claims

Reserves for professional liability risks were $1.741 billion and $1.627 billion at December 31, 2018 and 2017, respectively. The current portion of the reserves, $466 million and $429 million at December 31, 2018 and 2017, respectively, is included in other accrued expenses in the consolidated balance sheets. Provisions for losses related to professional liability risks were $447 million, $466 million and $430 million for 2018, 2017 and 2016, 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 2018, we recorded a reduction to the provision for professional liability risks of $70 million 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 2,200 and 2,500 individual claims at December 31, 2018 and 2017, 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 2018 and 2017, $358 million and $357 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 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 $40 million and $19 million at December 31, 2018 and 2017, respectively, recorded in other assets, and $10 million and $5 million at December 31, 2018 and 2017, 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

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (continued)

Financial Instruments (continued)

flow hedge relates is no longer likely, the amount in other comprehensive income (loss) 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 2018 presentation.

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 increased stock, or stock-based, ownership in the Company. The stock options, stock appreciation rights (SARs) and restricted share units (RSUs) granted vest solely based upon continued employment over a specific period of time, and the performance share units (PSUs) vest based upon both continued employment over a specific period of time and the achievement of predetermined financial targets over time. At December 31, 2018, there were 21,162 thousand 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, 2018, 7,827 thousand shares of common stock were reserved for issuance under the ESPP provisions. During 2018 and 2017, the Company recognized $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

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 2 SHARE-BASED COMPENSATION (continued)

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

number of PSUs earned can vary from zero (for actual performance of less than 80% of target) to two times the original PSU grant (for actual performance of 120% or more of target). Each grant is valued as a single award with an expected term equal to the average expected term of the component vesting tranches. We use historical exercise behavior data and other factors to estimate the expected term of the options and SARs. The expected term of the share-based award is limited by the contractual term, and employee post-vesting termination behavior is incorporated in the historical exercise behavior data.

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.

	2018	2017	2016
Risk-free interest rate	**2.62%**	2.13%	1.70%
Expected volatility	**29%**	31%	36%
Expected life, in years	**6.15**	6.17	6.25
Expected dividend yield	**1.37%**		

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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 2018, 2017 and 2016 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, 2015	12,165	10,427	22,592	$ 27.73		
Granted	1,601		1,601	69.96		
Exercised	(2,521)	(4,171)	(6,692)	15.85		
Cancelled	(309)	(126)	(435)	55.17		
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**	**6.1 years**	**$ 758**
	4,720	**2,667**	**7,387**	**$ 44.17**	**4.7 years**	**$ 593**

Options and SARs
exercisable, December 31,
2018

The weighted average fair values of stock options and SARs granted during 2018, 2017 and 2016 were $28.90, $28.47 and $26.60 per share, respectively. The total intrinsic value of stock options and SARs exercised during 2018, 2017 and 2016 was $456 million, $177 million and $398 million, respectively. The total fair value of RSUs and PSUs that vested during 2018, 2017 and 2016 was $413 million, $188 million and $216 million, respectively. As of December 31, 2018, the unrecognized compensation cost related to nonvested stock options and SARs was $89 million.

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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 2018, 2017 and 2016 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, 2015	5,302	1,740	1,371	8,413	$ 51.15
Granted	1,450		1,178	2,628	69.95
Vested	(2,242)	(870)		(3,112)	41.71
Cancelled	(399)	(80)	(163)	(642)	59.66
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**

As of December 31, 2018, the unrecognized compensation cost related to RSUs and PSUs was $304 million.

NOTE 3 ACQUISITIONS AND DISPOSITIONS

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. During 2016, we paid $343 million to acquire three hospital facilities and $233 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 $636 million, $693 million and $41 million in 2018, 2017 and 2016, 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 2018, we received proceeds of $758 million and recognized a net 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 a net pretax gain 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 a net pretax gain of $8 million ($5 million after tax) related to sales of real estate and other investments. During 2016, we received proceeds of $26 million and recognized a net pretax gain of $23 million ($19 million after tax) related to sales of real estate and other investments.

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 INCOME TAXES

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

	2018	2017	2016
Current:			
Federal	**$ 759**	$ 1,067	$ 1,129
State	**149**	120	125
Foreign	**23**	19	37
Deferred:			
Federal	**9**	423	75
State	**13**	3	(5)
Foreign	**(7)**	6	17
	$ 946	$ 1,638	$ 1,378

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.

Legislation or any additional guidance issued by federal and state taxing authorities or other standard-setting bodies related to the Tax Act may require us to make further adjustments to federal, state, and foreign tax assets and liabilities recorded as of December 31, 2018 and could materially impact our provision for income taxes and effective tax rate in the periods in which they are made.

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, 2018, 2017 and 2016 included tax benefits of $124 million, $82 million and $162 million, respectively, related to the settlement of employee equity awards. During 2016, the IRS completed its examination of our 2011 and 2012 tax years, resolving all outstanding federal tax issues. We reduced our provision for income taxes for the year ended December 31, 2016 by $51 million, including interest (net of tax), as a result of this resolution. Our foreign pretax income was $86 million, $91 million and $149 million for the years ended December 31, 2018, 2017 and 2016, respectively.

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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:

	2018	2017	2016
Federal statutory rate	**21.0%**	35.0%	35.0%
State income taxes, net of federal tax benefit	**2.9**	2.2	2.1
Change in liability for uncertain tax positions	**(0.1)**		(1.0)
Tax benefit from settlements of employee equity awards	**(2.4)**	(2.0)	(3.6)
Impact of Tax Act on deferred tax balances	**(1.6)**	7.8	
Other items, net	**0.2**	(0.5)	(0.2)
Effective income tax rate on income attributable to HCA Healthcare, Inc.	**20.0**	42.5	32.3
Income attributable to noncontrolling interests from consolidated partnerships	**(2.3)**	(5.1)	(3.6)
Effective income tax rate on income before income taxes	**17.7%**	37.4%	28.7%

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

	2018		2017	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed asset basis differences	**$**	**$ 340**	$	$ 260
Allowances for professional liability and other risks	**355**		345	
Accounts receivable	**274**		243	
Compensation	**256**		263	
Other	**424**	**491**	420	501
	$ 1,309	**$ 831**	$ 1,271	$ 761

At December 31, 2018, federal and state net operating loss carryforwards (expiring in years 2021 through 2037) available to offset future taxable income approximated $71 million and $94 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):

	2018	2017
Balance at January 1	**$ 399**	$ 377
Additions based on tax positions related to the current year	**22**	40
Additions for tax positions of prior years	**10**	11
Reductions for tax positions of prior years	**(14)**	(13)
Settlements	**(2)**	
Lapse of applicable statutes of limitations	**(25)**	(16)
Balance at December 31	**$ 390**	$ 399

Our liability for unrecognized tax benefits was $435 million, including accrued interest of $48 million and excluding $3 million that was recorded as reductions of the related deferred tax assets, as of December 31, 2018 ($439 million, $44 million and $4 million, respectively, as of December 31, 2017). Unrecognized tax benefits of $137 million ($145 million as of December 31, 2017) would affect the effective rate, if recognized.

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 INCOME TAXES (continued)

We are subject to examination by the IRS for tax years after 2014 as well as 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 2018, 2017 and 2016, we repurchased 14.070 million shares, 25.092 million shares and 36.325 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, 2018, 2017 and 2016 (dollars and shares in millions, except per share amounts):

	2018	2017	2016
Net income attributable to HCA Healthcare, Inc.	**$ 3,787**	$ 2,216	$ 2,890
Weighted average common shares outstanding	**347.297**	362.305	383.591
Effect of dilutive incremental shares	**8.006**	9.916	12.260
Shares used for diluted earnings per share	**355.303**	372.221	395.851
Earnings per share:			
Basic earnings per share	**$ 10.90**	$ 6.12	$ 7.53
Diluted earnings per share	**$ 10.66**	$ 5.95	$ 7.30

NOTE 6 INVESTMENTS OF INSURANCE SUBSIDIARIES

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

	2018			
	Amortized Cost	Unrealized Amounts Gains	Unrealized Amounts Losses	Fair Value
Debt securities	**$ 338**	**$ 5**	**$ (2)**	**$ 341**

Money market funds and other	**68**			**68**
	$ 406	**$ 5**	**$ (2)**	**409**
Amounts classified as current assets				**(47)**
Investment carrying value				**$ 362**

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 INVESTMENTS OF INSURANCE SUBSIDIARIES (continued)

	2017		
	Amortized Cost	Unrealized Amounts	Fair Value
		Gains Losses	
Debt securities	$ 361	$ 10 $	$ 371
Money market funds and other	101		101
	$ 462	$ 10 $	472
Amounts classified as current assets			(54)
Investment carrying value			$ 418

At December 31, 2018 and 2017, the investments of our insurance subsidiaries were classified as available-for-sale. Changes in temporary unrealized gains and losses are recorded as adjustments to other comprehensive income (loss).

Scheduled maturities of investments in debt securities at December 31, 2018 were as follows (dollars in millions):

	Amortized Cost	Fair Value
Due in one year or less	$ 3	$ 3
Due after one year through five years	64	65
Due after five years through ten years	201	203
Due after ten years	70	70
	$ 338	$ 341

The average expected maturity of the investments in debt securities at December 31, 2018 was 6.2 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 two parties 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.

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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, 2018 (dollars in millions):

	Notional Amount	Maturity Date	Fair Value
Pay-fixed interest rate swaps	$ 2,000	December 2021	$ 55
Pay-fixed interest rate swaps	500	December 2022	8

During the next 12 months, we estimate $24 million will be reclassified from other comprehensive income (OCI) and will reduce 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, 2018 (dollars in millions):

Derivatives in Cash Flow Hedging Relationships	Amount of Gain Recognized in OCI on Derivatives, Net of Tax	Location of Gain Reclassified from Accumulated OCI into Operations	Amount of Gain Reclassified from Accumulated OCI into Operations
Interest rate swaps	$ 18	Interest expense	$ 10

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, 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

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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

Cash Traded Investments (continued)

with reasonable levels of price transparency. Certain types of cash traded instruments are classified within Level 3 of the fair value hierarchy because they trade infrequently and therefore have little or no price transparency. The valuation of these securities involves the consideration of market factors and management s judgment.

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. We determined the credit valuation adjustments were not significant to the overall valuation of our derivatives at December 31, 2018 and 2017.

The following tables summarize our assets and liabilities measured at fair value on a recurring basis as of December 31, 2018 and 2017, aggregated by the level in the fair value hierarchy within which those measurements fall (dollars in millions):

		December 31, 2018 Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
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)		

	$ 362	**$ 21**	**$ 341**	**$**
Interest rate swaps (Other)	**$ 63**	**$**	**$ 63**	**$**

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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

	December 31, 2017			
		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
Investments of insurance subsidiaries:				
Debt securities	$ 371	$	$ 371	$
Money market funds and other	101	101		
Investments of insurance subsidiaries	472	101	371	
Less amounts classified as current assets	(54)	(54)		
	$ 418	$ 47	$ 371	$
Interest rate swaps (Other)	$ 50	$	$ 50	$

The estimated fair value of our long-term debt was $32.887 billion and $34.689 billion at December 31, 2018 and 2017, respectively, compared to carrying amounts, excluding net debt issuance costs, aggregating $32.978 billion and $33.222 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, 2018, follows (dollars in millions):

	2018	2017
Senior secured asset-based revolving credit facility (effective interest rate of 4.0%)	**$ 3,040**	$ 3,680
Senior secured revolving credit facility		
Senior secured term loan facilities (effective interest rate of 3.7%)	**3,801**	3,891
Senior secured notes (effective interest rate of 5.6%)	**13,800**	15,300
Other senior secured debt (effective interest rate of 5.6%)	**585**	599
Senior secured debt	**21,226**	23,470

Senior unsecured notes (effective interest rate of 6.3%)	**11,752**	9,752
Net debt issuance costs	**(157)**	(164)
Total debt (average life of 6.4 years, rates averaging 5.5%)	**32,821**	33,058
Less amounts due within one year	**788**	200
	$ 32,033	$ 32,858

During August 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

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 LONG-TERM DEBT (continued)

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.

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 ($3.040 billion outstanding at December 31, 2018) (the ABL credit facility); (ii) a $2.000 billion senior secured revolving credit facility maturing on June 28, 2022 (none outstanding at December 31, 2018 without giving effect to certain outstanding letters of credit); (iii) a $1.155 billion senior secured term loan A-5 facility maturing on June 10, 2020; (iv) a $1.489 billion senior secured term loan B-10 facility maturing on March 13, 2025; and (v) a $1.157 billion senior secured term loan B-11 facility maturing on March 18, 2023. 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) $3.000 billion aggregate principal amount of 6.50% first lien notes due 2020; (ii) $1.350 billion aggregate principal amount of 5.875% first lien notes due 2022; (iii) $1.250 billion aggregate principal amount of 4.75% first lien notes due 2023; (iv) $2.000 billion aggregate principal amount of 5.00% first lien notes due 2024; (v) $600 million aggregate principal amount of 4.25% first lien notes due 2019; (vi) $1.400 billion aggregate principal amount of 5.25% first lien notes due 2025; (vii) $1.500 billion aggregate principal amount of 5.25% first lien notes due 2026; (viii) $1.200 billion aggregate principal amount of 4.50% first lien notes due 2027; and (ix) $1.500 billion aggregate principal amount of 5.50% first lien notes due 2047. Capital leases and other secured debt totaled $585 million at December 31, 2018.

We use interest rate swap agreements to manage the variable rate exposure of our debt portfolio. At December 31, 2018, 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 senior secured credit facilities. The effect of the interest rate swaps is reflected in the effective interest rates for the senior secured credit facilities.

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 LONG-TERM DEBT (continued)

Senior Unsecured Notes

Senior unsecured notes consist of (i) $10.891 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 2020 through 2023, excluding amounts under the ABL credit facility, are $4.188 billion, $1.086 billion, $3.452 billion and $3.806 billion, respectively.

NOTE 10 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.

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 CONTINGENCIES (continued)

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. The Civil Division of the U.S. Department of Justice and the U.S. Attorney s Office for the Southern District of Texas have requested information about whether the Program as operated in Harris County complies with the laws and regulations applicable to provider related donations. The Company is cooperating with this request. We believe that our participation is and has been consistent with the requirements of the Program. However, at this time, we cannot predict what effect, if any, the request or resulting claims under the federal FCA, other statutes, regulations or laws, could have on the Company.

NOTE 11 LEASES

We lease medical office buildings and certain equipment under operating lease agreements. Commitments relating to noncancellable operating leases for each of the next five years and thereafter are as follows (dollars in millions):

For the Year Ended December 31,	
2019	$ 320
2020	304
2021	256
2022	203
2023	154
Thereafter	1,007
	2,244

Less sublease income	(25)
	$ 2,219

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.

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 CAPITAL STOCK (continued)

Share Repurchase Transactions

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 $2.0 billion October 2017 authorization. At December 31, 2018, we had $272 million of repurchase authorization available under the October 2017 authorization.

During October 2017, our board of directors authorized a share repurchase program for up to $2 billion of our outstanding common stock. 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 $2.0 billion November 2016 (which was completed during the fourth quarter of 2017) and the $2 billion October 2017 share repurchase programs. At December 31, 2017, we had $1.802 billion of repurchase authorization available under the October 2017 authorization.

During November 2016, our board of directors authorized a share repurchase program for up to $2 billion of our outstanding common stock. During May 2016, the Company repurchased 9.361 million shares of its common stock beneficially owned by affiliates of Kohlberg Kravis Roberts & Co. at a purchase price of $80.12 per share, the closing price of the Company s common stock on the New York Stock Exchange on May 10, 2016, less a discount of 1%. During 2016, we also repurchased 26.964 million shares of our common stock at an average price of $74.20 per share through market purchases, resulting in total repurchases of 36.325 million shares of our common stock at an average price of $75.72 per share for the year ended December 31, 2016 pursuant to the $3 billion October 2015 (which was completed during the fourth quarter of 2016) and the $2 billion November 2016 share repurchase programs. At December 31, 2016, we had $1.853 billion of repurchase authorization available under the November 2016 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 $499 million for 2018, $471 million for 2017 and $444 million for 2016. Our contributions are funded periodically 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 related to the HCA 401(k) plan. Benefits expense under this plan was $22 million for 2018, $40 million for 2017 and $20 million for 2016. Accrued benefits liabilities under this plan

totaled $205 million at December 31, 2018 and $201 million at December 31, 2017.

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 $26 million for 2018, $28 million for 2017 and $22 million for 2016. Accrued benefits liabilities under this plan totaled $195 million at December 31, 2018 and $223 million at December 31, 2017.

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 13 EMPLOYEE BENEFIT PLANS (continued)

We maintain defined benefit pension plans which resulted from certain hospital acquisitions in prior years. Benefits expense under these plans was $9 million for 2018, $14 million for 2017, and $21 million for 2016. Accrued benefits liabilities under these plans totaled $68 million at December 31, 2018 and $118 million at December 31, 2017.

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, 2018, the National Group included 88 hospitals located in Alaska, California, Florida, southern Georgia, Idaho, Indiana, northern Kentucky, Nevada, New Hampshire, South Carolina, Utah and Virginia, and the American Group included 85 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.

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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, legal claim benefits, 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):

	For the Years Ended December 31,		
	2018	**2017**	**2016**
Revenues:			
National Group	**$ 22,581**	$ 20,772	$ 19,845
American Group	**21,959**	20,912	19,670
Corporate and other	**2,137**	1,930	1,975
	$ 46,677	$ 43,614	$ 41,490
Equity in earnings of affiliates:			
National Group	**$ (4)**	$ (21)	$ (20)
American Group	**(40)**	(37)	(38)
Corporate and other	**15**	13	4
	$ (29)	$ (45)	$ (54)
Adjusted segment EBITDA:			
National Group	**$ 4,980**	$ 4,600	$ 4,565
American Group	**4,593**	4,231	4,173
Corporate and other	**(624)**	(598)	(520)
	$ 8,949	$ 8,233	$ 8,218

Depreciation and amortization:			
National Group	**$ 946**	$ 867	$ 806
American Group	**1,027**	986	908
Corporate and other	**305**	278	252
	$ 2,278	$ 2,131	$ 1,966

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HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 SEGMENT AND GEOGRAPHIC INFORMATION (continued)

	For the Years Ended December 31,		
	2018	**2017**	**2016**
Adjusted segment EBITDA	**$ 8,949**	$ 8,233	$ 8,218
Depreciation and amortization	**2,278**	2,131	1,966
Interest expense	**1,755**	1,690	1,707
Gains on sales of facilities	**(428)**	(8)	(23)
Losses on retirement of debt	**9**	39	4
Legal claim benefits			(246)
Income before income taxes	**$ 5,335**	$ 4,381	$ 4,810

	December 31,		
	2018	**2017**	**2016**
Assets:			
National Group	**$ 14,839**	$ 13,097	$ 12,320
American Group	**19,122**	18,136	16,208
Corporate and other	**5,246**	5,360	5,230
	$ 39,207	$ 36,593	$ 33,758

	National Group	**American Group**	**Corporate and Other**	**Total**
Goodwill and other intangible assets:				
Balance at December 31, 2015	$ 1,481	$ 4,638	$ 612	$ 6,731
Acquisitions		33	8	41
Foreign currency translation, amortization and other	(23)	(10)	(35)	(68)
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**

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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, 2015	$ 13	$ (74)	$ (135)	$ (69)	$ (265)
Unrealized losses on available-for-sale securities, net of $3 income tax benefit	(6)				(6)
Foreign currency translation adjustments, net of $87 income tax benefit		(137)			(137)
Defined benefit plans, net of $13 income tax benefit			(22)		(22)
Change in fair value of derivative instruments, net of $8 of income taxes				12	12
Expense reclassified into operations from other comprehensive income, net of $7 and $40, respectively, income tax benefits			11	69	80
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)
	(5)				**(5)**

Unrealized losses on available-for-sale securities, net of $2 income tax benefit					
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 benefits 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)**

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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):

	2018	2017
Professional liability risks	**$ 466**	$ 429
Defined contribution benefit plan	**459**	67
Interest	**429**	406
Taxes other than income	**308**	299
Other	**962**	782
	$ 2,624	$ 1,983

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

HCA Inc. is a 100% owned direct subsidiary of HCA Healthcare, Inc. On December 6, 2012, HCA Healthcare, Inc. issued $1.000 billion aggregate principal amount of 6.25% senior unsecured notes due 2021. 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, 2018 and 2017 and condensed consolidating statements of comprehensive income and cash flows for each of the three years in the period ended December 31, 2018, segregating HCA Healthcare, Inc. issuer, HCA Inc. issuer, the subsidiary guarantors, the subsidiary non-guarantors and eliminations, follow.

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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		
	(3,616)	3,589	20,007	17,674	3,688	41,342
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)	3,787	(2,755)	5,761	1,284	(3,688)	4,389
Net income attributable to			99	503		602

noncontrolling interests						
Net income (loss) attributable to HCA Healthcare, Inc.	$ 3,787	$ (2,755)	$ 5,662	$ 781	$ (3,688)	$ 3,787
Comprehensive income (loss) attributable to HCA Healthcare, Inc.	$ 3,779	$ (2,745)	$ 5,712	$ 713	$ (3,680)	$ 3,779

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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		
	(2,406)	3,127	19,453	16,583	2,476	39,233
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			108	419		527

noncontrolling interests						
Net income (loss) attributable to HCA Healthcare, Inc.	$ 2,216	$ (1,973)	$ 3,920	$ 529	$ (2,476)	$ 2,216
Comprehensive income (loss) attributable to HCA Healthcare, Inc.	$ 2,276	$ (1,953)	$ 3,898	$ 591	$ (2,536)	$ 2,276

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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, 2016

(Dollars in millions)

	HCA Healthcare, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Revenues	$	$	$ 24,427	$ 17,063	$	$ 41,490
Salaries and benefits			10,971	7,926		18,897
Supplies			4,090	2,843		6,933
Other operating expenses	6		3,912	3,578		7,496
Equity in earnings of affiliates	(2,738)		(7)	(47)	2,738	(54)
Depreciation and amortization			1,141	825		1,966
Interest expense (income)	64	2,756	(970)	(143)		1,707
Losses (gains) on sales of facilities			4	(27)		(23)
Losses on retirement of debt		4				4
Legal claim benefits		(246)				(246)
Management fees			(588)	588		
	(2,668)	2,514	18,553	15,543	2,738	36,680
Income (loss) before income taxes	2,668	(2,514)	5,874	1,520	(2,738)	4,810
Provision (benefit) for income taxes	(222)	(928)	2,133	395		1,378

Net income (loss)	2,890	(1,586)	3,741	1,125	(2,738)	3,432
Net income attributable to noncontrolling interests			93	449		542
Net income (loss) attributable to HCA Healthcare, Inc.	$ 2,890	$ (1,586)	$ 3,648	$ 676	$ (2,738)	$ 2,890
Comprehensive income (loss) attributable to HCA Healthcare, Inc.	$ 2,817	$ (1,505)	$ 3,637	$ 533	$ (2,665)	$ 2,817

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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
ASSETS						
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
	$ 33,644	$ 64	$ 24,223	$ 14,442	$ (33,166)	$ 39,207
LIABILITIES AND STOCKHOLDERS (DEFICIT) EQUITY						
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
	(4,950)	(24,790)	48,524	11,464	(33,166)	(2,918)
	$ 33,644	$ 64	$ 24,223	$ 14,442	$ (33,166)	$ 39,207

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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, 2017

(Dollars in millions)

	HCA Healthcare, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
ASSETS						
Current assets:						
Cash and cash equivalents	$ 1	$	$ 112	$ 619	$	$ 732
Accounts receivable, net			3,693	2,808		6,501
Inventories			1,030	543		1,573
Other			663	508		1,171
	1		5,498	4,478		9,977
Property and equipment, net			11,110	6,785		17,895
Investments of insurance subsidiaries				418		418
Investments in and advances to affiliates	29,581		22	177	(29,581)	199
Goodwill and other intangible assets			4,893	2,501		7,394
Other	510	50	47	103		710
	$ 30,092	$ 50	$ 21,570	$ 14,462	$ (29,581)	$ 36,593
LIABILITIES AND STOCKHOLDERS (DEFICIT) EQUITY						
Current liabilities:						
Accounts payable	$	$	$ 1,793	$ 813	$	$ 2,606

Accrued salaries			862	507		1,369
Other accrued expenses	29	378	536	1,040		1,983
Long-term debt due within one year		97	64	39		200
	29	475	3,255	2,399		6,158
Long-term debt, net	995	31,367	307	189		32,858
Intercompany balances	35,322	(9,742)	(25,228)	(352)		
Professional liability risks				1,198		1,198
Income taxes and other liabilities	552		357	465		1,374
	36,898	22,100	(21,309)	3,899		41,588
Stockholders (deficit) equity attributable to HCA Healthcare, Inc.	(6,806)	(22,050)	42,755	8,876	(29,581)	(6,806)
Noncontrolling interests			124	1,687		1,811
	(6,806)	(22,050)	42,879	10,563	(29,581)	(4,995)
	$ 30,092	$ 50	$ 21,570	$ 14,462	$ (29,581)	$ 36,593

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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
Cash flows from operating activities:						
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
Cash flows from investing activities:						

Purchase of property and equipment			(2,008)	(1,565)	(3,573)
Acquisition of hospitals and health care entities			(897)	(356)	(1,253)
Disposal 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)
Cash flows from financing activities:					
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 cash 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

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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
Cash flows from operating activities:						
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
Cash flows from investing activities:						

Purchase of property and equipment			(1,681)	(1,334)		(3,015)
Acquisition of hospitals and health care entities			(26)	(1,186)		(1,212)
Disposal 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)
Cash flows from financing activities:						
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

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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, 2016

(Dollars in millions)

	HCA Healthcare, Inc Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities:						
Net income (loss)	$ 2,890	$ (1,586)	$ 3,741	$ 1,125	$ (2,738)	$ 3,432
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:						
Change in operating assets and liabilities	(25)	39	(139)	167		42
Depreciation and amortization			1,141	825		1,966
Income taxes	123					123
Losses (gains) on sales of facilities			4	(27)		(23)
Losses on retirement of debt		4				4
Legal claim benefits		(246)				(246)
Amortization of debt issuance costs	1	33				34
Share-based compensation			251			251
Equity in earnings of affiliates	(2,738)				2,738	
Other	71			(1)		70
Net cash provided by (used in) operating activities	322	(1,756)	4,998	2,089		5,653
Cash flows from investing activities:						
Purchase of property and equipment			(1,554)	(1,206)		(2,760)
Acquisition of hospitals and health care entities			(199)	(377)		(576)
			10	16		26

Disposal of hospitals and health care entities						
Change in investments			(15)	79		64
Other				6		6
Net cash used in investing activities			(1,758)	(1,482)		(3,240)
Cash flows from financing activities:						
Issuance of long-term debt		5,400				5,400
Net change in revolving bank credit facilities		(110)				(110)
Repayment of long-term debt		(4,358)	(74)	(43)		(4,475)
Distributions to noncontrolling interests			(64)	(370)		(434)
Payment of debt issuance costs		(40)				(40)
Repurchases of common stock	(2,751)					(2,751)
Changes in intercompany balances with affiliates, net	2,532	864	(3,149)	(247)		
Other	(103)			5		(98)
Net cash (used in) provided by financing activities	(322)	1,756	(3,287)	(655)		(2,508)
Change in cash and cash equivalents			(47)	(48)		(95)
Cash and cash equivalents at beginning of period			160	581		741
Cash and cash equivalents at end of period	$	$	$ 113	$ 533	$	$ 646

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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 presentations for the years ended December 31, 2018, 2017 and 2016 are as follows (dollars in millions):

	2018	2017	2016
Presentation in HCA Healthcare, Inc. Consolidated Statements of Stockholders Deficit:			
Repurchases of common stock	**$ (1,530)**	$ (2,051)	$ (2,751)
Share-based benefit plans	**115**	281	233
Cash dividends declared ($1.40 per share)	**(496)**		
Other	**(12)**	(10)	(2)
Presentation in Healthtrust, Inc. The Hospital Company Consolidated Statements of Stockholder s Deficit:			
Distributions to HCA Healthcare, Inc., net of contributions from HCA Healthcare, Inc.	**$ (1,923)**	$ (1,780)	$ (2,520)

Presentation in HCA Healthcare, Inc. Consolidated Statements of Cash Flows (cash flows from financing activities):			
Repurchases of common stock	**$ (1,530)**	$ (2,051)	$ (2,751)
Payment of cash dividends	**(487)**		
Presentation in Healthtrust, Inc. The Hospital Company Consolidated Statements of Cash Flows (cash flows from financing activities):			
Cash distributions to HCA Healthcare, Inc.	**$ (2,017)**	$ (2,051)	$ (2,751)

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.

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HCA HEALTHCARE, INC.

QUARTERLY CONSOLIDATED FINANCIAL INFORMATION

(UNAUDITED)

(Dollars in millions, except per share amounts)

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

	2017			
	First	**Second**	**Third**	**Fourth**
Revenues	$ 10,623	$ 10,733	$ 10,696	$ 11,562
Net income	$ 777(e)	$ 795(f)	$ 530(g)	$ 641(h)
Net income attributable to HCA Healthcare, Inc.	$ 659(e)	$ 657(f)	$ 426(g)	$ 474(h)
Basic earnings per share	$ 1.78	$ 1.79	$ 1.18	$ 1.34
Diluted earnings per share	$ 1.74	$ 1.75	$ 1.15	$ 1.30

(a) First quarter results include $305 million of gains on sales of facilities (See Note 3 of the notes to consolidated financial statements).

(b) Second quarter results include $8 million of gains on sales of facilities (See Note 3 of the notes to consolidated financial statements).

(c) 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).

(d) Fourth quarter results include $6 million of gains on sales of facilities (See Note 3 of the notes to consolidated financial statements).

(e) First quarter results include $1 million of gains on sales of facilities (See Note 3 of the notes to consolidated financial statements).

(f) Second quarter results include $1 million of gains on sales of facilities (See Note 3 of the notes to consolidated financial statements).

(g) Third quarter results include $4 million of gains on sales of facilities (See Note 3 of the notes to consolidated financial statements) and $25 million of losses on retirement of debt.

(h)

Fourth quarter results include $1 million of losses on sales of facilities (See Note 3 of the notes to consolidated financial statements).