



2021
Annual Report
to Shareholders



**2021
Letter to our
Shareholders**



Left: Arian Culp, MD, Med Surg, Research Medical Center; David Porter, PA; Yvonne Adams, LPN; Aubree Hosiner, RN

To our valued shareholders,

This past year was another remarkable one for HCA Healthcare. Our hospitals managed through some of the highest COVID-19 surges of the pandemic while also improving our enterprise capabilities, allowing us to better support our 182 hospitals and more than 2,200 ambulatory sites of care.

We are proud that HCA Healthcare ended 2021 in its best position in decades based upon key metrics that we believe position our facilities as a provider system of choice in the communities we serve.

We could not have performed at this level without the resilience of our approximately 284,000 colleagues — and 45,000 affiliated physicians — who remained committed to providing our patients with high-quality care, even while the COVID-19 pandemic continued to surge. Through more than 35 million patient encounters, HCA Healthcare nurses, physicians, and colleagues across the enterprise withstood adversity and delivered patient-centered care every day.

HCA Healthcare's momentum continued to accelerate throughout this past year. We were able to accomplish this while staying true to our mission. We expanded our footprint in the communities we serve while also developing more comprehensive resources to support our caregivers and colleagues. We invested more in technology to improve our patients' experiences, advance our clinical capabilities, and gain efficiencies. And finally, we discovered new ways to capitalize on our diverse footprint by partnering with leading companies to help accelerate these strategic initiatives.

Strong financial performance

Our momentum, financial stewardship, and disciplined operating culture also allowed us to deliver a strong financial performance during 2021. Our revenues for the year totaled \$58.7 billion, a 14% increase from 2020. Diluted earnings per share increased 93% to \$21.16.

After suspending certain programs during 2020 in response to the COVID-19 pandemic, we were able to resume a balanced approach to capital allocation by:

1

Investing more than \$3.5 billion of capital expenditures to support and grow our facilities

2

Spending \$1.1 billion on acquisitions of hospitals and other sites of care, such as home health and urgent care

3

Repurchasing \$8.2 billion, or over 37 million shares, of common stock

4

Reinstating our quarterly dividend

In addition, we divested non-strategic assets, which generated over \$2.1 billion of pre-tax proceeds to redeploy.

We are proud of the impact this performance had on our people and our communities:



Our payroll and benefits for our approximately 284,000 colleagues were \$26.7 billion.

25.5%



We cared for those who are uninsured or under-insured by providing uncompensated care at an estimated cost of \$3.3 billion. Approximately 25.5% of our inpatient admissions and 46% of our emergency room visits were for the treatment of patients who were either uninsured or covered under Medicaid.

46%



As a taxpaying healthcare provider, we incurred approximately \$5.5 billion of federal, state, and local taxes, including \$2.8 billion of income, property, and sales and use taxes.

Supporting our caregivers

In 2021, demand for healthcare remained strong and was influenced by three different COVID-19 surges. We saw growth in most major categories of our business, and we expect to see continued growth in 2022. With this expected growth, HCA Healthcare continues to confront two critical staffing needs — nurses and physicians — by growing our clinical education and comprehensive graduate medical education programs, in addition to initiatives discussed below.

Similar to 2020, in 2021, we focused on caring for those suffering from the COVID-19 pandemic. From February 2020 to December 2021, our facilities cared for more than 271,000 COVID-19 inpatients, including more than 160,000 inpatients in 2021.

Again, it was because of our nurses, physicians, and colleagues that we were able to care for so many patients, loved ones, and community members. But the challenging labor environment and the growing demand for healthcare services present hurdles. That is why we have a multipronged strategy designed to meet these challenges and advance HCA Healthcare's mission.







Enhancing the nursing pipeline

Enhancing the nursing pipeline has become increasingly important to meet the ongoing demands of patient care throughout the healthcare industry. For us, responding to this need starts with strengthening our recruitment and retention functions. For example, we have advanced our benefits and invested in creating an environment where nurses can treat their patients and, ultimately, discharge them in a more productive manner. Additionally, in June 2021, we created a \$50 million “Investing in Our Colleagues” initiative to respond to feedback gathered through our Vital Voices program, an employee engagement survey conducted multiple times each year. Each facility used its portion of this initiative’s additional funds based on our nurses’ assessments of areas of greatest need to enhance patient care. We also continue to provide well-being support and resources through a partnership with PsychHub, a free COVID-19 mental health resource hub, and Nurse Care, a 24/7 free and confidential counseling program, to meet the needs of HCA Healthcare’s hospital-based nurses.





Additionally, in June 2021, we created a \$50 million “Investing in Our Colleagues” initiative to respond to feedback gathered through our Vital Voices program, an employee engagement survey conducted multiple times each year.

We have also increased our investments in our Galen College of Nursing, one of the largest educators of nurses in the United States. In 2021, we announced the expansion of our nursing college in Austin, Texas; Nashville, Tennessee; and Myrtle Beach, South Carolina. We have announced seven campuses since the acquisition in 2020. Furthermore, Galen College of Nursing has helped develop an innovative and evidence-based curriculum to prepare nurses for today’s workforce and meet the needs of patients. It has also provided a significant pipeline of nurses for our facilities, and, on an annual basis, we hope to hire three times the number of graduates over the next few years compared to the number of annual hires today.



Top: Janie Holmes, MSN, RN, CPN Nurse Residency Cohort Graduate Manager of Pediatric ICU, TriStar Centennial Medical Center
Bottom: Cardiac Sonographers Jill Romero, RDCS; Crystal Thompson, RDCS; Alexis Kohnle, RDCS; Andrew McCann, RDCS, Research Medical Center

Right: Alosh Madala, MD, Board
Certified Urologist, Research
Medical Center

Strengthening programs for tomorrow's physicians

HCA Healthcare recently announced that we offered 1,982 positions for our July 2021 graduate medical education (GME) programs — our largest incoming class to date and the largest among teaching hospitals in the United States. As a result, HCA Healthcare has become a significant provider of clinical and medical education and is the largest sponsor of GME programs in the United States, with 299 Accreditation Council for Graduate Medical Education (ACGME) accredited programs, more than 4,800 residents and fellows, and 59 teaching hospitals across 16 states. By growing our GME program, we strive to build our pipeline of physicians for our facilities and meet the growing needs of our communities.

We respect the autonomy and expertise of our physicians and advanced practice providers and collaborate with them through physician governance councils, operational and service line support, physician engagement and patient safety culture surveys, and our network of physician relationship specialists.

We have also invested in more clinical resources for our physicians, building state-of-the-art operating rooms, upgrading facilities, and advancing technology capabilities, like telehealth, to increase access to care and further support and protect our physicians. As one of the nation's leading healthcare providers, we are committed to investing in clinical resources so we can provide high-quality care to our patients.





Advancing our clinical excellence

Clinical excellence is what we stand for as an organization — quality and compassionate care that we'd expect for ourselves, our families, and our friends.

In its 2021 Hospital Safety Grades, The Leapfrog Group recognized 84% of HCA Healthcare hospitals with an A or B rating, as compared to 58% of hospitals nationally. In February 2021, 14 HCA Healthcare hospitals were recognized among the “250 Best Hospitals” by Healthgrades, which also recognized Mission Hospital, an HCA Healthcare affiliated hospital, as one of the “50 Best Hospitals.” In addition, 16 of the best performing hospitals in the nation are part of

HCA Healthcare, according to Fortune/ IBM Watson Health's 2021 “Top 100 Hospitals” Annual Study. This recognition testifies to the hard work of our nurses, physicians, and colleagues, and it's because of their dedication to clinical excellence that HCA Healthcare continues to advance healthcare standards.

We have also continued to share best practices to optimize our service lines across our facilities. As a result, in 2021, 18 HCA Healthcare facilities received Press Ganey Pinnacle of Excellence or Guardian of Excellence awards for patient experience.

Below, right: Vincent Narciso, MD, General Surgeon; AJ Eisenhart, Surgical Tech, and surgical team at Overland Park Regional Medical Center




In February 2021, 14 HCA Healthcare hospitals were recognized among the “250 Best Hospitals” by Healthgrades, which also recognized Mission Hospital, an HCA Healthcare affiliated hospital, as one of the “50 Best Hospitals.” In addition, 16 of the best performing hospitals in the nation are part of HCA Healthcare, according to Fortune/ IBM Watson Health’s 2021 “Top 100 Hospitals” Annual Study.



We believe leveraging our unique scale can accelerate learning. For example, early in 2021, HCA Healthcare’s clinical research team formed a consortium of prominent public and private research institutions to use our organization’s vast data on COVID-19 hospital care to improve patient outcomes and public knowledge. The COVID-19 Consortium of HCA Healthcare and Academia for Research GEneration (CHARGE) provides a framework for cooperation and coordination among all its members to pose research questions, scrutinize, and validate methods, and, most importantly, share and act on innovative ideas that will help lead to impactful results. The member institutions — including the

federal Agency for Healthcare Research and Quality (AHRQ), Johns Hopkins University, Duke University, Meharry Medical College, Harvard Pilgrim Health Care Institute, and others — accessed the data in a research program directed by the HCA Healthcare Research Institute (HRI). As of December 31, 2021, 12 studies were being conducted or had been completed using de-identified data from more than 210,000 patients in the HCA Healthcare COVID-19 Registry. Topics include the efficacy of therapeutics, operational efficiency in treating patients, predictive modeling for needing intensive care, and the effects of disparities.

Left: Elizabeth Catapang, ASCP, Microbiology Medical Technologist, Research Medical Center
Right: Ghadah Kazem, Medical Laboratory Scientist (ASCP), General Laboratory Manager, Research Medical Center



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Preparing for the next generation of healthcare

Next-generation patient care will require data-driven support to allow a sharper focus on safe, efficient, and effective patient care. HCA Healthcare is committed to establishing partnerships and exploring new initiatives to enhance care delivery.

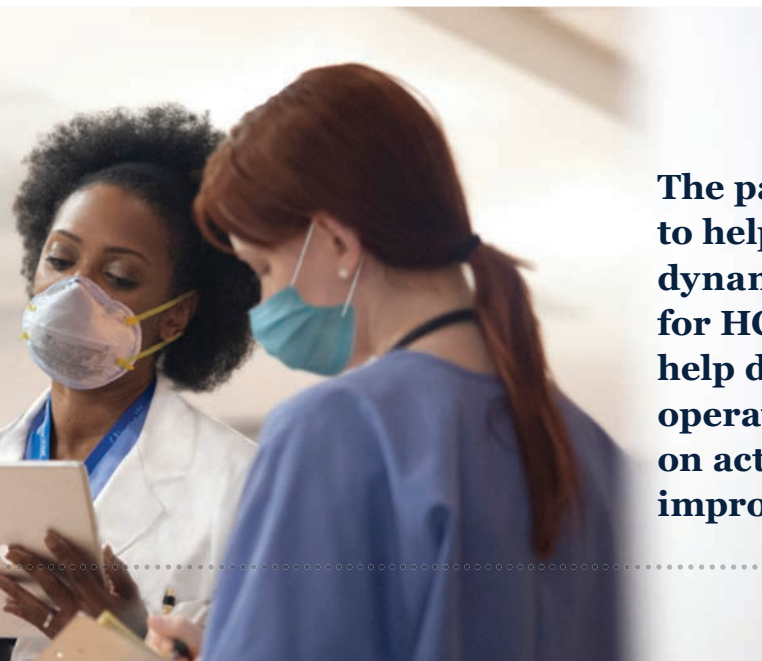




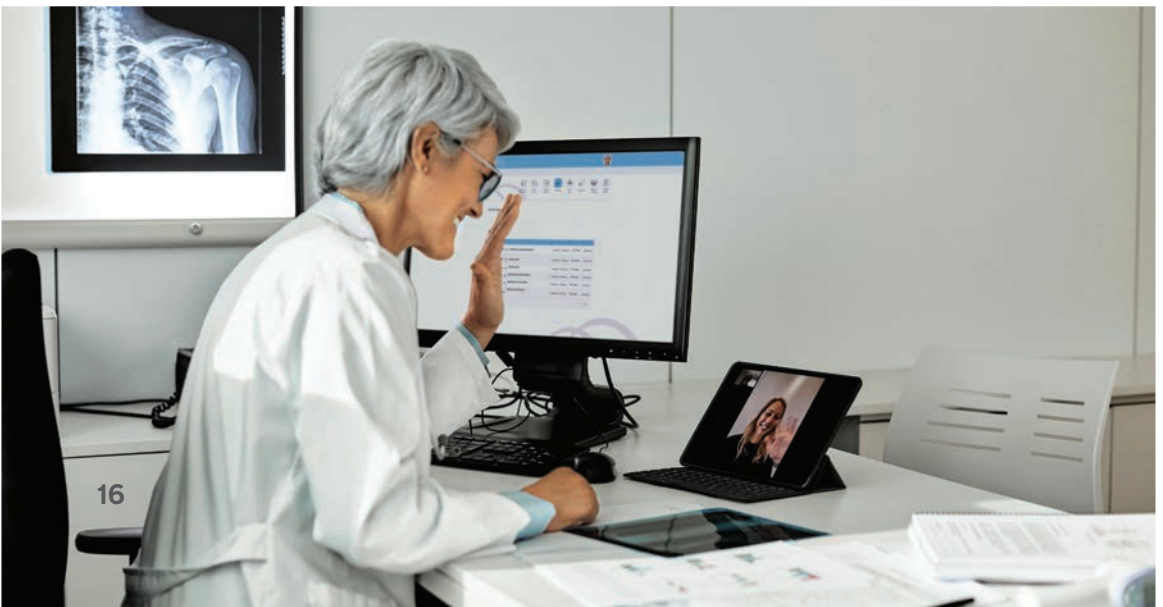
In May, we announced a multi-year strategic partnership with Google Cloud to enhance HCA Healthcare's use of information technology to accelerate digital transformation.

The partnership is designed to help create a secure and dynamic data analytics platform for HCA Healthcare and help develop next-generation operational models focused on actionable insights and improved workflows.

In combination with significant investments in mobility to support clinical care, the partnership with Google Cloud is expected to empower physicians, nurses, and others with workflow tools, analysis, and alerts on their mobile devices to help clinicians respond quickly to changes in a patient's condition. The partnership will also focus on aiding non-clinical support areas that may benefit from improved workflows through better use of data and insights, such as supply chain, human resources, and physical plant operations.



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In the spring of 2021, HCA Healthcare’s Information Technology Group (ITG) and Clinical Operations Group (COG) hosted a Coding for Caregivers “Hackathon” event that asked nurses to submit their ideas for improving work efficiencies at the patient bedside. HCA Healthcare nurses submitted more than 5,000 ideas which were reviewed by 29 teams comprised of nearly 600 participants — including clinical representatives, developers, project managers, and quality analysts — who provided solutions to improve care efficiencies for nurses across the organization. The collaboration produced a list of projects that are currently under development, including the introduction of an automated process for notifying clinicians when patient medications are refilled in their dispensing cabinets — saving valuable time and resources.

An additional clinical area of focus is care transformation. In 2021, we established a new office of Care Transformation and Innovation (CT&I) dedicated to using HCA Healthcare’s capacity and scale to help care teams achieve better, more efficient, digitally-enabled outcomes through increased integration of technology into clinical care. This work is supported by a variety of experts across our clinical care, data science, and technology groups.

Additionally, telehealth continues to be an essential point of access to healthcare for many of the communities we serve, and we are continuing to invest in our telehealth capabilities. For instance, in the past year, we’ve enabled multiple telehealth video and mobile applications to be used by 6,000 providers in our outpatient and hospital-based clinics and added more than 3,000 telehealth endpoints in our hospitals.

In 2021, we established a new office of Care Transformation and Innovation (CT&I) dedicated to using HCA Healthcare’s capacity and scale to help care teams achieve better, more efficient, digitally-enabled outcomes through increased integration of technology into clinical care.

HCA Healthcare shows up

When a patient needs care, we show up. When a natural disaster strikes our community, we show up. When a colleague needs support, we show up. Day in and day out, HCA Healthcare nurses and other colleagues show up to care for patients across our 182 hospitals and more than 2,200 ambulatory sites of care. Likewise, our more than 45,000 active and affiliated physicians across HCA Healthcare continually display courage and skill while caring for others. In addition to the patient care given in our healthcare facilities, HCA Healthcare teams serve their communities in many ways.

In May 2021, the HCA Healthcare Foundation announced the Healthier Tomorrow Fund, a new \$80 million community impact fund focused on addressing high-priority community needs and health equity. The fund provides grants to nonprofit organizations in 25 communities where HCA Healthcare has a presence.

Just as important, HCA Healthcare continued to support our communities affected by natural disasters. When Hurricane Ida made landfall in August 2021 as a Category 4 hurricane, our teams ensured our Louisiana hospitals had appropriate staff, medications, supplies, food, water, and generator power while also safely coordinating patient transfers to sister hospitals and other nearby facilities. When a severe tornado system struck Kentucky, HCA Healthcare stepped up to provide care at TriStar Greenview Regional Hospital and contributed \$250,000 in funding to support organizations providing relief services. When floods impacted Middle Tennessee, affecting many of our colleagues and neighbors, HCA Healthcare and the HCA Healthcare Foundation contributed \$250,000 to support relief efforts. We are also continuing to partner nationally with charitable organizations like the American Red Cross and March of Dimes.

In May 2021, the HCA Healthcare Foundation announced the Healthier Tomorrow Fund, a new \$80 million community impact fund focused on addressing high-priority community needs and health equity.



Top, left: Twenty-six HCA Healthcare volunteers, including Spencer Jones and Bev Sears (pictured), spent a day building a Habitat for Humanity home in Columbia, Tennessee.

Bottom: Matthew Pierson, MD, Neurosurgeon, Research Medical Center



Additionally, HCA Healthcare colleagues across the country acted against food insecurity with a holiday food drive and fundraiser that delivered nearly 370,000 meals to food banks in the communities we serve. The effort supported HCA Healthcare's inaugural Healthy Food for Healthier Tomorrows Food & Nutrition Drive, and included 77,830 meals donated by colleagues, 52,000 meals provided by colleague charitable donations, and 240,000 meals from \$60,000 in grants provided by the HCA Healthcare Foundation.

And while the opioid crisis continues to affect our communities, HCA Healthcare collected 15,566 pounds of unused and expired medications, exceeding last year's record of 13,523 pounds, during our third annual "Crush the Crisis" opioid take-back events. A total of 96 HCA Healthcare facilities across 17 states held events that were aimed at educating communities on the dangers of opioid misuse and the importance of safe and proper disposal of expired and unused prescription medications. The events collectively disposed of an estimated 10.7 million doses of medication.

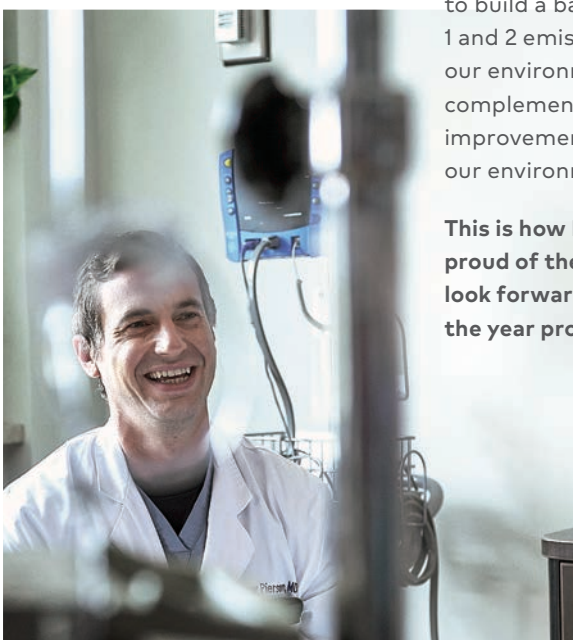
As part of our continued commitment to providing equitable access to high-quality care for all patients, HCA Healthcare formed the Health Equity Council in January 2021 to help identify and address health disparities within and outside of our hospitals, as well as to develop strategies that advance health equity. This cross-functional group of senior leaders led by our chief medical officer and chief diversity officer analyzes race, ethnicity, and other data to address disparities and improve patient quality, safety, and satisfaction outcomes for diverse populations.



We've also made a \$10 million commitment over three years to support Historically Black Colleges and Universities (HBCUs) and Hispanic-Serving Institutions (HSIs) in communities near our hospitals. We know our ability to serve diverse communities most effectively depends on a workforce that reflects those communities. In December 2021, HCA Healthcare donated \$1.5 million to Florida A&M University's School of Allied Health Sciences. This donation and future partnerships are intended to strengthen student pathways from undergraduate to graduate to management careers in healthcare, while also advancing diversity in healthcare and supporting the next generation of healthcare leaders.

Our dedication to the communities we serve reflects our desire to address critical environmental, social, and governance (ESG) issues. For instance, one of the ways we are accelerating our efforts and embracing our role in creating healthier tomorrows is through our environmental sustainability strategy. The strategy includes four main pillars: managing energy and water responsibly, enhancing our climate resilience, sourcing and consuming efficiently, and greening our capital programs. These pillars guide our work to build a balanced plan to support Scope 1 and 2 emissions reduction and to ensure our environmental strategy is designed to complement our commitment to the care and improvement of human life, which extends to our environment.

This is how HCA Healthcare shows up. We are proud of the work we have accomplished and look forward to sharing even more news as the year progresses.



Carrying our momentum

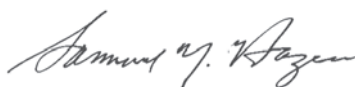
HCA Healthcare's success in 2021 is primarily due to the exceptional work of our nurses, physicians, and colleagues, along with the strong partnerships we have with outstanding organizations. From their efforts, we were named a 2021 World's Most Ethical Company by Ethisphere for the 11th year and were recognized on the 2021 LinkedIn Top Companies list.

The positive impact HCA Healthcare's caregivers and colleagues have on the communities we serve is profound, unmatched, and continues to grow. To that point, in 2021, we expanded our reach by opening and acquiring new facilities in Colorado, Florida, Tennessee, and Georgia. We also acquired a majority stake in Brookdale Health Care Services which is foundational to our ongoing efforts to provide quality home health and hospice care to our patients. We believe this joint venture will lead to improved care coordination across the HCA Healthcare network. Moving forward, we are confident that we are well-positioned with many diversified opportunities to allocate capital in a productive manner.

We believe HCA Healthcare's future is very bright. While COVID-19 continued to affect the country, our operating model delivered care for our patients, facilitated market share growth, and produced solid returns for our shareholders. We accomplished a lot in 2021, and we will continue working to carry this momentum into the new year.



Thomas F. Frist III
Chairman of the Board



Samuel N. Hazen
Chief Executive Officer



**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, 2021

Or

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

For the transition period from _____ to _____

Commission File Number 1-11239

HCA Healthcare, Inc.

(Exact Name of Registrant as Specified in its Charter)

Delaware
(State or Other Jurisdiction of
Incorporation or Organization)

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

One Park Plaza
Nashville, Tennessee
(Address of Principal Executive Offices)

37203
(Zip Code)

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

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

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

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

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

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

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

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

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

Large accelerated filer

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 has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report.

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

Auditor PCAOB ID Number: 42 Auditor Name: Ernst & Young LLP Auditor Location: Nashville, Tennessee, United States of America

As of January 31, 2022, there were 303,600,000 outstanding shares of the Registrant's common stock. As of June 30, 2021, the aggregate market value of the common stock held by nonaffiliates was approximately \$51.895 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 2022 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, 2021, we operated 182 hospitals, comprised of 175 general, acute care hospitals; five psychiatric hospitals; and two rehabilitation hospitals. In addition, we operated 125 freestanding surgery centers and 21 freestanding endoscopy 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, refer to HCA Healthcare, Inc. and its affiliates. The term “affiliates” means direct and indirect subsidiaries of HCA Healthcare, Inc. and partnerships and joint ventures in which such subsidiaries are partners. The terms “facilities” or “hospitals” refer to entities owned and operated by affiliates of HCA, and the term “employees” refers to employees of affiliates of HCA.

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

Our common stock is traded on the New York Stock Exchange (symbol “HCA”). Through our predecessors, we commenced operations in 1968. HCA Healthcare, Inc. 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 throughout this report 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 Investor Relations Department, 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.

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. We strive to be the provider system of choice in the communities we serve and to support our operations with unique enterprise capabilities and best-in-class economies of scale. 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, operational 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, home health, hospice, outpatient physical therapy home and community-based services providers, and various other facilities.

At December 31, 2021, we owned and operated 175 general, acute care hospitals with 48,030 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, 2021, we operated five psychiatric hospitals with 593 licensed beds. Our psychiatric hospitals provide therapeutic programs, including child, adolescent and adult psychiatric care and adolescent and adult alcohol and drug abuse treatment and counseling.

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

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

COVID-19 Pandemic

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic. Patient volumes and the related revenues for most of our services were significantly impacted during the latter portion of the first quarter and the first half of the second quarter of 2020 and have continued to be impacted as various policies were implemented by federal, state and local governments in response to the COVID-19 pandemic.

During the second quarter of 2021, our patient volumes improved as the effects of the pandemic moderated and certain pandemic-related restrictions and policies were eased. For the remainder of 2021, our patient volumes exhibited consistent growth over the prior year, with the exception of inpatient surgeries, and included a resurgence of COVID-19 admissions and the re-imposition of pandemic-related restrictions in certain markets. We believe the extent of the COVID-19 pandemic's impact on our operating results and financial condition has been and will continue to be driven by many factors, most of which are beyond our control and ability to forecast. Because of these uncertainties, we cannot estimate how long or to what extent the pandemic will impact our operations.

Summary Risk Factors

You should carefully read and consider the risk factors set forth under Item 1A, "Risk Factors," as well as all other information contained in this annual report on Form 10-K. Additional risks and uncertainties not presently known to us or that we currently deem immaterial may also affect us. If any of these risks occur, our business, financial position, results of operations, cash flows or prospects could be materially, adversely affected. Our business is subject to the following principal risks and uncertainties:

Risks related to the COVID-19 pandemic and other potential pandemics:

- The COVID-19 pandemic is significantly affecting our operations and could affect our business and financial condition. Our liquidity could also be negatively impacted by the COVID-19 pandemic, particularly if the U.S. economy remains unstable for a significant amount of time.
- We are unable to predict the ultimate impact of the CARES Act (as defined below) and other existing or future stimulus and relief legislation, if any, or the effect that such legislation and other governmental responses intended to assist providers in responding to COVID-19 may have on our business, financial condition, results of operations or cash flows. There can be no assurance as to the total amount of financial assistance or types of assistance we will receive, that we will be able to comply with the applicable terms and conditions to retain such assistance, or that we will be able to benefit from provisions intended to increase access to resources and ease regulatory burdens for health care providers.
- The emergence and effects related to a potential future pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations.

Risks related to our indebtedness:

- 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 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 debt agreements contain restrictions that limit our flexibility in operating our business.
- Discontinuation, reform or replacement of LIBOR may adversely affect our borrowing costs.

Risks related to human capital:

- Our operations may be adversely affected by competition for staffing, the shortage of experienced nurses and other health care professionals, vaccine mandates and labor union activity.
- We may be unable to attract, hire, and retain a highly qualified and diverse workforce, including key management.
- Our performance depends on our ability to recruit and retain quality physicians.

Risks related to technology, data privacy and cybersecurity:

- A cybersecurity incident could result in the compromise of our facilities, confidential data or critical data systems. A cybersecurity incident could also give rise to potential harm to patients; remediation and other expenses; and exposure to liability under HIPAA (as defined below), consumer protection laws, common law theories or other laws. Such incidents could subject us to litigation and foreign, federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.
- Our operations could be impaired by a failure of our information systems.
- Health care technology initiatives, particularly those related to patient data and interoperability, may adversely affect our operations.
- We may not be reimbursed for the cost of expensive, new technology.

Risks related to governmental regulation and other legal matters:

- Our results of operations may be adversely affected by health care reform efforts, including efforts to significantly change the Affordable Care Act (as defined below). We are unable to predict what, if any, and when additional health reform measures will be adopted or implemented, and the effects and ultimate impact of any such measures are uncertain.
- Changes in government health care programs may adversely affect our revenues.
- 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.
- State efforts to regulate the construction or expansion of health care facilities could impair our ability to operate and expand our operations.
- We may incur additional tax liabilities.
- We have been and could become the subject of government investigations, claims and litigation.
- We may be subject to liabilities from claims brought against our facilities, which are costly to defend and may require us to pay significant damages if not covered by insurance.

Risks related to operations, strategy, demand and competition:

- Our hospitals face competition for patients from other hospitals and health care providers.
- A deterioration in the collectability of uninsured and patient due accounts could adversely affect our results of operations.
- 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.
- 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.
- We may encounter difficulty acquiring hospitals and other health care businesses and 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.
- Our facilities are heavily concentrated in Florida and Texas, which makes us sensitive to regulatory, economic, public health, environmental and competitive conditions and changes in those states.
- Our business and operations are subject to risks related to climate change.
- The industry trend toward value-based purchasing may negatively impact our revenues.

Risks related to macroeconomic conditions:

- Our overall business results may suffer during periods of general economic weakness.
- We are exposed to market risk related to changes in the market values of securities and interest rates.

Risks related to ownership of our common stock:

- There can be no assurance that we will continue to pay dividends.
- Certain of our investors may continue to have influence over us.

Sources of Revenue

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

We receive payments for patient services from the federal government under the Medicare program, state governments under their respective Medicaid or similar programs, managed care plans (including plans offered through the American Health Benefit Exchanges (“Exchanges”)), private insurers and directly from patients. Our revenues by primary third-party payer classification and other (including uninsured patients) for the years ended December 31, 2021, 2020 and 2019 are summarized in the following table (dollars in millions):

	Years Ended December 31,					
	2021	Ratio	2020	Ratio	2019	Ratio
Medicare	\$10,447	17.8%	\$10,420	20.2%	\$10,798	21.0%
Managed Medicare	8,424	14.3	6,997	13.6	6,452	12.6
Medicaid	2,290	3.9	1,965	3.8	1,572	3.1
Managed Medicaid	3,124	5.3	2,621	5.1	2,450	4.8
Managed care and other insurers	30,295	51.6	26,535	51.5	26,544	51.6
International (managed care and other insurers)	1,336	2.3	1,120	2.2	1,162	2.3
Other	2,836	4.8	1,875	3.6	2,358	4.6
Revenues	<u>\$58,752</u>	<u>100.0%</u>	<u>\$51,533</u>	<u>100.0%</u>	<u>\$51,336</u>	<u>100.0%</u>

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

Our hospitals generally offer discounts from established charges to certain group purchasers of health care services, including private health insurers, employers, health maintenance organizations (“HMOs”), preferred provider organizations (“PPOs”) and other managed care plans, including health plans offered through the Exchanges. These discount programs generally limit our ability to increase revenues in response to increasing costs. See Item 1, “Business — Competition.” For services under Medicare, Medicaid, HMOs, PPOs and other managed care plans, patients are generally responsible for any exclusions, deductibles or coinsurance features of their coverage. The amounts of such exclusions, deductibles and coinsurance continue to increase. Collection of amounts due from individuals is typically more difficult than from government health care programs or other

third-party payers. We provide discounts to uninsured patients who do not qualify for Medicaid or for financial relief under our charity care policy. We may attempt to provide assistance to uninsured patients to help determine whether they may qualify for Medicaid, other federal or state assistance or charity care under our charity care policy. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Medicare

In addition to the reimbursement reductions and adjustments discussed below, the Budget Control Act of 2011 (the “BCA”) requires automatic spending reductions to reduce the federal deficit, including Medicare spending reductions of up to 2% per fiscal year, with a uniform percentage reduction across all Medicare programs. In 2013, the Centers for Medicare & Medicaid Services (“CMS”) began imposing a 2% reduction on Medicare payments. The Coronavirus Aid, Relief, and Economic Security (“CARES”) Act and related legislation temporarily suspended these reductions through March 31, 2022 and reduced the sequestration adjustment from 2% to 1% from April 1 through June 30, 2022. The full 2% reduction will resume on July 1, 2022. The BCA sequestration has been extended through 2030, with the reductions for 2030 set to increase to 2.25% for the first six months and to 3% for the second six months. In addition, the American Rescue Plan Act of 2021 (“ARPA”) increased the federal budget deficit in a manner that triggers an additional sequestration mandated under the Pay As You Go Act of 2010 (“PAYGO Act”). As a result, a further payment reduction of up to 4% was required to take effect in January 2022. However, Congress has delayed implementation of this payment reduction until 2023.

Inpatient Acute Care

Under the Medicare program, we receive reimbursement under a prospective payment system (“PPS”) for general, acute care hospital inpatient services. Under the hospital inpatient PPS, fixed payment amounts per inpatient discharge are established based on the patient’s assigned Medicare severity diagnosis-related group (“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. 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 2021, CMS increased the MS-DRG rate by approximately 2.9%. This increase reflected a market basket update of 2.4%, increased by a positive 0.5 percentage point adjustment in accordance with the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”). For federal fiscal year 2022, CMS increased the MS-DRG rate by approximately 2.5%. This increase reflects a market basket update of 2.7%, adjusted by a negative 0.7 percentage point productivity adjustment and a positive 0.5 percentage point adjustment required by MACRA. Additional adjustments may apply, depending on patient-specific or hospital-specific factors. For example, the two midnight rule limits payments to hospitals when services to Medicare

beneficiaries are payable as inpatient services. In addition, under the post-acute care transfer policy, Medicare reimbursement rates may be reduced when an inpatient hospital discharges a patient in a specified MS-DRG to certain post-acute care settings.

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

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

Under the Hospital Readmission Reduction Program (“HRRP”), payments to hospitals may also be reduced based on readmission rates. Each federal fiscal year, inpatient payments are reduced if a hospital experiences “excess” readmissions within the 30-day time period from the date of discharge for conditions designated by CMS. For federal fiscal year 2017 and subsequent years, CMS has designated six conditions or procedures, including heart attack, pneumonia and total hip arthroplasty. Hospitals with what CMS defines as excess readmissions for these conditions or procedures receive reduced payments for 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, under the Hospital Value-Based Purchasing (“HVBP”) Program, CMS reduces the inpatient PPS payment amount for all discharges by 2.0%. The total amount collected from these reductions is pooled, and the entire amount collected is redistributed as incentive 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. Hospitals that meet or exceed the quality performance standards receive greater reimbursement under the value-based purchasing program than they would have otherwise. Hospitals that do not achieve the necessary quality performance receive reduced Medicare inpatient hospital payments. Hospitals are scored on a number of individual measures that are categorized into four domains: clinical outcomes; efficiency and cost reduction; safety; and person and community engagement.

For the duration of the national public health emergency (“PHE”) declared as a result of the COVID-19 pandemic, which is ongoing, CMS has implemented a measure suppression policy across various hospital quality measurement and value-based purchasing programs. The policy is intended to ensure that these programs neither reward nor penalize hospitals based on circumstances caused by the PHE that the measures were not designed to accommodate. For example, CMS is modifying certain readmissions measures within the HRRP to exclude COVID-19 diagnosed patients. Under the HVBP Program in federal fiscal year 2022, as a result of the measure suppression policy, hospitals will receive a net neutral payment adjustment for each discharge that is equal to the 2% withheld under the program. In addition, facilities that experience extraordinary circumstances beyond their control that prevent satisfaction of program reporting requirements may request an exception from CMS.

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. 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. For calendar year 2021, CMS increased APC payment rates by an estimated 2.4%. This increase reflected a market basket increase of 2.4%. For calendar year 2022, CMS increased payment rates under the outpatient PPS by an estimated 2.0%. This increase reflects a market basket increase of 2.7% with a negative 0.7 percentage point productivity adjustment. 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.

Certain items and services furnished by off-campus provider-based departments, subject to certain exceptions, are not covered as outpatient department services under the outpatient PPS, but are reimbursed under the Medicare Physician Fee Schedule (“Physician Fee Schedule”), subject to adjustments as specified by CMS. In calendar year 2019, CMS began a two-year phase-in of an expanded site-neutral policy under which clinic visit services provided at all off-campus provider-based departments are reimbursed at the Physician Fee Schedule rate, which is generally lower than the PPS rate. Previously, this rate did not apply to “excepted” provider-based departments. In September 2019, a federal judge invalidated the expansion of the site-neutral payment policy for 2019. CMS appealed this decision and won, but had begun reprocessing the 2019 claims paid at the lower rates. As a result of its successful appeal, CMS has begun to reprocess the 2019 claims provided at excepted provider-based departments so that they are paid at the same rate as non-excepted provider-based departments for those services under the Physician Fee Schedule. For calendar year 2020, CMS issued a final rule implementing year two of the policy phase-in. For calendar year 2021 and beyond, CMS is continuing the expanded site-neutral payment policy.

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 are applied to non-340B-discounted drugs. In a final rule effective January 1, 2018, the U.S. Department of Health and Human Services (“HHS”) reduced the Medicare payments under the outpatient PPS for most drugs obtained at the 340B-discounted rates. This payment policy has been heavily litigated. In 2020, HHS prevailed at the circuit court level, with the court upholding its authority to implement this policy. However, in 2021, the group of hospitals challenging the policy appealed to the U.S. Supreme Court. Depending upon the decision and any prescribed remedy, this case could result in a decrease to the Company’s outpatient Medicare reimbursement. For calendar year 2022, HHS will continue to pay the reduced rates that took effect beginning in 2018.

Rehabilitation

CMS reimburses inpatient rehabilitation facilities (“IRFs”) on a PPS basis. Under the IRF PPS, patients are classified into case mix groups that reflect the relative resource intensity typically associated with the patient’s clinical condition. The case mix groups are based upon impairment, age, functional motor and cognitive scores, and comorbidities (additional diseases or disorders from which the patient suffers). IRFs are paid a predetermined amount per discharge that reflects the patient’s case mix group that is adjusted for facility-specific factors, such as area wage levels, proportion of low-income patients, and location in a rural area. Each federal fiscal year, the IRF rates are updated using a market basket index, which is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For federal fiscal year 2021, CMS increased IRF payment rates by an estimated 2.4%. For federal fiscal year 2022, CMS increased IRF payment rates by an estimated 1.9%, reflecting an IRF market basket update of 2.6% with a negative

0.7 percentage point productivity adjustment. In addition, CMS requires IRFs to report quality measures to avoid receiving a reduction of 2.0 percentage points to the market basket update. CMS has indicated that it is working toward a unified payment system for post-acute care services, including those provided by IRFs.

In order to qualify for classification as an IRF, at least 60% of a facility's inpatients during the most recent 12-month CMS-defined review period must have required intensive rehabilitation services for one or more of 13 specified conditions. IRFs must also meet additional coverage criteria, including patient selection and care requirements relating to pre-admission screenings, post-admission evaluations, ongoing coordination of care and involvement of rehabilitation physicians. A facility that fails to meet the 60% threshold, or other criteria to be classified as an IRF, will be paid under either the acute care hospital inpatient or outpatient PPS, which generally provide for lower payment amounts. As of December 31, 2021, we had two rehabilitation hospitals and 63 hospital rehabilitation units.

Psychiatric

Inpatient hospital services furnished in psychiatric hospitals and psychiatric units of general, acute care hospitals and critical access hospitals are reimbursed on a PPS basis. The inpatient psychiatric facility ("IPF") PPS is based upon a per diem payment, with adjustments to account for certain patient and facility characteristics. The IPF PPS contains an "outlier" policy for extraordinarily costly cases and an adjustment to a facility's base payment if it maintains a full-service emergency department. CMS has established the IPF PPS payment rate in a manner intended to be budget neutral. Each federal fiscal year, IPF payment rates are updated using a market basket index, which is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For federal fiscal year 2021, CMS increased IPF payment rates by an estimated 2.2%. For federal fiscal year 2022, CMS increased IPF payment rates by an estimated 2.0%, which reflects a 2.7% IPF market basket increase with a negative 0.7 percentage point productivity adjustment. Together with other policy changes, total payments to IPFs are anticipated to increase by 2.1% in federal fiscal year 2022. Inpatient psychiatric facilities are required to report quality measures to CMS to avoid receiving a 2.0 percentage point reduction to the market basket update. As of December 31, 2021, we had five psychiatric hospitals and 44 hospital psychiatric units.

Ambulatory Surgery Centers

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

Historically, CMS updated reimbursement rates for ASCs based on changes to the consumer price index. However, for calendar years through 2023, CMS updates to ASC reimbursement rates will be based on the hospital market basket index, partly to promote site-neutrality between hospitals and ASCs. For each federal fiscal year, the ASC payment system update is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For calendar year 2021, CMS increased ASC payment rates by 2.4%, which reflected a market basket increase of 2.4%. For calendar year 2022, CMS increased ASC payment rates by 2.0%, which reflects a market basket increase of 2.7% and a negative 0.7 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 market basket update.

Home Health

CMS reimburses home health agencies under the Home Health PPS. Home health agencies are paid a national, standardized 30-day period payment rate if a period of care meets a certain threshold of home health visits (periods of care that do not meet the visit threshold are paid a per-visit payment rate for the discipline providing care). The daily home health payment rate is adjusted for case-mix and area wage levels. An outlier adjustment may be paid for periods of care where costs exceed a specific threshold amount. Each calendar year, home health payment rates are updated using a market basket index, which is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For calendar year 2022, CMS increased home health payment rates by an estimated 3.2%, which reflects a 3.1% market basket increase reduced by a negative 0.5 percentage point productivity adjustment, among other changes. Home health agencies that do not submit required quality data are subject to a 2.0 percentage point reduction to the market basket update. In addition, beginning January 1, 2022, home health agencies are required to submit a one-time Notice of Admission (“NOA”) for each patient that establishes that the beneficiary is under a Medicare home health period of care. Failure to submit the NOA within 5 calendar days from the start of care will result in a reduction to the 30-day period payment amount for each day from the start of care date until the date the NOA is submitted.

Effective January 1, 2022, CMS began implementing a nationwide expansion of the Home Health Value-Based Purchasing (“HHVBP”) Model. Under the model, home health agencies will receive increases or reductions to their Medicare fee-for-service payments of up to 5%, based on performance against specific quality measures relative to the performance of other home health providers. Data collected in each performance year will impact Medicare payments two years later. Calendar year 2023 is the first performance year under the expanded HHVBP Model, which will affect payments in calendar year 2025.

Payment of claims for home health services may be impacted by the Review Choice Demonstration, a program intended to identify and prevent home health services fraud, reduce the number of Medicare appeals, and improve provider compliance with Medicare program requirements. The program applies only to home health agencies in certain states, including North Carolina, Florida and Texas. Providers in these states may initially select from the following claims review and approval processes: pre-claim review, post-payment review or a minimal post-payment review with a 25% payment reduction. Home health agencies that maintain high levels of compliance are eligible for additional, less burdensome options.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (“IMPACT Act”) requires HHS, in conjunction with the Medicare Payment Advisory Commission, to propose a unified post-acute care payment model by 2023. A unified post-acute care payment system would pay post-acute care providers, including home health agencies, under a single framework according to a patient’s characteristics, rather than based on the post-acute care setting where the patient receives treatment.

Hospice

Medicare beneficiaries who have a terminal illness and a life expectancy of six months or less may elect to receive hospice benefits (palliative care) instead of standard coverage of treatment for the terminal illness and related conditions. Hospice services are paid under the Hospice PPS, under which CMS sets a daily rate for each day a patient is enrolled in the hospice benefit. The daily rate depends on the level of care provided to a patient (routine home care, continuous home care, inpatient respite care, or general inpatient care). Daily rates are adjusted for factors such as area wage levels. Each federal fiscal year, hospice payment rates are updated using a market basket index, which is reduced by a productivity adjustment based on the BLS 10-year moving average of

changes in specified economy-wide productivity. For federal fiscal year 2022, CMS increased hospice payment rates by 2.0%, which reflects a 2.7% market basket update and a negative 0.7 percentage point productivity adjustment. Hospices that fail to satisfy quality reporting requirements receive a 2 percentage point reduction to the market basket update. Beginning in 2024, the payment reduction for failure to report quality data will increase to 4 percentage points.

Overall payments made by Medicare to each hospice are subject to an inpatient cap and an aggregate cap. The inpatient cap limits the number of days of inpatient care to no more than 20% of total patient care days. The aggregate cap limits the amount of Medicare reimbursement a hospice may receive, based on the number of Medicare patients served. The aggregate cap is updated annually. In federal fiscal year 2022, the aggregate cap is \$31,297.61. If a hospice's Medicare payments exceed its inpatient or aggregate caps, it must repay Medicare for the excess amount.

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 calendar year 2022, CMS reduced the conversion factor by approximately 3.71%. However, Congress approved a 3.0% payment increase for calendar year 2022, which will partially offset this reduction.

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 ("Advanced APM") track makes incentive payments available for participation in specific innovative payment models approved by CMS. Providers may earn a 5% Medicare incentive payment through 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. Alternatively, providers may participate in the MIPS track. Currently, providers electing this option may receive payment incentives or be subject to payment reductions based on their performance with respect to clinical quality, resource use, clinical improvement activities, and meeting Promoting Interoperability standards related to the meaningful use of EHRs. Performance data collected in 2022 will result in payment adjustments of up to 9% in 2024. CMS makes available an exception that permits clinicians to request reweighting of any or all performance categories if they encounter an extreme and uncontrollable circumstance or public health emergency, such as COVID-19, that is outside of their control. For performance year 2022, providers will generally be required to submit an application in order to request an exception.

Other

CMS uses fee schedules to pay for physical, occupational and speech therapies, durable medical equipment, clinical diagnostic laboratory services, nonimplantable orthotics and prosthetics and services provided by independent diagnostic testing facilities.

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 2022.

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

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

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

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

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

Managed Medicare

Under the Managed Medicare program (also known as Medicare Part C, or Medicare Advantage), the federal government contracts with private health insurers to provide members with Medicare Part A, Part B and Part D benefits. Managed Medicare plans can be structured as HMOs, PPOs or private fee-for-service plans. In

addition to covering Part A and Part B benefits, the health insurers may choose to offer supplemental benefits and impose higher premiums and plan costs on beneficiaries. CMS makes fee payment adjustments based on service benchmarks and quality ratings and publishes star ratings to assist beneficiaries with plan selection. According to CMS, over 40% 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. As a result of the COVID-19 pandemic, Medicaid enrollment has increased, and the federal government has made available enhanced federal Medicaid funding.

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 Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act") requires states to expand Medicaid coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level. However, states may opt out of the expansion without losing existing federal Medicaid funding. A number of states, including Texas and Florida, have opted out of the Medicaid expansion. For these states, the maximum income level required for individuals and families to qualify for Medicaid varies widely from state to state.

Because most states must operate with balanced budgets and because the Medicaid program is often a state's largest program, many states have adopted or may consider adopting various strategies to reduce their Medicaid expenditures. Outside of the government response to the COVID-19 pandemic, 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 or fund indigent care within the state. 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. Some states use, or have applied to use, waivers granted by CMS to implement Medicaid expansion, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. The prior presidential administration increased state flexibility in the administration of Medicaid programs, including by allowing states to condition enrollment on work or other community engagement. However, in January 2021, President Biden issued an executive order directing agencies to re-examine measures that reduce health insurance coverage or undermine Medicaid programs, including work requirements, and throughout 2021 CMS rescinded approvals of waivers involving certain eligibility and enrollment restrictions, including those allowing for work and community engagement requirements.

The Texas Healthcare Transformation and Quality Improvement Program ("Texas Waiver Program") is operated under a waiver granted by CMS under Section 1115 of the Social Security Act. The program provides funding for uncompensated care and supports several delivery system reform initiatives. However, there is currently uncertainty regarding the duration of the Texas Waiver Program. Although the previous presidential administration approved a 10-year extension of the program, through September 2030, CMS rescinded this extension in April 2021. Without the extension, the waiver would expire September 30, 2022. The Texas Attorney General filed a lawsuit challenging the rescission, and, in August 2021, a federal district judge granted a preliminary injunction temporarily reinstating the extension. While the lawsuit is pending, the Texas Health and Human Services Commission ("Texas HHSC") has re-submitted its application to extend the Texas Waiver Program. Additionally, the Texas HHSC's proposed directed payment program has not yet been renewed for the current program year that began September 1, 2021. Our supplemental Medicaid revenues from the directed payment program have been, and will continue to be, negatively impacted until the Texas HHSC and CMS finalize certain components of the program.

Federal funds under the Medicaid program may not be used to reimburse providers for treatment of 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. 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 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. In an effort to more closely tie funds to delivery and outcomes, CMS is limiting these “pass-through payments” to managed Medicaid plans and will generally prohibit such payments by 2027. However, CMS permits new pass-throughs of supplemental provider payments for up to a three-year period when states are transitioning Medicaid populations or services from a fee-for-service system to a managed care system.

Accountable Care Organizations and Bundled Payment Initiatives

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

The CMS Innovation Center 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 CMS Innovation Center has implemented bundled payment models, including the Bundled Payment Care Improvement Advanced (“BPCI Advanced”) program, which is voluntary and expected to run through December 2023. Participation in bundled payment programs is generally voluntary, but CMS currently requires providers in selected geographic areas to participate in a mandatory bundled program for specified orthopedic procedures and a model for end-stage renal disease treatment. In addition, CMS will require certain hospitals to participate in a radiation oncology model beginning as early as January 1, 2023.

In October 2021, CMS published an outline of the CMS Innovation Center’s strategy for the next decade, noting the need to accelerate the movement to value-based care and drive broader system transformation. By

2030, the CMS Innovation Center aims to have all fee-for-service Medicare beneficiaries and most Medicaid beneficiaries in a care relationship with accountability for quality and total cost of care. CMS also indicated it will streamline its payment model portfolio and consider how to ensure broad provider participation, including by implementing more mandatory models. Moreover, several private third-party payers are increasingly employing alternative payment models, which may increasingly shift financial risk to providers.

Disproportionate Share Hospital and Medicaid Supplemental Payments

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

Some states make additional payments to providers through the Medicaid program for certain specific claims. These supplemental payments may be in the form of Medicaid DSH payments, which help to offset hospital uncompensated care costs, or upper payment limit supplemental payments, which are intended to address the difference between Medicaid fee-for-service payments and Medicare reimbursement rates. CMS is considering changes to both types of payments. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. States have broad discretion to define which hospitals qualify for Medicaid DSH payments and the amount of such payments. The Affordable Care Act and subsequent legislation provide for reductions to the Medicaid DSH hospital program, but Congress has delayed the implementation of these reductions through 2023 (to begin in federal fiscal year 2024). Under current law, Medicaid DSH payments will be reduced by \$8 billion in each of federal fiscal years 2024 through 2027.

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 31%, 29% and 28% of our total admissions for the years ended December 31, 2021, 2020 and 2019, respectively. Managed care contracts are typically negotiated for terms between one and three years. While we generally received contracted annual average increases of approximately 4% from managed care payers during 2021, there can be no assurance that we will continue to receive increases in the future. Price transparency initiatives may impact our ability to obtain or maintain favorable contract terms. Effective January 1, 2022, the No Surprises Act (enacted as part of the Consolidated Appropriations Act, 2021 (“CAA”)) requires providers to send to a patient’s health plan a good faith estimate of the expected charges for furnishing scheduled items or services, including billing and diagnostic codes, prior to the scheduled date of the items or services. The estimate must cover any item or service that is reasonably expected to be provided in conjunction with the primary items or services, including those that may be delivered by another provider. However, HHS is deferring enforcement of certain requirements of the No Surprises Act related to the good faith estimates for scheduled items or services for insured patients. In addition, among other consumer protections, the No Surprises Act prohibits providers from charging patients an amount beyond the in-network cost sharing amount for emergency services rendered by out-of-network providers and non-emergency services rendered by out-of-network providers at certain in-network facilities, including hospitals. HHS has established a dispute resolution process for out-of-network providers and health plans to resolve payment disagreements when surprise billing protections apply. It is not clear what impact, if any, these or future 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. Effective January 1, 2022, the No Surprises Act requires providers to provide uninsured and self-pay patients a good faith estimate of the expected charges for furnishing scheduled items or services, including billing and diagnostic codes, prior to the scheduled date of the items or services. The estimate must cover any item or service that is reasonably expected to be provided in conjunction with the scheduled item or service or that is reasonably expected to be delivered by another provider. If the actual charges are substantially higher than the estimate, the patient can invoke a dispute resolution process to challenge the higher amount.

A high percentage of our uninsured patients are initially admitted through our emergency rooms. For the year ended December 31, 2021, approximately 85% of our admissions of uninsured patients occurred through our emergency rooms. The Emergency Medical Treatment and Labor Act (“EMTALA”) requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital’s emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the individual to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual’s ability to pay for treatment. In addition, health insurers are required to reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place.

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.

	<u>2021</u>	<u>2020</u>	<u>2019</u>
Number of hospitals at end of period	182	185	184
Number of freestanding outpatient surgery centers at end of period(a) . . .	125	121	123
Number of licensed beds at end of period(b)	48,803	49,265	49,035
Weighted average beds in service(c)	42,148	42,246	41,510
Admissions(d)	2,089,975	2,009,909	2,108,927
Equivalent admissions(e)	3,536,238	3,312,330	3,646,335
Average length of stay (days)(f)	5.2	5.1	4.9
Average daily census(g)	29,752	27,734	28,134
Occupancy rate(h)	71%	66%	68%
Emergency room visits(i)	8,475,345	7,450,307	9,161,129
Outpatient surgeries(j)	1,008,236	882,483	1,009,947
Inpatient surgeries(k)	522,069	522,385	566,635
Days revenues in accounts receivable(l)	49	45	50
Outpatient revenues as a % of patient revenues(m)	37%	35%	39%

- (a) Excludes freestanding endoscopy centers (21 at December 31, 2021 and 2020, and 20 at December 31, 2019).
- (b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.
- (c) Represents the average number of beds in service, weighted based on periods owned.
- (d) 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.
- (e) 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.
- (f) Represents the average number of days admitted patients stay in our hospitals.
- (g) Represents the average number of patients in our hospital beds each day.
- (h) Represents the percentage of hospital beds in service that are occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.
- (i) Represents the number of patients treated in our emergency rooms.
- (j) 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.
- (k) 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.
- (l) 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.
- (m) Represents the percentage of patient revenues related to patients who are not admitted to our hospitals.

Competition

Generally, other hospitals in the communities we serve provide services similar to those offered by our hospitals. Additionally, 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 continues to increase. As a result, most of our hospitals operate in a highly competitive environment. In some cases, competing facilities are more established than our hospitals. Some competing facilities are physician-owned or are owned by tax-supported government agencies and many others are owned by not-for-profit entities that may be supported by endowments, charitable contributions and/or tax revenues and are exempt from sales, property and income taxes. Such exemptions and support are not available to our hospitals and may provide the tax-supported or not-for-profit entities an advantage in funding capital expenditures. In certain localities there are large teaching hospitals that provide highly specialized facilities, equipment and services that may not be available at most of our hospitals. We also face competition from specialty hospitals and from both our own and unaffiliated freestanding ASCs for market share in certain high margin services. Psychiatric hospitals frequently attract patients from areas outside their immediate locale and, therefore, our psychiatric hospitals and units compete with both local and regional hospitals, including the psychiatric units of general, acute care hospitals.

Trends toward clinical and pricing transparency may impact our competitive position in ways that are difficult to predict. For example, hospitals are currently required to publish online a list of their standard charges for all items and services, including discounted cash prices and payer-specific and de-identified negotiated charges, in a publicly accessible online file. Hospitals are also required to publish a consumer-friendly list of standard charges for certain “shoppable” services (i.e., services that can be scheduled by a patient in advance) and associated ancillary services or, alternatively, maintain an online price estimator tool. CMS may impose civil monetary penalties for noncompliance with these price transparency requirements. Effective January 1, 2022, the No Surprises Act imposes additional price transparency requirements, including the requirement that providers send patients and health plans a good faith estimate of the expected charges and diagnostic codes prior to the scheduled date of the item or service. HHS is deferring enforcement of certain requirements of the No Surprises Act regarding providing good faith estimates for scheduled items or services for insured individuals.

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

Two of the most significant factors that impact 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, technology, equipment and employees. Accordingly, we strive to maintain and provide quality facilities, technology, equipment, employees and services for physicians and patients. Our hospitals face competition from competitors that are implementing physician alignment strategies, such as employing physicians, acquiring physician practice groups and participating in ACOs or other clinical integration models.

Another major factor in the competitive position of our hospitals is our ability to negotiate service contracts with group purchasers of health care services. Managed care plans attempt to direct and control the use of hospital services and obtain discounts from hospitals’ established gross charges. Similarly, employers and traditional health insurers continue to attempt to contain costs through negotiations with hospitals for managed care programs and discounts from established gross charges. Generally, hospitals compete for service contracts with group purchasers of health care services on the basis of price, market reputation, geographic location, quality and range of services, quality of the medical staff and convenience. Our future success will depend, in part, on our ability to retain and renew our contracts with third-party payers and enter into new contracts on favorable terms. Other health care providers may impact our ability to enter into contracts with third-party payers or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our

competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Price transparency initiatives and increasing vertical integration efforts involving third-party payers and health care providers, among other factors, may increase these challenges. Moreover, the trend toward consolidation among private third-party payers tends to increase payer bargaining power over fee structures. In addition, health reform efforts may lead to private third-party payers increasingly demanding reduced fees or being unwilling to negotiate reimbursement increases. Health plans increasingly utilize narrow networks that restrict the number of participating providers or tiered networks that impose significantly higher cost sharing obligations on patients that obtain services from providers in a disfavored tier. The importance of obtaining contracts with group purchasers of health care services varies from community to community, depending on the market strength of such organizations.

State certificate of need (“CON”) laws, which place limitations on a health care facility’s ability to expand services and facilities, make capital expenditures and otherwise make changes in operations, may also have the effect of restricting competition. We currently operate health care facilities in a number of states with CON laws or that require other types of approvals for the establishment or expansion of certain facility types or services. Before issuing a CON or other approval, these states consider the need for additional, changes in, or expanded health care facilities or services. Removal of these requirements could reduce barriers to entry and increase competition in our service areas. In those states that do not require state approval or that set relatively high levels of expenditures before they become reviewable by state authorities, competition in the form of new services, facilities and capital spending is more prevalent. Other federal and state laws and regulations may also adversely impact our ability to expand, such as a regulation commonly known as the “36 Month Rule,” which restricts the assumption of Medicare billing privileges for certain home health agencies. In addition, changes in licensure or other laws or regulations and recognition of new provider types or payment models could impact our competitive position. See Item 1, “Business — Regulation and Other Factors.”

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

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

Regulation and Other Factors

Licensure, Certification and Accreditation

Health care facility construction and operation are subject to numerous federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, fire prevention, rate-setting, building codes and environmental protection. Facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe our health care facilities are properly licensed under applicable state laws. Each of our acute care hospitals located in the United States is eligible to participate in Medicare and Medicaid programs and is accredited by The Joint Commission, with the exception of one hospital which is accredited by DNV. If any facility were to lose its Medicare or Medicaid certification, the facility would be unable to receive reimbursement from federal health care programs. From time to time, we may acquire a facility that is not accredited but for which we will seek accreditation. If any facility were to lose

accreditation, the facility would be subject to state surveys, potentially be subject to increased scrutiny by CMS and likely lose payment from private third-party payers.

The Controlled Substances Act and Drug Enforcement Administration (“DEA”) regulations require every person who dispenses controlled substances to be registered with the DEA at each principal place of business or professional practice where the person dispenses controlled substances, subject to limited exceptions. Each hospital or clinic must hold a DEA registration at each location and may be subject to similar state registration requirements. In addition, we are subject to a variety of federal and state statutes and regulations that govern operational issues related to pharmaceuticals and controlled substances, such as those related to packaging, storing, and dispensing of pharmaceutical drugs, inventory control and recordkeeping requirements for controlled substances, and other standards intended to prevent diversion of controlled substances. The DEA, the Department of Justice (“DOJ”), HHS, and state boards of pharmacy have broad enforcement powers, may conduct audits and investigations and can impose substantial fines and other penalties, including revocation of registration.

Management believes our facilities are in substantial compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change, and, in order to remain qualified, it may become necessary for us to make changes in our facilities, equipment, personnel and services. The requirements for licensure, certification and accreditation also include notification or approval in the event of the transfer or change of ownership or certain other changes. Failure to provide required notifications or obtain necessary approvals in these circumstances can result in the inability to complete an acquisition or change of ownership, loss of licensure, lapses in reimbursement or other penalties.

Certificates of Need

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

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.

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, knowledge of the law or the intent to violate the law is not required. Violations of the Anti-kickback Statute may be punished by criminal fines of up to \$100,000 per violation, imprisonment, substantial civil monetary penalties per violation that are subject to annual adjustment based on updates to the consumer price index and damages of up to three times the total amount of the remuneration and/or exclusion from participation in federal health care programs,

including Medicare and Medicaid. In addition, submission of a claim for services or items generated in violation of the Anti-kickback Statute may be subject to additional penalties under the federal False Claims Act (“FCA”) as a false or fraudulent claim.

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

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

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

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

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

Through a series of rulemakings, CMS has issued final regulations implementing the Stark Law. While these regulations were intended to clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. Further, we do not always have the benefit of significant regulatory or judicial interpretation of the Stark Law and its implementing

regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and are subject to continuing legal and regulatory change. We cannot assure that every relationship complies fully with the Stark Law.

Other Fraud and Abuse Provisions

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

In addition, the Eliminating Kickbacks in Recovery Act of 2018 ("EKRA") establishes criminal penalties for paying, receiving, soliciting or offering any remuneration in return for referring a patient to a laboratory, clinical treatment facility or recovery home, or in exchange for an individual using the services of one of these entities. The EKRA prohibitions apply to services covered by government health care programs and by private health plans. There is limited guidance with respect to the application of EKRA.

State Fraud and Abuse Laws

Many states in which we operate also have laws intended to prevent fraud and abuse within the health care industry. Some of these laws are similar to the Anti-kickback Statute, prohibiting payments to physicians for patient referrals, and to the Stark Law, prohibiting 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.

The Federal False Claims Act and Similar State Laws

We are subject to state and federal laws that govern the submission of claims for reimbursement and prohibit the making of false claims or statements. One of the most prominent of these laws is the FCA, which

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

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

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

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

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

Covered entities must report breaches of unsecured protected health information to affected individuals without unreasonable delay but not to exceed 60 days after discovery of the breach by a covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than

500 individuals. All non-permitted uses or disclosures of unsecured protected health information are presumed to be breaches unless the covered entity or business associate establishes that there is a low probability the information has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information.

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

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. Our facilities remain subject to federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties. For example, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions in response to data breaches. The California Consumer Privacy Act of 2018 (the “CCPA”), which was significantly amended by the California Privacy Rights Act (“CPRA”) effective January 1, 2022, affords consumers expanded privacy protections. Additionally, Virginia and Colorado passed comprehensive privacy legislation in 2021, and several privacy bills have been proposed both at the federal and state level that may result in additional legal requirements that impact our business. The potential effects of these laws are far-reaching and may require us to modify our data processing practices and policies and to incur substantial costs and expenses in order to comply. For example, residents in states with comprehensive privacy laws have expanded rights to access and require deletion and portability of their personal information, opt out of certain personal information sharing and receive detailed information about how their personal information is used. The CCPA and CPRA provide for civil penalties for violations, as well as a private right of action for data breaches.

Many foreign data privacy regulations (including the UK Data Protection Legislation) are more stringent than those in the United States. In the case of non-compliance with these regulations, regulators may impose administrative fines which are based on a multi-factored approach.

Health care providers and industry participants are also subject to a growing number of requirements intended to promote the interoperability and exchange of patient health information. For example, beginning April 5, 2021, health care providers and certain other entities are subject to information blocking restrictions pursuant to the 21st Century Cures Act that prohibit practices that are likely to interfere with the access, exchange or use of electronic health information, except as required by law or specified by HHS as a reasonable and necessary activity. Violations may result in penalties or other disincentives.

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. In recent years, the government has undertaken enforcement actions in which it has broadly interpreted a hospital's obligations with respect to screening and stabilizing patients who present with a psychiatric emergency. 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 practices or industry practices.

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

Both federal and state government agencies have increased their focus on and coordination of civil and criminal enforcement efforts in the health care area. Through the national Health Care Fraud and Abuse Control

Program, the OIG and the DOJ coordinate federal, state and local law enforcement activities with respect to health care fraud against both public and private health plans. The OIG and DOJ have, from time to time, established national enforcement initiatives that target all hospital providers, focusing on specific billing practices or other suspected areas of abuse. 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 and innovations. In recent years, Congress and certain state legislatures have passed a large number of laws and regulations intended to effect major change within the U.S. health care system, including the Affordable Care Act. The Affordable Care Act affects how health care services are covered, delivered and reimbursed through expanded health insurance coverage, reduced growth in Medicare program spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs that tie reimbursement to quality and integration. The Affordable Care Act increased health insurance coverage through a combination of private sector health insurance requirements, public program expansion and other reforms. For example, 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. However, a number of states, including Texas and Florida, have opted out of the Medicaid expansion provisions, which they may do without losing federal funding.

The Affordable Care Act has been subject to legislative and regulatory changes and court challenges. For example, effective January 1, 2019, the penalty associated with the individual mandate to maintain health insurance was eliminated. This change resulted in legal challenges to the constitutionality of the individual mandate and the validity of the Affordable Care Act as a whole. However, in June 2021, the U.S. Supreme Court determined that the plaintiffs lacked standing, allowing the law to remain in place.

The current presidential administration has indicated that it generally intends to protect and strengthen the Affordable Care Act and Medicaid programs. For example, in January 2021, President Biden issued an executive order that instructed certain governmental agencies to review and reconsider their existing policies and rules that limit access to health insurance coverage. In a final rule published in September 2021, HHS extended the annual open enrollment period for coverage through federal marketplaces and granted state exchanges flexibility to lengthen their open enrollment periods.

The Affordable Care Act has had a net positive effect on the Company to date, before considering the impact of Medicare reductions that began in 2010, and it is expected that the law, as presently implemented, will continue to have a positive contribution to the Company's results of operations. However, there is uncertainty regarding the ongoing net effect of the Affordable Care Act due to the potential for continued changes to the law's implementation and its interpretation by government agencies and courts, among other factors. There is also uncertainty regarding the potential impact of other reform efforts at the federal and state levels. For example,

some members of Congress have proposed measures that would expand government-sponsored coverage, including proposals to expand coverage of federally-funded insurance programs as an alternative to private insurance or establish a single-payer system (such reforms often referred to as “Medicare for All”). Some states have implemented or are considering measures such as individual health insurance mandates and public health insurance options. Other initiatives and proposals, including those aimed at price transparency and out-of-network charges, may impact prices and the relationships between health care providers, insurers and patients. For example, the No Surprises Act requires providers to send an insured patient’s health plan a good faith estimate of expected charges, including billing and diagnostic codes, prior to when the patient is scheduled to receive the item or service. HHS is deferring enforcement of this requirement until it issues additional regulations. These issues are further discussed in Item 1A, “Risk Factors.”

General Economic and Demographic Factors

The health care industry is impacted by changes in or uncertainty regarding the overall U.S. economy. The COVID-19 pandemic has adversely impacted, and may in the future adversely impact, economic conditions in the United States. In addition, budget deficits at federal, state and local government entities have had a negative impact on spending for many health and human service programs, including Medicare, Medicaid and similar programs, which represent significant payer sources for our hospitals and other providers. We anticipate that the federal deficit, the growing magnitude of Medicare and Medicaid expenditures and the aging of the U.S. population will continue to place pressure on government health care programs. Other risks we face during periods of economic weakness and high unemployment include potential declines in the population covered under managed care agreements, increased patient decisions to postpone or cancel elective and nonemergency health care procedures (including delaying surgical procedures), potential increases in the uninsured and underinsured populations, increased adoption of health plan structures that shift financial responsibility to patients and increased difficulties in collecting patient receivables for copayment and deductible amounts.

Compliance Program

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

Antitrust Laws

The federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, market allocation, bid-rigging, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties. Antitrust enforcement in the health care industry is currently a priority of the Federal Trade Commission and the DOJ, including with respect to hospital and physician practice acquisitions. 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 and growth strategy.

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 as presently in effect. Regulations limiting greenhouse gas

emissions and energy inputs may increase in coming years, which may increase our costs associated with compliance, disrupt and adversely affect our operations and could materially adversely affect our financial performance.

Our environmental strategy is designed to complement our mission of the care and improvement of human life, which extends to the environment. This strategy is centered on incorporating the following four pillars into our operations:

- Managing energy and water responsibly,
- Enhancing our climate resilience,
- Sourcing and consuming efficiently, and
- Greening our capital programs.

We are baselining our scope 1 and scope 2 greenhouse gas emissions and have engaged specialists to assist in identifying best practices and developing plans to reduce emissions while maximizing operational efficiencies. These efforts are led by task forces that examine operations in four key areas: construction and major renovation, energy and water, waste stream and environmentally preferable purchasing.

While we currently believe that compliance with existing environmental laws and regulations does not have a material impact on our operations, changes in consumer preferences and additional legislation or regulatory requirements, including those associated with the transition to a low-carbon economy, may increase costs associated with compliance, the operation of our facilities and supplies.

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 insurance subsidiary for losses up to \$75 million per occurrence. The insurance subsidiary has obtained reinsurance for professional liability risks generally above a retention level of either \$25 million or \$35 million per occurrence, depending on the jurisdiction for the related claim. 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 and subject to terms of coverage we believe to be reasonable.

Human Capital Resources

Our workforce is comprised of approximately 284,000 employees (as of December 31, 2021), including approximately 80,000 part-time employees (references herein to “employees” refer to employees of our affiliates). Our Board of Directors and its committees oversee human capital matters through regular reporting from management and advisors.

Diversity, Equity and Inclusion

We are committed to fostering a culture of inclusion that embraces and supports our patients, colleagues, partners, physicians and communities. Our workforce is comprised of approximately 78% women and 42% people of color. Our policies prohibit discrimination on the basis of age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law.

We are dedicated to being an employer of choice. We seek to recruit diverse candidates at all stages of their careers and through a variety of venues and programs. In the beginning of 2020, we launched a data-driven diversity, equity and inclusion (“DEI”) strategy based on internal and external research to support the advancement of people of color and women into leadership roles. We also partner with national organizations which promote diversity in leadership positions. Our Chief Diversity Officer leads a team that is responsible for advancing DEI and cultural competence initiatives across the Company. We have also established an Executive Diversity Council, sponsored by our Chief Executive Officer and comprised of executive leaders from the Company, to champion DEI across the Company and inform strategic decisions towards DEI goals and objectives. In addition to the Executive Diversity Council, we recently implemented fifteen Division Diversity, Equity and Inclusion Councils, comprised of diversity leaders and facility representatives, to support deployment of key DEI strategies and programs across the enterprise.

The Company’s Corporate Governance Guidelines reinforce its commitment to diversity by requiring the initial pool of candidates from which the Nominating and Corporate Governance Committee may recommend director nominees to include qualified female and racially/ethnically diverse candidates and the Nominating and Corporate Governance Committee to request that any third-party search firm that it engages to identify such candidates to include qualified female and racially/ethnically diverse candidates in such initial pool.

We encourage you to review the “Diversity, Equity and Inclusion” section of our website, as well as the “Part of the Solution” section of our 2021 Impact Report (available at www.hcahealthcareimpact.com) for more detailed information regarding our DEI and pay equity programs and initiatives. Nothing on our website, including our 2021 Impact Report or sections thereof, shall be deemed incorporated by reference into this annual report on Form 10-K.

Compensation and Benefits

To recruit and retain a highly qualified and diverse workforce, we design competitive compensation and benefits programs to support, recognize and reward the performance of our employees. In addition to salaries, these programs (which vary by location) include an Employee Stock Purchase Plan, a 401(k) Plan, health care and insurance benefits, health savings and flexible spending accounts, paid time off, family leave, family care resources, flexible work schedules, employee assistance programs, tuition and student loan assistance and on-site services, such as cafeterias and fitness centers, among many others.

Serving the Community

We provide our colleagues with opportunities to learn, serve, lead and give in their communities. By joining forces with other leading organizations, we maximize our ability to provide care for patients and populations. Through research, partnerships, policies and investments, we are tackling problems in our communities, from disaster relief to environmental sustainability. We also support the HCA Healthcare Foundation, whose mission is to promote health and well-being and strive to make a positive impact in all the communities HCA Healthcare serves by providing leadership, service and financial support to effective non-profit organizations.

Culture and Talent Development

HCA Healthcare’s culture is critical to our success. We seek to instill a culture across our system that includes making a positive impact on our patients, communities and each other. We seek to nurture a collaborative culture built on inclusion, compassion and respect. To assess and improve employee retention and engagement, we conduct colleague pulse surveys throughout the year and take action to address areas of concern. During 2021, we directed our efforts to improve our colleagues’ sense of belonging and leveraged the findings from our innovative pandemic survey to better respond to the needs of our communities and colleagues. We also seek to support our colleagues throughout their career journey, providing education, training, and opportunities to grow as clinicians and leaders. We also support our colleagues’ development through programs such as tuition

reimbursement, clinical training and certification, loan forgiveness and award-winning programs offered through the HCA Healthcare Leadership Institute.

Health, Safety and Wellness

We provide our employees and their families with access to a variety of health and wellness programs. In response to the COVID-19 pandemic, we implemented changes to address the interests of our patients, employees, medical staff members and contractors, as well as the communities in which we operate, such as providing PPE, COVID-19 screening for patients and certain hospital staff, and scrub laundering. During 2021:

- Over 33,000 quarantined caregivers unable to work received 100% of base pay through our Quarantine Pay Program;
- Approximately 25,000 calls were placed to the HCA Nurse Care line, a free, confidential 24-hour phone counseling support program for nurses; and
- \$10.7 million in assistance was provided by the HCA Healthcare Hope Fund to HCA Healthcare colleagues, including more than \$1 million provided to colleagues to help with the loss of household income, childcare costs or other unexpected financial challenges related to the COVID-19 pandemic.

Labor Matters

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, 2021, certain employees at 37 of our domestic hospitals are represented by various labor unions. During 2021, a decertification election was held that resulted in the elimination of a bargaining unit at a facility in Missouri. While no other elections are scheduled in 2022, it is possible that employees at additional hospitals may unionize in the future, or employees currently represented by labor unions may choose to reject that representation. We consider our employee relations to be good and have not experienced work stoppages that have materially, adversely affected our business or results of operations. However, it is possible that a material work stoppage at one or more of our hospitals may occur in the future.

Physicians are an integral part of the success of our hospitals in delivering quality care to our patients. 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.

Our facilities, like most health care facilities, have experienced rising labor costs and turnover. In some markets, nurse and medical support personnel availability and retention have become significant operating issues to health care providers, which issues have been exacerbated by the effects that the COVID-19 pandemic has had on health care personnel. Nurse and medical support shortages could result in a number of adverse impacts to our business, including capacity and growth constraints, reduced patient satisfaction, reduced physician satisfaction, impact on services offered, and increased costs, among others. To address this challenge, we have implemented several initiatives to improve retention, recruiting, compensation programs and productivity.

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 continue to increase. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. If there is additional union organizing activity or a significant portion of our employee base unionizes, our costs could increase. In addition, we operate in several states that have adopted mandatory nurse-staffing ratios. If these states reduce mandatory nurse-staffing ratios or additional states in which we operate adopt mandatory nurse-staffing ratios, such changes 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.

The inability to attract and retain quality clinical and non-clinical personnel could impair our capacity, ability to grow and our results of operations.

Information about our Executive Officers

As of February 1, 2022, our executive officers were as follows:

<u>Name</u>	<u>Age</u>	<u>Position(s)</u>
Samuel N. Hazen	61	Chief Executive Officer and Director
Jennifer L. Berres	51	Senior Vice President and Chief Human Resources Officer
Phillip G. Billington	54	Senior Vice President — Internal Audit Services
Jeff E. Cohen	50	Senior Vice President — Government Relations
Michael S. Cuffe, M.D.	56	Executive Vice President and Chief Clinical Officer
Jon M. Foster	60	President — American Group
Charles J. Hall	68	President — National Group
Michael R. McAlevey	58	Senior Vice President and Chief Legal Officer
A. Bruce Moore, Jr.	61	President — Service Line and Operations Integration
Sammie S. Mosier	47	Senior Vice President and Chief Nurse Executive
P. Martin Paslick	62	Senior Vice President and Chief Information Officer
Deborah M. Reiner	60	Senior Vice President — Marketing and Communications
William B. Rutherford	58	Executive Vice President and Chief Financial Officer
Joseph A. Sowell, III	65	Senior Vice President and Chief Development Officer
Kathryn A. Torres	58	Senior Vice President — Payer Contracting and Alignment
Kathleen M. Whalen	58	Senior Vice President and Chief Ethics and Compliance Officer
Christopher F. Wyatt	44	Senior Vice President and Controller

Samuel N. Hazen has served as Chief Executive Officer since January 2019 and was appointed as a director in September 2018. From November 2016 through December 2018, Mr. Hazen served as the Company’s President and Chief Operating Officer. Prior to that, he served as Chief Operating Officer of the Company from January 2015 to November 2016 and as President — Operations of the Company from 2011 to 2015. He also served as President — Western Group from 2001 to 2011 and as Chief Financial Officer — Western Group of the Company from 1995 to 2001. Prior to that time, Mr. Hazen served in various hospital, regional and division Chief Financial Officer positions with the Company, Humana Inc. and Galen Health Care, Inc.

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

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

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

Michael S. Cuffe, M.D. was appointed Executive Vice President and Chief Clinical Officer effective January 1, 2022. He previously served as President — Physician Services Group from October 2011 through December 2021. 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.

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

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

Michael R. McAlevey was appointed Senior Vice President and Chief Legal Officer in January 2022. Prior to joining HCA, Mr. McAlevey served in senior legal and executive roles at General Electric, most recently as Vice President, General Counsel and Business Development Leader for GE Healthcare since 2018. Prior to that, he served as General Counsel and Business Development Leader for GE Aviation from 2011 to 2018 and Chief Corporate, Securities and Finance Counsel for GE from 2003 to 2011. Before joining GE, Mr. McAlevey served as Deputy Director of the United States Securities and Exchange Commission's Division of Corporation Finance from 1998 to 2002.

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.

Sammie S. Mosier was appointed Senior Vice President and Chief Nurse Executive effective December 1, 2021. Dr. Mosier joined HCA in 1992 as a medical-surgical bedside nurse at Frankfort Regional Medical Center and has held progressive leadership roles, including as Vice President and Assistant Chief Nursing Executive-Clinical Services Group from 2019 to 2021.

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

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

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

Joseph A. Sowell, III was appointed as Senior Vice President and Chief Development Officer in December 2009. From 1987 to 1996 and again from 1999 to 2009, Mr. Sowell was a partner at the law firm of Waller Lansden Dortch & Davis where he specialized in the areas of health care law, mergers and acquisitions, joint ventures, private equity financing, tax law and general corporate law. He also co-managed the firm's corporate and commercial transactions practice. From 1996 to 1999, Mr. Sowell served as the head of development, and later as the Chief Operating Officer of Arcon Healthcare.

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

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

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

Item 1A. Risk Factors

If any of the events discussed in the following risk factors were to occur, our business, financial position, results of operations, cash flows or prospects could be materially, adversely affected. Additional risks and uncertainties not presently known to us or that we currently deem immaterial may also affect us. The COVID-19 pandemic amplifies and exacerbates many of the risks we face in our business operations, including those discussed below. Our business is subject to the following material risks and uncertainties.

Risks related to the COVID-19 pandemic and other potential pandemics:

The COVID-19 pandemic is significantly affecting our operations and could affect our business and financial condition. Our liquidity could also be negatively impacted by the COVID-19 pandemic, particularly if the U.S. economy remains unstable for a significant amount of time.

HHS first declared a PHE due to the COVID-19 pandemic in January 2020 and has since then continuously renewed this declaration. On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic. The COVID-19 pandemic continues to significantly affect our employees, patients, hospitals, communities and business operations, as well as the U.S. economy and financial markets. Although certain economic conditions improved throughout 2021, the pandemic continues to evolve. For example, the spread of differing variants of COVID-19 led to the reintroduction of certain public health controls during the second half of 2021. The full extent to which the COVID-19 pandemic will impact our business, results of operations, financial condition and liquidity will depend on future developments that are uncertain and cannot be accurately predicted. We are unable to predict the severity or duration of the pandemic, including whether there will be additional periods of increases in the number of COVID-19 cases in areas in which we operate, the availability, utilization and effectiveness of medical treatments and vaccines (including booster shots), the efficacy of public health controls, or the impact of any mutations of the virus. Florida and Texas, our two largest markets, have been and may in the future be “hot spots” of the COVID-19 pandemic. We are particularly sensitive to the increase in COVID-19 cases in Texas and Florida, where the pandemic could have a disproportionate effect on our business.

We have been working with federal, state and local health authorities to respond to COVID-19 cases in the markets we serve and continue to take and support measures to try to limit the spread of the virus and to mitigate the burden on the health care system. For example, we are subject to COVID-19 data reporting requirements, and some states are requiring hospitals to maintain a reserve of PPE and mandating COVID-19 screening for new patients and certain hospital staff. CMS has made COVID-19 data reporting requirements a Medicare condition of participation for hospitals, such that noncompliance with these requirements could result in termination from the Medicare program. We have incurred and will continue to incur additional costs related to protecting the health and well-being and meeting the needs of our patients, employees, medical staff members and contractors, including pandemic pay programs, hoteling our staff and additional scrub laundering. We expect to continue to incur additional costs, which may be significant, as we continue to implement operational changes in response to this pandemic. Further, our management is focused on mitigating the impact of the COVID-19 pandemic, which has required and will continue to require a substantial investment of time and resources across our enterprise, and which may affect management focus and impact our ability to properly prioritize and successfully execute on the Company’s other strategic initiatives.

As a front line provider of health care services, we have been and will continue to be impacted by the health and economic effects of COVID-19. Although we have implemented considerable safety measures, treatment of COVID-19 patients has associated risks to our employees, patients and physicians. These risks, and how clinical staff perceive and respond to them, may adversely affect our operating capacity. Despite considerable efforts to source vital supplies, we have experienced and may continue to experience supply chain disruptions, including delays and price increases in equipment, pharmaceuticals and medical supplies, and supply shortages. Our current PPE inventory is satisfactory, but we cannot be certain that our supplies will remain sufficient in the future. In addition, restrictive measures taken by governmental authorities to address the COVID-19 pandemic have impacted, and may continue to impact, the availability of employed and contract labor staffing for corporate support services, including, but not limited to, coding, billing, collection and other business office functions, which could adversely affect our execution of established control procedures that may not be sufficiently mitigated through execution of our business continuity plans. Continued staffing, equipment, laboratory resources and pharmaceutical and medical supplies shortages may impact our ability to schedule, admit and treat patients. In addition, the impact of labor shortages across the health care industry may result in other health care facilities, such as nursing homes, limiting admissions, which may constrain our ability to discharge patients to

such facilities and further exacerbate the demand on our resources, supplies and staffing. The COVID-19 pandemic has also resulted in an increased number of early retirements in our workforce. The combined impact of these factors, despite our efforts to mitigate their effect, could result in reduced employee morale and increased exposure to labor unrest, work stoppages or other workforce disruptions, which effects may last beyond the duration of the pandemic.

Actions taken by governmental authorities in response to the COVID-19 pandemic, including restrictions on elective procedures, and other restrictive measures, have reduced, and may in the future reduce, the volume of procedures performed at our facilities, as well as the volume of emergency room and physician office visits unrelated to COVID-19. We may be required to cancel elective procedures and close or reduce operating hours at our facilities in the future. Some state and local governments have issued orders or imposed rules affecting hospital capacity in order to prepare for and manage surges in COVID-19 patients. Although social contact restrictions have eased across the U.S. and most states have lifted moratoriums on non-emergent procedures, some restrictions remain in place. Further closings and restrictions on hours and services may be imposed or re-imposed for an unpredictable amount of time in connection with increasing or fluctuating COVID-19 cases. We have also selectively suspended elective procedures at certain facilities based upon local COVID-19 volume trends, bed capacity and staffing levels. It is unclear whether certain markets, such as Florida and Texas, will continue to experience periods of increases or spikes in the number of COVID-19 cases. Beginning in 2020 and continuing through 2021, we experienced increased patient acuity as a result of COVID-19 cases at our hospitals, which led to increased reimbursements. However, the impacts of COVID-19, including patient acuity levels, in future periods may vary, and could exert unpredictable and potentially negative effects on clinical performance metrics that impact reimbursement levels and could adversely affect our results of operations.

Even as government or industry-adopted restrictions are lifted, some individuals may choose to postpone medical care (including long-term care) for an undetermined period of time. While patient volumes began rebounding in the second quarter of 2021 as the effects of the pandemic moderated and pandemic-related restrictions and policies were eased, we experienced a resurgence in COVID-19 cases in the latter half of 2021, further impacting the return to pre-pandemic levels. As such, we cannot provide assurances as to the continued recovery and stability of pre-pandemic patient volumes or the ultimate impact on demand. Further, our patient volumes may be adversely impacted by the expanded use of telehealth services from other providers as a result of reduced regulatory barriers on the use and reimbursement of telehealth services and individuals becoming more comfortable with receiving remote care. The Company may not be able to timely innovate its strategies and technologies to meet changing consumer demands as a result of the COVID-19 pandemic. It is possible that the COVID-19 pandemic could impact patient behavior beyond the duration of the pandemic.

Broad economic factors resulting from the current COVID-19 pandemic, including inflationary pressures, supply chain disruptions, labor shortages, increased unemployment and underemployment rates and reduced consumer spending and confidence, also affect our service mix, revenue mix, payer mix and patient volumes, as well as our ability to collect outstanding receivables. Business closings and layoffs in the areas where we operate may lead to increases in the uninsured and underinsured populations and adversely affect demand for our services, as well as the ability of patients and other payers to pay for services rendered. Any increase in the amount or deterioration in the collectability of patient accounts receivable will adversely affect our cash flows and results of operations, requiring an increased level of working capital. In addition, our results and financial condition may be adversely affected by federal, state or local laws, regulations, orders, or other governmental or regulatory actions addressing the current COVID-19 pandemic or otherwise affecting the U.S. health care system in connection with the pandemic, which could result in direct or indirect restrictions to our business, financial condition, results of operations and cash flow. We may also be subject to claims from patients, employees and others exposed to COVID-19 at our facilities. Such actions may involve large demands, as well as substantial defense costs, though there is no certainty at this time whether any such claims will be filed or the outcome of such claims if filed. Our professional and general liability insurance, a portion of which is provided through our insurance subsidiary, may not cover all claims against us.

If general economic conditions, including inflation, deteriorate or remain volatile or uncertain for an extended period of time, our liquidity and ability to repay our outstanding debt may be harmed and the trading price of our common stock could decline. These factors may affect the availability, terms or timing on which we may obtain any additional funding and our ability to access our cash. There can be no assurance that we will be able to raise additional funds on terms acceptable to us, if at all.

The foregoing and other continued disruptions to our business as a result of the COVID-19 pandemic could heighten the risks in certain of the other risk factors described in this annual report on Form 10-K, any of which could have a material, adverse effect on our results of operations and financial position.

We are unable to predict the ultimate impact of the CARES Act and other existing or future stimulus and relief legislation, if any, or the effect that such legislation and other governmental responses intended to assist providers in responding to COVID-19 may have on our business, financial condition, results of operations or cash flows. There can be no assurance as to the total amount of financial assistance or types of assistance we will receive, that we will be able to comply with the applicable terms and conditions to retain such assistance, or that we will be able to benefit from provisions intended to increase access to resources and ease regulatory burdens for health care providers.

In response to the COVID-19 pandemic, federal and state governments have passed legislation, promulgated regulations and taken other administrative actions intended to assist health care providers in providing care to COVID-19 and other patients and to provide financial relief to health care providers. Together, the CARES Act, the Paycheck Protection Program and Health Care Enhancement (“PPPHCE”) Act, the CAA, and the ARPA authorize over \$186 billion in funding to be distributed to hospitals and other health care providers through the Public Health and Social Services Emergency Fund (“PHSSEF”), also known as the Provider Relief Fund. These funds are intended to reimburse eligible providers and suppliers for health care-related expenses or lost revenues attributable to the COVID-19 pandemic. HHS made some general distributions of provider relief funding to Medicare providers impacted by COVID-19, and also made targeted distributions to specific provider types and industry segments, including providers in areas particularly impacted by COVID-19, rural providers, providers of services with lower shares of Medicare reimbursement or who predominantly serve the Medicaid population and providers requesting reimbursement for treatment of uninsured Americans, among others. A portion of the available funding is being distributed to reimburse health care providers that submit claims requests for COVID-19-related treatment, testing, and vaccine administration for uninsured patients at Medicare rates. Recipients of these claims reimbursements must attest to and comply with certain terms and conditions, including confirming that patients are uninsured, limitations on balance billings and not using funds to reimburse expenses or losses that other sources are obligated to reimburse.

The CARES Act and related legislation also make other forms of financial assistance available to health care providers. For example, CMS has increased payment under the hospital inpatient PPS by 20% for discharges of individuals diagnosed with COVID-19 and provides an add-on payment for eligible inpatient cases that use certain new products to treat COVID-19. The CARES Act also expanded the Medicare Accelerated and Advance Payment Program, which makes available advance payments of Medicare funds in order to increase cash flow to providers.

During 2020, we received approximately \$4.4 billion of accelerated Medicare payments and approximately \$1.8 billion in general and targeted distributions from the Provider Relief Fund. During October 2020, we announced our decision to return, or repay early, all of our share of the Provider Relief Fund general and targeted distributions and all of the Medicare accelerated payments. During the fourth quarter of 2020, we returned, or repaid early, approximately \$6.1 billion of these funds.

The CARES Act and related legislation suspended the Medicare sequestration payment adjustment from May 1, 2020, through December 31, 2021, which would have otherwise reduced payments to Medicare providers by 2% as required by the BCA, but extended sequestration through 2030. Congress further delayed these sequestration cuts through March 31, 2022, and reduced the sequestration adjustment to 1% from April 1 through

June 30, 2022, but increased the reductions set for 2030. The APRA, in addition to providing funding for health care providers, increases the federal budget deficit in a manner that triggers an additional statutorily mandated sequestration under the PAYGO Act. As a result, an additional Medicare payment reduction of up to 4% was required to take effect in January 2022. However, Congress has delayed implementation of this payment reduction until 2023.

Beyond financial assistance, federal and state governments have enacted legislation, established regulations and issued waivers intended to expand access to and payment for telehealth services, increase access to medical supplies and equipment, prioritize review of drug applications to help with shortages of emergency drugs, and ease various legal and regulatory burdens on health care providers. HHS and CMS have announced other flexibilities for health care providers in response to COVID-19, such as relief from data submission requirements and measure suppression policies for providers participating in certain quality reporting programs. It is unclear how changes to these and other value-based programs will affect our financial condition.

There is still a high degree of uncertainty surrounding the ongoing impact of the CARES Act and related legislation passed and other efforts taken in response to the COVID-19 pandemic, and the pandemic continues to evolve. Some of the measures allowing for flexibility in delivery of care and various financial supports for health care providers are available only until funds expire or for the duration of the PHE, and it is unclear whether or for how long the PHE declaration will be extended. The current PHE determination expires April 16, 2022. The HHS Secretary may choose to renew the PHE declaration for successive 90-day periods for as long as the emergency continues to exist and may terminate the declaration whenever he determines that the PHE no longer exists. The federal government may consider additional stimulus and relief efforts, but we are unable to predict whether additional measures will be enacted or their impact. There can be no assurance as to the total amount of financial and other types of assistance we will receive under the CARES Act, PPPHCE Act, the CAA or future legislation, if any, or whether we shall retain, return or repay any future assistance, and it is difficult to predict the impact of such legislation on our operations. Further, there can be no assurance that the terms and conditions of provider relief funding or other relief programs will not change or be interpreted in ways that affect our ability to comply with such terms and conditions in the future (which could affect our ability or willingness to retain assistance), the amount of total stimulus funding we may receive or our eligibility to participate in such stimulus funding. For time periods prior to returning Provider Relief Funds, with respect to future assistance, if any, we do not return, and in those cases where our partners retain such assistance, we will continue to monitor our compliance with the terms and conditions of the Provider Relief Fund, including demonstrating that the distributions received have been used for health care-related expenses or lost revenue attributable to COVID-19. If we are unable to attest to or comply with current or future terms and conditions with respect to any assistance not voluntarily returned for our less-than-wholly owned partnerships, our ability to retain some or all of the distributions received may be impacted. We will continue to assess the potential impact of COVID-19 and government responses to the pandemic on our business, results of operations, financial condition and cash flows.

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

If a pandemic, epidemic, outbreak of an infectious disease or other public health crisis were to occur in an area in which we operate, our operations could be adversely affected. Such a crisis could diminish the public trust in health care facilities, especially hospitals that fail to accurately or timely diagnose, or are treating (or have treated) patients affected by infectious diseases. If any of our facilities were involved, or perceived as being involved, in treating patients from such an infectious disease, patients might cancel elective procedures or fail to seek needed care at our facilities, and our reputation may be negatively affected. Patient volumes may decline or volumes of uninsured and underinsured patients may increase, depending on the economic circumstances surrounding the pandemic, epidemic or outbreak. Further, a pandemic, epidemic or outbreak might adversely affect our operations by causing a temporary shutdown or diversion of patients, disrupting or delaying production and delivery of materials and products in the supply chain or 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, as well as the public's and the government's response to the pandemic, epidemic or outbreak, is difficult to predict and could adversely affect our operations.

Risks related to our indebtedness:

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, 2021, our total indebtedness was \$34.579 billion. As of December 31, 2021, we had availability of \$1.920 billion under our senior secured cash flow credit facility and \$1.720 billion under our senior secured 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, some of which may be exacerbated by the impact of the COVID-19 pandemic, 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, including the impact of the COVID-19 pandemic, and to certain financial, business and other factors beyond our control. We cannot assure you we will maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness.

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

We may find it necessary or prudent to refinance our outstanding indebtedness, the terms of which may not be favorable to us. Our ability to refinance our indebtedness on favorable terms, or at all, is directly affected by the then current global economic and financial conditions which affect the availability of debt financing and the

rates at which such financing is available. In addition, our ability to incur secured indebtedness (which would generally enable us to achieve better pricing than the incurrence of unsecured indebtedness) depends in part on the value of our assets, which depends, in turn, on the strength of our cash flows and results of operations, and on economic and market conditions and other factors.

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

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

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

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

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

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

also pledged as collateral under our first lien notes. If any of the lenders under the senior secured credit facilities accelerate the repayment of borrowings, there can be no assurance there will be sufficient assets to repay the senior secured credit facilities, the first lien notes and our other indebtedness.

Discontinuation, reform or replacement of LIBOR may adversely affect our borrowing costs.

As of December 31, 2021, we had \$4.740 billion of borrowings under our senior secured credit facilities that bore interest at a floating rate based on LIBOR and \$3.640 billion of unfunded commitments under those facilities. The U.K. Financial Conduct Authority announced in 2017 that it intends to phase out LIBOR by the end of 2021 and will not compel panel banks to continue to contribute to LIBOR after the end of 2021. However, the ICE Benchmark Administration, in its capacity as administrator of LIBOR, has published a consultation regarding its intention to continue publication of certain LIBOR tenors and subsequently confirmed it expects to cease publication of all remaining LIBOR tenors in June 2023. However, the Federal Reserve Board, the Office of the Comptroller of the Currency, and the Federal Deposit Insurance Corporation have encouraged banks to cease entering into new contracts that use U.S. dollar LIBOR as a reference rate no later than December 31, 2021. The Federal Reserve Board, together with the Alternative Reference Rates Committee, has chosen the Secured Overnight Financing Rate (“SOFR”) as the recommended risk-free reference rate. At this time, it is not possible to predict the effect any discontinuance, modification or other reforms to LIBOR, or the establishment of alternative reference rates such as SOFR, or any other reference rate, will have on us or our borrowing costs.

As of December 31, 2021, we also had a \$500 million interest rate swap agreement based on LIBOR that is scheduled to expire on December 30, 2022. If LIBOR becomes unavailable, it is unclear how payments under this agreement would be calculated. The International Swaps and Derivatives Association has published a standard protocol addressing the expected discontinuation of LIBOR, but there can be no assurance that such a protocol will be implemented with respect to our swap agreements.

Risks related to human capital:

Our operations may be adversely affected by competition for staffing, the shortage of experienced nurses and other health care professionals, vaccine mandates and labor union activity.

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 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, including at certain of our facilities. The COVID-19 pandemic has exacerbated workforce competition and shortages, and may continue to exacerbate workforce competition and shortages beyond the duration of the pandemic. 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 continue to increase and/or our capacity could be negatively impacted. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. If there is continued competition for these employees or additional union organizing activity or a significant portion of our employee base unionizes, it is possible our labor costs could increase. 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, federal and state laws and regulations may increase our costs of maintaining qualified nurses and other medical support personnel. We operate in several states that have adopted mandatory nurse-staffing ratios. If these states reduce mandatory nurse-staffing ratios or additional states in which we operate adopt mandatory nurse-staffing ratios, such changes 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 continue to increase, we may not be able to offset these increased costs as a significant percentage of our revenues consists of fixed, prospective payments.

Additionally, on November 5, 2021, CMS and the U.S. Occupational Safety and Health Administration (“OSHA”) published regulations and standards setting forth vaccination requirements for certain U.S. employees. CMS issued a health and safety regulation (“CMS Mandate”) requiring certain covered facilities (including hospitals, ambulatory surgery centers, home health agencies, hospices, providers of outpatient physical therapy and long-term care facilities, in each case, that are Medicare and Medicaid-certified providers) to ensure all staff who work in the covered facility and who provide care, treatment or other services for the facility and/or its patients are fully vaccinated against COVID-19. The CMS Mandate does not provide a testing option for covered staff. OSHA issued an Emergency Temporary Standard (“ETS”) mandating that employers with 100 or more employees design, implement, and enforce a mandatory COVID-19 vaccination policy or adopt a policy requiring employees to either receive a COVID-19 vaccination or undergo regular COVID-19 testing and wear a face covering at work. Both the OSHA ETS and the CMS Mandate were the subject of multiple legal challenges and injunction proceedings regarding whether the agencies exceeded their authority in implementing these regulations and standards, with the U.S. Supreme Court ultimately determining whether the ETS and/or CMS Mandate should be stayed pending resolution. On January 13, 2022, the U.S. Supreme Court lifted two injunctions previously staying the CMS Mandate in 24 states. The impact of the Supreme Court’s decision renders the CMS Mandate applicable on a nationwide basis pending further litigation on CMS’s authority. While CMS has extended the compliance deadlines for some states to mid-March 2022, the application of the CMS Mandate could adversely impact the availability of staff to provide services at covered facilities the Company owns, manages or operates. On January 13, 2022, the Supreme Court issued a nationwide injunction staying the implementation of the ETS pending further decision by the U.S. Court of Appeals for the Sixth Circuit regarding whether OSHA’s ETS exceeds Congressional authority. In response, on January 25, 2022, OSHA announced its withdrawal of the ETS. Additional vaccine and testing mandates may also be announced by state-run OSHA programs or state and local officials in jurisdictions in which we operate our business and which could adversely impact the availability of staff to provide services at covered facilities the Company owns, manages or operates. The unavailability of such staff, or the inability of the Company to control labor costs, could have a material, adverse effect on our capacity, growth prospects and 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. Our management is focused on mitigating the impact of the COVID-19 pandemic, which has required and will continue to require a substantial investment of time and resources across our enterprise. Failure to attract, hire, develop, motivate, and retain highly qualified and diverse employee talent, or failure to develop and implement an adequate succession plan for the management team, could disrupt our operations and adversely affect our business and our future success.

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

The success of our hospitals depends in part on the number and quality of the physicians on the medical staffs of our hospitals, the admitting and utilization practices of those physicians, maintaining good relations with those physicians and controlling costs related to the employment of physicians. Although we employ some physicians, physicians are often not employees of the hospitals at which they practice, and, in many of the markets we serve, most physicians have admitting privileges at other hospitals in addition to our hospitals. We continue to face increasing competition to recruit and retain quality physicians. Such physicians may terminate

their affiliation with our hospitals at any time. We anticipate facing 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 recruit and retain quality physicians to affiliate with our hospitals, our admissions may decrease, our operating performance may decline, and our capacity and growth prospects may be materially adversely affected. 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.

Risks related to technology, data privacy and cybersecurity:

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

We, directly and through our vendors and other third parties, collect and store on our networks and devices and third-party technology platforms 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 and to protect our systems, software, equipment, devices, and data from cybersecurity risks. In addition, medical devices manufactured by third parties that are used within our facilities are increasingly connected to the internet, hospital networks and other medical devices. The secure maintenance of this information and technology is critical to our business operations. We have implemented multiple layers of security measures to protect the confidentiality, integrity and availability of this data and the systems and devices that store and transmit such data. We embed security measures into software and system development processes, utilize current security technologies, and our defenses are monitored and routinely tested internally and by external parties. We vet the security and integrity of third-party technology platforms hosting infrastructure, applications, and data supporting our operations, and set contractual terms holding them to our security standards.

Despite these efforts, threats from malicious persons and groups, new vulnerabilities and advanced new attacks against information systems and devices against us or our vendors and other third parties create risk of cybersecurity incidents, including ransomware, malware and phishing incidents. We have seen, and believe we will continue to see, widely spread vulnerabilities, such as the Apache Log4j 2 vulnerability reported in December 2021, which could affect our or other parties' systems. Mitigation and remediation recommendations continue to evolve, and addressing this and other critical vulnerabilities is a priority for us. The volume and intensity of cyberattacks on hospitals and health systems continues to increase. We are regularly the target of attempted cybersecurity and other threats that could have a security impact, including those by third parties to access, misappropriate or manipulate our information or disrupt our operations, and we expect to continue to experience an increase in cybersecurity threats in the future. Moreover, hardware, software or applications we use may have inherent vulnerabilities or defects of design, manufacture or operations or could be inadvertently or intentionally implemented or used in a manner that could compromise information security. There can be no assurance that we or our vendors and other third parties will not be subject to cybersecurity threats and incidents that bypass our or their security measures, impact the integrity, availability or privacy of personal health information or other data subject to privacy laws or disrupt our or their information systems, devices or business, including our ability to provide various health care services. Further, consumer confidence in the integrity and security of personal information and critical operations data in the health care industry generally could be shaken to the extent there are successful cyberattacks at other health care services companies, which could have a material, adverse effect on our business, financial position or results of operations.

As a result, cybersecurity, privacy, 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. Our Audit and Compliance Committee includes the topic of cybersecurity risk and information security as one of its standing agenda items, and is frequently updated on management's ongoing actions to monitor, identify, assess and mitigate significant cybersecurity matters. Committee meetings regularly include a report from our Chief Security Officer to provide an update on (i) activities within our internal cybersecurity defense center to monitor and respond to both internal and third-party cyber events, (ii) ongoing threats that are being monitored and (iii) the current threat level assessment for the Company. As cyber threats continue to evolve, along with their increased volume and sophistication, 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. Although to date no cyberattack or other information or security breach, whether experienced by us or a third party, has resulted in material losses or other material consequences to us, there can be no assurance that our controls and procedures in place to monitor and mitigate the risks of cyber threats, including the remediation of critical information security and software vulnerabilities, will be sufficient and/or timely and that we will not suffer material losses or consequences in the future. Additionally, while we have in place insurance coverage designed to address certain aspects of cyber risks, such insurance coverage may be insufficient to cover all losses or all types of claims that may arise. 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.

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 such as inadvertent misuse by employees and cyberattacks, including ransomware and data theft, and natural disasters. Moreover, we rely on various third-party technology platforms, which are increasingly important to our business and continue to grow in complexity and scope. Failure to adequately manage implementations of new technology, updates or enhancements of such platforms or interfaces between platforms could place us at a competitive disadvantage, disrupt our operations, and have a material, adverse impact on our business and results of operations.

We have taken precautionary measures to prevent unanticipated problems that could affect our information systems. Nevertheless, we or our vendors and other third parties that we rely upon may experience system

failures and disruptions. 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.

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

The federal government is working to promote the adoption of health information technology and the promotion of nationwide health information exchange to improve health care. For example, HHS incentivizes the adoption and meaningful use of certified EHR technology through its Promoting Interoperability Programs. Eligible hospitals and eligible professionals, including our hospitals and employed professionals, are subject to reduced payments from Medicare if they fail to demonstrate meaningful use of certified EHR technology. As these technologies have become widespread, the focus has shifted to increasing patient access to health care data and interoperability. The 21st Century Cures Act prohibits information blocking by health care providers and certain other entities, which is defined as engaging in activities likely to interfere with the access, exchange or use of electronic health information, except as required by law or specified by HHS as a reasonable and necessary activity. Current and future initiatives related to health care technology and interoperability may require changes to our operations, impose new and complex compliance obligations and require investments in infrastructure. We may be subject to financial penalties or other disincentives or experience reputational damage for failure to comply. It is difficult to predict how these initiatives will affect our relationships with providers and vendors, participation in health care information exchanges or networks, the exchange of patient data, and patient engagement.

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

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

Risks related to governmental regulation and other legal matters:

Our results of operations may be adversely affected by health care reform efforts, including efforts to significantly change the Affordable Care Act. We are unable to predict what, if any, and when additional health reform measures will be adopted or implemented, and the effects and ultimate impact of any such measures are uncertain.

In recent years, Congress and certain state legislatures have passed a large number of laws and regulations intended to effect major change within the U.S. health care system, including the Affordable Care Act. The Affordable Care Act affects how health care services are covered, delivered and reimbursed through expanded health insurance coverage, reduced growth in Medicare program spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs that tie reimbursement to quality and integration. However, the Affordable Care Act has been subject to legislative and regulatory changes and court challenges. For example, effective January 1, 2019, the penalty associated with the individual mandate to maintain health insurance was eliminated. This change resulted in legal challenges to the constitutionality of the individual mandate and the validity of the Affordable Care Act as a whole. However, in June 2021, the U.S. Supreme Court determined that the plaintiffs lacked standing, allowing the law to remain in place.

There is uncertainty regarding whether, when and how the Affordable Care Act may be further changed, 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. However, President Biden has indicated that his administration generally intends to protect and strengthen the Affordable Care Act and Medicaid programs.

There is also uncertainty regarding whether, when, and what other health reform initiatives will be adopted and the impact of such efforts on providers and other health care industry participants. Some members of Congress have proposed measures that would expand government-sponsored coverage, including proposals to expand coverage of federally-funded insurance programs as an alternative to private insurance or establish a single-payer system (such reforms often referred to as “Medicare for All”), and some states are considering or have implemented public health insurance options. CMS administrators may grant states additional flexibility in the administration of state Medicaid programs and make changes to Medicaid payment models. Other health reform initiatives and proposals, such as price transparency requirements and the requirements of the No Surprises Act, may impact prices, our relationships with patients, payers or ancillary providers (such as anesthesiologists, radiologists, and pathologists), and our competitive position. Other industry participants, such as private payers and large employer groups and their affiliates, may also introduce financial or delivery system reforms. We are unable to predict the nature and success of such initiatives. Health care reform initiatives, including changes to the Affordable Care Act, may have an adverse effect on our business, results of operations, cash flow, capital resources, and liquidity.

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

A significant portion of our patient volume is derived from government health care programs, principally Medicare and Medicaid. Specifically, we derived 41.3% of our revenues from the Medicare and Medicaid programs in 2021. Changes in government health care programs, including Medicaid waiver programs, may reduce the reimbursement we receive and could adversely affect our business and results of operations. The Affordable Care Act made significant changes to Medicare and Medicaid, and future health reform efforts or further efforts to significantly change the Affordable Care Act may impact these programs.

In recent years, legislative and regulatory changes have resulted in limitations on and, in some cases, reductions in levels of payments to health care providers for certain services under the Medicare program. Congress has established automatic spending reductions that extend through 2030. 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. While this reduction has been suspended by the CARES Act and related legislation, it is scheduled to be reinstated April 1, 2022, when it will resume as a 1% reduction. The full 2% reduction will begin July 1, 2022, and the reductions set for 2030 were increased to up to 3%. As a result of the ARPA, an additional Medicare payment reduction of up to 4% was required to take effect in January 2022; however, Congress has delayed implementation of this reduction until 2023. We are unable to predict what other deficit reduction initiatives may be proposed by Congress. These reductions are in addition to reductions mandated by the Affordable Care Act and other laws. Further, from time to time, CMS revises the reimbursement systems used to reimburse health care providers, including changes to the inpatient hospital MS-DRG system and other payment systems, which may result in reduced Medicare payments. Further, under a site neutrality policy, clinic visit services provided by off-campus provider-based departments that were formerly paid under the outpatient PPS are now paid under the Physician Fee Schedule. The IMPACT Act requires HHS, in conjunction with the Medicare Payment Advisory Commission, to propose a unified post-acute care payment model by 2023. A unified post-acute care payment system would pay post-acute care providers, including home health agencies, under a single framework according to a patient’s characteristics, rather than based on the post-acute care setting where the patient receives treatment. CMS has issued final rules reducing Medicare payment rates under the outpatient PPS for drugs obtained under the 340B Drug Pricing Program, although this payment policy has been heavily litigated and is currently before the U.S. Supreme Court. In September 2021, HHS released a Comprehensive Plan for Addressing High Drug Prices, a report outlining principles for drug pricing reform. The report set forth a variety of potential legislative policies that Congress could pursue and summarized actions underway or under consideration by HHS to advance these principles. CMS may implement further 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 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, and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. Periods of economic weakness may increase the budgetary pressures on many states, and these budgetary pressures may result in decreased spending, or decreased spending growth, for Medicaid programs and the Children's Health Insurance Program in many states. Some states that provide Medicaid supplemental payments are reviewing these programs or have filed waiver requests with CMS to replace these programs, and CMS has performed and continues to perform compliance reviews of some states' programs and is considering changes to the requirements for such programs, which could result in Medicaid supplemental payments being reduced or eliminated. Further, legislation and administrative actions at the federal level may significantly alter the funding for, or structure of, the Medicaid program. For example, from time to time, Congress considers proposals to restructure the Medicaid program to involve block grants that would be administered by the states. The prior presidential administration increased state flexibility in the administration of Medicaid programs, including by allowing states to condition enrollment on work or other community engagement or to use a block grant funding structure. However, the current presidential administration issued an executive order directing agencies to re-examine measures that reduce health insurance coverage or undermine Medicaid programs, and the administration has rescinded approvals of waivers involving certain eligibility and enrollment restrictions, including those allowing for work and community engagement requirements.

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.

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;
- the confidentiality, maintenance, interoperability, exchange, data breach, identity theft and security of 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;
- the distribution, maintenance and dispensing of pharmaceuticals and controlled substances;
- debt collection, limits or prohibitions 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, EKRA, 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, laboratories 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 are subject to continuing legal and regulatory change. Thus, we cannot provide assurance that every relationship complies fully with the Stark Law. Unlike the Anti-kickback Statute, failure to meet an exception under the Stark Law results in a violation of the Stark Law, even if such violation is technical in nature.

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

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

A variety of state, national, foreign and international laws and regulations apply to the collection, use, retention, protection, security, disclosure, transfer and other processing of personal data. For example, the CCPA, which affords consumers expanded privacy protections such as the right to know what personal information is collected and how it is used, went into effect on January 1, 2020, and was recently significantly amended by the CPRA. California residents also have the right to request that a business delete their personal information unless it is necessary for the business to maintain for certain purposes, to direct a business to correct errors in their personal information, and to restrict the use and disclosure of sensitive information. They have the right to know if their personal information is being sold or shared and the right to opt out of the sale or disclosure. Beginning in 2023, under the CPRA’s amendments, as well as comprehensive privacy legislation passed in Virginia and

Colorado, residents of those states will have additional rights with respect to their personal information, such as a right to opt out of certain processing activities for sensitive data and a right to a portable copy of their personal information. The CPRA creates a new regulator responsible for enforcement of the CPRA, and enforcement priorities of this new regulatory body have yet to be determined. The CCPA and CPRA also provide for civil penalties for violations, as well as a private right of action for data breaches that may increase data breach litigation. Failure to comply with these and any other comprehensive privacy laws passed at the state or federal level may result in regulatory enforcement action and damage to our reputation. The potential effects of such legislation are far-reaching and may require us to modify our data processing practices and policies and to incur substantial costs and expenses to comply. With Brexit, our United Kingdom operations are no longer subject to the European Union's General Data Protection Regulation ("GDPR") but are subject to the UK Data Protection Legislation, which has been amended in connection with Brexit to be functionally similar to the GDPR and which contains stricter privacy restrictions than laws and regulations in the United States and provides for significant fines in the event of violations. These administrative fines are based on a multi-factored approach. Moreover, rules for data transfers outside of the United Kingdom and European Economic Area have changed significantly with Brexit and a recent Court of European Justice decision, and are subject to further revision and updated regulator guidance, making necessary compliance measures challenging to ascertain and implement with respect to our United Kingdom operations. We expect that there will continue to be new laws, regulations, regulatory guidance, and industry standards concerning privacy, data protection and information security proposed and enacted in various jurisdictions, which could impact our operations and cause us to incur substantial costs.

We send short message service, or SMS, text messages to patients. While we obtain consent from these individuals to send text messages, federal or state regulatory authorities or private litigants may claim that the notices and disclosures we provide, form of consents we obtain, or our SMS texting practices are not adequate or violate applicable law. In addition, we must ensure that our SMS texting practices comply with regulations and agency guidance under the Telephone Consumer Protection Act (the "TCPA"), a federal statute that protects consumers from unwanted telephone calls, faxes and text messages. While we strive to adhere to strict policies and procedures that comply with the TCPA, the Federal Communications Commission, as the agency that implements and enforces the TCPA, may disagree with our interpretation of the TCPA and subject us to penalties and other consequences for noncompliance. Determination by a court or regulatory agency that our SMS texting practices violate the TCPA could subject us to civil penalties and could require us to change some portions of our business. Even an unsuccessful challenge by patients or regulatory authorities of our activities could result in adverse publicity and could require a costly response from and defense by us. Moreover, if wireless carriers or their trade associations, which issue guidelines for texting programs, determine that we have violated their guidelines, our ability to engage in texting programs may be curtailed or revoked, which could impact our operations and cause us to incur costs related to implementing a workaround solution.

We engage in consumer debt collection for HCA-affiliated hospitals and certain non-affiliated hospitals. We also engage in credit reporting for certain non-affiliated hospitals. The federal Fair Debt Collection Practices Act, the Fair Credit Reporting Act and the TCPA restrict the methods that companies may use to contact and seek payment from consumer debtors regarding past due accounts and to report to consumer reporting agencies on the status of those accounts. Many states impose additional requirements on debt collection and credit reporting practices, and some of those requirements may be more stringent than the federal requirements.

Finally, we are subject to various federal, state and local statutes and ordinances regulating the discharge of materials into the environment. For example, our health care operations generate medical waste, such as pharmaceuticals, biological materials and disposable medical instruments, that must be handled, stored, transported, treated and disposed of in compliance with federal, state and local environmental laws and regulations. Environmental regulations also may apply when we build new facilities or renovate existing facilities. If we are found not to be in compliance with such laws and regulations, we may be liable for significant investigation and clean-up costs or be subject to enforcement actions by governmental authorities or lawsuits by

private plaintiffs. Moreover, any changes in the environmental regulatory framework (including legislative or regulatory efforts designed to address climate change) could have a material, adverse effect on our business.

If we fail to comply with these or other applicable laws and regulations, which are subject to change, we could be subject to liabilities, including civil penalties, money damages, lapses in reimbursement, the loss of our licenses to operate one or more facilities, exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs, civil lawsuits and criminal penalties. In addition, different interpretations or enforcement of, or amendments to, these and other laws and regulations in the future 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. The costs of compliance with, and the other burdens imposed by, these and other laws or regulatory actions may increase our operational costs, result in interruptions or delays in the availability of systems and/or result in a patient volume decline. We may also face audits or investigations by one or more domestic or foreign government agencies relating to our compliance with these regulations. An adverse outcome under any such investigation or audit, a determination that we have violated these or other laws or a public announcement that we are being investigated for possible violations could result in liability, result in adverse publicity, and adversely affect our business, financial condition, results of operations or prospects.

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

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

We may incur additional tax liabilities.

We are subject to tax in the United States as well as those states and foreign jurisdictions in which we do business. Changes in tax laws, including increases in tax rates, or interpretations of tax laws by taxing authorities or other standard setting bodies could increase our tax obligations and have a material, adverse impact on our results of operations.

We are also 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 Internal Revenue Service (“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 have been and could become the subject of government investigations, claims and litigation.

Health care companies are subject to numerous investigations by various government agencies. Further, under the FCA, private parties have the right to bring *qui tam*, or “whistleblower,” suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions. Certain of our individual facilities and/or

affiliates have received, and other facilities and/or affiliates may receive, government inquiries from, and may be subject to investigation by, federal and state agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material, adverse effect on our financial position, results of operations and liquidity.

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

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

We may be subject to liabilities from claims brought against our facilities, which are costly to defend and may require us to pay significant damages if not covered by insurance.

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 our insurance subsidiary. Management believes our reserves for self-insured retentions and insurance coverage are sufficient to cover insured claims arising out of the operation of our facilities, although some claims may exceed the scope or amount of the coverage limits of our insurance policies. Our 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.

Risks related to operations, strategy, demand and competition:

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

The health care business is highly competitive, and competition among hospitals and other health care providers for patients has intensified in recent years. Generally, other hospitals in the communities we serve provide services similar to those offered by our hospitals. CMS publicizes on its Care Compare website performance data related to quality measures and data on patient satisfaction surveys that hospitals submit in connection with their Medicare reimbursement. The Care Compare website provides an overall rating that synthesizes various quality measures into a single star rating for each hospital. Federal law provides for the future expansion of the number of quality measures that must be reported. If any of our hospitals achieve poor results (or results that are lower than our competitors) on quality measures or on patient satisfaction surveys, our competitive position could be negatively affected. Further, hospitals are currently required by law to publish online a list of their standard charges for all items and services, including discounted cash prices and payer-specific and de-identified negotiated charges. The No Surprises Act imposes additional price transparency requirements beginning January 1, 2022, including requiring providers to send health plans of insured patients and uninsured patients a good faith estimate of the expected charges and diagnostic codes prior to the scheduled date of the service or item. HHS is deferring enforcement of certain requirements of the No Surprises Act

applicable to providing estimates for insured individuals. It is not entirely clear how price transparency requirements will affect consumer behavior, our relationships with payers, or our ability to set and negotiate prices, but our competitive position could be negatively affected if our standard charges are higher or are perceived to be higher than the charges of our competitors.

The number of freestanding specialty hospitals, surgery centers, emergency departments, urgent care centers and diagnostic and imaging centers in the geographic areas in which we operate has increased. Many individuals are seeking a broader range of services at outpatient facilities as a result of the growing availability of stand-alone outpatient health care facilities, the increase in payer reimbursement policies that restrict inpatient coverage and the increase in the services that can be provided on an outpatient basis, including high margin services. Consequently, most of our hospitals operate in a highly competitive environment, which may put pressure on our pricing, ability to contract with third-party payers and 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. Some states that have historically imposed CON or similar prior approval requirements have removed or are considering removing these requirements, which may reduce barriers to entry and increase competition in our service areas. Changes in licensure or other regulations and recognition of new provider types or payment models could also impact our competitive position. If our competitors are better able to attract patients, make capital expenditures and maintain modern and technologically upgraded facilities and equipment, recruit physicians, expand services or obtain favorable third-party payer contracts at their facilities than our hospitals and other providers, we may experience an overall decline in patient volume. See Item 1, "Business — Competition."

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

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

The estimates for implicit price concessions are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal and state governmental and private employer health care coverage, the rate of growth in uninsured patient admissions and other collection indicators. At December 31, 2021, estimated implicit price concessions of \$6.784 billion had been recorded to

adjust our revenues and accounts receivable to the estimated amounts we expect to collect. The estimated cost of total uncompensated care was \$3.350 billion for 2021, \$3.483 billion for 2020 and \$3.733 billion for 2019.

Any increase in the amount or deterioration in the collectability of uninsured accounts receivable will adversely affect our cash flows and results of operations. Our facilities may experience growth in total uncompensated care as a result of a number of factors, including conditions impacting the overall economy and unemployment levels, both of which have been, and may in the future be, negatively impacted by the COVID-19 pandemic. Effective January 2019, Congress eliminated the financial penalty associated with the Affordable Care Act's individual mandate. Further, final rules issued in 2018 expand the availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the Affordable Care Act. These changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased. We are unable to predict what, if any, and when such changes will be made in the future.

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

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.

Broad economic factors resulting from the COVID-19 pandemic, including inflationary pressures, supply chain disruptions, labor shortages, increased unemployment and underemployment rates and reduced consumer spending and confidence, the continued shift to an outpatient setting and the aging population may impact our revenue mix. Private third-party payers, including HMOs, PPOs and other managed care plans, typically reimburse health care providers at a higher rate than Medicare, Medicaid or other government health care programs. Reimbursement rates are set forth by contract when our facilities are in-network, and payers utilize plan structures to encourage or require the use of in-network providers. Revenues derived from private third-party payers (domestic only) accounted for 51.6%, 51.5% and 51.6% of our revenues for 2021, 2020 and 2019, 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, impose significantly higher cost sharing obligations when care is obtained from providers in a disfavored tier or otherwise shift greater financial responsibility for care to individuals.

Other health care providers may impact our ability to enter into managed care contracts or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care plans to contract with us. In addition to increasing negotiating leverage of private third-party payers, alignment efforts between third-party payers and health care providers may result in other competitive advantages, such as greater access to performance and pricing data. Our future success will depend, in part, on our ability to retain and renew our third-party payer contracts and enter into new contracts on terms favorable to us, which may be impacted by price transparency initiatives. Cost-reduction strategies by large employer groups 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 further changes to the Affordable Care Act will have on our ability to negotiate reimbursement increases and participate in third-party payer networks on favorable terms. If we are unable to retain and negotiate favorable contracts with third-party payers or experience reductions in payment increases or amounts received from third-party payers, our revenues may be reduced.

In addition, our revenues may be reduced if we experience growth in self-pay volume. In recent years, federal and state legislatures have considered or passed various proposals potentially impacting the size of the uninsured population. The number and identity of states that choose to expand or otherwise modify Medicaid programs and the terms of expansion and other program modifications continue to evolve. These variables, among others, make it difficult to predict the number of uninsured individuals and what percentage of our total revenue will be comprised of self-pay revenues.

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

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

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, such as COVID-19, and medical conditions, seasonal and severe weather conditions, changes in treatment regimens and medical technology and other advances. Further, our inpatient volumes may decline if various inpatient hospital procedures become eligible for reimbursement by Medicare when performed in outpatient settings. 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.

We may encounter difficulty acquiring hospitals and other health care businesses and 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. Antitrust enforcement in the health care industry is currently a priority of the Federal Trade Commission and the DOJ, including with respect to hospital and physician practice acquisitions. Some states require CONs in order to acquire a hospital or

other facility, or to expand facilities or services. In addition, the acquisition of health care facilities often involves licensure approvals or reviews and complex change of ownership processes for Medicare and other payers. Further, many states have laws that restrict the conversion or sale of not-for-profit hospitals to for-profit entities. These laws may require prior approval from the state attorney general, advance notification of the attorney general or other regulators and community involvement. Attorneys general in states without specific requirements may exercise broad discretionary authority over transactions involving the sale of not-for-profits under their general obligations to protect the use of charitable assets. These legislative and administrative efforts often focus on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the non-profit seller and may include consideration of commitments for capital improvements and charity care by the purchaser. Also, the increasingly challenging regulatory and enforcement 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, public health, environmental and competitive conditions and changes in those states.

We operated 182 hospitals at December 31, 2021, and 91 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities' combined revenues represented 49% of our consolidated revenues for the year ended December 31, 2021. This geographic concentration makes us particularly sensitive to regulatory, economic, public health, environmental and competitive conditions in those states. Any material change in the current payment programs or regulatory, economic, public health, 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. Global climate change could also increase the intensity or frequency of hurricanes in those regions. 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.

Our business and operations are subject to risks related to climate change.

Global climate change presents both immediate and long-term physical risks (such as extreme weather conditions) and risks associated with the transition to a low-carbon economy (such as regulatory or technology changes). These changes could result in, for example, temporary declines in the number of patients seeking our services, closures of our hospitals and related facilities, and supply chain disruptions, as well as increased costs of products, commodities and energy (including utilities), and disruptions in our information systems, which in turn could negatively impact our business and results of operations. In addition, certain of our operations and facilities are located in regions that may be disproportionately impacted by the physical risks of climate change (including hurricanes and flooding), and we face the risk of losses incurred as a result of physical damage to our

hospitals and related facilities and business interruptions caused by such events. We maintain property insurance coverage to address the impact of physical damage to our facilities and for business interruption losses. However, such insurance coverage may be insufficient to cover all losses and we may experience a material, adverse effect on our results of operations that is not recoverable through our insurance policies. Additionally, if we experience a significant increase in climate-related events that result in material losses we may be unable to obtain similar levels of property insurance coverage in the future. In addition, changes in consumer preferences and additional legislation and regulatory requirements, including those associated with the transition to a low-carbon economy, may increase costs associated with compliance, the operation of our facilities and supplies. Regulations limiting greenhouse gas emissions and energy inputs may also increase in coming years, which may adversely impact us through increased compliance costs for us and our suppliers and vendors.

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”), and federal law 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 the following year.

Hospitals with excess readmission rates for conditions designated by CMS 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.

CMS 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. CMS pools the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by CMS. CMS scores each hospital 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. In response to the COVID-19 pandemic, CMS is applying a measure suppression policy to certain hospital quality measurement and value-based purchasing programs. The policy is intended to ensure that these programs neither reward nor penalize hospitals based on circumstances caused by the PHE that the measures were not designed to accommodate.

CMS has developed several alternative payment models that are intended to reduce costs and improve quality of care for Medicare beneficiaries and has signaled its intent to have states apply similar strategies in the Medicaid context. Examples of alternative payment models include bundled payment models in which, depending on whether overall CMS spending per episode exceeds or falls below a target specified by CMS and whether quality standards are met, hospitals may receive supplemental Medicare payments or owe repayments to CMS. Generally, participation in bundled payment programs is voluntary, but CMS currently requires hospitals in selected markets to participate in a bundled payment initiative for specified orthopedic procedures and in a model for end-stage renal disease treatment. In addition, CMS will require certain hospitals to participate in a radiation oncology model beginning as early as January 1, 2023. 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.

In October 2021, the CMS Innovation Center released an outline of its strategy for the next decade, noting the need to accelerate the movement to value-based care and drive broader system transformation. By 2030, the

CMS Innovation Center aims to have all fee-for-service Medicare beneficiaries and the vast majority of Medicaid beneficiaries in an accountable care relationship with providers who are responsible for quality and total medical costs. The CMS Innovation Center signaled its intent to streamline its payment models and to increase provider participation through implementation of more mandatory models.

There are also several state-driven value-based care initiatives. For example, some states have aligned quality metrics across payers through legislation or regulation. Some private third-party payers are also transitioning toward alternative payment models or implementing other value-based care strategies. For example, many large private third-party payers currently require hospitals to report quality data, and several private third-party payers do not reimburse hospitals for certain preventable adverse events. Further, we have implemented a policy pursuant to which we do not bill patients or third-party payers for fees or expenses incurred due to certain preventable adverse events.

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

Risks related to macroeconomic conditions:

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

The COVID-19 pandemic has adversely impacted, and may in the future adversely impact, economic conditions in the United States. Budget deficits at federal, state and local government entities have had a negative impact on spending, and may continue to negatively impact spending for health and human service programs, including Medicare, Medicaid and similar programs, which represent significant third-party payer sources for our hospitals. We anticipate that the federal deficit, the growing magnitude of Medicare and Medicaid expenditures and the aging of the U.S. 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), which may lead to poorer health and higher acuity interventions, 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.

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

We are exposed to market risk related to changes in market values of securities. The COVID-19 pandemic has increased volatility of the capital and credit markets and has adversely impacted economic conditions. The investment securities held by our insurance subsidiaries were \$541 million at December 31, 2021. 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, 2021, we had a net unrealized gain of \$16 million on the insurance subsidiaries' investment securities.

We are exposed to market risk related to market illiquidity. Investment securities of our insurance subsidiaries could be impaired by the inability to access the capital markets. Should the insurance subsidiaries

require significant amounts of cash in excess of normal cash requirements to pay claims and other expenses on short notice, we may have difficulty selling these investments in a timely manner or be forced to sell them at a price less than what we might otherwise have been able to in a normal market environment. We may be required to recognize credit-related impairments on long-term investments in future periods should issuers default on interest payments or should the fair market valuations of the securities deteriorate due to ratings downgrades or other issue specific factors.

We are also exposed to market risk related to changes in interest rates that impact the amount of the interest expense we incur with respect to our floating rate obligations as well as the value of certain investments. We periodically enter into interest rate swap agreements to manage our exposure to these fluctuations. Our interest rate swap agreements involve the exchange of fixed and variable rate interest payments between two parties, based on common notional principal amounts and maturity dates.

Risks related to ownership of our common stock:

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 a regular quarterly cash dividend. However, in response to the COVID-19 pandemic, the Company took the precautionary step to enhance its financial flexibility by suspending its quarterly dividend program in the second quarter of 2020. In February 2021, the Board of Directors approved the resumption of the Company's quarterly cash dividend program following evaluation of the Company's financial position. During 2021, the Board of Directors declared four quarterly dividends of \$0.48 per share, or \$1.92 per share in the aggregate, on our common stock. On January 26, 2022, our Board of Directors declared a quarterly dividend of \$0.56 per share on our common stock payable on March 31, 2022 to stockholders of record at the close of business on March 17, 2022.

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 suspension or elimination of our dividend payments could have a negative effect on our stock price.

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 23% as of January 31, 2022). 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 or any transaction that requires stockholder approval.

Item 1B. *Unresolved Staff Comments*

None.

Item 2. Properties

The following table lists, by state, the number of hospitals (general, acute care, psychiatric and rehabilitation) directly or indirectly owned and operated by us as of December 31, 2021:

<u>State</u>	<u>Hospitals</u>	<u>Beds</u>
Alaska	1	250
California	5	1,856
Colorado	7	2,471
Florida	46	12,740
Georgia	5	1,477
Idaho	2	454
Indiana	1	278
Kansas	4	1,400
Kentucky	2	384
Louisiana	3	923
Missouri	5	1,058
Nevada	3	1,452
New Hampshire	3	418
North Carolina	7	1,181
South Carolina	3	983
Tennessee	14	2,742
Texas	45	13,517
Utah	8	1,031
Virginia	11	3,300
 <u>International</u>		
England	7	888
	<u>182</u>	<u>48,803</u>

In addition to the hospitals listed in the above table, we directly or indirectly operate 125 freestanding surgery centers and 21 freestanding endoscopy 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 four 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 2,045,000 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

The information set forth in Note 11 – Contingencies in the notes to the consolidated financial statements is incorporated herein by reference.

Item 4. Mine Safety Disclosures

None.

PART II

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

During January 2020 and 2019, our Board of Directors authorized share repurchase programs for up to \$4 billion (\$2 billion for each authorization) of our outstanding common stock. During February 2021, our Board of Directors authorized an additional \$6 billion for share repurchases of the Company’s outstanding common stock. The January 2020 and 2019 authorizations were completed during 2021, and at December 31, 2021, there was \$586 million of share repurchase authorization that remained available under the February 2021 authorization. During January 2022, our Board of Directors authorized an additional \$8 billion for share repurchases of the Company’s outstanding common stock.

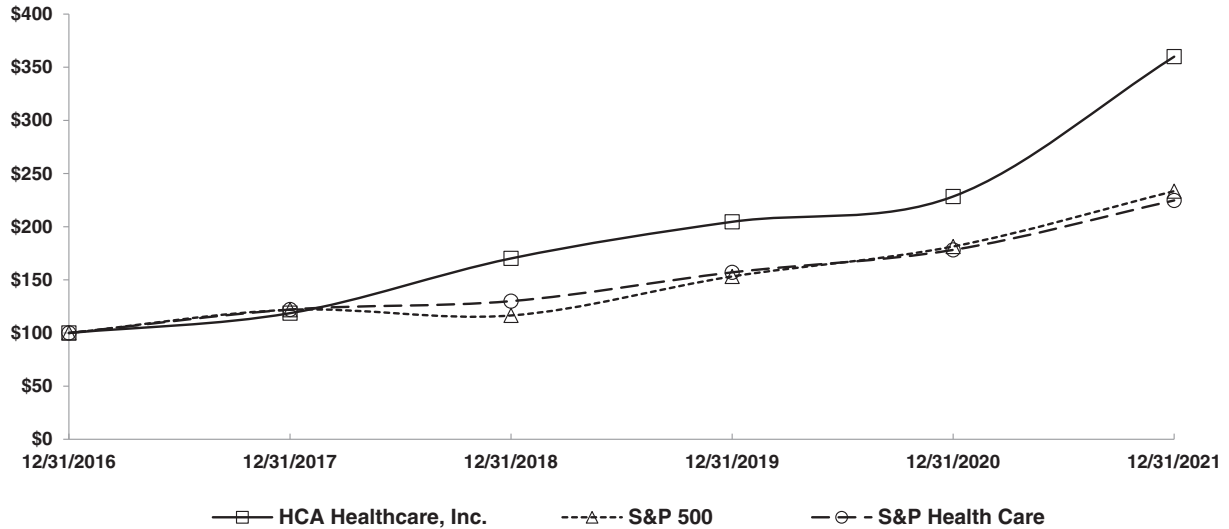
All repurchases made during the fourth quarter of 2021, as detailed below, were made pursuant to the February 2021 share repurchase authorization and were made in the open market.

The following table provides certain information with respect to our repurchases of common stock from October 1, 2021 through December 31, 2021 (dollars in millions, except per share amounts).

<u>Period</u>	<u>Total Number of Shares Purchased</u>	<u>Average Price Paid per Share</u>	<u>Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs</u>	<u>Approximate Dollar Value of Shares That May Yet Be Purchased Under Publicly Announced Plans or Programs</u>
October 1, 2021 through October 31, 2021	3,124,638	\$245.17	3,124,638	\$1,892
November 1, 2021 through November 30, 2021	2,677,717	\$245.44	2,677,717	\$1,235
December 1, 2021 through December 31, 2021	2,667,173	\$243.16	2,667,173	\$ 586
Total for Fourth Quarter 2021	<u>8,469,528</u>	\$244.62	<u>8,469,528</u>	\$ 586

Our common stock is traded on the New York Stock Exchange (“NYSE”) (symbol “HCA”). During 2021, our Board of Directors declared four quarterly dividends of \$0.48 per share, or \$1.92 per share in the aggregate, on our common stock. On January 26, 2022, our Board of Directors declared a quarterly dividend of \$0.56 per share on our common stock payable on March 31, 2022 to stockholders of record at the close of business on March 17, 2022. 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. At the close of business on February 7, 2022, there were approximately 400 holders of record of our common stock.

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



	<u>12/31/2016</u>	<u>12/31/2017</u>	<u>12/31/2018</u>	<u>12/31/2019</u>	<u>12/31/2020</u>	<u>12/31/2021</u>
HCA Healthcare, Inc.	\$100.00	\$118.67	\$170.15	\$204.61	\$228.42	\$359.96
S&P 500	100.00	121.83	116.49	153.17	181.35	233.41
S&P Health Care	100.00	122.08	129.97	157.04	178.15	224.70

The graph shows the cumulative total return to our stockholders for the five-year period ended December 31, 2021, 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, 2016 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.

Item 6. [Reserved]

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

Forward-Looking Statements

This annual report on Form 10-K includes certain disclosures that contain "forward-looking statements," within the meaning of the federal securities laws, which involve risks and uncertainties. Forward-looking statements include statements regarding expected share-based compensation expense, expected capital expenditures, expected dividends, expected share repurchases, expected net claim payments and all other statements that do not relate solely to historical or current facts, and can be identified by the use of words like "may," "believe," "will," "expect," "project," "estimate," "anticipate," "plan," "initiative" or "continue." These forward-looking statements are based on our current plans and expectations and are subject to a number of known and unknown uncertainties and risks, many of which are beyond our control, which could significantly affect current plans and expectations and our future financial position and results of operations. These factors include, but are not limited to, (1) developments related to COVID-19, including, without limitation, the length and severity of the pandemic and the spread of virus strains with new epidemiological characteristics; the volume of canceled or rescheduled procedures and the volume of COVID-19 patients cared for across our health systems; measures we are taking to respond to the COVID-19 pandemic; the impact and terms of government and administrative regulation and stimulus and relief measures (including the Families First Coronavirus Response Act, the Coronavirus Aid, Relief, and Economic Security ("CARES") Act, the Paycheck Protection Program and Health Care Enhancement Act, the Consolidated Appropriations Act, 2021, the American Rescue Plan Act of 2021 ("ARPA") and other enacted and potential future legislation) and whether various stimulus and relief programs continue or new similar programs are enacted in the future; changes in revenues due to declining patient volumes, changes in payer mix and deteriorating macroeconomic conditions (including increases in uninsured and underinsured patients); potential increased expenses related to labor, supply chain or other expenditures; workforce disruptions, including the impact of any current or future vaccine mandates; supply shortages and disruptions; and the timing, availability and adoption of effective medical treatments and vaccines (including boosters), (2) the impact of our substantial indebtedness and the ability to refinance such indebtedness on acceptable terms, as well as risks associated with disruptions in the financial markets and the business of financial institutions as the result of the COVID-19 pandemic, which could impact us from a financial perspective, (3) the impact of current and future federal and state health reform initiatives and possible changes to other federal, state or local laws and regulations affecting the health care industry, including, but not limited to, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act"), and the effects of additional changes to the Affordable Care Act, its implementation, or interpretation (including through executive orders and court challenges), and proposals to expand coverage of federally-funded insurance programs as an alternative to private insurance or establish a single-payer system (such reforms often referred to as "Medicare for All"), and also including any such laws or governmental regulations which are adopted in response to the COVID-19 pandemic, (4) the effects related to the implementation of sequestration spending reductions required under the Budget Control Act of 2011, related legislation extending these reductions, and those required under the Pay-As-You-Go Act of 2010 ("PAYGO Act") as a result of the federal budget deficit impact of the ARPA, and the potential for future deficit reduction legislation that may alter these spending reductions, which include cuts to Medicare payments, or

HCA HEALTHCARE, INC.

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

Forward-Looking Statements (continued)

create additional spending reductions, (5) increases in the amount and risk of collectability of uninsured accounts and deductibles and copayment amounts for insured accounts, (6) the ability to achieve operating and financial targets, and attain expected levels of patient volumes and control the costs of providing services, (7) 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, (8) increases in wages and the ability to attract and retain qualified management and personnel, including affiliated physicians, nurses and medical and technical support personnel, (9) the highly competitive nature of the health care business, (10) 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, (11) the efforts of health insurers, health care providers, large employer groups and others to contain health care costs, (12) the outcome of our continuing efforts to monitor, maintain and comply with appropriate laws, regulations, policies and procedures, (13) the availability and terms of capital to fund the expansion of our business and improvements to our existing facilities, (14) changes in accounting practices, (15) changes in general economic conditions nationally and regionally in our markets, including inflation and economic and business conditions (and the impact thereof on the economy, financial markets and banking industry) resulting from the COVID-19 pandemic, (16) the emergence of and effects related to other pandemics, epidemics and infectious diseases, (17) future divestitures which may result in charges and possible impairments of long-lived assets, (18) changes in business strategy or development plans, (19) delays in receiving payments for services provided, (20) the outcome of pending and any future tax audits, disputes and litigation associated with our tax positions, (21) potential adverse impact of known and unknown government investigations, litigation and other claims that may be made against us, (22) the impact of potential cybersecurity incidents or security breaches, (23) our ongoing ability to demonstrate meaningful use of certified electronic health record ("EHR") technology and the impact of interoperability requirements, (24) the impact of natural disasters, such as hurricanes and floods, or similar events beyond our control, (25) changes in U.S. federal, state, or foreign tax laws including interpretive guidance that may be issued by taxing authorities or other standard setting bodies, and (26) 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, which forward-looking statements reflect management's views only as of the date of this report. We undertake no obligation to revise or update any forward-looking statements, whether as a result of new information, future events or otherwise.

COVID-19 Pandemic

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic. Patient volumes and the related revenues for most of our services were significantly impacted during the latter portion of the first quarter and the first half of the second quarter of 2020 and have continued to be impacted as various policies were implemented by federal, state and local governments in response to the COVID-19 pandemic. During the second quarter of 2021, our patient volumes improved as the effects of the pandemic moderated and certain pandemic-related restrictions and policies were eased. For the remainder of 2021, our patient volumes exhibited consistent growth over the prior year, with the exception of inpatient surgeries, and included a resurgence of COVID-19 admissions and the re-imposition of pandemic-related restrictions in certain markets. We believe the extent of the COVID-19 pandemic's impact on our operating results and financial condition has

HCA HEALTHCARE, INC.

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

COVID-19 Pandemic (continued)

been and will continue to be driven by many factors, most of which are beyond our control and ability to forecast. Because of these uncertainties, we cannot estimate how long or to what extent the pandemic will impact our operations.

2021 Operations Summary

Net income attributable to HCA Healthcare, Inc. totaled \$6.956 billion, or \$21.16 per diluted share, for 2021, compared to \$3.754 billion, or \$10.93 per diluted share, for 2020. The 2021 results include gains on sales of facilities of \$1.620 billion, or \$3.69 per diluted share, and losses on retirement of debt of \$12 million, or \$0.03 per diluted share. The 2020 results include losses on sales of facilities of \$7 million, or \$0.02 per diluted share, and losses on retirement of debt of \$295 million, or \$0.66 per diluted share. The 2020 results also include \$60 million, or \$0.13 per diluted share, of employee retention payroll tax credits, as provided for by the CARES Act. Revenues for 2021 and 2020, respectively, include \$33 million, or \$0.07 per diluted share, and \$55 million, or \$0.12 per diluted share, related to the settlement of Medicare outlier calculations for prior periods. Revenues for 2020 also include \$69 million, or \$0.15 per diluted share, related to the resolution of transaction price differences regarding certain services performed in prior periods. During 2021 and 2020, we recorded reductions to the provision for professional liability risks of \$87 million, or \$0.20 per diluted share, and \$112 million, or \$0.25 per diluted share, respectively. Our provisions for income taxes for 2021 and 2020 include tax benefits of \$119 million, or \$0.36 per diluted share, and \$92 million, or \$0.27 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 328.752 million shares and 343.605 million shares for the years ended December 31, 2021 and 2020, respectively. During 2021, we repurchased 37.812 million shares of our common stock.

Revenues increased to \$58.752 billion for 2021 from \$51.533 billion for 2020. Revenues increased 14.0% and 14.4%, respectively, on a consolidated basis and on a same facility basis for 2021, compared to 2020. The consolidated revenues increase can be primarily attributed to the combined impact of a 6.8% increase in revenue per equivalent admission and a 6.8% increase in equivalent admissions. The same facility revenues increase resulted primarily from the combined impact of a 6.3% increase in revenue per equivalent admission and a 7.6% increase in equivalent admissions.

During 2021, consolidated admissions increased 4.0% and same facility admissions increased 4.8%, compared to 2020. Inpatient surgical volumes declined 0.1% on a consolidated basis and increased 0.4% on a same facility basis during 2021, compared to 2020. Outpatient surgical volumes increased 14.2% on a consolidated basis and increased 14.1% on a same facility basis during 2021, compared to 2020. Emergency room visits increased 13.8% on a consolidated basis and increased 15.1% on a same facility basis during 2021, compared to 2020.

The estimated cost of total uncompensated care declined \$133 million for 2021, compared to 2020. Consolidated and same facility uninsured admissions declined 4.4% and 3.5%, respectively, and consolidated and same facility uninsured emergency room visits declined 7.8% and 6.3%, respectively, for 2021, compared to 2020.

Interest expense totaled \$1.566 billion for 2021, compared to \$1.584 billion for 2020. The \$18 million decline in interest expense for 2021 was due to a decline in the average effective interest rate.

HCA HEALTHCARE, INC.

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

2021 Operations Summary (continued)

Cash flows from operating activities declined \$273 million, from \$9.232 billion for 2020 to \$8.959 billion for 2021. The decline in cash flows from operating activities was related to a negative change in working capital items of \$1.781 billion, primarily from an increase in accounts receivable, offset by the increase in net income, excluding the non-cash impact of losses and gains on sales of facilities, losses on retirement of debt and depreciation and amortization.

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. We strive to be the provider system of choice in the communities we serve and to support our operations with unique enterprise capabilities and best-in-class economies of scale. 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, imaging centers and home health and hospice services, as well as seeking to improve coordination of care and patient retention across our markets.

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

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

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

HCA HEALTHCARE, INC.

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

Business Strategy (continued)

across our extensive network will enable us to continue to manage costs effectively. We continue to invest in our Parallon subsidiary group to leverage key components of our support infrastructure, including revenue cycle management, health care group purchasing, supply chain management and staffing functions.

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

Critical Accounting Policies and Estimates

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

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

Revenues

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

Patients treated at hospitals for non-elective care, who have income at or below 400% of the federal poverty level, are eligible for charity care, 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. Patients treated at hospitals for non-elective care, who have income above 400% of the federal poverty level, are eligible for certain other discounts which 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. We apply additional discounts to limit patient responsibility for certain emergency services. The federal poverty level is

HCA HEALTHCARE, INC.

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

Critical Accounting Policies and Estimates (continued)

Revenues (continued)

established by the federal government and is based on income and family size. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in revenues. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care. We may attempt to provide assistance to uninsured patients to help determine whether they may qualify for Medicaid, other federal or state assistance, or charity care. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Implicit price concessions relate primarily to amounts due directly from patients. Estimated implicit price concessions are recorded for all uninsured accounts, regardless of the age of those accounts. Accounts are written off when all reasonable collection efforts have been performed. The estimates for implicit price concessions are based upon management’s assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical writeoffs and collections at facilities that represent a majority of our revenues and accounts receivable (the “hindsight analysis”) as a primary source of information in estimating the collectability of our accounts receivable. We perform the hindsight analysis quarterly, utilizing rolling twelve-months accounts receivable collection and writeoff data. We believe our quarterly updates to the estimated implicit price 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 revenues.

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

	<u>2021</u>	<u>2020</u>	<u>2019</u>
Patient care costs (salaries and benefits, supplies, other operating expenses and depreciation and amortization)	\$49,074	\$44,271	\$44,118
Cost-to-charges ratio (patient care costs as percentage of gross patient charges)	11.3%	12.0%	12.0%
Total uncompensated care	\$29,642	\$29,029	\$31,105
Multiply by the cost-to-charges ratio	11.3%	12.0%	12.0%
Estimated cost of total uncompensated care	<u>\$ 3,350</u>	<u>\$ 3,483</u>	<u>\$ 3,733</u>

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.

HCA HEALTHCARE, INC.

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

Critical Accounting Policies and Estimates (continued)

Professional Liability Claims

We, along with virtually all health care providers, operate in an environment with professional liability risks. Our facilities are insured by our insurance subsidiary for losses up to \$75 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 either \$25 million or \$35 million per occurrence, depending on the jurisdiction for the related claim. We purchase excess insurance on an occurrence reported basis for losses in excess of amounts insured by our insurance subsidiary. Provisions for losses related to professional liability risks were \$453 million, \$435 million and \$497 million for the years ended December 31, 2021, 2020 and 2019, respectively. During 2021, 2020 and 2019, we recorded reductions to the provision for professional liability risks of \$87 million, \$112 million and \$50 million, respectively, due to the receipt of updated actuarial information.

Reserves for professional liability risks represent the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The estimated ultimate cost includes 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 \$1.752 billion to \$2.098 billion at December 31, 2021 and \$1.710 billion to \$2.050 billion at December 31, 2020. 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 \$22 million or reduce the reserve estimate by \$21 million. A 2.5% change in the expected claim severity trend could be reasonably likely and would increase the reserve estimate by \$107 million or reduce the reserve estimate by \$98 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

HCA HEALTHCARE, INC.

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

Critical Accounting Policies and Estimates (continued)

Professional Liability Claims (continued)

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 2,100 and 2,300 individual claims at December 31, 2021 and 2020, respectively, and estimates for unreported potential claims. The time period required to resolve these claims can vary depending upon the jurisdiction and whether the claim is settled or litigated. The average time period between the occurrence and final resolution for our professional liability claims is approximately four years, although the facts and circumstances of each individual claim can result in an occurrence-to-resolution timeframe that varies from this average. The estimation of the timing of payments beyond a year can vary significantly.

Reserves for professional liability risks were \$2.022 billion and \$1.963 billion at December 31, 2021 and 2020, respectively. The current portion of these reserves, \$508 million and \$477 million at December 31, 2021 and 2020, 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 \$55 million and \$39 million receivable under reinsurance and excess insurance contracts at December 31, 2021 and 2020, respectively) were \$1.967 billion and \$1.924 billion at December 31, 2021 and 2020, respectively. The estimated total net reserves for professional liability risks at December 31, 2021 and 2020 are comprised of \$874 million and \$833 million, respectively, of case reserves for known claims and \$1.093 billion and \$1.091 billion, respectively, of reserves for incurred but not reported claims.

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

	<u>2021</u>	<u>2020</u>	<u>2019</u>
Net reserves for professional liability claims, January 1	\$1,924	\$1,781	\$1,692
Provision for current year claims	530	519	499
Favorable development related to prior years' claims . . .	(77)	(84)	(2)
Total provision	453	435	497
Payments for current year claims	5	5	8
Payments for prior years' claims	379	287	400
Total claim payments	384	292	408
Effect of new retroactive reinsurance contracts	(26)	—	—
Net reserves for professional liability claims, December 31	<u>\$1,967</u>	<u>\$1,924</u>	<u>\$1,781</u>

Income Taxes

We calculate our provision for income taxes using the asset and liability method, under which deferred tax assets and liabilities are recognized by identifying the temporary differences that arise from the recognition of items in different periods for tax and accounting purposes. Deferred tax assets generally represent the tax effects of amounts expensed in our income statement for which tax deductions will be claimed in future periods. Interest

HCA HEALTHCARE, INC.

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

Critical Accounting Policies and Estimates (continued)

Income Taxes (continued)

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.

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 14.0% to \$58.752 billion for 2021 from \$51.533 billion for 2020 and increased 0.4% for 2020 from \$51.336 billion for 2019. The increase in revenues in 2021 can be primarily attributed to the combined impact of a 6.8% increase in revenue per equivalent admission and a 6.8% increase in equivalent admissions compared to the prior year. The increase in revenues in 2020 can be primarily attributed to the net impact of a 10.5% increase in revenue per equivalent admission offset by a 9.2% decline in equivalent admissions compared to the prior year.

Same facility revenues increased 14.4% for the year ended December 31, 2021 compared to the year ended December 31, 2020 and declined 0.1% for the year ended December 31, 2020 compared to the year ended December 31, 2019. The 14.4% increase for 2021 can be primarily attributed to the combined impact of a 6.3% increase in revenue per equivalent admission and a 7.6% increase in equivalent admissions. The 0.1% decline for 2020 can be primarily attributed to the net impact of a 9.3% decline in same facility equivalent admissions offset by a 10.1% increase in same facility revenue per equivalent admission.

Consolidated admissions increased 4.0% during 2021 compared to 2020 and declined 4.7% during 2020 compared to 2019. Consolidated surgeries increased 8.9% during 2021 compared to 2020 and declined 10.9% during 2020 compared to 2019. Consolidated emergency room visits increased 13.8% during 2021 compared to 2020 and declined 18.7% during 2020 compared to 2019.

Same facility admissions increased 4.8% during 2021 compared to 2020 and declined 4.8% during 2020 compared to 2019. Same facility surgeries increased 9.0% during 2021 compared to 2020 and declined 10.7%

HCA HEALTHCARE, INC.

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

Results of Operations (continued)

Revenue/Volume Trends (continued)

during 2020 compared to 2019, primarily driven by the pandemic-related impact on outpatient surgeries. Same facility emergency room visits increased 15.1% during 2021 compared to 2020 and declined 18.8% during 2020 compared to 2019. During the second quarter of 2021, our patient volumes improved as the effects of the pandemic moderated and certain pandemic-related restrictions and policies were eased. For the remainder of 2021, our patient volumes exhibited consistent growth over the prior year, with the exception of inpatient surgeries, and included a resurgence of COVID-19 admissions.

Same facility uninsured emergency room visits declined 6.3% and same facility uninsured admissions declined 3.5% during 2021 compared to 2020. Same facility uninsured emergency room visits declined 21.0% and same facility uninsured admissions declined 7.0% during 2020 compared to 2019. The decline in uninsured admissions in 2021, compared to 2020, was primarily due to the reimbursement received, as provided for under the Families First Coronavirus Response Act and subsequent legislation, for uninsured patients diagnosed with COVID-19 and the resulting classification of those patients as an insured admission, as well as general declines in patient volumes resulting from the pandemic’s impact on our operations. The decline in uninsured admissions in 2020, compared to 2019, was primarily due to general declines in patient volumes resulting from the pandemic’s impact on our operations.

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, 2021, 2020 and 2019 are set forth below.

	<u>Years Ended December 31,</u>		
	<u>2021</u>	<u>2020</u>	<u>2019</u>
Medicare	23%	26%	29%
Managed Medicare	21	20	18
Medicaid	5	5	5
Managed Medicaid	13	12	12
Managed care and insurers	31	29	28
Uninsured	7	8	8
	<u>100%</u>	<u>100%</u>	<u>100%</u>

The approximate percentages of our inpatient revenues related to Medicare, managed Medicare, Medicaid, managed Medicaid, and managed care and insurers for the years ended December 31, 2021, 2020 and 2019 are set forth below.

	<u>Years Ended December 31,</u>		
	<u>2021</u>	<u>2020</u>	<u>2019</u>
Medicare	23%	27%	28%
Managed Medicare	16	15	15
Medicaid	6	5	5
Managed Medicaid	6	6	5
Managed care and insurers	49	47	47
	<u>100%</u>	<u>100%</u>	<u>100%</u>

HCA HEALTHCARE, INC.

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

Results of Operations (continued)

Revenue/Volume Trends (continued)

At December 31, 2021, we owned and operated 46 hospitals and 30 surgery centers in the state of Florida. Our Florida facilities' revenues totaled \$13.670 billion, \$11.442 billion and \$11.494 billion for the years ended December 31, 2021, 2020 and 2019, respectively. At December 31, 2021, we owned and operated 45 hospitals and 35 surgery centers in the state of Texas. Our Texas facilities' revenues totaled \$15.344 billion, \$13.528 billion and \$13.101 billion for the years ended December 31, 2021, 2020 and 2019, respectively. During 2021, 2020 and 2019, 56% of our admissions for each year and 49%, 49% and 48%, respectively, of our revenues were generated by our Florida and Texas facilities. Uninsured admissions in Florida and Texas represented 72% of our uninsured admissions each year during 2021, 2020 and 2019.

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 would phase out federal matching funds for Designated State Health Programs under waivers granted under Section 1115 of the Social Security Act. The Texas Healthcare Transformation and Quality Improvement Program ("Texas Waiver Program") currently operates pursuant to a Medicaid waiver. Without an extension, the waiver would expire September 30, 2022. While the lawsuit is pending, the Texas Health and Human Services Commission ("Texas HHSC") has re-submitted its application to extend the Texas Waiver Program. Our Texas Medicaid revenues included Medicaid supplemental waiver payments of \$534 million, \$599 million and \$416 million during 2021, 2020 and 2019, respectively. Additionally, the Texas HHSC's proposed directed payment program has not yet been renewed for the current program year that began September 1, 2021. Our supplemental Medicaid revenues from the directed payment program have been, and will continue to be, negatively impacted until the Texas HHSC and CMS finalize certain components of the program.

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

HCA HEALTHCARE, INC.

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

Results of Operations (continued)

Operating Results Summary

The following are comparative summaries of operating results and certain operating data for the years ended December 31, 2021, 2020 and 2019 (dollars in millions):

	2021		2020		2019	
	Amount	Ratio	Amount	Ratio	Amount	Ratio
Revenues	\$58,752	100.0	\$51,533	100.0	\$51,336	100.0
Salaries and benefits	26,779	45.6	23,874	46.3	23,560	45.9
Supplies	9,481	16.1	8,369	16.2	8,481	16.5
Other operating expenses	9,961	17.0	9,307	18.1	9,481	18.5
Equity in earnings of affiliates	(113)	(0.2)	(54)	(0.1)	(43)	(0.1)
Depreciation and amortization	2,853	4.9	2,721	5.3	2,596	5.0
Interest expense	1,566	2.7	1,584	3.1	1,824	3.6
Losses (gains) on sales of facilities	(1,620)	(2.8)	7	—	(18)	—
Losses on retirement of debt	12	—	295	0.6	211	0.4
	<u>48,919</u>	<u>83.3</u>	<u>46,103</u>	<u>89.5</u>	<u>46,092</u>	<u>89.8</u>
Income before income taxes	9,833	16.7	5,430	10.5	5,244	10.2
Provision for income taxes	2,112	3.6	1,043	2.0	1,099	2.1
Net income	7,721	13.1	4,387	8.5	4,145	8.1
Net income attributable to noncontrolling interests	765	1.3	633	1.2	640	1.3
Net income attributable to HCA Healthcare, Inc.	<u>\$ 6,956</u>	<u>11.8</u>	<u>\$ 3,754</u>	<u>7.3</u>	<u>\$ 3,505</u>	<u>6.8</u>
% changes from prior year:						
Revenues	14.0%		0.4%		10.0%	
Income before income taxes	81.1		3.6		(1.7)	
Net income attributable to HCA Healthcare, Inc.	85.3		7.1		(7.4)	
Admissions(a)	4.0		(4.7)		5.2	
Equivalent admissions(b)	6.8		(9.2)		6.6	
Revenue per equivalent admission	6.8		10.5		3.2	
Same facility % changes from prior year(c):						
Revenues	14.4		(0.1)		5.9	
Admissions(a)	4.8		(4.8)		2.8	
Equivalent admissions(b)	7.6		(9.3)		3.5	
Revenue per equivalent admission	6.3		10.1		2.3	

(a) Represents the total number of patients admitted to our hospitals and is used by management and certain investors as a general measure of inpatient volume.

(b) Equivalent admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Equivalent admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The equivalent admissions computation "equates" outpatient revenue to the volume measure (admissions) used to measure inpatient volume, resulting in a general measure of combined inpatient and outpatient volume.

(c) Same facility information excludes the operations of hospitals and their related facilities that were either acquired, divested or removed from service during the current and prior year.

HCA HEALTHCARE, INC.

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

Results of Operations (continued)

Operating Results Summary (continued)

Operating Data:

	<u>2021</u>	<u>2020</u>	<u>2019</u>
Number of hospitals at end of period	182	185	184
Number of freestanding outpatient surgical centers at end of period(a) . .	125	121	123
Number of licensed beds at end of period(b)	48,803	49,265	49,035
Weighted average beds in service(c)	42,148	42,246	41,510
Admissions(d)	2,089,975	2,009,909	2,108,927
Equivalent admissions(e)	3,536,238	3,312,330	3,646,335
Average length of stay (days)(f)	5.2	5.1	4.9
Average daily census(g)	29,752	27,734	28,134
Occupancy(h)	71%	66%	68%
Emergency room visits(i)	8,475,345	7,450,307	9,161,129
Outpatient surgeries(j)	1,008,236	882,483	1,009,947
Inpatient surgeries(k)	522,069	522,385	566,635
Days revenues in accounts receivable(l)	49	45	50
Outpatient revenues as a % of patient revenues(m)	37%	35%	39%

- (a) Excludes freestanding endoscopy centers (21 at December 31, 2021 and 2020, and 20 at December 31, 2019).
- (b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.
- (c) Represents the average number of beds in service, weighted based on periods owned.
- (d) 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.
- (e) 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.
- (f) Represents the average number of days admitted patients stay in our hospitals.
- (g) Represents the average number of patients in our hospital beds each day.
- (h) Represents the percentage of hospital beds in service that are occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.
- (i) Represents the number of patients treated in our emergency rooms.
- (j) 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.
- (k) 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.
- (l) 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.
- (m) Represents the percentage of patient revenues related to patients who are not admitted to our hospitals.

HCA HEALTHCARE, INC.

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

Results of Operations (continued)

Key Performance Indicators

We present certain metrics and statistical information that management uses when assessing our results of operations. We believe this information is useful to investors as it provides insight to how management evaluates operational performance and trends between reporting periods. Information on how these metrics and statistical information are defined is provided in the previous tables summarizing operating results and operating data.

Years Ended December 31, 2021 and 2020

Net income attributable to HCA Healthcare, Inc. totaled \$6.956 billion, or \$21.16 per diluted share, for 2021, compared to \$3.754 billion, or \$10.93 per diluted share, for 2020. The 2021 results include gains on sales of facilities of \$1.620 billion, or \$3.69 per diluted share, and losses on retirement of debt of \$12 million, or \$0.03 per diluted share. The 2020 results include losses on sales of facilities of \$7 million, or \$0.02 per diluted share, and losses on retirement of debt of \$295 million, or \$0.66 per diluted share. The 2020 results also include \$60 million, or \$0.13 per diluted share, of employee retention payroll tax credits, as provided for by the CARES Act. Revenues for 2021 and 2020, respectively, include \$33 million, or \$0.07 per diluted share, and \$55 million, or \$0.12 per diluted share, related to the settlement of Medicare outlier calculations for prior periods. Revenues for 2020 also include \$69 million, or \$0.15 per diluted share, related to the resolution of transaction price differences regarding certain services performed in prior periods. During 2021 and 2020, we recorded reductions to the provision for professional liability risks of \$87 million, or \$0.20 per diluted share, and \$112 million, or \$0.25 per diluted share, respectively. Our provisions for income taxes for 2021 and 2020 include tax benefits of \$119 million, or \$0.36 per diluted share, and \$92 million, or \$0.27 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 328.752 million shares and 343.605 million shares for the years ended December 31, 2021 and 2020, respectively. During 2021, we repurchased 37.812 million shares of our common stock.

During 2021, consolidated admissions increased 4.0% and same facility admissions increased 4.8% compared to 2020. Consolidated inpatient surgeries declined 0.1% and same facility inpatient surgeries increased 0.4% during 2021 compared to 2020. Emergency room visits increased 13.8% on a consolidated basis and increased 15.1% on a same facility basis during 2021 compared to 2020.

Revenues increased 14.0% to \$58.752 billion for 2021 from \$51.533 billion for 2020. The increase in revenues was primarily due to the combined impact of a 6.8% increase in revenue per equivalent admission and a 6.8% increase in equivalent admissions compared to 2020. Same facility revenues increased 14.4% due primarily to the combined impact of a 6.3% increase in revenue per equivalent admission and a 7.6% increase in equivalent admissions compared to 2020.

Salaries and benefits, as a percentage of revenues, were 45.6% in 2021 and 46.3% in 2020. Salaries and benefits per equivalent admission increased 5.1% in 2021 compared to 2020. Same facility labor rate increases averaged 7.5% for 2021 compared to 2020 primarily due to an increased utilization of contract, overtime and other premium rate labor costs during 2021 to support our clinical staff and address the surges of COVID-19 cases during 2021. Share-based compensation expense was \$440 million in 2021 and \$362 million in 2020.

Supplies, as a percentage of revenues, were 16.1% in 2021 and 16.2% in 2020. Supply costs per equivalent admission increased 6.1% in 2021 compared to 2020. Supply costs per equivalent admission increased 3.4% for

HCA HEALTHCARE, INC.

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

Results of Operations (continued)

Years Ended December 31, 2021 and 2020 (continued)

medical devices, 6.6% for pharmacy supplies and 8.4% for general medical and surgical items in 2021 compared to 2020. The increase in pharmacy supplies is primarily related to COVID-19 therapies used in the surges of COVID-19 cases during 2021, and the increase in general medical and surgical items is primarily related to increased utilization of PPE and COVID-19 testing supplies.

Other operating expenses, as a percentage of revenues, were 17.0% in 2021 and 18.1% in 2020. 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 \$453 million and \$435 million for 2021 and 2020, respectively. During 2021 and 2020, we recorded reductions of \$87 million, or \$0.20 per diluted share, and \$112 million, or \$0.25 per diluted share, respectively, to our provision for professional liability risks related to the receipt of updated actuarial information.

Equity in earnings of affiliates was \$113 million for 2021 and \$54 million for 2020. The \$59 million increase relates primarily to improved operating results of three equity method investments (two physician practices and a freestanding surgery center).

Depreciation and amortization, as a percentage of revenues, were 4.9% in 2021 and 5.3% in 2020. Depreciation expense was \$2.826 billion for 2021 and \$2.693 billion for 2020. The increase of \$133 million in depreciation expense relates primarily to capital expenditures at our existing facilities (same facility depreciation expense increased \$128 million).

Interest expense declined to \$1.566 billion for 2021 from \$1.584 billion for 2020. The \$18 million decline in interest expense was due to a decline in the average effective interest rate. Our average debt balance was \$32.109 billion for 2021 compared to \$31.940 billion for 2020. The average interest rate for our long-term debt was 4.9% for 2021 and 5.0% for 2020.

Gains on sales of facilities were \$1.620 billion for 2021, and losses on sales of facilities were \$7 million for 2020. The gains on sales of facilities for 2021 are primarily related to the sales of five hospitals in Georgia and other health care entity investments.

During June 2021, we issued \$2.350 billion aggregate principal amount of senior secured notes comprised of \$850 million aggregate principal amount of 2 3/8% notes due 2031 and \$1.500 billion aggregate principal amount of 3 1/2% notes due 2051 (the "June 2021 Notes"). We also amended and restated our senior secured revolving credit facility and our senior secured asset-based revolving credit facility, including increasing availability under the asset-based revolving credit facility to \$4.500 billion, extending the maturity date on both facilities to June 30, 2026 and entering into \$2.000 billion of new term loan facilities (the "Credit Agreement Transactions"). We used the net proceeds from the June 2021 Notes and the Credit Agreement Transactions to retire \$3.657 billion of term loan facilities. The pretax loss on retirement of debt was \$12 million. During February 2020, we issued \$2.700 billion aggregate principal amount of 3.50% senior unsecured notes due 2030. During March 2020, we used the net proceeds for the redemption of all \$1.000 billion outstanding aggregate principal amount of HCA Healthcare, Inc.'s 6.25% senior notes due 2021 and, together with available funds, for the redemption of all \$2.000 billion outstanding aggregate principal amount of HCA Inc.'s 7.50% senior notes due 2022. The pretax loss on retirement of debt was \$295 million.

HCA HEALTHCARE, INC.

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

Results of Operations (continued)

Years Ended December 31, 2021 and 2020 (continued)

The effective tax rates were 23.3% and 21.7% for 2021 and 2020, respectively. The effective tax rate computations exclude net income attributable to noncontrolling interests as it relates to consolidated partnerships. Our provisions for income taxes for 2021 and 2020 include tax benefits of \$119 million and \$92 million, respectively, related to employee equity award settlements. Excluding the effect of these adjustments, the effective tax rates for 2021 and 2020 would have been 24.6% and 23.7%, respectively.

Net income attributable to noncontrolling interests increased from \$633 million for 2020 to \$765 million for 2021. The increase in net income attributable to noncontrolling interests related primarily to the partnership operations of two of our Texas markets and our surgery center partnerships.

For results of operations comparisons relating to years ending December 31, 2020 and 2019, refer to our annual report on Form 10-K, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations for the year ended December 31, 2020, filed with the Securities and Exchange Commission on February 19, 2021.

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 health care entities, repurchases of our common stock, dividends to stockholders and distributions to noncontrolling interests. Our primary cash sources are cash flows from operating activities, issuances of debt and equity securities and sales of hospitals and health care entities.

Cash provided by operating activities totaled \$8.959 billion in 2021 compared to \$9.232 billion in 2020 and \$7.602 billion in 2019. The \$273 million decline in cash provided by operating activities for 2021, compared to 2020, was related to a negative change in working capital items of \$1.781 billion, primarily from an increase in accounts receivable, offset by the increase in net income, excluding the non-cash impact of losses and gains on sales of facilities, losses on retirement of debt and depreciation and amortization. The \$1.630 billion increase in cash provided by operating activities for 2020, compared to 2019, was primarily related to the increase in net income, excluding losses and gains on sales of facilities and losses on retirement of debt, of \$330 million and positive changes in working capital items of \$1.366 billion, primarily from the increase in accounts payable and accrued expenses and the collection of accounts receivable. During 2020, we deferred \$688 million of Social Security taxes as allowed for under the CARES Act. Half of these taxes were paid in January 2022 and the remainder will be paid in 2023. Working capital totaled \$3.960 billion at December 31, 2021 and \$3.629 billion at December 31, 2020. Cash payments for interest and income taxes increased \$1.075 billion for 2021 compared to 2020 and declined \$154 million for 2020 compared to 2019.

Cash used in investing activities was \$2.643 billion, \$3.393 billion and \$5.720 billion in 2021, 2020 and 2019, respectively. Excluding acquisitions, capital expenditures were \$3.577 billion in 2021, \$2.835 billion in 2020 and \$4.158 billion in 2019. We expended \$1.105 billion, \$568 million and \$1.682 billion for acquisitions of hospitals and health care entities during 2021, 2020 and 2019, respectively. In response to the risks the COVID-19 pandemic presents to our business, we reduced certain planned projects and capital expenditures during 2020. Planned capital expenditures are expected to approximate \$4.2 billion in 2022. At December 31, 2021, there were projects under construction which had an estimated additional cost to complete and equip over

HCA HEALTHCARE, INC.

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

Liquidity and Capital Resources (continued)

the next five years of approximately \$4.239 billion. We expect to finance capital expenditures with internally generated and borrowed funds. Sales of hospitals and health care entities increased \$2.092 billion for 2021, compared to 2020, primarily related to the proceeds from our sales of five hospitals in Georgia and other health care entity investments.

Cash used in financing activities totaled \$6.655 billion in 2021, \$4.677 billion in 2020 and \$1.771 billion in 2019. During 2021, we had a net increase of \$3.255 billion in our indebtedness, paid dividends of \$624 million and paid \$8.215 billion for repurchases of common stock. During 2020, we made net payments of \$3.217 billion related to our indebtedness, paid dividends of \$153 million and paid \$441 million for repurchases of our common stock. During 2019, we had a net increase of \$567 million in our indebtedness, paid dividends of \$550 million and paid \$1.031 billion for repurchases of our common stock. During 2021, 2020 and 2019, we made distributions to noncontrolling interests of \$749 million, \$626 million and \$542 million, respectively.

We, or our affiliates, may in the future repurchase portions of our debt or equity securities, subject to certain limitations, from time to time in either the open market or through privately negotiated transactions, in accordance with applicable SEC and other legal requirements. The timing, prices, and sizes of purchases depend upon prevailing trading prices, general economic and market conditions, and other factors, including applicable securities laws.

During January 2020 and 2019, our Board of Directors authorized share repurchase programs for up to \$4 billion (\$2 billion for each authorization) of our outstanding common stock. During February 2021, our Board of Directors authorized an additional \$6 billion for share repurchases of the Company's outstanding common stock. The January 2020 and 2019 authorizations were completed during 2021, and at December 31, 2021, there was \$586 million of share repurchase authorization that remained available under the February 2021 authorization. During January 2022, our Board of Directors authorized an additional \$8 billion for share repurchases of the Company's outstanding common stock. Funds for the repurchase of debt or equity securities have, and are expected to, come primarily from cash generated from operations and borrowed funds.

During 2021, our Board of Directors declared four quarterly dividends of \$0.48 per share, or \$1.92 per share in the aggregate, on our common stock. On January 26, 2022, our Board of Directors declared a quarterly dividend of \$0.56 per share on our common stock payable on March 31, 2022 to stockholders of record at the close of business on March 17, 2022. The timing and amount of future cash dividends will vary based on a number of factors, including future capital requirements for strategic transactions, share repurchases and investing in our existing markets, the availability of financing on acceptable terms, debt service requirements, changes to applicable tax laws or corporate laws, changes to our business model and periodic determinations by our Board of Directors that cash dividends are in the best interest of stockholders and are in compliance with all applicable laws and agreements of the Company.

In addition to cash flows from operations, available sources of capital include amounts available under our senior secured credit facilities (\$3.640 billion as of December 31, 2021 and \$3.258 billion as of January 31, 2022) and anticipated access to public and private debt and equity markets.

Investments of our insurance subsidiaries, held to maintain statutory equity levels and to provide liquidity to pay claims, totaled \$541 million and \$504 million at December 31, 2021 and 2020, respectively. The insurance subsidiary maintained net reserves for professional liability risks of \$154 million and \$188 million at

HCA HEALTHCARE, INC.

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

Liquidity and Capital Resources (continued)

December 31, 2021 and 2020, respectively. Our facilities are insured by our insurance subsidiary for losses up to \$75 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 \$1.813 billion and \$1.736 billion at December 31, 2021 and 2020, respectively. Claims payments, net of reinsurance recoveries, during the next 12 months are expected to approximate \$497 million. We estimate that approximately \$448 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 \$34.579 billion and \$31.004 billion at December 31, 2021 and 2020, respectively. Our interest expense was \$1.566 billion for 2021 and \$1.584 billion for 2020.

During June 2021, we issued \$2.350 billion aggregate principal amount of senior secured notes comprised of \$850 million aggregate principal amount of 2 3/8% notes due 2031 and \$1.500 billion aggregate principal amount of 3 1/2% notes due 2051 (the "June 2021 Notes"). We also amended and restated our senior secured revolving credit facility and our senior secured asset-based revolving credit facility, including increasing availability under the asset-based revolving credit facility to \$4.500 billion, extending the maturity date on both facilities to June 30, 2026 and entering into \$2.000 billion of new term loan facilities (the "Credit Agreement Transactions"). We used the net proceeds from the June 2021 Notes and the Credit Agreement Transactions to retire \$3.657 billion of term loan facilities.

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 for the foreseeable future.

Summarized Financial Information

HCA Inc., a direct wholly-owned subsidiary of HCA Healthcare, Inc., is the primary obligor under a substantial portion of our indebtedness, including our senior secured credit facilities, senior secured notes and senior unsecured notes. The senior secured notes and senior unsecured notes issued by HCA Inc. are fully and unconditionally guaranteed on an unsecured basis by HCA Healthcare, Inc. The senior secured credit facilities and senior secured notes are fully and unconditionally guaranteed on a senior secured basis 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 senior secured asset-based revolving credit facility). For a list of subsidiary guarantors, see Exhibit 22 to this annual report on Form 10-K.

The subsidiary guarantees rank senior in right of payment to all subordinated indebtedness of each subsidiary guarantor, equally in right of payment with all senior indebtedness of the subsidiary guarantor and are structurally subordinated in right of payment to all indebtedness and other liabilities of any non-guarantor subsidiaries of the subsidiary guarantors (other than indebtedness and liabilities owed to one of the subsidiary guarantors). The subsidiary guarantees are secured by first-priority liens on the subsidiary guarantors' assets, subject to certain exceptions, that secure our senior secured cash flow credit facility on a first-priority basis. The

HCA HEALTHCARE, INC.

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

Liquidity and Capital Resources (continued)

Summarized Financial Information (continued)

subsidiary guarantees are secured by second-priority liens on the subsidiary guarantors' assets that secure our senior secured asset-based revolving credit facility on a first-priority basis and our senior secured cash flow credit facility on a second-priority basis.

The subsidiary guarantees may be automatically and unconditionally released and discharged upon certain customary events, including in the event such guarantee is released under our senior secured credit facilities. The indentures governing the senior secured notes include a "savings clause" intended to limit each subsidiary guarantor's obligations as necessary to prevent the guarantee from constituting a fraudulent conveyance under applicable law, which could reduce a subsidiary guarantor's liability on its guarantee to zero. For further information regarding the guarantees, refer to the applicable indentures that are filed as exhibits to this annual report on Form 10-K.

Summarized financial information is presented on a combined basis and transactions between the combining entities have been eliminated. Financial information for nonguarantor entities has been excluded. The summarized operating results information for the year ended December 31, 2021 and the summarized balance sheet information at December 31, 2021, for HCA Healthcare, Inc., HCA Inc. and the subsidiary guarantors (the Parent, Subsidiary Issuer and Subsidiary Guarantors) follow (dollars in millions):

Year Ended December 31, 2021:	<u>Year Ended December 31, 2021</u>
Revenues	\$ 34,889
Income before income taxes	6,061
Net income	4,666
Net income attributable to Parent, Subsidiary Issuer and Subsidiary Guarantors	4,564
At December 31, 2021:	<u>December 31, 2021</u>
Current assets	\$ 8,268
Property and equipment, net	15,559
Goodwill and other intangible assets	5,694
Total noncurrent assets	22,370
Total assets	30,638
Current liabilities	5,697
Long-term debt, net	33,904
Intercompany balances	3,423
Income taxes and other liabilities	1,053
Total noncurrent liabilities	38,912
Stockholders' deficit attributable to Parent, Subsidiary Issuer and Subsidiary Guarantors	(14,124)
Noncontrolling interests	153

HCA HEALTHCARE, INC.

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

Liquidity and Capital Resources (continued)

Summarized Financial Information (continued)

The first-priority liens securing the subsidiary guarantees discussed above include liens on (i) substantially all of the capital stock of substantially all wholly owned first-tier subsidiaries of HCA Inc. or of subsidiary guarantors (but limited to 65% of the stock of any such wholly owned first-tier subsidiary that is a foreign subsidiary), subject to certain limited exceptions, and (ii) substantially all indebtedness owing to HCA Inc. or to the subsidiary guarantors, including any and all intercompany indebtedness owed by HCA Healthcare, Inc. or any subsidiary thereof to HCA Inc., or any subsidiary guarantor. For a list of affiliates whose securities are pledged as collateral for the senior secured notes, see Exhibit 22 to this annual report on Form 10-K.

Under the first lien intercreditor agreement, the administrative agent for the lenders under the cash flow credit facility, subject to the occurrence of certain events, has the exclusive right to direct foreclosures and take other actions with respect to these liens, and the trustee for the senior secured notes has no right to take any such actions. In certain circumstances, including upon certain events of default under the senior secured credit facilities and the senior secured notes, the collateral agent in respect of the cash flow credit facility and the senior secured notes could proceed against the collateral granted to it to secure such indebtedness, including the aforementioned pledged capital stock and pledged indebtedness, and require such collateral to be delivered to the collateral agent to the extent not already in its possession for purposes of perfecting the lien on such assets. For further information regarding the collateral, including events or circumstances that may require delivery of the collateral, refer to the applicable indentures, the first lien intercreditor agreement, the cash flow credit agreement and the pledge agreement that are filed as exhibits to this annual report on Form 10-K.

There is no trading market for any of HCA Healthcare, Inc.'s affiliates whose securities are pledged as collateral for the senior secured notes.

Rule 13-02 of Regulation S-X requires the presentation of summarized financial information of the combined affiliates whose securities are pledged as collateral for the senior secured notes unless such information is not material. The rule provides that such information is not material if the assets, liabilities and results of operations of the combined affiliates whose securities are pledged as collateral are not materially different than the corresponding amounts presented in the consolidated financial statements of the Registrant. Healthtrust, Inc. — The Hospital Company ("Healthtrust") is the first-tier subsidiary of HCA Inc., and the common stock of Healthtrust is pledged as collateral for the senior secured notes. Due to the corporate structure relationship of HCA Healthcare, Inc. and Healthtrust, all of HCA Healthcare, Inc.'s operating subsidiaries, including all other affiliates whose securities are pledged as collateral for the senior secured notes, are also subsidiaries of Healthtrust. The corporate structure relationship, combined with the application of push-down accounting in Healthtrust's consolidated financial statements related to HCA Healthcare Inc.'s debt and financial instruments, mean that the assets, liabilities and results of operations of Healthtrust (and, therefore, of the combined affiliates whose securities are pledged as collateral for the senior secured notes) are not materially different than the corresponding amounts presented in the financial statements of HCA Healthcare, Inc. As a result, summarized financial information of affiliates whose securities are pledged as collateral for the senior secured notes is not required to be presented under Rule 13-02.

HCA HEALTHCARE, INC.

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

Market Risk

We are exposed to market risk related to changes in market values of securities. Our insurance subsidiaries held \$541 million of investment securities at December 31, 2021. 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, 2021, we had a net unrealized gain of \$16 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 insurance subsidiaries could be impaired by the inability to access the capital markets. Should the insurance subsidiaries require significant amounts of cash in excess of normal cash requirements to pay claims and other expenses on short notice, we may have difficulty selling these investments in a timely manner or be forced to sell them at a price less than what we might otherwise have been able to in a normal market environment. We may be required to recognize credit-related impairments on our investment securities in future periods should issuers default on interest payments or should the fair market valuations of the securities deteriorate due to ratings downgrades or other issue-specific factors.

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

With respect to our interest-bearing liabilities, approximately \$4.240 billion of long-term debt at December 31, 2021 was subject to variable rates of interest, while the remaining balance in long-term debt of \$30.339 billion at December 31, 2021 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 4.9% for 2021 and 5.0% for 2020.

The estimated fair value of our total long-term debt was \$38.541 billion at December 31, 2021. 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 \$42 million. To mitigate the impact of fluctuations in interest rates, we generally target a majority of our debt portfolio to be maintained at fixed rates.

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

HCA HEALTHCARE, INC.

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

Market Risk (continued)

Financial Instruments

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

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

Tax Examinations

The Internal Revenue Service ("IRS") was conducting an examination of the Company's 2016, 2017 and 2018 federal income tax returns and the 2019 return for one affiliated partnership at December 31, 2021. We are also subject to examination by state and foreign taxing authorities. Management believes HCA Healthcare, Inc., its predecessors, subsidiaries and affiliates properly reported taxable income and paid taxes in accordance with applicable laws and agreements established with the IRS, state and foreign taxing authorities, and final resolution of any disputes will not have a material, adverse effect on our results of operations or financial position. However, if payments due upon final resolution of any issues exceed our recorded estimates, such resolutions could have a material, adverse effect on our results of operations or financial position.

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, 2021.

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.

(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, 2021, 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, 2021, 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, 2021 and 2020, and the related consolidated statements of income, comprehensive income, stockholders' equity (deficit), and cash flows for each of the three years in the period ended December 31, 2021, and the related notes and our report dated February 18, 2022 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 18, 2022

(c) Changes in Internal Control Over Financial Reporting

During the fourth quarter of 2021, there were no changes in our internal control over financial reporting that materially affected or are reasonably likely to materially affect our internal control over financial reporting.

Item 9B. *Other Information*

None.

Item 9C. *Disclosure Regarding Foreign Jurisdictions that Prevent Inspections*

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 2022 Annual Meeting of Stockholders with respect to our directors and is set forth in Item 1 of Part I of this annual report on Form 10-K with respect to our executive officers. The information required by this Item contained in such definitive proxy materials is incorporated herein by reference.

Information on the beneficial ownership reporting for our directors and executive officers required by this Item is contained under the caption "Delinquent Section 16(a) Reports" in the definitive proxy materials to be filed in connection with our 2022 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 2022 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 Investor Relations Department, 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 2022 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 2022 Annual Meeting of Stockholders, which information is incorporated herein by reference.

This table provides certain information as of December 31, 2021 with respect to our equity compensation plans:

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

	(a)	(b)	(c)
	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))
Equity compensation plans approved by security holders	10.722(1)	\$113.15(1)	21.463(2)
Equity compensation plans not approved by security holders	—	—	—
Total	<u>10.722</u>	<u>\$113.15</u>	<u>21.463</u>

- (1) Includes 2.191 million restricted share units which vest solely based upon continued employment over a specific period of time and 2.083 million performance share units which vest based upon continued employment over a specific period of time and the achievement of predetermined financial targets over time. The performance share units reported reflect the number of performance share units that would vest upon achievement of target performance; the number of performance share units that vest can vary from zero (for actual performance less than 90% of target) to two times the units granted (for actual performance of 110% or more of target). The weighted average exercise price does not take these restricted share units and performance share units into account.
- (2) Includes 16.290 million shares available for future grants under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates and 5.173 million shares of common stock reserved for future issuance under the HCA Holdings, Inc. Employee Stock Purchase Plan.

* For additional information concerning our equity compensation plans, see the discussion in Note 2 — Share-Based Compensation in the notes to the consolidated financial statements.

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

The information required by this Item is set forth under the headings “Certain Relationships and Related Party Transactions” and “Corporate Governance” in the definitive proxy materials to be filed in connection with our 2022 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 2022 Annual Meeting of Stockholders, which information is incorporated herein by reference.

PART IV

Item 15. Exhibits and Financial Statement Schedules

(a) Documents filed as part of the report:

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

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

3. List of Exhibits

- 2.1 — Agreement and Plan of Merger, dated July 24, 2006, by and among HCA Inc., Hercules Holding II, LLC and Hercules Acquisition Corporation (filed as Exhibit 2.1 to the Company's Current Report on Form 8-K filed July 25, 2006, 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, and incorporated herein by reference).
- 3.1 — Amended and Restated Certificate of Incorporation of the Company (restated for SEC filing purposes only) (filed as Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020, and incorporated herein by reference).
- 3.2 — Second Amended and Restated Bylaws of the Company (restated for SEC filing purposes only) (filed as Exhibit 3.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020, and incorporated herein by reference).
- 4.1 — Description of Registered Securities (filed as Exhibit 4.1 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2020, and incorporated herein by reference).
- 4.2 — Specimen Certificate for shares of Common Stock, par value \$0.01 per share, of the Company (filed as Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2017, and incorporated herein by reference).
- 4.3 — Security Agreement, dated as of November 17, 2006, by and 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, and incorporated herein by reference).
- 4.4 — Pledge Agreement, dated as of November 17, 2006, by and 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, and incorporated herein by reference).
- 4.5(a) — \$13,550,000,000 — €1,000,000,000 Credit Agreement, dated as of November 17, 2006, by and 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, and incorporated herein by reference).

- 4.5(b) — Amendment No. 1 to the Credit Agreement, dated as of February 16, 2007, by and 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, and incorporated herein by reference).
- 4.5(c) — Amendment No. 2 to the Credit Agreement, dated as of March 2, 2009, by and 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, and incorporated herein by reference).
- 4.5(d) — Amendment No. 3 to the Credit Agreement, dated as of June 18, 2009, by and 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, and incorporated herein by reference).
- 4.5(e) — Extension Amendment No. 1 to the Credit Agreement, dated as of April 6, 2010, by and 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, and incorporated herein by reference).
- 4.5(f) — Amended and Restated Joinder Agreement No. 1, dated as of November 8, 2010, by and among each of the financial institutions listed as a “Replacement-1 Revolving Credit Lender” on Schedule A thereto, HCA Inc., Bank of America, N.A., as Administrative Agent and as Collateral Agent, and the other parties listed on the signature pages thereto (filed as Exhibit 4.1 to the Company’s Quarterly Report on Form 10-Q for the quarter ended September 30, 2010, and incorporated herein by reference).
- 4.5(g) — Restatement Agreement, dated as of May 4, 2011, by and among HCA Inc., HCA UK Capital Limited, the lenders party thereto and Bank of America, N.A., as administrative agent and collateral agent to the Credit Agreement, dated as of November 17, 2006, as amended on February 16, 2007, March 2, 2009, June 18, 2009, April 6, 2010 and November 8, 2010 (filed as Exhibit 10.1 to the Company’s Current Report on Form 8-K filed May 9, 2011, and incorporated herein by reference).
- 4.5(h) — Extension Amendment No. 1, dated as of April 25, 2012, by and among HCA Inc., HCA UK Capital Limited, each of the U.S. Guarantors, each of the European Guarantors, the lenders party thereto and Bank of America, N.A., as administrative agent, swingline lender and letter of credit issuer (filed as Exhibit 10.1 to the Company’s Current Report on Form 8-K filed April 26, 2012, and incorporated herein by reference).

- 4.5(i) — Restatement Agreement, dated as of February 26, 2014, to (i) the Credit Agreement, dated as of November 17, 2006 and as amended and restated as of May 4, 2011, by and among the HCA Inc., HCA UK Capital Limited, the lenders party thereto and Bank of America, N.A., as administrative agent and collateral agent and (ii) the U.S. Guarantee, dated as of November 17, 2006, by and among the guarantors party thereto and Bank of America, N.A., as administrative agent (filed as Exhibit 4.1 to the Company’s Current Report on Form 8-K filed February 28, 2014, and incorporated herein by reference).
- 4.5(j) — Supplement No. 14, dated as of November 9, 2015, to the U.S. Guarantee, dated as of November 17, 2006 and amended and restated on February 26, 2014, by and among the guarantors party thereto and Bank of America, N.A., as administrative agent (filed as Exhibit 4.4(j) to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).
- 4.5(k) — Schedule of Omitted Supplements to the U.S. Guarantee, dated as of November 17, 2006 and amended and restated on February 26, 2014, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.
- 4.5(l) — Restatement Agreement, dated as of June 28, 2017, to the Credit Agreement, dated as of November 17, 2006, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.1 to the Company’s Current Report on Form 8-K filed June 30, 2017, and incorporated herein by reference).
- 4.5(m) — Joinder Agreement No. 8, dated as of July 16, 2019, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.1 to the Company’s Current Report on Form 8-K filed July 22, 2019, and incorporated herein by reference).
- 4.5(n) — Joinder Agreement No. 9, dated as of October 8, 2019, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.1 to the Company’s Current Report on Form 8-K filed October 10, 2019, and incorporated herein by reference).
- 4.5(o) — Joinder Agreement No. 10, dated as of November 20, 2019, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.1 to the Company’s Current Report on Form 8-K filed November 21, 2019, and incorporated herein by reference).
- 4.5(p) — Restatement Agreement, dated as of June 30, 2021, to the Credit Agreement, dated as of November 17, 2006, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.10 to the Company’s Current Report on Form 8-K filed July 1, 2021, and incorporated herein by reference).
- 4.6(a) — Security Agreement, dated as November 17, 2006, and amended and restated as of March 2, 2009, by and 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, and incorporated herein by reference).
- 4.6(b) — Supplement No. 2, dated as of October 27, 2011, to the Amended and Restated Security Agreement, dated as of March 2, 2009, as supplemented, by and among the subsidiary grantor named therein and Bank of America, N.A., as collateral agent (filed as Exhibit 4.5(b) to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).

- 4.6(c) — Schedule of Omitted Supplements to the Security Agreement, dated as of November 17, 2006 and amended and restated as of March 2, 2009, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.
- 4.7(a) — Pledge Agreement, dated as of November 17, 2006, and amended and restated as of March 2, 2009, by and 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, and incorporated herein by reference).
- 4.7(b) — Supplement No. 1 dated as of October 27, 2011 to the Amended and Restated Pledge Agreement, dated as of March 2, 2009, by and among the subsidiary pledgors named therein and Bank of America, N.A., as collateral agent (filed as Exhibit 4.6(b) to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).
- 4.7(c) — Schedule of Omitted Supplements to the Pledge Agreement, dated as of November 6, 2006 and amended and restated as of March 2, 2009, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.
- 4.8(a) — \$2,500,000,000 Credit Agreement, dated as of September 30, 2011, by and among HCA Inc., the subsidiary borrowers party thereto, the lenders from time to time party thereto and Bank of America, N.A., as administrative agent (filed as Exhibit 4.4 to the Company’s Current Report on Form 8-K filed October 3, 2011, and incorporated herein by reference).
- 4.8(b) — Restatement Agreement, dated as of March 7, 2014, to the Credit Agreement, dated as of September 30, 2011, by and among HCA Inc., the subsidiary borrowers party thereto, the lenders party thereto and Bank of America, N.A. as administrative agent and collateral agent (filed as Exhibit 4.1 to the Company’s Current Report on Form 8-K filed March 11, 2014, and incorporated herein by reference).
- 4.8(c) — Joinder Agreement and Amendment No. 1, dated as of October 30, 2014, to the Credit Agreement, dated as of September 30, 2011 and amended and restated as of March 7, 2014, by and among HCA Inc., the subsidiary borrowers party thereto, the lenders party thereto and Bank of America, N.A. as administrative agent and collateral agent (filed as Exhibit 4.1 to the Company’s Current Report on Form 8-K filed October 31, 2014, and incorporated herein by reference).
- 4.8(d) — Restatement Agreement, dated as of June 28, 2017, to the Credit Agreement, dated as of September 30, 2011, by and among HCA Inc., as borrower, the subsidiary borrowers party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.2 to the Company’s Current Report on Form 8-K filed June 30, 2017, and incorporated herein by reference).
- 4.8(e) — Joinder Agreement, dated as of January 3, 2018, to the Credit Agreement, dated as of September 30, 2011 (as amended and restated on March 7, 2014, as further amended on October 30, 2014, and as further amended and restated on June 28, 2017), by and among the subsidiary borrowers party thereto and Bank of America, N.A., as administrative agent (filed as Exhibit 4.7(e) to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).
- 4.8(f) — Restatement Agreement, dated as of June 30, 2021, to the Credit Agreement, dated as of September 30, 2011, by and among HCA Inc., as parent 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 4.11 to the Company’s Current Report on Form 8-K filed July 1, 2021, and incorporated herein by reference).

- 4.9(a) — Security Agreement, dated as of September 30, 2011, by and among HCA Inc., the subsidiary borrowers party thereto and Bank of America, N.A., as collateral agent (filed as Exhibit 4.5 to the Company’s Current Report on Form 8-K filed October 3, 2011, and incorporated herein by reference).
- 4.9(b) — Supplement No. 1, dated as of October 27, 2011, to the Security Agreement dated as of September 30, 2011, by and among the subsidiary borrower party thereto and Bank of America, N.A., as collateral agent (filed as Exhibit 4.8(b) to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).
- 4.9(c) — Schedule of Omitted Supplements to the Security Agreement dated as of September 30, 2011, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.
- 4.10(a) — General Intercreditor Agreement, dated as of November 17, 2006, by and between Bank of America, N.A., as First Lien Collateral Agent, and The Bank of New York, as Junior Lien Collateral Agent (filed as Exhibit 4.13(a) to the Company’s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.10(b) — Receivables Intercreditor Agreement, dated as of November 17, 2006, by and among Bank of America, N.A., as ABL Collateral Agent, Bank of America, N.A., as CF Collateral Agent and The Bank of New York, as Bonds Collateral Agent (filed as Exhibit 4.13(b) to the Company’s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.10(c) — First Lien Intercreditor Agreement, dated as of April 22, 2009, by and among Bank of America, N.A. as Collateral Agent, Bank of America, N.A. as Authorized Representative under the Credit Agreement and Law Debenture Trust Company of New York as the Initial Additional Authorized Representative (filed as Exhibit 4.5 to the Company’s Current Report on Form 8-K filed April 28, 2009, and incorporated herein by reference).
- 4.10(d) — Additional General Intercreditor Agreement, dated as of August 1, 2011, by and among Bank of America, N.A., in its capacity as First Lien Collateral Agent, The Bank of New York Mellon, in its capacity as Junior Lien Collateral Agent and in its capacity as trustee for the Second Lien Notes issued on November 17, 2006, and The Bank of New York Mellon Trust Company, N.A., in its capacity as trustee for the Second Lien Notes issued on February 19, 2009 (filed as Exhibit 4.9 to the Company’s Current Report on Form 8-K filed August 1, 2011, and incorporated herein by reference).
- 4.10(e) — Additional Receivables Intercreditor Agreement, dated as of August 1, 2011, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent (filed as Exhibit 4.10 to the Company’s Current Report on Form 8-K filed August 1, 2011, and incorporated herein by reference).
- 4.10(f) — Additional General Intercreditor Agreement, dated as of February 16, 2012, by and among Bank of America, N.A., in its capacity as First Lien Collateral Agent, The Bank of New York Mellon, in its capacity as Junior Lien Collateral Agent and in its capacity as trustee for the Second Lien Notes issued on November 17, 2006, and The Bank of New York Mellon Trust Company, N.A., in its capacity as trustee for the Second Lien Notes issued on February 19, 2009 (filed as Exhibit 4.9 to the Company’s Current Report on Form 8-K filed February 16, 2012, and incorporated herein by reference).
- 4.10(g) — Additional Receivables Intercreditor Agreement, dated as of February 16, 2012, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent (filed as Exhibit 4.10 to the Company’s Current Report on Form 8-K filed February 16, 2012, and incorporated herein by reference).

- 4.10(h) — Additional General Intercreditor Agreement, dated as of October 23, 2012, by and among Bank of America, N.A., in its capacity as First Lien Collateral Agent, The Bank of New York Mellon, in its capacity as Junior Lien Collateral Agent and in its capacity as trustee for the Second Lien Notes issued on November 17, 2006, and The Bank of New York Mellon Trust Company, N.A., in its capacity as trustee for the Second Lien Notes issued on February 19, 2009 (filed as Exhibit 4.10 to the Company’s Current Report on Form 8-K filed October 23, 2012, and incorporated herein by reference).
- 4.10(i) — Additional Receivables Intercreditor Agreement, dated as of October 23, 2012, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent (filed as Exhibit 4.11 to the Company’s Current Report on Form 8-K filed October 23, 2012, and incorporated herein by reference).
- 4.11 — Registration Rights Agreement, dated as of November 22, 2010, by and 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, and incorporated herein by reference).
- 4.12 — Registration Rights Agreement, dated as of March 16, 1989, by and among HCA-Hospital Corporation of America and the persons listed on the signature pages thereto (filed as Exhibit 4.14 to the Company’s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.13 — Assignment and Assumption Agreement, dated as of February 10, 1994, by and between HCA-Hospital Corporation of America and Columbia Healthcare Corporation relating to the Registration Rights Agreement, as amended (filed as Exhibit 4.15 to the Company’s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.14(a) — Indenture, dated as of December 16, 1993, by and between the Company and The First National Bank of Chicago, as Trustee (filed as Exhibit 4.16(a) to the Company’s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.14(b) — First Supplemental Indenture, dated as of May 25, 2000, by and between the Company and Bank One Trust Company, N.A., as Trustee (filed as Exhibit 4.16(b) to the Company’s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.14(c) — Second Supplemental Indenture, dated as of July 1, 2001, by and between the Company and Bank One Trust Company, N.A., as Trustee (filed as Exhibit 4.16(c) to the Company’s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.14(d) — Third Supplemental Indenture, dated as of December 5, 2001, by and between the Company and The Bank of New York, as Trustee (filed as Exhibit 4.16(d) to the Company’s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.14(e) — Fourth Supplemental Indenture, dated as of November 14, 2006, by and 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, and incorporated herein by reference).
- 4.15 — Form of 7.5% Debenture due 2023 (filed as Exhibit 4.17 to the Company’s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.16 — Form of 8.36% Debenture due 2024 (filed as Exhibit 4.18 to the Company’s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.17 — Form of Fixed Rate Global Medium-Term Note (filed as Exhibit 4.19 to the Company’s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

- 4.18 — Form of Floating Rate Global Medium-Term Note (filed as Exhibit 4.20 to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.19 — Form of 7.69% Note due 2025 (filed as Exhibit 4.10 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2004, and incorporated herein by reference).
- 4.20 — Form of 7.50% Debenture due 2095 (filed as Exhibit 4.23 to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.21 — Form of 7.05% Debenture due 2027 (filed as Exhibit 4.24 to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
- 4.22 — 7.50% Note due 2033 in the principal amount of \$250,000,000 (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed November 6, 2003, 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, by and 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. 5, dated as of October 23, 2012, by and 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, and incorporated herein by reference).
- 4.26(a) — Supplemental Indenture No. 6, dated as of October 23, 2012, by and 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, and incorporated herein by reference).
- 4.26(b) — Supplemental Indenture, dated as of March 31, 2020, by and among the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.13(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2020, and incorporated herein by reference).
- 4.26(c) — Schedule of Omitted Supplemental Indentures to Supplemental Indentures, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.
- 4.27 — Form of 5.875% Senior Notes due 2023 (included in Exhibit 4.25).
- 4.28 — Form of 4.75% Senior Secured Notes due 2023 (included in Exhibit 4.26(a)).
- 4.29 — Indenture, dated as of December 6, 2012, by and 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, and incorporated herein by reference).

- 4.30 — Supplemental Indenture No. 8, dated as of March 17, 2014, by and 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, and incorporated herein by reference).
- 4.31 — Form of 5.00% Senior Secured Notes due 2024 (included in Exhibit 4.30).
- 4.32 — 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, and incorporated herein by reference).
- 4.33 — Supplemental Indenture No. 10, dated as of October 17, 2014, by and 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, and incorporated herein by reference).
- 4.34 — Form of 5.25% Senior Secured Notes due 2025 (included in Exhibit 4.33).
- 4.35 — 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, and incorporated herein by reference).
- 4.36 — Supplemental Indenture No. 11, dated as of January 16, 2015, by and 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, and incorporated herein by reference).
- 4.37 — Form of 5.375% Senior Notes due 2025 (included in Exhibit 4.36).
- 4.38 — Supplemental Indenture No. 12, dated as of May 20, 2015, by and 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, and incorporated herein by reference).
- 4.39 — Supplemental Indenture No. 13, dated as of November 13, 2015, by and 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, and incorporated herein by reference).
- 4.40 — Form of 5.875% Senior Notes due 2026 (included in Exhibit 4.39).
- 4.41 — Supplemental Indenture No. 14, dated as of December 8, 2015, by and 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, and incorporated herein by reference).
- 4.42 — Supplemental Indenture No. 15, dated as of March 15, 2016, by and 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, and incorporated herein by reference).

- 4.43 — Form of 5.250% Senior Secured Notes due 2026 (included in Exhibit 4.42).
- 4.44 — 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, and incorporated herein by reference).
- 4.45 — Supplemental Indenture No. 16, dated as of August 15, 2016, by and 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, and incorporated herein by reference).
- 4.46 — Form of 4.500% Senior Secured Notes due 2027 (included in Exhibit 4.45).
- 4.47 — 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, and incorporated herein by reference).
- 4.48 — Supplemental Indenture No. 17, dated as of December 9, 2016, by and 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, and incorporated herein by reference).
- 4.49 — Supplemental Indenture No. 18, dated as of June 22, 2017, by and 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 June 22, 2017, and incorporated herein by reference).
- 4.50 — Form of 5.500% Senior Secured Notes due 2047 (included in Exhibit 4.49).
- 4.51 — 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 June 22, 2017, and incorporated herein by reference).
- 4.52 — Supplemental Indenture No. 19, dated as of August 23, 2018, by and 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 August 23, 2018, and incorporated herein by reference).
- 4.53 — Form of 5.375% Senior Notes Due 2026 (included in Exhibit 4.52).
- 4.54 — Supplemental Indenture No. 20, dated as of August 23, 2018, by and 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 August 23, 2018, and incorporated herein by reference).
- 4.55 — Form of 5.625% Senior Notes Due 2028 (included in Exhibit 4.54).
- 4.56 — Supplemental Indenture No. 21, dated as of January 22, 2019, by and 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 January 22, 2019, and incorporated herein by reference).

- 4.57 — Supplemental Indenture No. 22, dated as of January 30, 2019, by and 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 January 30, 2019, and incorporated herein by reference).
- 4.58 — Form of 5.875% Senior Notes Due 2029 (included in Exhibit 4.57).
- 4.59 — Supplemental Indenture No. 23, dated as of June 12, 2019, by and 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 June 12, 2019, and incorporated herein by reference).
- 4.60 — Supplemental Indenture No. 24, dated as of June 12, 2019, by and among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed June 12, 2019, and incorporated herein by reference).
- 4.61 — Supplemental Indenture No. 25, dated as of June 12, 2019, by and among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed June 12, 2019, and incorporated herein by reference).
- 4.62 — Form of 4 1/8% Senior Secured Notes due 2029 (included in Exhibit 4.59).
- 4.63 — Form of 5 1/8% Senior Secured Notes due 2039 (included in Exhibit 4.60).
- 4.64 — Form of 5 1/4% Senior Secured Notes due 2049 (included in Exhibit 4.61).
- 4.65 — Additional Receivables Intercreditor Agreement, dated as of June 12, 2019, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as First Lien Collateral Agent (filed as Exhibit 4.11 to the Company's Current Report on Form 8-K filed June 12, 2019, and incorporated herein by reference).
- 4.66 — Supplemental Indenture No. 26, dated as of February 26, 2020, by and 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 February 26, 2020, and incorporated herein by reference).
- 4.67 — Form of 3.500% Senior Notes Due 2030 (included in Exhibit 4.66).
- 4.68 — Supplemental Indenture No. 27, dated as of June 30, 2021, by and 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 July 1, 2021, and incorporated herein by reference).
- 4.69 — Supplemental Indenture No. 28, dated as of June 30, 2021, by and among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed July 1, 2021, and incorporated herein by reference).
- 4.70 — Form of 2 3/8% Senior Secured Notes Due 2031 (included in Exhibit 4.68).
- 4.71 — Form of 3 1/2% Senior Secured Notes Due 2051 (included in Exhibit 4.69).

- 4.72 — Additional Receivables Intercreditor Agreement, dated as of June 30, 2021, 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 4.9 to the Company’s Current Report on Form 8-K filed July 1, 2021, and incorporated herein by reference).
- 10.1 — Form of Indemnity Agreement with certain officers and directors (filed as Exhibit 10.3 to the Company’s Registration Statement on Form S-4 (File No. 333-145054) and incorporated herein by reference).
- 10.2(a) — 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates as Amended and Restated (filed as Exhibit 10.11(b) to the Company’s Registration Statement on Form S-1 (File No. 333-171369), and incorporated herein by reference).*
- 10.2(b) — First Amendment to 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.1 to the Company’s Quarterly Report on Form 10-Q for the quarter ended June 30, 2011, 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, 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, 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 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, and incorporated herein by reference).*
- 10.5 — 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, and incorporated herein by reference).*
- 10.6 — Retirement Agreement, dated as of January 1, 2002, by and between the Company and Thomas F. Frist, Jr., M.D. (filed as Exhibit 10.30 to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2001, and incorporated herein by reference).*
- 10.7(a) — 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, and incorporated herein by reference).*
- 10.7(b) — Amendment, dated December 22, 2020, to Amended and Restated HCA Supplemental Executive Retirement Plan (filed as Exhibit 10.7(b) to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2020, and incorporated herein by reference).*
- 10.8(a) — 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, and incorporated herein by reference).*

- 10.8(b) — Amendment to the Amended and Restated HCA Restoration Plan, effective June 5, 2020 (filed as Exhibit 10.5 to the Company’s Quarterly Report on Form 10-Q for the quarter ended June 30, 2020, and incorporated herein by reference).*
- 10.9(a) — 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 , and incorporated herein by reference).*
- 10.9(b) — 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, and incorporated herein by reference).*
- 10.9(c) — 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, and incorporated herein by reference).*
- 10.9(d) — Second Amendment to Employment Agreement effective January 29, 2015 (Samuel N. Hazen) (filed as Exhibit 10.23(i) to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2014 (File No. 001-11239), and incorporated herein by reference).*
- 10.9(e) — 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, and incorporated herein by reference).*
- 10.9(f) — 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, and incorporated herein by reference).*
- 10.9(g) — 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, and incorporated herein by reference).*
- 10.9(h) — Fifth Amendment to Employment Agreement effective January 1, 2019 (Samuel N. Hazen) (filed as Exhibit 10.14(i) to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).*
- 10.10 — Indemnification Priority and Information Sharing Agreement, dated as of November 1, 2009, by and 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 , and incorporated herein by reference).
- 10.11 — Assignment and Assumption Agreement, dated November 22, 2010, by and among HCA Inc., HCA Holdings, Inc. and HCA Merger Sub LLC (filed as Exhibit 10.1 to the Company’s Current Report on Form 8-K filed November 24, 2010, and incorporated herein by reference).
- 10.12 — Omnibus Amendment to Various Stock and Option Plans and the Management Stockholders’ Agreement, dated November 22, 2010 (filed as Exhibit 10.2 to the Company’s Current Report on Form 8-K filed November 24, 2010, and incorporated herein by reference).*
- 10.13 — Omnibus Amendment to Stock Option Agreements Issued Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as amended, effective February 16, 2011 (filed as Exhibit 10.38 to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2010, and incorporated herein by reference).*
- 10.14 — Stockholders’ Agreement, dated as of March 9, 2011, by and among the Company, Hercules Holding II, LLC and the other signatories thereto (filed as Exhibit 10.1 to the Company’s Current Report on Form 8-K filed March 16, 2011, and incorporated herein by reference).

- 10.15 — Amendment, dated as of September 21, 2011, to the Stockholders' Agreement, dated as of March 9, 2011 (filed as Exhibit 10.2 to the Company's Current Report on Form 8-K filed September 21, 2011, and incorporated herein by reference).
- 10.16 — Form of Director Restricted Share Unit Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, and incorporated herein by reference).*
- 10.17 — Executive Severance Policy (filed as Exhibit 10.46 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2013, and incorporated herein by reference).*
- 10.18 — HCA Holdings, Inc. Employee Stock Purchase Plan (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 25, 2014 (File No. 001-11239), and incorporated herein by reference).*
- 10.19 — Form of 2015 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed February 4, 2015, and incorporated herein by reference).*
- 10.20 — Form of 2016 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.50 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2015, and incorporated herein by reference).*
- 10.21 — Form of Director Restricted Share Unit Agreement (Annual Award) Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016, and incorporated herein by reference).*
- 10.22 — Form of 2017 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.42 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2016, and incorporated herein by reference).*
- 10.23 — 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, and incorporated herein by reference).*
- 10.24 — Form of 2019 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.41 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).*
- 10.25 — Form of 2019 Performance Share Unit Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.42 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).*
- 10.26 — HCA Healthcare, Inc. 2019 Senior Officer Performance Excellence Program (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 2, 2019, and incorporated herein by reference).*

- 10.27 — Form of 2020 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.32 to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2019, and incorporated herein by reference).*
- 10.28 — Form of 2020 Performance Share Unit Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.33 to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2019, and incorporated herein by reference).*
- 10.29 — 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc., and its Affiliates (filed as Exhibit 4.4 to the Company’s Registration Statement on Form S-8, and incorporated herein by reference).*
- 10.30 — Form of Stock Appreciation Right Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 4.5 to the Company’s Registration Statement on Form S-8 (File No. 333-237967), and incorporated herein by reference).*
- 10.31 — Form of Employee Restricted Share Unit Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 4.6 to the Company’s Registration Statement on Form S-8 (File No. 333-237967), and incorporated herein by reference).*
- 10.32 — Form of Performance Share Unit Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 4.7 to the Company’s Registration Statement on Form S-8 (File No. 333-237967), and incorporated herein by reference).*
- 10.33 — HCA Healthcare, Inc. 2020 Senior Officer Performance Excellence Program (filed as Exhibit 10.1 to the Company’s Current Report on Form 8-K filed April 2, 2020, and incorporated herein by reference).*
- 10.34 — Form of Director Restricted Share Unit Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 10.2 to the Company Quarterly Report on Form 10-Q for the quarter ended March 31, 2020, and incorporated herein by reference).*
- 10.35 — Form of 2021 Stock Appreciation Right Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 10.37 to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2020, and incorporated herein by reference).*
- 10.36 — Form of 2021 Performance Share Unit Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 10.38 to the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2020, and incorporated herein by reference).*
- 10.37 — HCA Healthcare, Inc. 2021 Senior Officer Performance Excellence Program (filed as Exhibit 10.1 to the Company’s Current Report on Form 8-K filed April 9, 2021, and incorporated herein by reference).*
- 10.38 — Form of 2022 Stock Appreciation Right Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates.*

- 10.39 — Form of 2022 Performance Share Unit Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates.*
- 21 — List of Subsidiaries.
- 22 — List of Subsidiary Guarantors and Pledged Securities.
- 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, 2021, filed with the SEC on February 18, 2022, formatted in Extensible Business Reporting Language (XBRL): (i) the consolidated balance sheets at December 31, 2021 and 2020, (ii) the consolidated income statements for the years ended December 31, 2021, 2020 and 2019, (iii) the consolidated comprehensive income statements for the years ended December 31, 2021, 2020 and 2019, (iv) the consolidated statements of stockholders' equity (deficit) for the years ended December 31, 2021, 2020 and 2019, (v) the consolidated statements of cash flows for the years ended December 31, 2021, 2020 and 2019, and (vi) the notes to consolidated financial statements.
- 104 — The cover page from the Company's Annual Report on Form 10-K for the year ended December 31, 2021, formatted in Inline XBRL (included in Exhibit 101).

* Management compensatory plan or arrangement.

Item 16. Form 10-K Summary

None.

HCA HEALTHCARE, INC.

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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, 2021 and 2020, the related consolidated statements of income, comprehensive income, stockholders' equity (deficit) and cash flows for each of the three years in the period ended December 31, 2021, 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, 2021 and 2020, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2021, 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, 2021, 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 18, 2022 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.

Critical Audit Matters

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

Revenue Recognition

Description of the Matter

For the year ended December 31, 2021, the Company's revenues were \$58.752 billion. As discussed in Note 1 to the consolidated financial statements, revenues are based upon the estimated amounts the Company expects to be entitled to receive from patients and third-party payers. Estimates of contractual allowances under managed care, commercial, and governmental insurance plans are based upon the payment terms specified in the related contractual agreements or as mandated under government payer programs. Management continually reviews the contractual allowances estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals. Revenues related to uninsured patients and uninsured copayment and deductible amounts for patients who have health care insurance coverage may have discounts applied (uninsured discounts and contractual discounts). The Company also records estimated implicit price concessions (based primarily on historical collection experience) related to uninsured accounts to record these revenues and accounts receivable at the estimated amounts the Company expects to collect. The primary collection risks relate to uninsured patient accounts, including amounts owed from patients after insurance has paid the amounts covered by the applicable agreement. Implicit price concessions relate primarily to amounts due directly from patients and are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators.

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

How We Addressed the Matter in Our Audit

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

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

Professional Liability Claims

Description of the Matter

At December 31, 2021, the Company's reserves for professional liability risks were \$2.022 billion and the Company's related provision for losses for the year ended December 31, 2021 was \$453 million. As discussed in Note 1 to the consolidated financial statements, reserves for professional liability risks represent the estimated ultimate cost of all reported and unreported losses incurred and unpaid as of the consolidated balance sheet date. Management determines professional liability reserves and provisions for losses using individual case-basis valuations and actuarial analyses. Trends in the average frequency (number of claims) and ultimate average severity (cost per claim) of claims are significant assumptions in estimating the reserves.

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

How We Addressed the Matter in Our Audit

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

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

/s/ Ernst & Young LLP

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

Nashville, Tennessee
February 18, 2022

HCA HEALTHCARE, INC.
CONSOLIDATED INCOME STATEMENTS
FOR THE YEARS ENDED DECEMBER 31, 2021, 2020 AND 2019
(Dollars in millions, except per share amounts)

	<u>2021</u>	<u>2020</u>	<u>2019</u>
Revenues	\$ 58,752	\$ 51,533	\$ 51,336
Salaries and benefits	26,779	23,874	23,560
Supplies	9,481	8,369	8,481
Other operating expenses	9,961	9,307	9,481
Equity in earnings of affiliates	(113)	(54)	(43)
Depreciation and amortization	2,853	2,721	2,596
Interest expense	1,566	1,584	1,824
Losses (gains) on sales of facilities	(1,620)	7	(18)
Losses on retirement of debt	12	295	211
	<u>48,919</u>	<u>46,103</u>	<u>46,092</u>
Income before income taxes	9,833	5,430	5,244
Provision for income taxes	2,112	1,043	1,099
Net income	7,721	4,387	4,145
Net income attributable to noncontrolling interests	765	633	640
Net income attributable to HCA Healthcare, Inc.	<u>\$ 6,956</u>	<u>\$ 3,754</u>	<u>\$ 3,505</u>
Per share data:			
Basic earnings per share	\$ 21.52	\$ 11.10	\$ 10.27
Diluted earnings per share	\$ 21.16	\$ 10.93	\$ 10.07
Shares used in earnings per share calculations (in millions):			
Basic	323.315	338.274	341.210
Diluted	328.752	343.605	348.226

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

HCA HEALTHCARE, INC.
CONSOLIDATED COMPREHENSIVE INCOME STATEMENTS
FOR THE YEARS ENDED DECEMBER 31, 2021, 2020 AND 2019
(Dollars in millions)

	<u>2021</u>	<u>2020</u>	<u>2019</u>
Net income	\$7,721	\$4,387	\$4,145
Other comprehensive income (loss) before taxes:			
Foreign currency translation	(9)	18	5
Unrealized (losses) gains on available-for-sale securities	(16)	14	15
Defined benefit plans	87	(71)	(63)
Pension costs included in salaries and benefits	28	28	13
	115	(43)	(50)
Change in fair value of derivative financial instruments	1	(66)	(50)
Interest costs (benefits) included in interest expense	37	24	(17)
	38	(42)	(67)
Other comprehensive income (loss) before taxes	128	(53)	(97)
Income taxes (benefits) related to other comprehensive income items	30	(11)	(18)
Other comprehensive income (loss)	98	(42)	(79)
Comprehensive income	7,819	4,345	4,066
Comprehensive income attributable to noncontrolling interests	765	633	640
Comprehensive income attributable to HCA Healthcare, Inc.	<u>\$7,054</u>	<u>\$3,712</u>	<u>\$3,426</u>

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

HCA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS
DECEMBER 31, 2021 AND 2020
(Dollars in millions)

	2021	2020
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 1,451	\$ 1,793
Accounts receivable	8,095	7,051
Inventories	1,986	2,025
Other	2,010	1,464
	13,542	12,333
Property and equipment, at cost:		
Land	2,496	2,269
Buildings	19,211	18,471
Equipment	28,256	27,082
Construction in progress	1,387	1,495
	51,350	49,317
Accumulated depreciation	(27,287)	(26,118)
	24,063	23,199
Investments of insurance subsidiaries	438	388
Investments in and advances to affiliates	448	422
Goodwill and other intangible assets	9,540	8,578
Right-of-use operating lease assets	2,113	2,024
Other	598	546
	\$ 50,742	\$ 47,490
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable	\$ 4,111	\$ 3,535
Accrued salaries	1,912	1,720
Other accrued expenses	3,322	3,240
Long-term debt due within one year	237	209
	9,582	8,704
Long-term debt, less debt issuance costs and discounts of \$248 and \$236	34,342	30,795
Professional liability risks	1,514	1,486
Right-of-use operating lease obligations	1,755	1,673
Income taxes and other liabilities	2,060	1,940
Stockholders' equity:		
Common stock \$0.01 par; authorized 1,800,000,000 shares; outstanding 305,476,800 shares — 2021 and 339,425,600 shares — 2020	3	3
Capital in excess of par value	—	294
Accumulated other comprehensive loss	(404)	(502)
Retained earnings (deficit)	(532)	777
	(933)	572
Stockholders' equity (deficit) attributable to HCA Healthcare, Inc.	2,422	2,320
Noncontrolling interests	1,489	2,892
	\$ 50,742	\$ 47,490

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

HCA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY (DEFICIT)
FOR THE YEARS ENDED DECEMBER 31, 2021, 2020 AND 2019
(Dollars in millions)

	Equity (Deficit) Attributable to HCA Healthcare, Inc.						
	Common Stock		Capital in Excess of Par Value	Accumulated Other Comprehensive Loss	Retained Earnings (Deficit)	Equity Attributable to Noncontrolling Interests	Total
	Shares (in millions)	Par Value					
Balances, December 31, 2018	342.895	\$3	\$ —	\$(381)	\$(4,572)	\$2,032	\$(2,918)
Comprehensive income							
(loss)				(79)	3,505	640	4,066
Repurchase of common							
stock	(7.949)		(302)		(729)		(1,031)
Share-based benefit plans . . .	3.500		313				313
Cash dividends declared							
(\$1.60 share)					(555)		(555)
Distributions						(542)	(542)
Other			(11)			113	102
Balances, December 31, 2019	338.446	3	—	(460)	(2,351)	2,243	(565)
Comprehensive income							
(loss)				(42)	3,754	633	4,345
Repurchase of common							
stock	(3.287)				(441)		(441)
Share-based benefit plans . . .	4.267		300		(35)		265
Cash dividends declared							
(\$0.43 share)					(150)		(150)
Distributions						(626)	(626)
Other			(6)			70	64
Balances, December 31, 2020	339.426	3	294	(502)	777	2,320	2,892
Comprehensive income				98	6,956	765	7,819
Repurchase of common							
stock	(37.812)		(578)		(7,637)		(8,215)
Share-based benefit plans . . .	3.863		280				280
Cash dividends declared							
(\$1.92 share)					(628)		(628)
Distributions						(749)	(749)
Other			4			86	90
Balances, December 31, 2021	<u>305.477</u>	<u>\$3</u>	<u>\$ —</u>	<u>\$(404)</u>	<u>\$(532)</u>	<u>\$2,422</u>	<u>\$ 1,489</u>

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

HCA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2021, 2020 AND 2019
(Dollars in millions)

	<u>2021</u>	<u>2020</u>	<u>2019</u>
Cash flows from operating activities:			
Net income	\$ 7,721	\$ 4,387	\$ 4,145
Adjustments to reconcile net income to net cash provided by operating activities:			
Increase (decrease) in cash from operating assets and liabilities:			
Accounts receivable	(962)	327	(326)
Inventories and other assets	(540)	(304)	(158)
Accounts payable and accrued expenses	999	1,255	396
Depreciation and amortization	2,853	2,721	2,596
Income taxes	(70)	41	250
Losses (gains) on sales of facilities	(1,620)	7	(18)
Losses on retirement of debt	12	295	211
Amortization of debt issuance costs	27	30	30
Share-based compensation	440	362	347
Other	99	111	129
Net cash provided by operating activities	<u>8,959</u>	<u>9,232</u>	<u>7,602</u>
Cash flows from investing activities:			
Purchase of property and equipment	(3,577)	(2,835)	(4,158)
Acquisition of hospitals and health care entities	(1,105)	(568)	(1,682)
Sales of hospitals and health care entities	2,160	68	61
Change in investments	(117)	(20)	25
Other	(4)	(38)	34
Net cash used in investing activities	<u>(2,643)</u>	<u>(3,393)</u>	<u>(5,720)</u>
Cash flows from financing activities:			
Issuances of long-term debt	4,344	2,700	6,451
Net change in revolving credit facilities	2,780	(2,480)	(560)
Repayment of long-term debt	(3,869)	(3,437)	(5,324)
Distributions to noncontrolling interests	(749)	(626)	(542)
Payment of debt issuance costs	(38)	(35)	(73)
Payment of dividends	(624)	(153)	(550)
Repurchase of common stock	(8,215)	(441)	(1,031)
Other	(284)	(205)	(142)
Net cash used in financing activities	<u>(6,655)</u>	<u>(4,677)</u>	<u>(1,771)</u>
Effect of exchange rate changes on cash and cash equivalents	(3)	10	8
Change in cash and cash equivalents	(342)	1,172	119
Cash and cash equivalents at beginning of period	1,793	621	502
Cash and cash equivalents at end of period	<u>\$ 1,451</u>	<u>\$ 1,793</u>	<u>\$ 621</u>
Interest payments	\$ 1,502	\$ 1,607	\$ 1,914
Income tax payments, net	\$ 2,182	\$ 1,002	\$ 849

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

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 — ACCOUNTING POLICIES

Reporting Entity

HCA Healthcare, Inc. is a holding company whose affiliates own and operate hospitals and related health care entities. The term “affiliates” includes direct and indirect subsidiaries of HCA Healthcare, Inc. and partnerships and joint ventures in which such subsidiaries are partners. At December 31, 2021 these affiliates owned and operated 182 hospitals, 125 freestanding surgery centers, 21 freestanding endoscopy 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 herein and unless otherwise stated or indicated by context, refer to HCA Healthcare, Inc. and its affiliates. The terms “facilities” or “hospitals” refer to entities owned and operated by affiliates of HCA and the term “employees” refers to employees of affiliates of HCA.

Basis of Presentation

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

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

The majority of our expenses are “cost of revenue” items. Costs that could be classified as general and administrative include our corporate office costs, which were \$400 million, \$416 million and \$370 million for the years ended December 31, 2021, 2020 and 2019, respectively.

COVID-19 Pandemic

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic. Patient volumes and the related revenues for most of our services were significantly impacted during the latter portion of the first quarter and the first half of the second quarter of 2020 and have continued to be impacted as various policies were implemented by federal, state and local governments in response to the COVID-19 pandemic. During the second quarter of 2021, our patient volumes improved as the effects of the pandemic moderated and certain pandemic-related restrictions and policies were eased. For the remainder of 2021, our patient volumes exhibited consistent growth over the prior year, with the exception of inpatient surgeries, and included a resurgence of COVID-19 admissions and the re-imposition of pandemic-related restrictions in certain markets. We believe the extent of the COVID-19 pandemic’s impact on our operating results and financial condition has been and will continue to be driven by many factors, most of which are beyond our control and ability to forecast. Because of these uncertainties, we cannot estimate how long or to what extent the pandemic will impact our operations.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 — ACCOUNTING POLICIES (continued)

Revenues

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

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

	Years Ended December 31,					
	<u>2021</u>	<u>Ratio</u>	<u>2020</u>	<u>Ratio</u>	<u>2019</u>	<u>Ratio</u>
Medicare	\$10,447	17.8%	\$10,420	20.2%	\$10,798	21.0%
Managed Medicare	8,424	14.3	6,997	13.6	6,452	12.6
Medicaid	2,290	3.9	1,965	3.8	1,572	3.1
Managed Medicaid	3,124	5.3	2,621	5.1	2,450	4.8
Managed care and other insurers	30,295	51.6	26,535	51.5	26,544	51.6
International (managed care and other insurers) ...	1,336	2.3	1,120	2.2	1,162	2.3
Other	2,836	4.8	1,875	3.6	2,358	4.6
Revenues	<u>\$58,752</u>	<u>100.0%</u>	<u>\$51,533</u>	<u>100.0%</u>	<u>\$51,336</u>	<u>100.0%</u>

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Estimated reimbursement amounts are adjusted in subsequent periods as cost reports are prepared and filed and as final settlements are determined (in relation to certain government programs, primarily

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 — ACCOUNTING POLICIES (continued)

Revenues (continued)

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 \$53 million, \$70 million and \$51 million in 2021, 2020 and 2019, respectively. The adjustments to estimated reimbursement amounts related primarily to cost reports filed during previous years resulted in a net increase to revenues of \$19 million in 2021, a net reduction to revenues of \$5 million in 2020 and a net increase to revenues of \$13 million in 2019.

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.

Patients treated at hospitals for non-elective care, who have income at or below 400% of the federal poverty level, are eligible for charity care, 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. Patients treated at hospitals for non-elective care, who have income above 400% of the federal poverty level, are eligible for certain other discounts which 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. We apply additional discounts to limit patient responsibility for certain emergency services. The federal poverty level is established by the federal government and is based on income and family size. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in revenues. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care. We may attempt to provide assistance to uninsured patients to help determine whether they may qualify for Medicaid, other federal or state assistance, or charity care. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

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

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

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 — ACCOUNTING POLICIES (continued)

Revenues (continued)

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 revenues. At December 31, 2021 and 2020, estimated implicit price concessions of \$6.784 billion and \$6.108 billion, respectively, had been recorded to adjust our revenues and accounts receivable to the estimated amounts we expect to collect.

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

	2021	2020	2019
Patient care costs (salaries and benefits, supplies, other operating expenses and depreciation and amortization)	\$49,074	\$44,271	\$44,118
Cost-to-charges ratio (patient care costs as percentage of gross patient charges)	11.3%	12.0%	12.0%
Total uncompensated care	\$29,642	\$29,029	\$31,105
Multiply by the cost-to-charges ratio	11.3%	12.0%	12.0%
Estimated cost of total uncompensated care	\$ 3,350	\$ 3,483	\$ 3,733

The total uncompensated care amounts include charity care of \$13.644 billion, \$13.763 billion and \$13.260 billion for the years ended December 31, 2021, 2020 and 2019, respectively. The estimated cost of charity care was \$1.542 billion, \$1.652 billion and \$1.591 billion for the years ended December 31, 2021, 2020 and 2019, respectively.

Cash and Cash Equivalents

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

Our cash management system provides for daily investment of available balances and the funding of outstanding checks when presented for payment. Outstanding, but unrepresented, checks totaling \$536 million and \$495 million at December 31, 2021 and 2020, 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.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 — ACCOUNTING POLICIES (continued)

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 49 days, 45 days and 50 days at December 31, 2021, 2020 and 2019, respectively. The five-day decline during 2020 was primarily related to the COVID-19 impacts of continuing to collect our accounts receivable from the pre-COVID-19 period, while experiencing lower revenues (primarily during the first and second quarters of 2020) that slowed the return of our accounts receivable balances back to pre-COVID-19 levels in 2021. 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 \$2.826 billion in 2021, \$2.693 billion in 2020 and \$2.579 billion in 2019. 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, 2021 and 2020, the investment securities held by our insurance subsidiaries were classified as “available-for-sale” as defined in Accounting Standards Codification (“ASC”) No. 320, *Investments — Debt Securities* and are recorded at fair value. The investment securities are held for the purpose of providing a funding source to pay liability claims covered by the insurance subsidiaries. We perform quarterly assessments of individual investment securities to determine whether declines in fair value are due to credit-related or noncredit-related factors. Our investment securities evaluation process involves subjective judgments, often involves estimating the outcome of future events, and requires a significant level of professional judgment in determining whether a credit-related impairment has occurred. We evaluate, among other things, the financial position and

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 — ACCOUNTING POLICIES (continued)

Investments of Insurance Subsidiaries (continued)

near term prospects of the issuer, conditions in the issuer's industry, liquidity of the investment, changes in the amount or timing of expected future cash flows from the investment, and recent downgrades of the issuer by a rating agency, to determine if, and when, a decline in the fair value of an investment below amortized cost is considered to be a credit-related impairment. The extent to which the fair value of the investment is less than amortized cost and our ability and intent to retain the investment, to allow for any anticipated recovery of the investment's fair value, are important components of our investment securities evaluation process.

Goodwill and Intangible Assets

Goodwill is not amortized but is subject to annual impairment tests. In addition to the annual impairment review, impairment reviews are performed whenever circumstances indicate a possible impairment may exist. Impairment testing for goodwill is done at the reporting unit level. Reporting units are one level below the business segment level, and our impairment testing is performed at the operating division level. We compare the fair value of the reporting unit assets to the carrying amount, on at least an annual basis, to determine if there is potential impairment. If the fair value of the reporting unit assets is less than their carrying value, an impairment loss is recognized. Fair value is estimated based upon internal evaluations of each reporting unit that include quantitative analyses of market multiples, revenues and cash flows and reviews of recent sales of similar facilities. No goodwill impairments were recognized during 2021, 2020 or 2019.

During 2021, goodwill increased by \$1.002 billion related to acquisitions and declined by \$75 million related to foreign currency translation and other adjustments. During 2020, goodwill increased by \$279 million related to acquisitions, including the finalization of the accounting for certain prior year acquisitions, and declined by \$9 million related to foreign currency translation and other adjustments.

During 2021, identifiable intangible assets increased by \$60 million related to acquisitions and declined by \$25 million due to amortization and other adjustments. During 2020, identifiable intangible assets increased by \$65 million related to acquisitions, including the finalization of the accounting for certain prior year acquisitions, and declined by \$26 million due to amortization and other adjustments. Identifiable intangible assets with finite lives are amortized over estimated lives ranging generally from three to 10 years. The gross carrying amounts of amortizable identifiable intangible assets at December 31, 2021 and 2020 were \$274 million and \$249 million, respectively, and accumulated amortization was \$175 million and \$149 million, respectively. The gross carrying amounts of indefinite-lived identifiable intangible assets at December 31, 2021 and 2020 were \$304 million and \$269 million, respectively. Indefinite-lived identifiable intangible assets are not amortized but are subject to annual impairment tests, and impairment reviews are performed whenever circumstances indicate a possible impairment may exist.

Debt Issuance Costs and Discounts

Debt issuance costs and discounts are amortized based upon the terms of the respective debt obligations. The gross carrying amount of debt issuance costs and discounts at December 31, 2021 and 2020 was \$446 million and \$411 million, respectively, and accumulated amortization was \$198 million and \$175 million, respectively. Amortization of debt issuance costs and discounts is included in interest expense and was \$27 million, \$30 million and \$30 million for 2021, 2020 and 2019, respectively.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 — ACCOUNTING POLICIES (continued)

Professional Liability Claims

Reserves for professional liability risks were \$2.022 billion and \$1.963 billion at December 31, 2021 and 2020, respectively. The current portion of the reserves, \$508 million and \$477 million at December 31, 2021 and 2020, respectively, is included in “other accrued expenses” in the consolidated balance sheets. Provisions for losses related to professional liability risks were \$453 million, \$435 million and \$497 million for 2021, 2020 and 2019, 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 2021, 2020 and 2019, we recorded reductions to the provision for professional liability risks of \$87 million, \$112 million and \$50 million, respectively, due to the receipt of updated actuarial information. Loss and loss expense reserves represent the estimated ultimate net cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves for unpaid losses and loss expenses are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. Adjustments to the estimated reserve amounts are included in current operating results. The reserves for professional liability risks cover approximately 2,100 and 2,300 individual claims at December 31, 2021 and 2020, 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 2021 and 2020, \$384 million and \$292 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 our insurance subsidiary. Subject, in most cases, to a \$15 million per occurrence self-insured retention, our facilities are insured by our insurance subsidiary for losses up to \$75 million per occurrence. The insurance subsidiary has obtained reinsurance for professional liability risks generally above a retention level of either \$25 million or \$35 million per occurrence, depending on the jurisdiction for the related claim. 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 \$44 million and \$31 million at December 31, 2021 and 2020, respectively, recorded in “other assets,” and \$11 million and \$8 million at December 31, 2021 and 2020, 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

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 — ACCOUNTING POLICIES (continued)

Financial Instruments (continued)

the impact of the forecasted transactions when they occur. In the event the forecasted transaction to which a cash flow hedge relates is no longer likely, the amount in other comprehensive income is recognized in earnings and generally the derivative is terminated.

The net interest paid or received on interest rate swaps is recognized as an adjustment 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.

NOTE 2 — SHARE-BASED COMPENSATION

Stock Incentive Plans

Our stock incentive plans are designed to promote the long-term financial interests and growth of the Company by attracting and retaining management and other personnel, motivating them to achieve long range goals and aligning their interests with those of our stockholders through opportunities for stock-based compensation and stock ownership in the Company. Stock option, stock appreciation right (“SARs”) and restricted share unit (“RSUs”) grants vest solely based upon continued employment over a specific period of time, and performance share unit (“PSUs”) grants vest based upon both continued employment over a specific period of time and the achievement of predetermined financial targets over a specific period of time. At December 31, 2021 there were 16.290 million shares available for future grants.

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, 2021, 5.173 million shares of common stock were reserved for ESPP issuances. During 2021, 2020 and 2019, the Company recognized \$15 million, \$13 million and \$12 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 plans generally vest based on continued employment (“Time Stock Options and SARs” and “RSUs”) or based upon continued employment and the achievement of certain financial targets (“Performance Stock Options and SARs” and “PSUs”). PSUs have a three-year cumulative earnings per share target, and the number of PSUs earned can vary from zero (for actual performance of less than 90% of target for 2021, 2020 and 2019 grants) to two times the original PSU grant (for actual performance of 110% or more of target for 2021, 2020 and 2019 grants). Each

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 2 — SHARE-BASED COMPENSATION (continued)

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

grant is valued as a single award with an expected term equal to the average expected term of the component vesting tranches. The expected term of the share-based award is limited by the contractual term. We use historical exercise behavior data and other factors to estimate the expected term of the options and SARs.

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

	<u>2021</u>	<u>2020</u>	<u>2019</u>
Risk-free interest rate	0.68%	1.44%	2.50%
Expected volatility	36%	27%	27%
Expected life, in years	6.17	6.15	6.18
Expected dividend yield	1.10%	1.19%	1.16%

Information regarding Time Stock Options and SARs and Performance Stock Options and SARs activity during 2021, 2020 and 2019 is summarized below (share amounts in thousands):

	<u>Time Stock Options and SARs</u>	<u>Performance Stock Options and SARs</u>	<u>Total Stock Options and SARs</u>	<u>Weighted Average Exercise Price</u>	<u>Weighted Average Remaining Contractual Term</u>	<u>Aggregate Intrinsic Value (dollars in millions)</u>
Options and SARs outstanding,						
December 31, 2018	9,360	2,667	12,027	\$ 61.49		
Granted	1,349	—	1,349	138.31		
Exercised	(1,137)	(523)	(1,660)	44.45		
Cancelled	(522)	—	(522)	93.26		
Options and SARs outstanding,						
December 31, 2019	9,050	2,144	11,194	71.79		
Granted	1,120	—	1,120	144.47		
Exercised	(2,159)	(1,325)	(3,484)	44.07		
Cancelled	(175)	—	(175)	111.69		
Options and SARs outstanding,						
December 31, 2020	7,836	819	8,655	91.53		
Granted	877	—	877	174.98		
Exercised	(2,443)	(533)	(2,976)	67.57		
Cancelled	(108)	—	(108)	138.32		
Options and SARs outstanding,						
December 31, 2021	<u>6,162</u>	<u>286</u>	<u>6,448</u>	\$113.15	6.2 years	\$927
Options and SARs exercisable,						
December 31, 2021	3,486	286	3,772	\$ 89.70	5.0 years	\$631

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 2 — SHARE-BASED COMPENSATION (continued)

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

The weighted average fair values of stock options and SARs granted during 2021, 2020 and 2019 were \$54.57, \$35.98 and \$38.21 per share, respectively. The total intrinsic value of stock options and SARs exercised during 2021, 2020 and 2019 was \$404 million, \$328 million and \$153 million, respectively. As of December 31, 2021, the unrecognized compensation cost related to nonvested stock options and SARs was \$46 million.

Information regarding RSUs and PSUs activity during 2021, 2020 and 2019 is summarized below (share amounts in thousands):

	<u>RSUs</u>	<u>PSUs</u>	<u>Total RSUs and PSUs</u>	<u>Weighted Average Grant Date Fair Value</u>
RSUs and PSUs outstanding, December 31, 2018	3,123	3,422	6,545	\$ 86.32
Granted	973	796	1,769	138.45
Performance adjustment	—	227	227	69.94
Vested	(1,216)	(1,251)	(2,467)	75.97
Cancelled	(260)	(159)	(419)	103.27
RSUs and PSUs outstanding, December 31, 2019	2,620	3,035	5,655	105.23
Granted	1,048	808	1,856	144.17
Performance adjustment	—	206	206	81.89
Vested	(1,030)	(1,364)	(2,394)	88.63
Cancelled	(162)	(93)	(255)	124.50
RSUs and PSUs outstanding, December 31, 2020	2,476	2,592	5,068	125.40
Granted	899	689	1,588	174.34
Performance adjustment	—	684	684	102.02
Vested	(992)	(1,772)	(2,764)	106.62
Cancelled	(192)	(110)	(302)	149.07
RSUs and PSUs outstanding, December 31, 2021	<u>2,191</u>	<u>2,083</u>	<u>4,274</u>	\$150.32

The total fair value of RSUs and PSUs that vested during 2021, 2020 and 2019 was \$475 million, \$349 million and \$346 million, respectively. As of December 31, 2021, the unrecognized compensation cost related to RSUs and PSUs was \$420 million.

NOTE 3 — ACQUISITIONS AND DISPOSITIONS

During 2021, we paid \$67 million to acquire two hospital facilities, one in southern Georgia and one in Tennessee, \$594 million to acquire a network of urgent care centers in Florida and \$114 million to acquire other nonhospital health care entities (noncontrolling interests of \$117 million were recorded). The acquisition of the network of urgent care centers occurred during December 2021. At December 31, 2021, our purchase accounting procedures were not complete, and completion of these procedures will include an analysis of the leases assumed and our review for possible identifiable intangible assets acquired. We also paid \$330 million and assumed certain liabilities to acquire an 80% interest (noncontrolling interests of \$100 million were recorded) in a venture providing post-acute care services (home health and hospice). During 2020, we paid \$568 million to acquire a hospital in New Hampshire and other nonhospital health care entities. During 2019, we paid \$1.384 billion to

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 3 — ACQUISITIONS AND DISPOSITIONS (continued)

acquire a seven-hospital health system in North Carolina and \$298 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 \$1.002 billion, \$279 million and \$332 million in 2021, 2020 and 2019, 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 2021, we received proceeds of \$1.502 billion and recognized a pretax gain of \$1.226 billion (\$920 million after tax) related to the sale of five hospital facilities in Georgia, comprised of three facilities from our American Group (northern Georgia market) and two facilities from our National Group (southern Georgia market). We also received proceeds of \$658 million and recognized a pretax gain of \$394 million (\$294 million after tax) related to sales of other health care entity investments and real estate. During 2020, we received proceeds of \$68 million and recognized a pretax loss of \$7 million (\$9 million after tax) related to the sale of a hospital facility from our American Group (Mississippi market) and sales of real estate and other investments. During 2019, we received proceeds of \$61 million and recognized a pretax gain of \$18 million (\$13 million after tax) related to the sale of a hospital facility from our American Group (a Louisiana market) and sales of real estate and other investments.

NOTE 4 — INCOME TAXES

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

	<u>2021</u>	<u>2020</u>	<u>2019</u>
Current:			
Federal	\$1,769	\$1,021	\$ 670
State	311	126	134
Foreign	15	5	17
Deferred:			
Federal	24	(73)	254
State	(18)	(39)	29
Foreign	11	3	(5)
	\$2,112	\$1,043	\$1,099

Our provision for income taxes for the years ended December 31, 2021, 2020 and 2019 included tax benefits of \$119 million, \$92 million and \$65 million, respectively, related to the settlement of employee equity awards. Our foreign pretax income was \$64 million, \$9 million and \$50 million for the years ended December 31, 2021, 2020 and 2019, respectively.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 — INCOME TAXES (continued)

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

	<u>2021</u>	<u>2020</u>	<u>2019</u>
Federal statutory rate	21.0%	21.0%	21.0%
State income taxes, net of federal tax benefit	2.0	1.9	2.7
Change in liability for uncertain tax positions	0.7	(0.2)	0.4
Tax benefit from settlements of employee equity awards	(1.2)	(1.8)	(1.3)
Other items, net	0.8	0.8	1.1
Effective income tax rate on income attributable to HCA			
Healthcare, Inc.	23.3	21.7	23.9
Income attributable to noncontrolling interests from consolidated partnerships	(1.8)	(2.5)	(2.9)
Effective income tax rate on income before income taxes	<u>21.5%</u>	<u>19.2%</u>	<u>21.0%</u>

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

	<u>2021</u>		<u>2020</u>	
	<u>Assets</u>	<u>Liabilities</u>	<u>Assets</u>	<u>Liabilities</u>
Depreciation and fixed asset basis differences	\$ —	\$ 737	\$ —	\$ 678
Allowances for professional liability and other risks	426	—	407	—
Accounts receivable	348	—	283	—
Compensation	502	—	487	—
Right-of-use lease assets and obligations	428	419	416	409
Other	499	652	485	606
	<u>\$2,203</u>	<u>\$1,808</u>	<u>\$2,078</u>	<u>\$1,693</u>

At December 31, 2021, federal and state net operating loss carryforwards (expiring in years 2024 through 2040) available to offset future taxable income approximated \$31 million and \$99 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):

	<u>2021</u>	<u>2020</u>
Balance at January 1	\$469	\$522
Additions based on tax positions related to the current year	57	(3)
Additions for tax positions of prior years	66	13
Reductions for tax positions of prior years	(6)	(30)
Settlements	(3)	(22)
Lapse of applicable statutes of limitations	(7)	(11)
Balance at December 31	<u>\$576</u>	<u>\$469</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 — INCOME TAXES (continued)

Our liability for unrecognized tax benefits was \$642 million, including accrued interest of \$99 million and excluding \$33 million that was recorded as reductions of the related deferred tax assets, as of December 31, 2021 (\$508 million, \$73 million and \$34 million, respectively, as of December 31, 2020). Unrecognized tax benefits of \$217 million as of December 31, 2021 (\$157 million as of December 31, 2020) would affect the effective rate, if recognized.

The Internal Revenue Service (“IRS”) was conducting an examination of the Company’s 2016, 2017 and 2018 federal income tax returns and the 2019 return for one affiliated partnership at December 31, 2021. We are also subject to examination by state and foreign taxing authorities. Depending on the resolution of any federal, state and foreign tax disputes, the completion of examinations by federal, state or foreign taxing authorities, or the expiration of statutes of limitation for specific taxing jurisdictions, we believe it is reasonably possible that our liability for unrecognized tax benefits may significantly increase or decrease within the next 12 months. However, we are currently unable to estimate the range of any possible change.

NOTE 5 — EARNINGS PER SHARE

We compute basic earnings per share using the weighted average number of common shares outstanding. We compute diluted earnings per share using the weighted average number of common shares outstanding plus the dilutive effect of outstanding stock options, SARs, RSUs and PSUs, computed using the treasury stock method. During 2021, 2020 and 2019, we repurchased 37.812 million shares, 3.287 million shares and 7.949 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, 2021, 2020 and 2019 (dollars and shares in millions, except per share amounts):

	<u>2021</u>	<u>2020</u>	<u>2019</u>
Net income attributable to HCA Healthcare, Inc.	\$ 6,956	\$ 3,754	\$ 3,505
Weighted average common shares outstanding	323.315	338.274	341.210
Effect of dilutive incremental shares	5.437	5.331	7.016
Shares used for diluted earnings per share	<u>328.752</u>	<u>343.605</u>	<u>348.226</u>
Earnings per share:			
Basic earnings per share	\$ 21.52	\$ 11.10	\$ 10.27
Diluted earnings per share	\$ 21.16	\$ 10.93	\$ 10.07

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 — INVESTMENTS OF INSURANCE SUBSIDIARIES

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

	2021			
	Amortized Cost	Unrealized Amounts		Fair Value
		Gains	Losses	
Debt securities	\$400	\$18	\$(2)	\$ 416
Money market funds and other	125	—	—	125
	<u>\$525</u>	<u>\$18</u>	<u>\$(2)</u>	<u>541</u>
Amounts classified as current assets				<u>(103)</u>
Investment carrying value				<u>\$ 438</u>
	2020			
	Amortized Cost	Unrealized Amounts		Fair Value
		Gains	Losses	
Debt securities	\$384	\$32	\$—	\$ 416
Money market funds and other	88	—	—	88
	<u>\$472</u>	<u>\$32</u>	<u>\$—</u>	<u>504</u>
Amounts classified as current assets				<u>(116)</u>
Investment carrying value				<u>\$ 388</u>

At December 31, 2021 and 2020, the investments in debt securities of our insurance subsidiaries were classified as “available-for-sale.” Changes in unrealized gains and losses are recorded as adjustments to other comprehensive income (loss).

Scheduled maturities of investments in debt securities at December 31, 2021 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	128	135
Due after five years through ten years	176	183
Due after ten years	93	95
	<u>\$400</u>	<u>\$416</u>

The average expected maturity of the investments in debt securities at December 31, 2021 was 6.1 years, compared to the average scheduled maturity of 9.5 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.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 — FINANCIAL INSTRUMENTS

Interest Rate Swap Agreements

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

The following table sets forth our interest rate swap agreement, which has been designated as a cash flow hedge, at December 31, 2021 (dollars in millions):

	Notional Amount	Maturity Date	Fair Value
Pay-fixed interest rate swap	\$500	December 2022	\$(8)

During the next 12 months, we estimate \$8 million will be reclassified from accumulated other comprehensive income (“OCI”) and will be included in interest expense.

Derivatives — Results of Operations

The following table presents the effect of our interest rate swaps on our results of operations for the year ended December 31, 2021 (dollars in millions):

Derivatives in Cash Flow Hedging Relationships	Amount of Gain Recognized in OCI on Derivatives, Net of Tax	Location of Loss Reclassified from Accumulated OCI into Operations	Amount of Loss Reclassified from Accumulated OCI into Operations
Interest rate swaps	\$1	Interest expense	\$37

Credit-risk-related Contingent Features

We have an agreement with our derivative counterparty that contains a provision where we could be declared in default on our derivative obligation if repayment of the underlying indebtedness is accelerated by the lender due to our default on the indebtedness. As of December 31, 2021, we have not been required to post any collateral related to this agreement. If we had breached this provision at December 31, 2021, we would have been required to settle our obligation under the agreement at the estimated termination value of \$8 million.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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.

Investment Securities

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

Derivative Financial Instruments

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

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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

The following tables summarize our assets and liabilities measured at fair value on a recurring basis as of December 31, 2021 and 2020, aggregated by the level in the fair value hierarchy within which those measurements fall (dollars in millions):

	December 31, 2021			
	Fair Value	Fair Value Measurements Using		
		Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
Investments of insurance subsidiaries:				
Debt securities	\$ 416	\$ —	\$416	\$—
Money market funds and other	125	125	—	—
Investments of insurance subsidiaries	541	125	416	—
Less amounts classified as current assets	(103)	(103)	—	—
	<u>\$ 438</u>	<u>22</u>	<u>\$416</u>	<u>\$—</u>
Liabilities:				
Interest rate swap (Other accrued expenses)	\$ 8	\$ —	\$ 8	\$—

	December 31, 2020			
	Fair Value	Fair Value Measurements Using		
		Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
Investments of insurance subsidiaries:				
Debt securities	\$ 416	\$ —	\$416	\$—
Money market funds and other	88	88	—	—
Investments of insurance subsidiaries	504	88	416	—
Less amounts classified as current assets	(116)	(87)	(29)	—
	<u>\$ 388</u>	<u>1</u>	<u>\$387</u>	<u>\$—</u>
Liabilities:				
Interest rate swaps (Income taxes and other liabilities) . .	\$ 46	\$ —	\$ 46	\$—

The estimated fair value of our long-term debt was \$38.541 billion and \$35.814 billion at December 31, 2021 and 2020, respectively, compared to carrying amounts, excluding debt issuance costs and discounts, aggregating \$34.827 billion and \$31.240 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.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 — LONG-TERM DEBT

A summary of long-term debt at December 31, including related interest rates at December 31, 2021, follows (dollars in millions):

	<u>2021</u>	<u>2020</u>
Senior secured asset-based revolving credit facility (effective interest rate of 1.4%)	\$ 2,780	\$ —
Senior secured revolving credit facility	—	—
Senior secured term loan facilities (effective interest rate of 2.1%)	1,960	3,671
Senior secured notes (effective interest rate of 4.8%)	16,200	13,850
Other senior secured debt (effective interest rate of 4.3%)	935	767
Senior secured debt	<u>21,875</u>	<u>18,288</u>
Senior unsecured notes (effective interest rate of 5.5%)	12,952	12,952
Debt issuance costs and discounts	(248)	(236)
Total debt (average life of 8.9 years, rates averaging 4.6%)	<u>34,579</u>	<u>31,004</u>
Less amounts due within one year	237	209
	<u>\$34,342</u>	<u>\$30,795</u>

During June 2021, we issued \$2.350 billion aggregate principal amount of senior secured notes comprised of \$850 million aggregate principal amount of 2 3/8% notes due 2031 and \$1.500 billion aggregate principal amount of 3 1/2% notes due 2051 (the “June 2021 Notes”). We also amended and restated our senior secured revolving credit facility and our senior secured asset-based revolving credit facility, including increasing availability under the asset-based revolving credit facility to \$4.500 billion, extending the maturity date on both facilities to June 30, 2026 and entering into a new \$1.500 billion term loan A facility and a new \$500 million term loan B facility (the “Credit Agreement Transactions”). We used the net proceeds from the June 2021 Notes and the Credit Agreement Transactions to retire \$3.657 billion of term loan facilities. The pretax loss on retirement of debt was \$12 million.

Senior Secured Credit Facilities And Other Senior Secured Debt

We have entered into the following senior secured credit facilities: (i) a \$4.500 billion asset-based revolving credit facility maturing on June 30, 2026 with a borrowing base of 85% of eligible accounts receivable, subject to customary reserves and eligibility criteria (\$2.780 billion outstanding at December 31, 2021) (the “ABL credit facility”); (ii) a \$2.000 billion senior secured revolving credit facility maturing on June 30, 2026 (none outstanding at December 31, 2021 without giving effect to certain outstanding letters of credit); (iii) a \$1.462 billion senior secured term loan A facility maturing on June 30, 2026; and (iv) a \$498 million senior secured term loan B facility maturing on June 30, 2028. We refer to the facilities described under (ii) through (iv) 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.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 — LONG-TERM DEBT (continued)

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

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 consist of (i) \$1.250 billion aggregate principal amount of 4.75% first lien notes due 2023; (ii) \$2.000 billion aggregate principal amount of 5.00% first lien notes due 2024; (iii) \$1.400 billion aggregate principal amount of 5.25% first lien notes due 2025; (iv) \$1.500 billion aggregate principal amount of 5.25% first lien notes due 2026; (v) \$1.200 billion aggregate principal amount of 4.50% first lien notes due 2027; (vi) \$2.000 billion aggregate principal amount of 4 1/8% first lien notes due 2029; (vii) \$850 million aggregate principal amount of 2 3/8% first lien notes due 2031; (viii) \$1.000 billion aggregate principal amount of 5 1/8% first lien notes due 2039; (ix) \$1.500 billion aggregate principal amount of 5.50% first lien notes due 2047; (x) \$2.000 billion aggregate principal amount of 5 1/4% first lien notes due 2049; and (xi) \$1.500 billion aggregate principal amount of 3 1/2% first lien notes due 2051. Finance leases and other secured debt totaled \$935 million at December 31, 2021.

We use interest rate swap agreements to manage the variable rate exposure of our debt portfolio. At December 31, 2021, we had entered into an effective interest rate swap agreement, in a notional amount of \$500 million, 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 swap is reflected in the effective interest rates for the senior secured credit facilities.

Senior Unsecured Notes

Senior unsecured notes consist of (i) \$12.091 billion aggregate principal amount of senior notes with maturities ranging from 2023 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").

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 — LONG-TERM DEBT (continued)

General Debt Information (continued)

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 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 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 2023 through 2026 are \$2.857 billion, \$2.353 billion, \$4.607 billion and \$5.279 billion, respectively.

NOTE 10 — LEASES

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

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 — LEASES (continued)

The following table presents our lease-related assets and liabilities at December 31, 2021 and 2020 (dollars in millions):

	Balance Sheet Classification	2021	2020
Assets:			
Operating leases	Right-of-use operating lease assets	\$ 2,113	\$ 2,024
Finance leases	Property and equipment	637	553
Total lease assets		\$ 2,750	\$ 2,577
Liabilities:			
Current:			
Operating leases	Other accrued expenses	\$ 392	\$ 379
Finance leases	Long-term debt due within one year	143	128
Noncurrent:			
Operating leases	Right-of-use operating lease obligations	1,755	1,673
Finance leases	Long-term debt	577	494
Total lease liabilities		\$ 2,867	\$ 2,674
Weighted-average remaining term:			
Operating leases		10.2 years	10.4 years
Finance leases		10.4 years	11.5 years
Weighted-average discount rate:			
Operating leases		4.4%	4.8%
Finance leases		4.4%	5.4%

The following table presents certain information related to lease expense for finance and operating leases for the years ended December 31, 2021, 2020 and 2019 (dollars in millions):

	2021	2020	2019
Finance lease expense:			
Depreciation and amortization	\$ 135	\$ 106	\$ 93
Interest	29	31	32
Operating leases(1)	478	447	389
Short-term lease expense(1)	354	322	316
Variable lease expense(1)	157	154	150
	\$1,153	\$1,060	\$980

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

The following table presents supplemental cash flow information for the years ended December 31, 2021, 2020 and 2019 (dollars in millions):

	2021	2020	2019
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows for operating leases	\$474	\$445	\$404
Operating cash flows for finance leases	29	31	32
Financing cash flows for finance leases	123	86	79

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 — LEASES (continued)

Maturities of Lease Liabilities

The following table reconciles the undiscounted minimum lease payment amounts to the operating and finance lease liabilities recorded on the balance sheet at December 31, 2021 and 2020 (dollars in millions):

	2021		2020	
	Operating Leases	Finance Leases	Operating Leases	Finance Leases
Year 1	\$ 438	\$ 165	\$ 431	\$ 155
Year 2	378	126	366	125
Year 3	320	132	307	81
Year 4	267	98	255	82
Year 5	219	70	207	51
Thereafter	<u>1,148</u>	<u>350</u>	<u>1,136</u>	<u>353</u>
Total minimum lease payments	<u>2,770</u>	<u>941</u>	2,702	847
Less: amount of lease payments representing interest ...	<u>(623)</u>	<u>(221)</u>	<u>(650)</u>	<u>(225)</u>
Present value of future minimum lease payments	<u>2,147</u>	<u>720</u>	2,052	622
Less: current lease obligations	<u>(392)</u>	<u>(143)</u>	<u>(379)</u>	<u>(128)</u>
Long-term lease obligations	<u>\$1,755</u>	<u>\$ 577</u>	<u>\$1,673</u>	<u>\$ 494</u>

NOTE 11 — CONTINGENCIES

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

Government Investigations, Claims and Litigation

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

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 11 — CONTINGENCIES (continued)

Government Investigations, Claims and Litigation (continued)

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

NOTE 12 — CAPITAL STOCK

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

Share Repurchase Transactions

During January 2022 and February 2021, our Board of Directors authorized share repurchase programs for up to \$8 billion and \$6 billion, respectively, of the Company’s outstanding common stock. During January 2020, January 2019 and October 2017, our Board of Directors authorized share repurchase programs for up to \$6 billion (\$2 billion for each authorization) of our outstanding common stock.

During 2021, we repurchased 37.812 million shares of our common stock at an average price of \$217.25 per share through market purchases pursuant to the \$2 billion share repurchase program authorized during January 2019 (which was completed during 2021), the \$2 billion share repurchase program authorized during January 2020 (which was completed during 2021) and the \$6 billion share repurchase program authorized during February 2021. At December 31, 2021, we had \$586 million of repurchase authorization available under the February 2021 authorization. During 2020, we repurchased 3.287 million shares of our common stock at an average price of \$134.18 per share through market purchases pursuant to the \$2 billion share repurchase program authorized during January 2019. During 2019, we repurchased 7.949 million shares of our common stock at an average price of \$129.71 per share through market purchases pursuant to the October 2017 authorization (which was completed during 2019) and the January 2019 authorization.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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). Benefits expense under these plans totaled \$560 million for 2021, \$552 million for 2020 and \$532 million for 2019. Our matching contributions are funded during the year following the participant contributions.

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 a base amount and attaining 1,000 or more hours of service during the plan year. Company credits to participants' hypothetical account balances (the Restoration Plan is not funded) depend upon participants' compensation, years of vesting service, hypothetical investment returns (gains or losses) and certain IRS limitations. Benefits expense under this plan was \$38 million for 2021, \$35 million for 2020 and \$44 million for 2019. Accrued benefits liabilities under this plan totaled \$258 million at December 31, 2021 and \$242 million at December 31, 2020.

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 \$22 million for 2021, \$24 million for 2020 and \$19 million for 2019. Accrued benefits liabilities under this plan totaled \$201 million at December 31, 2021 and \$204 million at December 31, 2020.

We maintain defined benefit pension plans which resulted from certain hospital acquisitions in prior years. Benefits expense under these plans was \$4 million for 2021, \$8 million for 2020, and \$11 million for 2019. Accrued benefits liabilities under these plans totaled \$9 million at December 31, 2021 and \$96 million at December 31, 2020.

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, 2021, the National Group included 96 hospitals located in Alaska, California, Florida, Georgia, Idaho, Indiana, northern Kentucky, Nevada, New Hampshire, North Carolina, South Carolina, Utah and Virginia, and the American Group included 79 hospitals located in Colorado, Kansas, southern Kentucky, Louisiana, Missouri, Tennessee and Texas. We also operate seven hospitals in England, and these facilities are included in the Corporate and other group.

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 — SEGMENT AND GEOGRAPHIC INFORMATION (continued)

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

	For the Years Ended December 31,		
	2021	2020	2019
Revenues:			
National Group	\$29,826	\$25,694	\$25,913
American Group	26,152	23,593	23,173
Corporate and other	2,774	2,246	2,250
	\$58,752	\$51,533	\$51,336
Equity in earnings of affiliates:			
National Group	\$ (33)	\$ (28)	\$ (2)
American Group	(53)	(42)	(44)
Corporate and other	(27)	16	3
	\$ (113)	\$ (54)	\$ (43)
Adjusted segment EBITDA:			
National Group	\$ 7,200	\$ 5,532	\$ 5,634
American Group	6,156	5,333	4,904
Corporate and other	(712)	(828)	(681)
	\$12,644	\$10,037	\$ 9,857
Depreciation and amortization:			
National Group	\$ 1,359	\$ 1,216	\$ 1,161
American Group	1,183	1,164	1,117
Corporate and other	311	341	318
	\$ 2,853	\$ 2,721	\$ 2,596

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 — SEGMENT AND GEOGRAPHIC INFORMATION (continued)

	For the Years Ended December 31,		
	2021	2020	2019
Adjusted segment EBITDA	\$12,644	\$10,037	\$ 9,857
Depreciation and amortization	2,853	2,721	2,596
Interest expense	1,566	1,584	1,824
Losses (gains) on sales of facilities	(1,620)	7	(18)
Losses on retirement of debt	12	295	211
Income before income taxes	<u>\$ 9,833</u>	<u>\$ 5,430</u>	<u>\$ 5,244</u>

	December 31,		
	2021	2020	2019
Assets:			
National Group	\$21,205	\$18,913	\$18,290
American Group	21,428	20,760	20,608
Corporate and other	8,109	7,817	6,160
	<u>\$50,742</u>	<u>\$47,490</u>	<u>\$45,058</u>

	National Group	American Group	Corporate and Other	Total
Goodwill and other intangible assets:				
Balance at December 31, 2018	\$1,597	\$5,729	\$ 627	\$7,953
Acquisitions	155	39	138	332
Foreign currency translation, amortization and other	(13)	(3)	—	(16)
Balance at December 31, 2019	1,739	5,765	765	8,269
Acquisitions	38	27	279	344
Foreign currency translation, amortization and other	(2)	(17)	(16)	(35)
Balance at December 31, 2020	1,775	5,775	1,028	8,578
Acquisitions	735	67	260	1,062
Foreign currency translation, amortization and other	(18)	(10)	(72)	(100)
Balance at December 31, 2021	<u>\$2,492</u>	<u>\$5,832</u>	<u>\$1,216</u>	<u>\$9,540</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 15 — OTHER COMPREHENSIVE LOSS

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

	<u>Unrealized Gains on Available- for-Sale Securities</u>	<u>Foreign Currency Translation Adjustments</u>	<u>Defined Benefit Plans</u>	<u>Change in Fair Value of Derivative Instruments</u>	<u>Total</u>
Balances at December 31, 2018	\$ 3	\$(283)	\$(148)	\$ 47	\$(381)
Unrealized gains on available-for-sale securities, net of \$4 of income taxes	11	—	—	—	11
Foreign currency translation adjustments, net of \$5 of income taxes	—	—	—	—	—
Defined benefit plans, net of \$14 income tax benefit	—	—	(49)	—	(49)
Change in fair value of derivative instruments, net of \$13 income tax benefit	—	—	—	(37)	(37)
Expense (income) reclassified into operations from other comprehensive income, net of \$3 income tax benefit and \$3 of income taxes, respectively	<u>—</u>	<u>—</u>	<u>10</u>	<u>(14)</u>	<u>(4)</u>
Balances at December 31, 2019	14	(283)	(187)	(4)	(460)
Unrealized gains on available-for-sale securities, net of \$3 of income taxes	11	—	—	—	11
Foreign currency translation adjustments, net of \$6 of income taxes	—	12	—	—	12
Defined benefit plans, net of \$16 income tax benefit	—	—	(55)	—	(55)
Change in fair value of derivative instruments, net of \$15 income tax benefit	—	—	—	(51)	(51)
Expense reclassified into operations from other comprehensive income, net of \$6 and \$5 of income tax benefits, respectively	<u>—</u>	<u>—</u>	<u>22</u>	<u>19</u>	<u>41</u>
Balances at December 31, 2020	25	(271)	(220)	(36)	(502)
Unrealized losses on available-for-sale securities, net of \$3 income tax benefit	(13)	—	—	—	(13)
Foreign currency translation adjustments, net of \$2 income tax benefit	—	(7)	—	—	(7)
Defined benefit plans, net of \$20 of income taxes . . .	—	—	67	—	67
Change in fair value of derivative instruments	—	—	—	1	1
Expense reclassified into operations from other comprehensive income, net of \$7 and \$8 income tax benefits, respectively	<u>—</u>	<u>—</u>	<u>21</u>	<u>29</u>	<u>50</u>
Balances at December 31, 2021	<u>\$ 12</u>	<u>\$(278)</u>	<u>\$(132)</u>	<u>\$ (6)</u>	<u>\$(404)</u>

HCA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 — ACCRUED EXPENSES

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

	<u>2021</u>	<u>2020</u>
Professional liability risks	\$ 508	\$ 477
Defined contribution benefit plans	549	547
Right-of-use operating leases	392	379
Taxes other than income	361	343
Interest	353	315
Government stimulus refund liability	79	83
Other	<u>1,080</u>	<u>1,096</u>
	<u>\$3,322</u>	<u>\$3,240</u>

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CERTIFICATIONS

I, Samuel N. Hazen, certify that:

1. I have reviewed this annual report on Form 10-K of HCA Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit and compliance committee of the Registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

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

Date: February 18, 2022

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CERTIFICATIONS

I, William B. Rutherford, certify that:

1. I have reviewed this annual report on Form 10-K of HCA Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit and compliance committee of the Registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

By: /S/ WILLIAM B. RUTHERFORD

William B. Rutherford
Executive Vice President and Chief Financial Officer

Date: February 18, 2022

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**CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of HCA Healthcare, Inc. (the “Company”) on Form 10-K for the year ended December 31, 2021, as filed with the Securities and Exchange Commission on the date hereof (the “Report”), each of the undersigned certifies, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

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

February 18, 2022

By: /S/ WILLIAM B. RUTHERFORD
William B. Rutherford
Executive Vice President and Chief Financial Officer

February 18, 2022

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This document contains forward-looking statements within the meaning of federal securities laws. These forward-looking statements are based on our current plans and expectations and are subject to a number of known and unknown uncertainties and risks, including those set forth in our earnings releases and reports filed with the Securities and Exchange Commission.

All references to "Company," "HCA," "HCA Healthcare," "we," and "us" as used herein refer to HCA Healthcare, Inc. and its affiliates.

Directors

Thomas F. Frist III
Chairman
HCA Healthcare

Founder and
Managing Principal
Frist Capital

Samuel N. Hazen
Chief Executive Officer
HCA Healthcare

Meg G. Crofton
Retired President
Parks and Resorts Operations
The Walt Disney Company

Robert J. Dennis
Retired Chairman and
Chief Executive Officer
Genesco Inc.

Nancy-Ann DeParle
Co-founder and
Managing Partner
Consonance Capital
Partners

William R. Frist
Principal
Frist Capital

Charles O. Holliday, Jr.
Retired Chairman and
Chief Executive Officer
DuPont

Hugh F. Johnston
Vice Chairman and
Chief Financial Officer
PepsiCo, Inc.

Michael W. Michelson
Retired Member
KKR Management LLC

Wayne J. Riley, M.D., M.B.A.
President of SUNY
Downstate Health
Sciences University

Andrea B. Smith
Retired Chief
Administrative Officer
Bank of America Corporation

Executive Officers

Samuel N. Hazen
Chief Executive Officer
and Director

Jennifer L. Berres
Senior Vice President and
Chief Human Resources Officer

Phillip G. Billington
Senior Vice President –
Internal Audit Services

Jeff E. Cohen
Senior Vice President –
Government Relations

Michael S. Cuffe, M.D.
Executive Vice President and
Chief Clinical Officer

Jon M. Foster
President – American Group

Charles J. Hall
President – National Group

Michael R. McAlevy
Senior Vice President and
Chief Legal Officer

A. Bruce Moore, Jr.
President – Service Line
and Operations Integration

Sammie S. Mosier
Senior Vice President and
Chief Nurse Executive

P. Martin Paslick
Senior Vice President and
Chief Information Officer

Deborah M. Reiner
Senior Vice President –
Marketing and
Communications

William B. Rutherford
Executive Vice President
and Chief Financial Officer

Joseph A. Sowell, III
Senior Vice President and
Chief Development Officer

Kathryn A. Torres
Senior Vice President –
Payer Contracting
and Alignment

Kathleen M. Whalen
Senior Vice President and
Chief Ethics and
Compliance Officer

Christopher F. Wyatt
Senior Vice President
and Controller



One Park Plaza
Nashville, Tennessee 37203
www.HCAhealthcare.com

Corporate Information

Transfer Agent and Registrar

EQ Shareowner Services
P.O. Box 64874
St. Paul, Minnesota 55164-0874
Toll free: 800-468-9716

Certified/Overnight Mail

EQ Shareowner Services
1110 Centre Pointe Curve, Suite 101
Mendota Heights, Minnesota 55120

Independent Registered Public Accounting Firm

Ernst & Young LLP
Nashville, Tennessee

Corporate Headquarters

One Park Plaza
Nashville, Tennessee 37203
615-344-9551

Form 10-K

The Company has filed an annual report on Form 10-K for the year ended December 31, 2021 with the United States Securities and Exchange Commission (SEC). Shareholders may obtain a copy of this report, without charge, by writing:

Investor Relations, HCA Healthcare, Inc., One Park Plaza, Nashville, TN 37203
or by visiting the Company's website at www.hcahealthcare.com.

Common Stock and Dividend Information

The Common Stock of HCA Healthcare, Inc. is listed on the New York Stock Exchange (NYSE) under the symbol "HCA". On February 25, 2022, the Company had approximately 400 shareholders of record. On January 26, 2022, the Company's Board of Directors declared a quarterly dividend of \$0.56 per share on our common stock payable on March 31, 2022 to shareholders of record on March 17, 2022. Future declarations of quarterly dividends and the establishment of future record and payment dates are subject to the final determination of the Company's Board of Directors.

Annual Meeting of Shareholders

The annual meeting of shareholders will be held on April 21, 2022, at 2:00 pm local time in a virtual meeting format only, via live webcast at www.virtualshareholdermeeting.com/HCA2022. Shareholders of record as of February 25, 2022 are invited to attend the virtual meeting.

