LAKELAND BANCORP INC
Form 10-Q
August 06, 2010
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SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-Q

(Mark one)

x QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the quarterly period ended June 30, 2010

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 000-17820

LAKELAND BANCORP, INC.

(Exact name of registrant as specified in its charter)

New Jersey	22-2953275
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
250 Oak Ridge Road, Oak Ridge, New Jersey	07438
(Address of principal executive offices)	(Zip Code)

(973) 697-2000
(Registrant s telephone number, including area code)

(Former name, former address and former fiscal year, if changed since last report.)

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 x No ¨

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, any Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (Section 232.405 of this chapter) during the preceding 12 months (or such shorter period that the registrant was required to submit and post such files). Yes ¨ No ¨ Not applicable.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act: (Check one):

Large accelerated filer ¨ Accelerated filer x Non-accelerated filer ¨ Smaller reporting Company ¨

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act.):

Yes ¨ No x

APPLICABLE ONLY TO CORPORATE ISSUERS:

Indicate the number of shares outstanding of each of the issuer s classes of common stock, as of the latest practicable date.

As of July 30, 2010 there were 24,036,709 outstanding shares of Common Stock, no par value.

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The Securities and Exchange Commission maintains a web site which contains reports, proxy and information statements and other information relating to registrants that file electronically at the address: http:// / www.sec.gov.

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Lakeland Bancorp, Inc. and Subsidiaries

CONSOLIDATED BALANCE SHEETS

ASSETS:	June 30, 2010 (unaudited)	(dollars in thousands)	December 31, 2009
Cash	$51,543		$31,869
Federal funds sold and Interest-bearing deposits due from banks	1,416		26,794
Total cash and cash equivalents	52,959		58,663
Investment securities available for sale, at fair value	439,968		375,530
Investment securities held to maturity; fair value of $75,134 in 2010 and $84,389 in 2009	72,186		81,821
Loans and leases, net of deferred costs	1,992,256		2,009,721
Leases held for sale	3,233		7,314
Less: allowance for loan and lease losses	27,728		25,563
Net loans	1,967,761		1,991,472
Premises and equipment - net	28,082		29,196
Accrued interest receivable	8,874		8,943
Goodwill	87,111		87,111
Other identifiable intangible assets, net	1,109		1,640
Bank owned life insurance	42,491		41,720
Other assets	38,016		47,872
TOTAL ASSETS	$2,738,557		$2,723,968
LIABILITIES			
Deposits:			
Noninterest bearing	$358,054		$323,175
Savings and interest-bearing transaction accounts	1,352,373		1,368,272
Time deposits under $100 thousand	266,891		283,512
Time deposits $100 thousand and over	192,827		182,228
Total deposits	2,170,145		2,157,187
Federal funds purchased and securities sold under agreements to repurchase	54,176		63,672
Long-term debt	145,900		145,900
Subordinated debentures	77,322		77,322
Other liabilities	13,152		11,901
TOTAL LIABILITIES	2,460,695		2,455,982
Commitments and contingencies			
STOCKHOLDERS EQUITY			
Preferred stock, Series A, no par value, $1,000 liquidation value, authorized 1,000,000 shares; issued 59,000 shares at June 30, 2010 and December 31, 2009	56,350		56,023
Common stock, no par value; authorized shares, 40,000,000; issued 24,740,564 shares, at June 30, 2010 and December 31, 2009	258,567		259,521

Accumulated deficit	(29,841)	(34,961)
Treasury stock, at cost, 713,171 shares at June 30, 2010 and 868,428 at December 31, 2009	(9,845)	(11,940)
Accumulated other comprehensive income (loss)	2,631	(657)
TOTAL STOCKHOLDERS EQUITY	277,862	267,986
TOTAL LIABILITIES AND STOCKHOLDERS EQUITY	$2,738,557	$2,723,968

The accompanying notes are an integral part of these financial statements.

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Lakeland Bancorp, Inc. and Subsidiaries

UNAUDITED CONSOLIDATED STATEMENTS OF OPERATIONS

	For the three months ended June 30,		For the six months ended June 30,	
	2010	2009	2010	2009
	(In thousands, except per share data)			
INTEREST INCOME				
Loans, leases and fees	$28,049	$29,156	$56,301	$59,298
Federal funds sold and interest-bearing deposits with banks	40	31	68	57
Taxable investment securities	3,009	3,372	5,992	6,791
Tax-exempt investment securities	497	594	1,017	1,163
TOTAL INTEREST INCOME	31,595	33,153	63,378	67,309
INTEREST EXPENSE				
Deposits	3,868	7,149	8,273	14,908
Federal funds purchased and securities sold under agreements to repurchase	31	29	68	67
Long-term debt	2,767	3,492	5,521	6,959
TOTAL INTEREST EXPENSE	6,666	10,670	13,862	21,934
NET INTEREST INCOME	24,929	22,483	49,516	45,375
Provision for loan and lease losses	5,001	34,083	9,880	40,459
NET INTEREST INCOME (LOSS) AFTER PROVISION FOR LOAN AND LEASE LOSSES	19,928	(11,600)	39,636	4,916
NONINTEREST INCOME				
Service charges on deposit accounts	2,500	2,699	4,948	5,366
Commissions and fees	833	873	1,718	1,696
Gains (losses) on investment securities	0	(532)	1	353
Income on bank owned life insurance	385	818	771	1,149
Gains (losses) on leasing related assets	555	(529)	859	(344)
Other income	280	82	365	164
TOTAL NONINTEREST INCOME	4,553	3,411	8,662	8,384
NONINTEREST EXPENSE				
Salaries and employee benefits	8,996	8,739	17,899	17,322
Net occupancy expense	1,636	1,597	3,431	3,471
Furniture and equipment	1,221	1,220	2,391	2,484
Stationery, supplies and postage	386	401	812	821
Marketing expense	648	784	1,202	1,341
Core deposit intangible amortization	266	266	531	531
FDIC insurance expense	964	2,416	1,897	3,316
Collection expense	159	377	307	882
Legal expense	423	192	764	301
Other real estate and repossessed asset expense	198	665	235	785
Other expenses	2,210	2,997	4,418	5,151
TOTAL NONINTEREST EXPENSE	17,107	19,654	33,887	36,405
Income (loss) before provision for income taxes	7,374	(27,843)	14,411	(23,105)

Income tax expense (benefit)	2,621	(15,121)	5,092	(13,558)
NET INCOME (LOSS)	$4,753	($12,722)	$9,319	($9,547)
Dividends on Preferred Stock and Accretion	904	885	1,802	1,424
Net Income (Loss) Available to Common Stockholders	$3,849	($13,607)	$7,517	($10,971)
PER SHARE OF COMMON STOCK				
Basic earnings (loss)	$0.16	($0.58)	$0.31	$(0.46)
Diluted earnings (loss)	$0.16	($0.58)	$0.31	$(0.46)
Dividends	$0.05	$0.10	$0.10	$0.20

The accompanying notes are an integral part of these financial statements.

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Lakeland Bancorp, Inc. and Subsidiaries

UNAUDITED CONSOLIDATED STATEMENTS OF CHANGES IN STOCKHOLDERS EQUITY

Six Months ended June 30, 2010

	Common stock					Accu
	Number of Shares	Amount	Series A Preferred Stock	Accumulated deficit	Treasury Stock	Compr Incom
				(dollars in thousands)		
ER 31, 2009	24,740,564	$259,521	$56,023	($34,961)	($11,940)	
e:						
				9,319		
ncome, net of tax						
ncome						
				(1,475)		
			327	(327)		
tion		277				
tock awards		(476)			476	
vidend reinvestment and stock purchase plan		(286)		(415)	731	

6, hospitals located in markets selected by CMS, including many of our facilities, will te in the Comprehensive Care for Joint Replacement (CJR) model, a five-year bundled sed on knee and hip replacements. Unlike the BPCI initiative, which is voluntary, the atory in the selected geographic areas. The model aims to support better and more iciaries by encouraging hospitals, physicians, and post-acute care providers to work ality and coordination of care from the initial hospitalization through recovery. The CJR yment and quality measurements by evaluating participating hospitals against quality e spending targets established by CMS for each episode of care. An episode of care s hospital admission, ends 90 days post-discharge, and includes all related items and nder Medicare Part A and Part B for all Medicare fee-for-service beneficiaries, subject ed by CMS. At the end of a model performance year, actual episode spending is are target episode price for the responsible hospital. Depending on whether overall

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alls below the target and whether quality standards are met, hospitals may receive e payments or owe repayments to CMS.

w also provides for a bundled payment demonstration project for Medicaid services, but emented this project. HHS may select up to eight states to participate, and these state particular categories of beneficiaries, selected diagnoses or geographic regions of the e programs will provide one payment for both hospital and physician services provided r certain episodes of inpatient care.

e Hospital Payments

payments for services provided directly to beneficiaries, Medicare makes additional that treat a disproportionately large number of low-income patients (Medicaid and ible to receive Supplemental Security Income). Disproportionate Share Hospital (DSH) ed annually based on certain statistical information required by HHS and are paid as a MS-DRG payments.

orm Law, Medicare DSH payments are reduced to 25% of the amount they otherwise ent the law. The remaining 75% of the amount that would otherwise be paid under ctively pooled, and this pool is reduced further each year by a formula that reflects onal level of uninsured who are under 65 years of age. Thus, the greater the level of ously uninsured nationally, the more the Medicare DSH payment pool will be reduced. hen to be paid, out of the reduced DSH payment pool, an amount allocated based upon oviding uncompensated care.

care to a disproportionately high number of low-income patients may receive Medicaid ederal government distributes federal Medicaid DSH funds to each state based on a e states then distribute the DSH funding among qualifying hospitals. States have broad hich hospitals qualify for Medicaid DSH payments and the amount of such payments. aw, as modified by the Bipartisan Budget Act of 2013, provides for reductions to the l program in federal fiscal years 2016 through 2020. Subsequent legislation has delayed the reductions until fiscal year 2018 and extended the reductions through fiscal year aw, Medicaid DSH will be reduced annually as follows: 2018 ($2 billion); 2019 ($3 ion); 2021 ($5 billion); 2022 ($6 billion); 2023 ($7 billion); and 2024 and 2025 ($8 ued a final rule in 2013 establishing the methodology for allocating the cuts among the ume of Medicaid inpatients and levels of uncompensated care in each state. Under that ained the ability to manage the reduced allotments and to allocate these cuts among ate. However, due to the delays in the onset of the reductions, a new methodology will cal year 2017.

rtment of Defense s health care program for members of the armed forces. For inpatient imburses hospitals based on a DRG system modeled on the Medicare inpatient PPS. For RICARE reimburses hospitals based on a PPS that is similar to that utilized for services beneficiaries.

ting in the Medicare, Medicaid and TRICARE programs, whether paid on a reasonable PPS, are required to meet certain financial reporting requirements. Federal and, where tions require the submission of annual cost reports covering the revenues, costs and

with the services provided by each hospital to Medicare beneficiaries and Medicaid

quired under the Medicare and Medicaid programs are subject to routine audits, which ents to the amounts ultimately determined to be due to us under these reimbursement s often require several years to reach the final determination of amounts due to or from ms. Providers also have rights of appeal, and it is common to contest issues raised in

her Discounted Plans

offer discounts from established charges to certain large group purchasers of health care nanaged care plans and private insurance companies. Admissions reimbursed by care and other insurers were 30% of our total admissions for each of the years ended 014 and 2013, respectively. Managed care contracts are typically negotiated for terms e years. While we generally received contracted annual average increases that were to 5.0% from managed care payers during 2015, there can be no assurance that we will creases in the future. It is not clear what impact, if any, the increased obligations on and other health plans imposed by the Health Reform Law will have on our ability to nt increases or the impact of plans offered through the Exchanges on us.

y Patients

our uninsured patients are initially admitted through our emergency rooms. For the year 015, approximately 83% of our admissions of uninsured patients occurred through our e Emergency Medical Treatment and Labor Act (EMTALA) requires any hospital that icare program to conduct an appropriate medical screening examination of every person ospital s emergency room for treatment and, if the individual is suffering from an condition, to either stabilize that condition or make an appropriate transfer of the that can handle the condition. The obligation to screen and stabilize emergency medical rdless of an individual s ability to pay for treatment. The Health Reform Law requires rse hospitals for emergency services provided to enrollees without prior authorization whether a participating provider contract is in place. Further, the Health Reform Law at seek to decrease the number of uninsured individuals, including requirements and als to obtain, and large employers to provide, insurance coverage. These mandates are impact of screening for and stabilizing emergency medical conditions. However, many regarding the impact of the Health Reform Law, including how many previously will obtain and maintain coverage as a result of the law, the change, if any, in the d outpatient hospital services that are sought by and provided to previously uninsured ges to the payer mix and any increases in plan structures that result in higher patient .

cord Incentives

ery and Reinvestment Act of 2009 (ARRA) provides for Medicare and Medicaid or eligible hospitals and for eligible professionals that adopt and meaningfully use gy and provides for penalties for eligible hospitals and eligible professionals that do not y use EHR technology. Through December 2015, approximately $32 billion in incentive ade through the Medicare and Medicaid EHR incentive programs to eligible hospitals als.

ncentive program, eligible hospitals that demonstrate meaningful use will receive r up to four fiscal years. As of federal fiscal year 2015, acute care hospitals that have

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ngful use of certified EHR technology in an applicable prior reporting period receive
updates under inpatient PPS.

s who demonstrate meaningful use are entitled to incentive payments for up to five
alendar year 2015, eligible professionals who have failed to demonstrate meaningful use
ology in an applicable prior reporting period face Medicare payment reductions.

ncentive program is voluntary for states to implement. For participating states, the
tive program provides incentive payments for acute care hospitals and eligible
et certain volume percentages of Medicaid patients, as well as children s hospitals.
rticipate in a single state s Medicaid EHR incentive program. Eligible professionals can
er the Medicaid incentive program or the Medicare incentive program and can change
time. Eligible hospitals may participate in both the Medicare and Medicaid incentive

ve payments under the Medicaid program, providers must either adopt, implement,
te meaningful use of certified EHR technology during their first participation year or
rate meaningful use of certified EHR technology in subsequent participation years.
ived for up to six participation years. There is no penalty for hospitals or professionals
ling to meet EHR meaningful use requirements.

mportant factors relating to the overall utilization of a hospital are the quality and market
and the number and quality of physicians and other health care professionals providing
he facility. Generally, we believe the ability of a hospital to be a market leader is
dth of services, level of technology, quality and condition of the facilities, emphasis on
nvenience for patients and physicians. Other factors that impact utilization include the
tion, local economic conditions and market penetration of managed care programs.

ets forth certain operating statistics for our health care facilities. Health care facility to certain seasonal fluctuations, including decreases in patient utilization during holiday n the cold weather months. The data set forth in this table includes only those facilities or financial reporting purposes.

	Years Ended December 31,				
	2015	**2014**	**2013**	**2012**	**2011**
end of					
	168	166	165	162	163
g					
ers at					
	116	113	115	112	108
ds at					
	43,771	43,356	42,896	41,804	41,594
nsed					
	43,620	43,132	42,133	41,795	39,735
	1,868,800	1,795,300	1,744,100	1,740,700	1,620,400
(d)	**3,122,700**	2,958,700	2,844,700	2,832,100	2,595,900
	4.9	4.8	4.8	4.7	4.8
)	**25,084**	23,835	22,853	22,521	21,123
	58%	55%	54%	54%	53%
s(h)	**8,050,200**	7,450,700	6,968,100	6,912,000	6,143,500
	909,400	891,600	881,900	873,600	799,200
	529,900	518,900	508,800	506,500	484,500

those beds for which a facility has been granted approval to operate from the applicable ncy.
erage number of licensed beds, weighted based on periods owned.
al number of patients admitted to our hospitals and is used by management and certain eral measure of inpatient volume.
ions are used by management and certain investors as a general measure of combined atient volume. Equivalent admissions are computed by multiplying admissions by the sum of gross inpatient revenue and gross outpatient revenue and then dividing nt by gross inpatient revenue. The equivalent admissions computation equates to the volume measure (admissions) used to measure inpatient volume, resulting in a f combined inpatient and outpatient volume.
erage number of days admitted patients stay in our hospitals.
erage number of patients in our hospital beds each day.
rcentage of hospital licensed beds occupied by patients. Both average daily census and ovide measures of the utilization of inpatient rooms.
mber of patients treated in our emergency rooms.
mber of surgeries performed on patients who were not admitted to our hospitals. Pain endoscopy procedures are not included in outpatient surgeries.
mber of surgeries performed on patients who have been admitted to our hospitals. and endoscopy procedures are not included in inpatient surgeries.

pitals in the communities we serve provide services similar to those offered by our ly, in recent years the number of freestanding specialty hospitals, surgery centers, ts, urgent care centers and diagnostic and imaging centers in the geographic areas in ncreased significantly. As a result, most of our hospitals operate in a highly competitive cases, competing hospitals are more established than our hospitals. Some competing -owned or are owned by tax-supported government agencies and many others are owned

es that may be supported by endowments, charitable contributions and/or tax revenues
ales, property and income taxes. Such exemptions and support are not available to our

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ax-supported or not-for-profit entities an advantage in funding capital expenditures. In
e are large teaching hospitals that provide highly specialized facilities, equipment and
be available at most of our hospitals. We also face competition from specialty hospitals
and unaffiliated freestanding ASCs for market share in certain high margin services.

requently attract patients from areas outside their immediate locale and, therefore, our
ompete with both local and regional hospitals, including the psychiatric units of general,

gned to ensure our hospitals are competitive. We believe our hospitals compete within
the basis of many factors, including the quality of care, ability to attract and retain
lled clinical personnel and other health care professionals, location, breadth of services,
ality and condition of the facilities and prices charged. Hospitals must make public a list
es for items and services or their policies for providing a list of such charges in response
e increased our focus on operating outpatient services with improved accessibility and
ce for patients, and increased predictability and efficiency for physicians.

ficant factors to the competitive position of a hospital are the number and quality of
ith or employed by the hospital. Although physicians may at any time terminate their
spital we operate, our hospitals seek to retain physicians with varied specialties on the
affs and to attract other qualified physicians. We believe physicians refer patients to a
f the quality and scope of services it renders to patients and physicians, the quality of
cal staff, the location of the hospital and the quality of the hospital s facilities, equipment
dingly, we strive to maintain and provide quality facilities, equipment, employees and
s and patients. Our hospitals face competition from competitors that are implementing
strategies, such as employing physicians, acquiring physician practice groups and
or other clinical integration models.

n the competitive position of our hospitals is our ability to negotiate service contracts
oup health care services. Managed care plans attempt to direct and control the use of
obtain discounts from hospitals established gross charges. In addition, employers and
ers continue to attempt to contain costs through negotiations with hospitals for managed
counts from established gross charges. Generally, hospitals compete for service contracts
services purchasers on the basis of price, market reputation, geographic location, quality
quality of the medical staff and convenience. Our future success will depend, in part, on
nd renew our managed care contracts and enter into new managed care contracts on
r health care providers may impact our ability to enter into managed care contracts or
our reimbursement and other favorable terms and conditions. For example, some of our
tiate exclusivity provisions with managed care plans or otherwise restrict the ability of
ies to contract with us. The trend toward consolidation among non-government payers
r bargaining power over fee structures. In addition, various provisions of the Health
g the Exchanges and limitations on rescissions of coverage and pre-existing condition
to non-government payers increasingly demanding reduced fees or being unwilling to
ent increases. Most of the plans offered through the Exchanges provide for narrow
he number of participating providers or tiered networks that impose significantly higher
s on patients that obtain services from providers in a disfavored tier. The importance of
th managed care organizations varies from community to community, depending on the
n organizations.

ed (CON) laws, which place limitations on a health care facility s ability to expand
make capital expenditures and otherwise make changes in operations, may also have the

ompetition. We currently operate health care facilities in a number of states with CON
ther types of approvals for the establishment or expansion of certain facility types or
ng a CON or other approval, these states consider the need for additional or expanded
r services. In those states that do not require state approval or that set relatively high
s before they become reviewable by state authorities, competition in the form of new
capital spending is more prevalent. See Item 1, Business Regulation and Other Factors.

e industry as a whole face the challenge of continuing to provide quality patient care
ng costs and strong competition for patients. Changes in medical technology, existing
regulations and interpretations and managed care contracting for provider services by
t payers remain ongoing challenges.

lengths of stay and reimbursement amounts continue to be negatively affected by
mission authorization, utilization review and payer pressure to maximize outpatient and
delivery services for less acutely ill patients. The Health Reform Law expanded the use
by Medicare contractors by eliminating statutory restrictions on their use. Increased
n constraints and payer pressures are expected to continue. To meet these challenges, we
pdate our facilities or acquire or construct new facilities where appropriate, to enhance
prehensive array of outpatient services, offer market competitive pricing to private payer
ies and equipment and offer new or expanded programs and services.

r Factors

n and Accreditation

onstruction and operation are subject to numerous federal, state and local regulations
acy of medical care, equipment, personnel, operating policies and procedures,
uate records, fire prevention, rate-setting and compliance with building codes and
tion laws. Facilities are subject to periodic inspection by governmental and other
ntinued compliance with the various standards necessary for licensing and accreditation.
care facilities are properly licensed under applicable state laws. Each of our acute care
he United States is eligible to participate in Medicare and Medicaid programs and is
nt Commission. If any facility were to lose its Medicare or Medicaid certification, the
le to receive reimbursement from federal health care programs. If any facility were to
facility would be subject to state surveys, potentially be subject to increased scrutiny by
payment from non-government payers. Management believes our facilities are in
e with current applicable federal, state, local and independent review body regulations
quirements for licensure, certification and accreditation are subject to change and, in
fied, it may become necessary for us to make changes in our facilities, equipment,
. The requirements for licensure, certification and accreditation also include notification
nt of the transfer or change of ownership or certain other changes. Failure to provide
s or obtain necessary approvals in these circumstances can result in the inability to
n or change of ownership, loss of licensure, lapses in reimbursement or other penalties.

we operate hospitals and other health care facilities, the construction or expansion of
he acquisition of existing facilities, the transfer or change of ownership and the addition
s may be subject to review by and prior approval of, or notifications to, state regulatory
N program. Such laws generally require the reviewing state agency to determine the
ional or expanded health care facilities and services. Failure to provide required
necessary state approvals can result in the inability to expand facilities, complete an
wnership or other penalties.

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

Program Regulations

deral health care program, including the Medicare and Medicaid programs, is heavily
d regulation. If a hospital fails to substantially comply with the numerous conditions of
Medicare and Medicaid programs or performs certain prohibited acts, the hospital s
deral health care programs may be terminated, or civil and/or criminal penalties may be
an Budget Act of 2015 requires civil monetary penalties to increase by up to 150% by
increase annually thereafter based on updates to the consumer price index.

l Security Act known as the Anti-kickback Statute prohibits providers and others from
oliciting, receiving, offering or paying any remuneration with the intent of generating
services or items covered by a federal health care program. Courts have interpreted this
eld that there is a violation of the Anti-kickback Statute if just one purpose of the
erate referrals, even if there are other lawful purposes. Furthermore, the Health Reform
owledge of the law or the intent to violate the law is not required. Violations of the
may be punished by a criminal fine of up to $25,000 for each violation or imprisonment,
of up to $50,000 per violation and damages of up to three times the total amount of the
exclusion from participation in federal health care programs, including Medicare and
submission of a claim for services or items generated in violation of the Anti-kickback
to additional penalties under the federal False Claims Act (FCA) as a false or fraudulent

r regulatory agencies, is responsible for identifying and eliminating fraud, abuse and
ies out this mission through a nationwide program of audits, investigations and
provides guidance to the industry through various methods including advisory opinions
lerts. These Special Fraud Alerts do not have the force of law, but identify features of
actions that the government believes may cause the arrangements or transactions to
ack Statute or other federal health care laws. The OIG has identified several incentive
stitute suspect practices, including: (a) payment of any incentive by a hospital each time
atient to the hospital, (b) the use of free or significantly discounted office space or
s usually located close to the hospital, (c) provision of free or significantly discounted
her staff services, (d) free training for a physician s office staff in areas such as
es and laboratory techniques, (e) guarantees which provide, if the physician s income fails
ined level, the hospital will pay any portion of the remainder, (f) low-interest or
oans which may be forgiven if a physician refers patients to the hospital, (g) payment of
an s travel and expenses for conferences, (h) coverage on the hospital s group health
nappropriately low cost to the physician, (i) payment for services (which may include
ospital) which require few, if any, substantive duties by the physician, (j) purchasing
physicians at prices in excess of their fair market value, (k) rental of space in physician
n fair market value terms, by persons or entities to which physicians refer, and
ntities (frequently referred to as physician-owned distributorships or PODs) that derive
r arranging for the sale of,

evices ordered by their physician-owners for use on procedures that physician-owners
atients at hospitals or ASCs. The OIG has encouraged persons having information about
above types of incentives to physicians to report such information to the OIG.

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

Special Fraud Alerts and Special Advisory Bulletins, the OIG issues compliance program
pes of health care providers. The OIG guidance identifies a number of risk areas under
e statutes and regulations. These areas of risk include compensation arrangements with
t arrangements with physicians and joint venture relationships with physicians.

gress, the OIG has published safe harbor regulations that outline categories of activities
n prosecution under the Anti-kickback Statute. Currently, there are statutory exceptions
arious activities, including the following: certain investment interests, space rental,
ctitioner recruitment, personnel services and management contracts, sale of practice,
anties, discounts, employees, group purchasing organizations, waiver of beneficiary
tible amounts, managed care arrangements, obstetrical malpractice insurance subsidies,
practices, freestanding surgery centers, ambulance replenishing, and referral agreements

or a business arrangement does not fall within a safe harbor or is identified in a Special
dvisory Bulletin or other guidance does not necessarily render the conduct or business
der the Anti-kickback Statute. However, such conduct and business arrangements may
ny by government enforcement authorities.

financial relationships with physicians and others who either refer or influence the
ur hospitals, other health care facilities and employed physicians, including employment
lical director agreements and professional service agreements. We also have similar
ysicians and facilities to which patients are referred from our facilities and other
, we provide financial incentives, including minimum revenue guarantees, to recruit
mmunities served by our hospitals. While we endeavor to comply with the applicable
f our current arrangements, including joint ventures and financial relationships with
eferral sources and persons and entities to which we refer patients, do not qualify for safe

ur arrangements with physicians and other referral sources and referral recipients have
ply with current law and available interpretations, there can be no assurance regulatory
hese laws will determine these financial arrangements comply with the Anti-kickback
cable laws. An adverse determination could subject us to liabilities under the Social
er laws, including criminal penalties, civil monetary penalties and exclusion from
are, Medicaid or other federal health care programs.

ct also includes a provision commonly known as the Stark Law. The Stark Law prohibits
ng Medicare and Medicaid patients to entities with which they or any of their immediate
a financial relationship, if these entities provide certain designated health

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le by Medicare or Medicaid unless an exception applies. The Stark Law also prohibits designated health services reimbursable by Medicare and Medicaid from billing the d programs for any items or services that result from a prohibited referral and requires mounts received for items or services provided pursuant to the prohibited referral on a ated health services include inpatient and outpatient hospital services, clinical laboratory y services. Sanctions for violating the Stark Law include denial of payment, civil up to $15,000 per claim submitted and exclusion from the federal health care programs. unts received as a result of a prohibited referral on a timely basis may constitute a false d may result in civil penalties and additional penalties under the FCA. The statute also of up to $100,000 for a circumvention scheme. Civil monetary penalties will increase by nd annually thereafter, as described above.

o the self-referral prohibition for many of the customary financial arrangements between ers, including employment contracts, leases and recruitment agreements. Unlike safe i-kickback Statute with which compliance is voluntary, a financial relationship must uirement of a Stark Law exception or the arrangement is in violation of the Stark Law. xception for a physician s ownership interest in an entire hospital, the Health Reform an-owned hospitals established after December 31, 2010 from billing for Medicare or rred by their physician owners. As a result, the law effectively prevents the formation of l hospitals that participate in Medicare or Medicaid. While the Health Reform Law hysician-owned hospitals, it does not allow these hospitals to increase the percentage of nd significantly restricts their ability to expand services.

lemakings, CMS has issued final regulations implementing the Stark Law. While these ded to clarify the requirements of the exceptions to the Stark Law, it is unclear how the ret many of these exceptions for enforcement purposes. Further, we do not always have cant regulatory or judicial interpretation of the Stark Law and its implementing mpt to structure our relationships to meet an exception to the Stark Law, but the nting the exceptions are detailed and complex, and we cannot assure that every fully with the Stark Law.

we operate also have laws similar to the Anti-kickback Statute that prohibit payments to referrals and laws similar to the Stark Law that prohibit certain self-referrals. The scope road because they can often apply regardless of the source of payment for care, and little eir interpretation or enforcement. These statutes typically provide for criminal and civil ss of licensure.

e Provisions

Portability and Accountability Act of 1996 (HIPAA) broadened the scope of certain by adding several criminal provisions for health care fraud offenses that apply to all ns. The Social Security Act also imposes criminal and civil penalties for making false s to Medicare and Medicaid. False claims include, but are not limited to, billing for or for misrepresenting actual services rendered in order to obtain higher reimbursement, goods and services and cost report fraud. Federal enforcement officials have the ability care and Medicaid any investors, officers and managing employees associated with have committed health care fraud, even if the officer or managing employee had no ud. Criminal and civil penalties may be imposed for a number of other prohibited ilure to return known overpayments, certain gainsharing arrangements, billing Medicare tantially in excess of a provider s usual charges, offering remuneration to influence a beneficiary s

care provider, contracting with an individual or entity known to be excluded from a gram, making or accepting a payment to induce a physician to reduce or limit services, ving any remuneration in return for referring an individual for an item or service payable re program. Like the Anti-kickback Statute, these provisions are very broad. Civil sed for the failure to report and return an overpayment within 60 days of identifying the date a corresponding cost report is due, whichever is later. To avoid liability, providers nings, carefully and accurately code claims for reimbursement, promptly return urately prepare cost reports.

ons, including the federal Civil Monetary Penalty Law, require a lower burden of proof buse laws, including the Anti-kickback Statute. Civil monetary penalties that may be eral Civil Monetary Penalty Law range from $10,000 to $50,000 per act. The Bipartisan equires these penalties to increase by up to 150% by August 1, 2016, and annually ed above. In some cases, violations of the Civil Monetary Penalty Law may result in e times the remuneration offered, paid, solicited or received. In addition, a violator may ion from federal and state health care programs. Federal and state governments ederal Civil Monetary Penalty Law, especially where they believe they cannot meet the f requirements under the Anti-kickback Statute. Further, individuals can receive up to nformation on Medicare fraud and abuse that leads to the recovery of at least $100 of the Medicare Integrity Program.

ims Act and Similar State Laws

and federal laws that govern the submission of claims for reimbursement and prohibit aims or statements. One of the most prominent of these laws is the FCA, which may be l government directly or by a *qui tam* plaintiff, or whistleblower, on the government s t may use the FCA to prosecute Medicare and other government program fraud in areas billing for services not provided and submitting false cost reports. In addition, the FCA e in connection with the Exchanges created under the Health Reform Law, if those y federal funds. When a private party brings a *qui tam* action under the FCA, the aware of the lawsuit until the government commences its own investigation or makes a r it will intervene. If a defendant is determined by a court of law to be liable under the ay be required to pay three times the actual damages sustained by the government, plus lties of between $5,500 and $11,000 for each separate false claim. Civil monetary by up to 150% in 2016, and annually thereafter, as described above.

tial bases for liability under the FCA. Liability often arises when an entity knowingly for reimbursement to the federal government. The FCA defines the term knowingly ple negligence will not give rise to liability under the FCA, submitting a claim with ts truth or falsity constitutes a knowing submission under the FCA and, therefore, may ssion of claims for services or items generated in violation of the Anti-kickback Statute raudulent claim under the FCA. Whistleblowers and the federal government have taken courts have held, that providers who allegedly have violated other statutes, such as the by submitted false claims under the FCA. False claims under the FCA also include the er failure to report and refund amounts owed to the government in a timely manner on of an overpayment. Effective March 14, 2016, an overpayment is deemed to be on has, or should have through reasonable diligence, determined that an overpayment tified the overpayment.

ves at least $5 million annually in Medicaid payments must have written policies for all rs or agents, providing detailed information about false claims, false statements and ions under certain federal laws, including the FCA, and similar state laws. In addition, an incentive to states to enact false claims laws comparable to the FCA. A number of

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have adopted their own false claims provisions as well as their own whistleblower h a private party may file a civil lawsuit in state court. We have adopted and distributed he FCA and relevant state laws.

Simplification and Privacy and Security Requirements

implification Provisions of HIPAA and implementing regulations require the use of ata transmission standards for certain health care claims and payment transactions electronically. These provisions are intended to encourage electronic commerce in the s required by the Health Reform Law, HHS is in the process of adopting standards for ansactions and establishing operating rules to promote uniformity in the implementation lectronic transaction. In addition, HIPAA requires that each provider use a National MS published a final rule requiring the use of updated standard code sets for certain ures known as ICD-10 code sets. Health plans and providers, including our hospitals, nsition to the ICD-10 code sets by October 1, 2015, which required significant .

rity regulations promulgated pursuant to HIPAA extensively regulate the use and lly identifiable health information, known as protected health information, and require ding health plans and most health care providers, to implement administrative, physical rds to protect the security of such information. Certain provisions of the security and ply to business associates (entities that handle protected health information on behalf of business associates are subject to direct liability for violation of the regulations. In ity may be subject to penalties as a result of a business associate violating HIPAA, if the ound to be an agent of the covered entity.

t report breaches of unsecured protected health information to affected individuals delay but not to exceed 60 days of discovery of the breach by a covered entity or its nust also be made to HHS and, in certain situations involving large breaches, to the d to publish on its website a list of all covered entities that report a breach involving uals. All non-permitted uses or disclosures of unsecured protected health information are hes unless the covered entity or business associate establishes that there is a low ation has been compromised. Various state laws and regulations may also require us to uals in the event of a data breach involving individually identifiable information.

A privacy and security regulations may result in criminal penalties and in civil penalties violation for a maximum of $1,500,000 in a calendar year for violations of the same equired to perform compliance audits and has announced its intent to perform audits in forcement by HHS, state attorneys general are authorized to bring civil actions seeking mages in response to violations that threaten the privacy of state residents. HHS may ons through informal means, such as allowing a covered entity to implement a corrective has the discretion to move directly to impose monetary penalties and is required to iolations resulting from willful neglect. We enforce a HIPAA compliance plan, which ith the HIPAA privacy and security regulations and under which a HIPAA compliance ompliance. The HIPAA privacy regulations and security regulations have and will nificant costs on our facilities in order to comply with these standards.

other laws and legislative and regulatory initiatives at the federal and state levels d security concerns. Our facilities remain subject to any federal or state privacy-related trictive than the privacy regulations issued under HIPAA. These laws vary and could nalties. For example, the Federal Trade Commission uses its consumer protection orcement actions in response to data breaches.

n the United States are subject to EMTALA. This federal law requires any hospital
edicare program to conduct an appropriate medical screening examination of every
ts to the hospital s emergency room for treatment and, if the individual is suffering from
l condition, to either stabilize the condition or make an appropriate transfer of the
able to handle the condition. The obligation to screen and stabilize emergency medical
rdless of an individual s ability to pay for treatment. There are severe penalties under
l fails to screen or appropriately stabilize or transfer an individual or if the hospital
eatment in order to first inquire about the individual s ability to pay. Penalties for
A include civil monetary penalties and exclusion from participation in the Medicare
n injured individual, the individual s family or a medical facility that suffers a financial
f a hospital s violation of the law can bring a civil suit against the hospital.

lly interprets EMTALA to cover situations in which individuals do not actually present
ency room, but present for emergency examination or treatment to the hospital s campus,
pital-based clinic that treats emergency medical conditions or are transported in a
lance, subject to certain exceptions. At least one court has interpreted the law also to
t has been notified of a patient s pending arrival in a non-hospital owned ambulance.
enerally apply to individuals admitted for inpatient services. The government has
investigate and enforce EMTALA violations actively. We believe our hospitals operate
ce with EMTALA.

Medicine/Fee Splitting

which we operate have laws prohibiting corporations and other entities from employing
medicine for a profit and making certain direct and indirect payments to, or entering into
ents with, health care providers designed to induce or encourage the referral of patients
tion of, particular providers for medical products and services. Possible sanctions for
ictions include loss of license and civil and criminal penalties. In addition, agreements
on and the physician may be considered void and unenforceable. These statutes vary
often vague and have seldom been interpreted by the courts or regulatory agencies.

nvestigations

public attention has focused in recent years on the hospital industry. This media and
es in government personnel and other factors have led to increased scrutiny of the health
as may be disclosed in our SEC filings, we are not aware of any material investigations
federal or state health care laws or regulations. It is possible that governmental entities
tions or litigation in the future at facilities we operate and that such matters could result
, as well as adverse publicity. It is also possible that our executives and managers could
nental investigations or litigation or named as defendants in private litigation.

care, Medicaid and other governmental billings result in heightened scrutiny of our
ue to monitor all aspects of our business and have developed a comprehensive ethics and
hat is designed to meet or exceed applicable federal guidelines and industry standards.
s area is complex and constantly evolving, governmental investigations or litigation may
s that are inconsistent with our or industry practices.

urrounding current investigations, governmental authorities have taken positions on a
uding some for which little official interpretation previously has been available, that
ent with practices that have been common within the industry and that previously have
this manner. In some instances, government investigations that have in the past been
vil provisions of federal law may now be conducted as criminal investigations.

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e government agencies have increased their focus on and coordination of civil and efforts in the health care area. The OIG and the Department of Justice (DOJ) have, from ed national enforcement initiatives, targeting all hospital providers that focus on specific er suspected areas of abuse. The Health Reform Law includes additional federal funding 10 years to fight health care fraud, waste and abuse, including $30 million in federal dition, governmental agencies and their agents, such as MACs, fiscal intermediaries and audits of our health care operations. Private payers may conduct similar post-payment form internal audits and monitoring.

enforcement initiatives, federal and state investigations have addressed a wide variety of erations such as: cost reporting and billing practices, including for Medicare outliers; s with referral sources; physician recruitment activities; physician joint ventures; and ollection practices for self-pay patients. We engage in many of these routine health care activities that could be the subject of governmental investigations or inquiries. For gnificant Medicare and Medicaid billings, numerous financial arrangements with eferral sources to our hospitals, and joint venture arrangements involving physician our individual facilities have received, and other facilities may receive, government may be subject to investigation by, federal and state agencies. Any additional ompany, our executives or managers could result in significant liabilities or penalties to ublicity.

aw changes how health care services are covered, delivered and reimbursed through uninsured individuals, reduced growth in Medicare program spending, reductions in d DSH payments, and the establishment of programs that tie reimbursement to quality ition, the law reforms certain aspects of health insurance, expands existing efforts to tie d payments to performance and quality, and strengthens fraud and abuse enforcement.

w will expand coverage through a combination of public program expansion and private and other reforms.

ogram coverage expansion is occurring through changes in Medicaid, and to a lesser e Children s Health Insurance Program (CHIP). The most significant changes expand the ls eligible for Medicaid coverage and permit individuals with relatively higher incomes th Reform Law requires all state Medicaid programs to provide, and the federal ze, Medicaid coverage to virtually all adults under 65 years old with incomes at or under o apply a 5% income disregard to the eligibility standard, so that eligibility is effectively incomes up to 138% of the FPL. However, states may opt out of the expansion without l Medicaid funding. States that choose not to implement the Medicaid expansion are blished by the Health Reform Law to cover most of the expansion costs. A number of s and Florida, have chosen not to participate in the expanded Medicaid program, but ose to implement the expansion at a later date. For states that do not participate, the el required for individuals and families to qualify for Medicaid varies widely from state

federal and state program, the federal government provides states with matching funds ge, known as the federal medical assistance percentage (FMAP). Beginning in 2014, an enhanced FMAP for the individuals enrolled in Medicaid pursuant to the Health AP percentage is as follows: 100% for calendar years 2014 through 2016; 95% for 2017;

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2019; and 90% in 2020 and thereafter. CMS has indicated that states that only partially programs will not receive an enhanced FMAP.

Reform Law, the federal government subsidizes states that create non-Medicaid plans comes are greater than 133% of the FPL but do not exceed 200% of the FPL. Approved to receive federal funding. The amount of that funding per individual is equal to 95% of have been provided for that individual had he or she enrolled in a health plan offered hanges, as discussed below.

ten have attempted to reduce Medicaid spending by limiting benefits and tightening equirements. However, for children, the Health Reform Law requires states to at least gibility standards that were established prior to the enactment of the law until October 1,

on

lth coverage through the private sector as a result of the Health Reform Law occurs ents applicable to health insurers, employers and individuals. Health insurers must keep al costs lower than 15% of premium revenue for the group market and lower than 20% individual markets or rebate to enrollees the amount spent in excess of the percentage. urers are not permitted to deny coverage to children based upon a pre-existing condition dent care coverage for children up to 26 years old. Health insurers are prohibited from age limits, dropping coverage, excluding persons based upon pre-existing conditions or ny individual who is willing to pay the premiums for such coverage.

subject to new requirements and incentives to provide health insurance benefits to their mployers with 50 or more employees that do not offer health insurance will be subject to yee obtains government-subsidized coverage through an Exchange. The employer 2,000 to $3,000 per employee, subject to certain thresholds and conditions.

w uses various means to induce individuals who do not have health insurance to obtain are required to maintain health insurance for a minimum defined set of benefits or pay a ty in most cases is the greater of $695 or 2.5% of income in 2016, and indexed to a cost n subsequent years. The Internal Revenue Service (IRS), in consultation with HHS, is ng the tax penalty, although the Health Reform Law limits the availability of certain IRS isms. In addition, for individuals and families below 400% of the FPL, the cost of ance through the Exchanges is subsidized by the federal government. Those with lower o receive greater subsidies. It is anticipated that those at the lowest income levels will eir premiums subsidized by the federal government, in some cases in excess of 95% of

ase of health insurance by individuals and small employers, the Health Reform Law te establish or participate in an Exchange or default to a federally-operated Exchange by h insurers participating in an Exchange must offer a set of minimum benefits, as defined r more benefits. Health insurers must offer at least two, and may offer up to five, levels he percentage of medical expenses that must be paid by the enrollee. These levels are m, gold, silver, bronze and catastrophic plans, with gold and silver being the two ans. Each level of plan must require the enrollee to share the following percentages of o the deductible/copayment limit: platinum, 10%; gold, 20%; silver, 30%; bronze, 40%; %. Health insurers may establish varying deductible/copayment levels, up to the statutory h insurers must cover 100% of the amount of medical expenses in excess of the limit.

ing

1, Business Sources of Revenue, the Health Reform Law provides for spending
e, Medicaid and other federal health care programs. It also increasingly ties payment for
comes, provides for the creation of ACOs, and creates incentives and other initiatives to
nt care across settings and over time.

pital Limitations

we have faced competition from hospitals that have physician ownership. The Health
newly created physician-owned hospitals from billing for Medicare patients referred by
rs. As a result, the law effectively prevents the formation of new physician-owned
ate in Medicare and Medicaid after December 31, 2010. While the law grandfathers
ned hospitals, it does not allow these hospitals to increase the percentage of physician
antly restricts their ability to expand services.

Fraud and Abuse

aw makes several significant changes to health care fraud and abuse laws, provides
nt tools to the government, increases cooperation between agencies by establishing
sharing of information and enhances criminal and administrative penalties for
xample, the Health Reform Law: (1) provides $350 million in increased federal funding
ealth care fraud, waste and abuse; (2) expands the scope of the RAC program to include
d; (3) authorizes HHS, in consultation with the OIG, to suspend Medicare and Medicaid
er of services or a supplier pending an investigation of a credible allegation of fraud;
e contractors with additional flexibility to conduct random prepayment reviews; and
s for returning overpayments made by governmental health programs and expands FCA
ure to timely repay identified overpayments.

rm Law on the Company

th insurance coverage under the Health Reform Law may result in an increase in the
ng our facilities who have either private or public program coverage. In addition, the
rovides for initiatives that create possible sources of additional revenue, such as ACOs.
ve effects of the Health Reform Law could be offset, and the Company could be
, by reductions to the Medicare and Medicaid programs. Although the Health Reform
sitive effect on the Company to date, before considering the impact of Medicare
in 2010, substantial uncertainty remains regarding the ongoing net effect of the Health
Company because the resolution of a number of material factors remains unclear as
Risk Factors .

d Demographic Factors

y is impacted by the overall United States economy. Budget deficits at federal, state and
ities have had a negative impact on spending for many health and human service
Medicare, Medicaid and similar programs, which represent significant payer sources for
cipate that the federal deficit, the growing magnitude of Medicare expenditures and the
ates population will continue to place pressure on federal health care programs. Other
eriods of economic weakness and high unemployment include potential declines in the
der managed care agreements, increased patient decisions to postpone or cancel elective
lth care procedures, increases in the uninsured and underinsured populations, increased
n structures that shift financial responsibility to patients and further difficulties in our
eivables for copayment and deductible amounts. The Health Reform Law seeks to

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of uninsured individuals, but it is difficult to predict the full impact of the Health Reform

ehensive ethics and compliance program that is designed to meet or exceed applicable industry standards. The program is intended to monitor and raise awareness of various ng employees and to emphasize the importance of complying with governmental laws art of the ethics and compliance program, we provide annual ethics and compliance ees and encourage all employees to report any violations to their supervisor, an ethics er or a toll-free telephone ethics line. The Health Reform Law requires providers to ents of compliance program criteria to be established by HHS, on a timeline to be s a condition of enrollment in the Medicare or Medicaid programs, and we may have to e programs to comply with these new criteria.

ent and most states have enacted antitrust laws that prohibit certain types of conduct mpetitive. These laws prohibit price fixing, market allocation, bid-rigging, concerted monopolization, price discrimination, tying arrangements, acquisitions of competitors at have, or may have, an adverse effect on competition. Violations of federal or state lt in various sanctions, including criminal and civil penalties. Antitrust enforcement in y is currently a priority of the Federal Trade Commission and the DOJ. We believe we ith such federal and state laws, but courts or regulatory authorities may reach a ture that could adversely affect our operations.

ers

ous federal, state and local statutes and ordinances regulating the discharge of materials We do not believe that we will be required to expend any material amounts in order to s and regulations.

alth care industry, we are subject to claims and legal actions by patients in the ordinary bject, in most cases, to a $15 million per occurrence self-insured retention, our facilities 00% owned insurance subsidiary for losses up to $50 million per occurrence. The as obtained reinsurance for professional liability risks generally above a retention level currence. We also maintain professional liability insurance with unrelated commercial cess of amounts insured by our insurance subsidiary.

elated insurance companies, coverage for cyber security incidents, directors and officers loss in amounts we believe are adequate. The cyber security and directors and officers n include a $5 million corporate deductible. In addition, we will continue to purchase ectors and officers on an ongoing basis. The property coverage includes varying on the cause of the property damage. These deductibles range from $500,000 per claim d property values for certain flood and wind and earthquake related incidents.

cal Staffs

, we had approximately 233,000 employees, including approximately 59,000 part-time herein to employees refer to employees of our affiliates. We are subject to various

s that regulate wages, hours, benefits and other terms and conditions relating to
mber 31, 2015, certain employees at 38 of our domestic hospitals are represented by
While no elections are expected in 2016, it is possible additional hospitals may unionize
ider our employee relations to be good and have not experienced work stoppages that
rsely affected our business or results of operations. Our hospitals, like most hospitals,
ng labor costs. In some markets, nurse and medical support personnel availability has
perating issue to health care providers. To address this challenge, we have implemented
mprove retention, recruiting, compensation programs and productivity.

ed by licensed physicians, including both employed physicians and physicians who are
hospitals. Some physicians provide services in our hospitals under contracts, which
erm of service, provide and establish the duties and obligations of such physicians,
e of certain performance criteria and fix compensation for such services. Any licensed
o be accepted to the medical staff of any of our hospitals, but the hospital s medical staff
verning board of the hospital, in accordance with established credentialing criteria, must
the staff. Members of the medical staffs of our hospitals often also serve on the medical
s and may terminate their affiliation with one of our hospitals at any time.

o continue to enhance wages and benefits to recruit and retain nurses and other medical
o hire more expensive temporary or contract personnel. As a result, our labor costs could
end on the available labor pool of semi-skilled and unskilled employees in each of the
perate. Certain proposed changes in federal labor laws and the National Labor Relations
B) modification of its election procedures could increase the likelihood of employee
. To the extent a significant portion of our employee base unionizes, our costs could
addition, the states in which we operate could adopt mandatory nurse-staffing ratios or
ory nurse-staffing ratios already in place. State-mandated nurse-staffing ratios could
bor costs, and have an adverse impact on revenues if we are required to limit patient
meet the required ratios.

the Registrant

, our executive officers were as follows:

	Age	Position(s)
	59	Chairman, Chief Executive Officer and Director
	68	Senior Vice President Finance
	69	Senior Vice President
	50	Senior Vice President Clinical Excellence
.	50	President Physician Services Group
	57	Senior Vice President Corporate Affairs
	57	Senior Vice President and Chief Nursing Officer
	54	President American Group
	62	President National Group
	55	Chief Operating Officer
	55	President Service Line and Operations Integration
	53	Senior Vice President Provider Relations
	56	Senior Vice President and Chief Information Officer
D.	54	President Clinical Services Group and Chief Medical Officer
	52	Executive Vice President and Chief Financial Officer
	59	Senior Vice President and Chief Development Officer
	61	Senior Vice President Internal Audit Services
	60	Senior Vice President Human Resources
	59	Senior Vice President and Controller
	55	Senior Vice President Employer and Payer Engagement
	62	Senior Vice President, General Counsel and Chief Labor Relations Officer
	66	Senior Vice President and Chief Ethics and Compliance Officer

as appointed Chairman and Chief Executive Officer effective December 31, 2014. President and Chief Executive Officer from January 1, 2014 to December 31, 2014 and the Company since December 2009. Mr. Johnson previously served the Company as Financial Officer from February 2011 through December 2013 and Executive Vice nancial Officer from July 2004 to February 2011. Prior to that time, he served as Senior ontroller from July 1999 until July 2004 and as Vice President and Controller of the mber 1998 to July 1999. From April 1995 to October 1998, Mr. Johnson served as Vice Company. Prior to that time, Mr. Johnson served as Director of Tax for Healthtrust, Inc. from September 1987 to April 1995.

s served as Senior Vice President Finance since July 1999 and also served as Treasurer November 1996 to July 2014. Mr. Anderson also served as Vice President Finance from y 1999. From March 1993 until September 1993, Mr. Anderson served as Vice President rer of Galen Health Care, Inc. From July 1988 to March 1993, Mr. Anderson served as nce and Treasurer of Humana Inc. Mr. Anderson is a member of the board of directors of dings, Inc.

nas served as Senior Vice President of the Company since February 1994. He is ment and investor relations. Prior to that time, Mr. Campbell served as HCA-Hospital ca s Vice President for Investor, Corporate and Government Relations. Mr. Campbell Corporation of America in 1972. Mr. Campbell serves on the board of the Coalition to alth Care, as a member of the American Hospital Association s President s Forum, and on e committee of the Federation of American Hospitals.

appointed Senior Vice President Clinical Excellence in January 2015. Prior to that time,
ice President Clinical Excellence from September 2011 to January 2015 and Chief
A s TriStar Division from October 2010 to September 2011. He served as Chief Medical
Medical Center from September 2008 to October 2010 and also served as interim Chief
he Sarah Cannon Cancer Centers for the TriStar Division from October 2009 to March
so served as Clinical Professor of Surgery at Vanderbilt University School of Medicine
8 and previously served as Professor of Surgery from 2005 to 2008 and Associate
2005.

nas served as President Physician Services Group since October 2011. From October
Dr. Cuffe also served as a Vice President of the Company. Prior to that time, Dr. Cuffe
y Health System as Vice President for Ambulatory Services and Chief Medical Officer
ctober 2011 and Vice President Medical Affairs from June 2005 to March 2011. He also
y School of Medicine as Vice Dean for Medical Affairs from June 2008 to March 2011,
Department of Medicine from August 2009 to August 2010 and Associate Professor of
2005 to October 2011. Prior that time, Dr. Cuffe served in various leadership roles with
search Institute, Duke University Medical Center and Duke University School of

pointed Senior Vice President Corporate Affairs of the Company in December 2012.
served as the Company s Senior Vice President Communications from February 2011 to
ice President of Communications from November 1997 to February 2011. Ms. Davis
rom Burson-Marsteller, where she was a Managing Director and served as Corporate
n American operations. Ms. Davis also held a number of Public Affairs positions in the
d Reagan Administrations. Ms. Davis is an attorney and serves as chair of the Public
or the Federation of American Hospitals.

ght was appointed Senior Vice President and Chief Nursing Officer in January 2015.
ously served as Vice President and Chief Nursing Officer from 2007 to January 2015.
HCA in 1992 as a critical care nurse at Lewisville Medical Center in Texas and became
of HCA s San Antonio Community Hospital in 1996. Dr. Englebright currently serves as
Representative to The Joint Commission s Board of Commissioners and chairs the Board
tional Patient Safety Foundation.

pointed President American Group in January 2013. Prior to that, Mr. Foster served as
Group from February 2011 to January 2013 and as Division President for the Central and
rom January 2006 to February 2011. Mr. Foster joined HCA in March 2001 as President
s HealthCare in Austin, Texas and served in that position until February 2011. Prior to
Mr. Foster served in various executive capacities within the Baptist Health System,
and The Methodist Hospital System in Houston, Texas.

ppointed President National Group in February 2011. Prior to that, Mr. Hall served as
roup from October 2006 to February 2011. Mr. Hall had previously served the Company
Florida Division from April 2003 until October 2006, as President of the East Florida
1999 until April 2003, as a Market President in the East Florida Division from January
1998, as President of the South Florida Division from February 1996 until December
t of the Southwest Florida Division from October 1994 until February 1996, and in
s since 1987.

appointed Chief Operating Officer in January 2015. Prior to that time, he served as
s of the Company from February 2011 to January 2015. Mr. Hazen served as President
July 2001 to February 2011 and as Chief Financial Officer Western Group of the
1995 to July 2001. Mr. Hazen served as Chief Financial Officer North Texas Division

February 1994 to July 1995. Prior to that time, Mr. Hazen served in various hospital and al Officer positions with Humana Inc. and Galen Health Care, Inc.

as appointed President Service Line and Operations Integration in February 2011. Prior l served as President Outpatient Services Group since January 2006. Mr. Moore served nt and as Chief Operating Officer Outpatient Services Group from July 2004 to January ice President Operations Administration from July 1999 until July 2004. Mr. Moore ent Operations Administration of the Company from September 1997 to July 1999, as efits from October 1996 to September 1997, and as Vice President Compensation from ber 1996.

s appointed Senior Vice President Provider Relations in January 2015. Prior to that time, resident National Sales from April 2008 to January 2015. From 2000 to 2008, various capacities with Pfizer Inc., including Vice President of Sales for the Customer 05 to 2008.

appointed Senior Vice President and Chief Information Officer of the Company in June e, he served as Vice President and Chief Operating Officer of Information Technology & 2010 to May 2012 and Vice President Information Technology & Services Field ember 2006 to February 2010. From January 1998 to September 2006, he served in t roles in the Company s Information Technology & Services department. Mr. Paslick 1985.

in was appointed President Clinical Services Group and Chief Medical Officer in Perlin had served as Chief Medical Officer and Senior Vice President Quality of the st 2006 to November 2007. Prior to joining the Company, Dr. Perlin served as Under in the U.S. Department of Veterans Affairs since April 2004. Dr. Perlin joined the nistration in November 1999 where he served in various capacities, including as Deputy ealth from July 2002 to April 2004, and as Chief Quality and Performance Officer from ptember 2002. He also served as Senior Advisor to the Acting Secretary of the U.S. s Affairs from July 2014 to September 2014 and is the immediate past Chairman for the sociation.

has served as the Company s Executive Vice President and Chief Financial Officer since therford previously served as Chief Operating Officer of the Company s Clinical and oup from January 2011 to January 2014 and Chief Financial Officer of the Company s Group from November 2008 to January 2011. Prior to that time, Mr. Rutherford was Consulting Group of Tennessee from July 2007 to November 2008 and was Chief sychiatric Solutions, Inc. from March 2006 to June 2007. Mr. Rutherford also previously tions with the Company from 1986 to 2005, including Chief Financial Officer of what s Eastern Group, Director of Internal Audit and Director of Operations Support.

vas appointed as Senior Vice President and Chief Development Officer of the Company om 1987 to 1996 and again from 1999 to 2009, Mr. Sowell was a partner at the law firm ortch & Davis where he specialized in the areas of health care law, mergers and tures, private equity financing, tax law and general corporate law. He also co-managed nd commercial transactions practice. From 1996 to 1999, Mr. Sowell served as the head of as the Chief Operating Officer of Arcon Healthcare.

s served as Senior Vice President Internal Audit Services of the Company since July ved as Vice President Internal Audit Services from November 1997 to July 1999. From tober 1997, Mr. Steakley was a partner with Ernst & Young LLP.

ved as Senior Vice President Human Resources of the Company since November 2003. ice President Compensation and Recruitment of the Company from November 1997 to March 1995 to November 1997, Mr. Steele served as Assistant Vice President

s served as Senior Vice President and Controller since December 2008. Mr. Stinnett cial Officer Eastern Group from October 2005 to December 2008 and Chief Financial st Division from July 1999 to October 2005. Mr. Stinnett served as Chief Financial dent of Finance of Franciscan Health System of the Ohio Valley from 1995 until 1999, capacities with Franciscan Health System of Cincinnati and Providence Hospital in time.

ppointed Senior Vice President Employer and Payer Engagement (former Senior Vice c Pricing and Analytics) in February 2011. From October 2006 to February 2011, s Vice President Strategic Pricing and Analytics. Prior to that, Mr. Vallarino served as aged Care for the Western Group of the Company from January 1998 to October 2006.

has served as Senior Vice President and General Counsel of the Company since hief Labor Relations Officer since March 2009. Mr. Waterman served as a partner in the Watkins from September 1993 to October 1997; he was Chair of the firm s health care

rved as Senior Vice President and Chief Ethics and Compliance Officer of the Company m October 1997 to May 2007, Mr. Yuspeh served as Senior Vice President Ethics, porate Responsibility of the Company. From September 1991 until October 1997, tner with the law firm of Howrey & Simon. As a part of his law practice, Mr. Yuspeh 997 as Coordinator of the Defense Industry Initiative on Business Ethics and Conduct.

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scussed in the following risk factors were to occur, our business, financial position, cash flows or prospects could be materially, adversely affected. Additional risks and ently known, or currently deemed immaterial, may also constrain our business and

ge could adversely affect our ability to raise additional capital to fund our operations, ct to changes in the economy or our industry, expose us to interest rate risk to the extent bt and prevent us from meeting our obligations.

ged. As of December 31, 2015, our total indebtedness was $30.488 billion. As of e had availability of $1.959 billion under our senior secured revolving credit facility and ur asset-based revolving credit facility, after giving effect to letters of credit and ions. Our high degree of leverage could have important consequences, including:

vulnerability to downturns or adverse changes in general economic, industry or onditions and adverse changes in government regulations;

bstantial portion of cash flows from operations to be dedicated to the payment of interest on our indebtedness, therefore reducing our ability to use our cash flows to fund s, capital expenditures and future business opportunities;

o the risk of increased interest rates as certain of our unhedged borrowings are at
of interest;

bility to make strategic acquisitions or causing us to make nonstrategic divestitures;

bility to obtain additional financing for working capital, capital expenditures, share
roduct or service line development, debt service requirements, acquisitions and general
ther purposes; and

bility to adjust to changing market conditions and placing us at a competitive
compared to our competitors who are less highly leveraged.
ries have the ability to incur additional indebtedness in the future, subject to the
n our senior secured credit facilities and the indentures governing our outstanding notes.
added to our current debt levels, the related risks that we now face could intensify.

o generate sufficient cash to service all of our indebtedness and may not be able to
dness on favorable terms. If we are unable to do so, we may be forced to take other
bligations under our indebtedness, which may not be successful.

cheduled payments on or to refinance our debt obligations depends on our financial
g performance, which are subject to prevailing economic and competitive conditions and
usiness and other factors beyond our control. We cannot assure you we will maintain a
m operating activities sufficient to permit us to pay the principal, premium, if any, and
dness.

t our operations through our subsidiaries. Accordingly, repayment of our indebtedness is
ration of cash flows by our subsidiaries and their ability to make such cash available to
epayment or otherwise. Our subsidiaries may not be able to, or may not be permitted to,
enable us to make payments in respect of our indebtedness. Each subsidiary is a distinct
r certain circumstances, legal and contractual restrictions may limit our ability to obtain
ries.

ary or prudent to refinance our outstanding indebtedness, the terms of which may not be
bility to refinance our indebtedness on favorable terms, or at all, is directly affected by
economic and financial conditions. In addition, our ability to incur secured indebtedness
ly enable us to achieve better pricing than the incurrence of unsecured indebtedness)
value of our assets, which depends, in turn, on the strength of our cash flows and results
conomic and market conditions and other factors.

capital resources are insufficient to fund our debt service obligations or we are unable to
dness, we may be forced to reduce or delay investments and capital expenditures, or to
ional capital or restructure our indebtedness. These alternative measures may not be
t permit us to meet our scheduled debt service obligations. If our operating results and
sufficient to meet our debt service obligations, we could face substantial liquidity
e required to dispose of material assets or operations to meet our debt service and other
ot be able to consummate those dispositions, or the proceeds from the dispositions may
t any debt service obligations then due.

ontain restrictions that limit our flexibility in operating our business.

edit facilities and, to a lesser extent, the indentures governing our outstanding notes
ants that limit our ability to engage in specified types of transactions. These covenants
f our subsidiaries ability to, among other things:

al indebtedness or issue certain preferred shares;

on, repurchase or make distributions in respect of our capital stock or make other
ments;

nvestments;

r assets;

erge, sell or otherwise dispose of all or substantially all of our assets; and

ain transactions with our affiliates.
revolving credit facility, when (and for as long as) the combined availability under our credit facility and our senior secured revolving credit facility is less than a specified period of time or, if a payment or bankruptcy event of default has occurred and is osited into any of our depository accounts will be transferred on a daily basis into a the administrative agent and applied to prepay loans under the asset-based revolving llateralize letters of credit issued thereunder.

ed credit facilities, we are required to satisfy and maintain specified financial ratios. Our financial ratios can be affected by events beyond our control, and there can be no tinue to meet those ratios. A breach of any of these covenants could result in a default w credit facility and the asset-based revolving credit facility. Upon the occurrence of an these senior secured credit facilities, the lenders thereunder could elect to declare all nder the senior secured credit facilities to be immediately due and payable and terminate tend further credit, which would also result in an event of default under a significant ding indebtedness. If we were unable to repay those amounts, the lenders under the acilities could proceed against the collateral granted to them to secure such indebtedness. nificant portion of our assets under our senior secured credit facilities and that collateral ateral under our first lien notes. If any of the lenders under the senior secured credit e repayment of borrowings, there can be no assurance there will be sufficient assets to d credit facilities, the first lien notes and our other indebtedness.

petition for patients from other hospitals and health care providers.

ess is highly competitive, and competition among hospitals and other health care has intensified in recent years. Generally, other hospitals in the communities we serve r to those offered by our hospitals. In addition, CMS publicizes on its Hospital Compare ata related to quality measures and data on patient satisfaction surveys hospitals submit r Medicare reimbursement. Federal law provides for the future expansion of the number hat must be reported. Additional quality measures and future trends toward clinical e an unanticipated impact on our competitive position and patient volumes. Further, tablish and update annually a public listing of the hospital s standard charges for items f our hospitals achieve poor results (or results that are lower than our competitors) on es or on patient satisfaction surveys or if our standard charges are higher than our t volumes could decline.

er of freestanding specialty hospitals, surgery centers, emergency departments, urgent nostic and imaging centers in the geographic areas in which we operate has increased ult, most of our hospitals operate in a highly competitive environment. Some of the e with our hospitals are physician-owned or are owned by governmental agencies or tions supported by endowments, charitable contributions and/or tax revenues and can ditures and operations on a tax-exempt basis. Our hospitals face competition from mplementing physician alignment strategies, such as employing physicians, acquiring oups and participating in ACOs or other clinical integration models. Our hospitals

ty hospitals and with both our own and unaffiliated freestanding surgery centers for
high margin services and for quality physicians and personnel. If ASCs are better able
ronment

ur hospitals may experience a decline in patient volume, and we may experience a ven if those patients use our ASCs. In states that do not require a CON or other type of hase, construction or expansion of health care facilities or services, competition in the facilities and capital spending is more prevalent. Further, if our competitors are better make capital expenditures and maintain modern and technologically upgraded facilities it physicians, expand services or obtain favorable managed care contracts at their pitals and ASCs, we may experience an overall decline in patient volume. See Item 1, ion.

collectability of uninsured and patient due accounts could adversely affect our results of

n risks of our accounts receivable relate to the uninsured patient accounts and patient e primary insurance carrier has paid the amounts covered by the applicable agreement, ty amounts (exclusions, deductibles and copayments) remain outstanding. The provision relates primarily to amounts due directly from patients. Medicare reimburses hospitals edicare bad debts. To be eligible for reimbursement, the amounts claimed must meet ling that the debt is related to unpaid deductible or coinsurance amounts and that the to collect the fees from the Medicare beneficiary.

ovision for doubtful accounts is based upon management s assessment of historical ted net collections, business and economic conditions, trends in federal and state vate employer health care coverage, the rate of growth in uninsured patient admissions ndicators. At December 31, 2015, our allowance for doubtful accounts represented of the $5.636 billion patient due accounts receivable balance. The sum of the provision uninsured discounts and charity care increased from $15.565 billion for 2013 to $15.943 $18.287 billion for 2015.

mount or deterioration in the collectability of uninsured accounts receivable will ash flows and results of operations. Our facilities may experience growth in bad debts, nd charity care as a result of a number of factors, including conditions impacting the igh unemployment. The Health Reform Law contains provisions that seek to decrease, of uninsured individuals through reforms, most of which became effective January 1, to predict the full impact of the Health Reform Law. For example, a number of states Medicaid expansion. Further, certain provisions have been delayed. For example, the ich requires firms with 50 or more full-time employees to offer health insurance or pay plemented until January 1, 2016. Even after full implementation of the Health Reform e to experience bad debts and have to provide uninsured discounts and charity care for states that choose not to implement the Medicaid expansion, for undocumented aliens to enroll in an Exchange or government health care programs and for certain others who ce coverage. Further, implementation of the Health Reform Law could result in some heir current insurance plans in favor of lower cost Medicaid plans or other insurance reimbursement levels. We may also be adversely affected by the growth in patient as a result of increases in the adoption of plan structures that shift greater responsibility through greater exclusions and copayment and deductible amounts.

t health care programs may adversely affect our revenues.

of our patient volume is derived from government health care programs, principally id. Specifically, we derived 42.1% of our revenues from the Medicare and Medicaid nges in government health care programs may reduce the reimbursement we receive and our business and results of operations.

lative and regulatory changes have resulted in limitations on and, in some cases, payments to health care providers for certain services under the Medicare program. The ic spending reductions of $1.2 trillion for federal fiscal years 2013 through 2021, minus enacted by Congress and debt service costs. However, the percentage reduction for more than 2% for a fiscal year, with a uniform percentage reduction across all Medicare ctions have been extended by Congress through 2025. We are unable to predict what initiatives may be proposed by Congress or whether Congress will attempt to suspend or tic budget cuts. These reductions are in addition to reductions mandated by the Health rovides for material reductions in the growth of Medicare program spending, including e market basket updates and Medicare DSH funding. Further, from time to time, CMS ment systems used to reimburse health care providers, including changes to the MS-DRG ment systems, which may result in reduced Medicare payments. For example, CMS has ferred to as the two midnight rule. Under the rule, for admissions on or after October 1, d to Medicare beneficiaries are only payable as inpatient hospital services when there is tion that the hospital care is medically necessary and will be required across two sual circumstances. Stays expected to need fewer than two midnights of hospital care lical review on a case-by-case basis. QIOs are handling the reviews of short inpatient through RAC audits potentially will begin in 2016.

ust operate with balanced budgets and because the Medicaid program is often a state s e states have enacted or may consider enacting legislation designed to reduce their s. Further, many states have also adopted, or are considering, legislation designed to oll Medicaid recipients in managed care programs and/or impose additional taxes on nce or expand the states Medicaid systems. The economic downturn increased the n many states, and these budgetary pressures have resulted, and likely may continue to ending, or decreased spending growth, for Medicaid programs and CHIP in many states. de Medicaid supplemental payments are reviewing these programs or have filed waiver replace these programs, and CMS has performed and continues to perform compliance s programs, which could result in Medicaid supplemental payments being reduced or , Texas operates a Medicaid Waiver Program pursuant to a waiver that expires on Texas has submitted an application to extend its Waiver Program, but CMS has not yet cannot predict whether the Texas Medicaid Waiver Program will be extended, continue uarantee that revenues recognized from the program will not decrease.

w made changes to the Medicaid program and will likely cause additional changes in the he Health Reform Law provides for material reductions to Medicaid DSH funding. The ay require further state legislative and regulatory changes in order for states to comply and to participate in grants and other incentive opportunities. A number of states have caid expansion provisions of the Health Reform Law, but these states could choose to on at a later date. It is unclear how many states will ultimately implement the Medicaid f the law.

rcial third-party payers rely on all or portions of Medicare payment systems to determine es to government health care programs that reduce payments under these programs may ments from commercial third-party payers.

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

ict the ultimate impact of the Health Reform Law, which represents a significant change stry.

aw changes how health care services are covered, delivered, and reimbursed through uninsured individuals, reduced growth in Medicare program spending, reductions in caid DSH payments and the establishment and expansion of programs that tie lity and integration. In addition, the law reforms certain aspects of health insurance, tended to strengthen fraud and abuse enforcement and establishes ACOs and bundled s.

th insurance coverage under the Health Reform Law may result in an increase in the ng our facilities who have either private or public program coverage, and our facilities th Reform Law initiatives that create possible sources of additional revenue. However, f the Health Reform Law could be offset and the Company could be significantly s to the Medicare and Medicaid programs. Although the Health Reform Law has had a he Company to date, before considering the impact of Medicare reductions that began in ertainty remains regarding the ongoing net effect of the Health Reform Law on the resolution of a number of material factors remains unclear, including the following:

tes will ultimately implement the Medicaid expansion provisions and under what terms;

or and impact of further delays in or complications related to implementation of the n Law (for example, there were significant problems during the initial implementation ges that negatively impacted the ability of individuals to purchase health insurance);

of enactment of additional federal or state health care reforms and possible changes to form Law;

d long-term viability of the Exchanges, which may be impacted by whether a sufficient vers participate in the Exchanges;

participate in health insurance plans offered through the Exchanges and the terms of our as well as treatment of out of network claims;

eviously uninsured individuals will obtain coverage as a result of the Health Reform

ge of the newly insured patients will be covered under the Medicaid program and what ll be covered by private health insurers;

which states will enroll new Medicaid participants in managed care programs;

ich insurance coverage expands, including the pace of different types of coverage

any, in the volume of inpatient and outpatient hospital services that are sought by and
reviously uninsured individuals;

o hospitals by private payers for newly covered individuals and individuals with existing
uding those covered through health insurance plans offered through the Exchanges,
n may have been previously covered by employer-sponsored plans;

y state governments and private payers pursuant to contracts with the state under the
gram for newly covered individuals;

ne value-based purchasing provisions of the Health Reform Law on our hospitals
the effects of other quality programs;

e of individuals in the Exchanges who select restricted network plans, since health
ng those kinds of products have traditionally sought to pay lower rates to hospitals;

overall revenues the Company will generate from Medicare and Medicaid business
ctions are implemented (42.1% of our revenues in 2015 were from Medicare and

Health Reform Law s annual productivity adjustment to the market basket;

tation and amounts of Medicare DSH reductions and the allocation of the Medicaid ns to our hospitals;

ACO efforts to coordinate care and reduce costs, including the possibility that they will bursement;

nature of potential changes to Medicare reimbursement methods, such as an emphasis ayments or coordination of care programs;

ompany s revenues from Medicaid supplemental programs developed through a oved waiver program will be adversely affected because there may be reductions in e and local government funding for the programs or the programs may be discontinued and

court challenges, the 2016 federal election and efforts to repeal or revise the Health

ents with commercial insurance declines or we are unable to retain and negotiate th nongovernment payers, including managed care plans, our revenues may be reduced.

s, including HMOs, PPOs and other managed care plans, typically reimburse health care ate than Medicare, Medicaid or other government health care programs. Reimbursement ontract when our facilities are in-network, and payers utilize plan structures to encourage n-network providers. Revenues derived from nongovernment payers (domestic only) 54.4% and 54.6% of our revenues for 2015, 2014 and 2013, respectively. As a result, our ncrease patient volumes covered by nongovernment payers and to maintain and obtain th nongovernment payers significantly affects the revenues and operating results of our

s, including managed care payers, continue to demand discounted fee structures, and the ation among nongovernment payers tends to increase their bargaining power over fee s provisions of the Health Reform Law are implemented, including the Exchanges, rs increasingly may demand reduced fees and utilize plan structures such as narrow etworks that limit beneficiary provider choices or impose significantly higher cost en care is obtained from providers in a disfavored tier. Other health care providers may nter into managed care contracts or negotiate increases in our reimbursement and other onditions. For example, some of our competitors may negotiate exclusivity provisions ns or otherwise restrict the ability of managed care companies to contract with us. Our end, in part, on our ability to retain and renew our managed care contracts and enter into ontracts on terms favorable to us. It is not clear what impact, if any, the increased ed care payers and other payers imposed by the Health Reform Law will have on our mbursement increases and participate in plan networks on favorable terms. If we are negotiate favorable contracts with managed care plans or experience reductions in mounts received from nongovernment payers, our revenues may be reduced.

nds on our ability to recruit and retain quality physicians.

spitals depends in part on the number and quality of the physicians on the medical staffs dmitting and utilization practices of those physicians, maintaining good relations with

controlling costs related to the employment of physicians. Although we employ some
s are often not employees of the hospitals at which they practice and, in many of the
st physicians have admitting privileges at other hospitals in addition to our hospitals.
terminate their affiliation with our hospitals at any time. If we are unable to provide
onnel or technologically advanced equipment and hospital facilities that meet the needs

tients, they may be discouraged from referring patients to our facilities, admissions may ting performance may decline.

petition for staffing, which may increase labor costs and reduce profitability.

pendent on the efforts, abilities and experience of our management and medical support ses, pharmacists and lab technicians, as well as our physicians. We compete with other n recruiting and retaining qualified management and support personnel responsible for each of our hospitals, including nurses and other nonphysician health care professionals. availability of nurses and other medical support personnel has been a significant lth care providers. We may be required to continue to enhance wages and benefits to es and other medical support personnel or to hire more expensive temporary or contract lt, our labor costs could increase. We also depend on the available labor pool of lled employees in each of the markets in which we operate. Certain proposed changes in d the NLRB s modification of its election procedures could increase the likelihood of n attempts. To the extent a significant portion of our employee base unionizes, it is ts could increase materially. When negotiating collective bargaining agreements with greements are renewals or first contracts, there is the possibility that strikes could occur process, and our continued operation during any strikes could increase our labor costs. s in which we operate could adopt mandatory nurse-staffing ratios or could reduce ng ratios already in place. State-mandated nurse-staffing ratios could significantly affect n adverse impact on revenues if we are required to limit admissions in order to meet the labor costs increase, we may not be able to raise rates to offset these increased costs. percentage of our revenues consists of fixed, prospective payments, our ability to pass costs is constrained. Our failure to recruit and retain qualified management, nurses and personnel, or to control labor costs, could have a material, adverse effect on our results

th extensive laws and government regulations, we could suffer penalties or be required nges to our operations.

y is required to comply with extensive and complex laws and regulations at the federal, ment levels relating to, among other things:

ding for services and properly handling overpayments;

ss and classification of level of care provided, including proper classification of issions, observation services and outpatient care;

with physicians and other referral sources and referral recipients;

adequacy of medical care;

dical equipment and services;

of medical and support personnel;

, maintenance, data breach, identity theft and security issues associated with
and personal information and medical records;

bilization and transfer of individuals who have emergency medical conditions;

ification and enrollment with government programs;

r budget review;

n;

filing of cost reports;

cies and procedures;

rding competitors;

cilities and services; and

l protection.
the federal Anti-kickback Statute, the federal Stark Law, the FCA and similar state laws.
financial relationships with physicians and others who either refer or influence the
our hospitals, other health care facilities and employed physicians or who are the
and these laws govern those relationships. The OIG has enacted safe harbor regulations
eemed protected from prosecution under the Anti-kickback Statute. While we endeavor
plicable safe harbors, certain of our current arrangements, including joint ventures and
with physicians and other referral sources and persons and entities to which we refer
fy for safe harbor protection. Failure to qualify for a safe harbor does not mean the
rily violates the Anti-kickback Statute but may subject the arrangement to greater
e cannot offer assurance that practices outside of a safe harbor will not be found to
ck Statute. Allegations of violations of the Anti-kickback Statute may be brought under
etary Penalty Law, which requires a lower burden of proof than other fraud and abuse
ti-kickback Statute.

ships with referring physicians and their immediate family members must comply with
ting an exception. We attempt to structure our relationships to meet an exception to the
ulations implementing the exceptions are detailed and complex, and we cannot provide
elationship complies fully with the Stark Law. Unlike the Anti-kickback Statute, failure
under the Stark Law results in a violation of the Stark Law, even if such violation is

late the Anti-kickback Statute or Stark Law, or if we improperly bill for our services, we
e the FCA, either under a suit brought by the government or by a private person under a
ower, suit. See Item 1, Business Regulation and Other Factors.

care facilities in the United Kingdom and have operations and commercial relationships
er foreign jurisdictions and, as a result, are subject to certain U.S. and foreign laws
s generally, including anti-corruption laws. The Foreign Corrupt Practices Act regulates
ir dealings with foreign officials, prohibiting bribes and similar practices, and requires
ords that fairly and accurately reflect transactions and appropriate internal accounting
he United Kingdom Bribery Act has wide jurisdiction over certain activities that affect

ith these or other applicable laws and regulations, we could be subject to liabilities,
es, the loss of our licenses to operate one or more facilities, exclusion of one or more
ation in the Medicare, Medicaid and other federal and state health care programs and

ve the benefit of significant regulatory or judicial interpretation of these laws and
re, different interpretations or enforcement of, or amendment to, these or other laws and
ject our current or past practices to allegations of impropriety or illegality or could
nges in our facilities, equipment, personnel, services, capital expenditure programs and
determination that we have violated these or other laws, or the public announcement
stigated for possible violations of these or other laws, could have a material, adverse
financial condition, results of operations or prospects, and our business reputation could
addition, other legislation or regulations at the federal or state level may be adopted that
siness.

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ld become the subject of governmental investigations, claims and litigation.

s are subject to numerous investigations by various governmental agencies. Further, e parties have the right to bring *qui tam*, or whistleblower, suits against companies that r payments to, or improperly retain overpayments from, the government. Some states tate whistleblower and false claims provisions. Certain of our individual facilities have ilities may receive, government inquiries from, and may be subject to investigation by, ncies. Depending on whether the underlying conduct in these or future inquiries or e considered systemic, their resolution could have a material, adverse effect on our lts of operations and liquidity.

s and their agents, such as the MACs, fiscal intermediaries and carriers, as well as the Medicaid programs, conduct audits of our health care operations. Private payers may ayment audits, and we also perform internal audits and monitoring. Depending on the found in such audits and whether the underlying conduct could be considered systemic, e audits could have a material, adverse effect on our financial position, results of y.

ACs on a contingency fee basis to conduct post-payment reviews to detect and correct the fee-for-service Medicare program. The Health Reform Law expands the RAC nclude managed Medicare plans and Medicaid claims. RAC denials are appealable; rently significant delays in the assignment of new Medicare appeals to Administrative gatively impacts our ability to appeal RAC payment denials. In 2014, HHS offered to he net allowable amount associated with inpatient status claims denials in exchange for l medical claims appealed. We accepted the settlement offer and executed an ent with HHS.

nploys MICs to perform post-payment audits of Medicaid claims and identify ealth Reform Law increases federal funding for the MIC program. In addition to RACs edicaid agencies and other contractors have increased their review activities.

ut of compliance with any of these laws, regulations or programs, depending on the our business, our financial position and our results of operations could be negatively

utilization practices and treatment methodologies, governmental or managed care educe inpatient services or surgical procedures and other factors outside our control r medical services may reduce our revenues.

Medicare, managed Medicare, Medicaid, managed Medicaid and commercial third-party duce admissions, intensity of services, surgical volumes and lengths of stay, in some s utilization review, have affected and are expected to continue to affect our facilities. ils the review of the admission and course of treatment of a patient by health plans. The o issues national or local coverage determinations that restrict the circumstances under for certain services. Inpatient utilization, average lengths of stay and occupancy rates ely affected by payer-required preadmission authorization, coverage restrictions and by payer pressure to maximize outpatient and alternative health care delivery services tients. Efforts to impose more stringent cost controls are expected to continue. For Reform Law expanded the use of prepayment review by Medicare contractors by restrictions on their use. Additionally, trends in physician treatment protocols and an design, such as plans that shift increased costs and accountability for care to patients, gical volumes and admissions in favor of lower intensity and lower cost treatment

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

esults may suffer during periods of general economic weakness.

eral, state and local government entities have had a negative impact on spending, and tively impact spending, for health and human service programs, including Medicare, programs, which represent significant payer sources for our hospitals. Other risks we economic weakness and high unemployment include potential declines in the population d care agreements, patient decisions to postpone or cancel elective and nonemergency s (including delaying surgical procedures), potential increases in the uninsured and ns and further difficulties in collecting patient copayment and deductible receivables.

ard value-based purchasing may negatively impact our revenues.

e health care industry toward value-based purchasing of health care services. These g programs include both public reporting of quality data and preventable adverse events efficiency of care provided by facilities. Governmental programs including Medicare itals to report certain quality data to receive full reimbursement updates. In addition, nburse for care related to certain preventable adverse events (also called never events). aw also prohibits the use of federal funds under the Medicaid program to reimburse assistance provided to treat HACs. As of federal fiscal year 2015, the 25% of hospitals justed HAC rates in the designated performance period receive a 1% reduction in their e payments.

readmission rates for conditions designated by HHS will receive a reduction in their g Medicare payments for all Medicare inpatient discharges, not just discharges relating ect to the excess readmission standard. The reduction in payments to hospitals with capped at 3% for federal fiscal year 2015 and subsequent years.

lth Reform Law, HHS has implemented a value-based purchasing program for inpatient reduces inpatient hospital payments for all discharges by 1.75% in federal fiscal year increases to 2% in federal fiscal year 2017 and for subsequent years. HHS pools the n these reductions to fund payments to reward hospitals that meet or exceed certain standards established by HHS. HHS estimates that it will distribute $1.5 billion to cal year 2016 based on their achievement (relative to other hospitals) and improvement tal s own past performance). Hospitals that meet or exceed the quality performance greater reimbursement under the value-based purchasing program than they would have

16, hospitals located in markets selected by CMS will be required to participate in the ar mandatory bundled payment initiative focused on knee and hip replacements. will be evaluated against quality standards and Medicare spending targets established by e of care. Depending on whether overall CMS spending per episode exceeds or falls whether quality standards are met, hospitals may receive supplemental Medicare ayments to CMS. Mandatory participation in demonstration projects, particularly e potential to affect payment, may negatively impact our results of operations.

ial payers currently require hospitals to report quality data, and several commercial rse hospitals for certain preventable adverse events. Further, we have implemented a ich we do not bill patients or third-party payers for fees or expenses incurred due to verse events.

d purchasing programs, including programs that condition reimbursement on patient become more common and to involve a higher percentage of reimbursement amounts. ggressive goals for adopting alternative payment models, which may include additional other alternative payment programs, and commercial insurers may also transition away ayment models. We are unable at this time to predict our future reductions and payments or how this trend will affect our results of operations, but it could negatively impact our

e impaired by a failure of our information systems.

ur information systems is critical to our business operations. In addition to our shared ur information systems are essential to a number of critical areas of our operations,

d financial reporting;

llecting accounts;

mpliance;

ns;

ds and document storage;

nagement;

ricing and administering managed care contracts and supply contracts; and

uality of care and collecting data on quality measures necessary for full Medicare tes.

ay be vulnerable to damage from a variety of sources, including telecommunications or man acts and natural disasters. We have taken precautionary measures to prevent ns that could affect our information systems. Nevertheless, we may experience system ce of any system failure could result in interruptions, delays, the loss or corruption of interruptions in the availability of systems, all of which could have a material, adverse position and results of operations and harm our business reputation.

nt could result in a loss of confidential data, give rise to remediation and other expenses, under HIPAA, consumer protection laws, or other common law theories, subject us to nd state governmental inquiries, damage our reputation, and otherwise be disruptive to

on our networks sensitive information, including intellectual property, proprietary and personally identifiable information of our patients and employees. In addition, we investments in technology to adopt and utilize EHR and to become meaningful users of echnology. The secure maintenance of this information is critical to our business mplemented multiple layers of security measures to protect the confidentiality, integrity is data through technology, processes, and our people. We utilize current security defenses are monitored and routinely tested internally and by external parties. Despite om malicious persons and groups, new vulnerabilities and advanced new attacks against create risk of cybersecurity incidents. There can be no assurance that we will not be y incidents

y measures, result in loss of personal health information or other data subject to privacy ormation systems or business. As a result, cybersecurity and the continued development ur controls, processes and practices designed to protect our information systems from uthorized access remain a priority for us. As cyber threats continue to evolve, we may be nificant additional resources to continue to modify or enhance our protective measures emediate any cybersecurity vulnerabilities. The occurrence of any of these events could terruptions and delays; (ii) the loss, misappropriation, corruption or unauthorized access and potential liability under privacy, security and consumer protection laws or other v) federal and state governmental inquiries, any of which could have a material, adverse position and results of operations and harm our business reputation.

to demonstrate meaningful use of certified electronic health record systems, or if the 10 coding system affects our billing or collections, our operations could be adversely

ospitals and eligible professionals that have failed to demonstrate meaningful use of logy in an applicable prior reporting period are subject to reduced payments from continue to demonstrate meaningful use of certified EHR technology could have a t on our financial position and results of operations.

ders, including our hospitals, were required to transition by October 1, 2015 to the new , which greatly expands the number and detail of billing codes used for inpatient claims. ore detailed ICD-10 coding system could result in decreased reimbursement if the use of n conditions being reclassified to MS-DRGs or commercial payer payment groupings imbursement than assigned under the previous system.

ffects related to a pandemic, epidemic or outbreak of an infectious disease could erations.

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

te the construction or expansion of health care facilities could impair our ability to r operations.

arly in the eastern part of the country, require health care providers to obtain prior as a CON, for the purchase, construction or expansion of health care facilities, to make itures or to make changes in services or bed capacity. In giving approval, these states dditional or expanded health care facilities or services. We currently operate health care f states with CON laws or that require other types of approvals for the establishment or facility types or services. The failure to obtain any requested CON or other required our ability to operate or expand operations. Any such failure could, in turn, adversely ract patients and physicians to our facilities and grow our revenues, which would have r results of operations.

fficulty acquiring hospitals and other health care businesses, encounter challenges tions of acquired hospitals and other health care businesses and become liable for liabilities as a result of acquisitions.

business strategy is acquiring hospitals and other health care businesses. We may acquiring new facilities or other businesses as a result of competition from other e willing to pay purchase prices that are higher than we believe are reasonable. Some n order to acquire a hospital or other facility or to expand facilities or services. In on of health care facilities often involves licensure approvals or reviews and complex rocesses for Medicare and other payers. Further, many states have laws that restrict the ot-for-profit hospitals to for-profit entities. These laws may require prior approval from eral, advance notification of the attorney general or other regulators and community ys general in states without specific requirements may exercise broad discretionary tions involving the sale of not-for-profits under their general obligations to protect the s. These conversion legislative and administrative efforts often focus on the appropriate divested and the use of the proceeds of the sale by the non-profit seller and may include nmitments for capital improvements and charity care by the purchaser. Also, the ng regulatory and enforcement environment may negatively impact our ability to acquire s if they are found to have material unresolved compliance issues, such as repayment g compliance issues as well as completion of oversight, review or approval processes or even prevent our ability to acquire hospitals or other businesses and increase our

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

avily concentrated in Florida and Texas, which makes us sensitive to regulatory, tal and competitive conditions and changes in those states.

itals at December 31, 2015, and 81 of those hospitals are located in Florida and Texas. s facilities combined revenues represented approximately 47% of our consolidated ended December 31, 2015. This concentration makes us particularly sensitive to environmental and competitive conditions and changes in those states. Any material payment programs or regulatory, economic, environmental or competitive conditions in a disproportionate effect on our overall business results.

als in Florida, Texas and other areas across the Gulf Coast are located in hurricane-prone icanes have had a disruptive effect on the operations of our hospitals in Florida, Texas and the patient populations in those states. Our business activities could be harmed by a ricane season or even a single storm, and the property insurance we obtain may not be es from future hurricanes or other natural disasters.

iabilities from claims by taxing authorities.

Division began an audit of HCA Holdings, Inc. s 2011 and 2012 federal income tax We are also subject to examination by state and foreign taxing authorities.

HCA Holdings, Inc., its predecessors, subsidiaries and affiliates properly reported
aid taxes in accordance with applicable laws and agreements established with the IRS,
g authorities and final resolution of any disputes will not have a material, adverse effect
tions or financial position. However, if payments due upon final resolution of any issues
estimates, such resolutions could have a material, adverse effect on our results of
position.

iabilities from claims brought against our facilities.

ation relating to our business practices, including claims and legal actions by patients
nary course of business alleging malpractice, product liability or other legal theories.
seek large sums of money as damages and involve significant defense costs. We insure a
onal liability risks through a 100% owned subsidiary. Management believes our reserves
ions and insurance coverage are sufficient to cover insured claims arising out of the
ies. Our 100% owned liability insurance subsidiary has entered into certain reinsurance
e subsidiary remains liable to the extent that the reinsurers do not meet their obligations
contracts. If payments for claims exceed actuarially determined estimates, are not
or reinsurers, if any, fail to meet their obligations, our results of operations and financial
rsely affected.

rket risk related to changes in the market values of securities and interest rate changes.

rket risk related to changes in market values of securities. The investments in debt and
100% owned insurance subsidiaries were $478 million and $4 million, respectively, at
hese investments are carried at fair value, with changes in unrealized gains and losses
stments to other comprehensive income. At December 31, 2015, we had a net unrealized
the insurance subsidiaries investment securities.

rket risk related to market illiquidity. Investments in debt and equity securities of our
e subsidiaries could be impaired by the inability to access the capital markets. Should the
e subsidiaries require significant amounts of cash in excess of normal cash requirements
r expenses on short notice, we may have difficulty selling these investments in a timely
o sell them at a price less than what we might otherwise have been able to in a normal
We may be required to recognize other-than-temporary impairments on long-term
periods should issuers default on interest payments or should the fair market valuations
orate due to ratings downgrades or other issue specific factors.

o market risk related to changes in interest rates, and we periodically enter into interest
o manage our exposure to these fluctuations. Our interest rate swap agreements involve
and variable rate interest payments between two parties, based on common notional
maturity dates. The notional amounts of the swap agreements represent balances used to
of cash flows and are not our assets or liabilities.

inue to have influence over us and may have conflicts of interest with us in the future.

06, HCA Inc. was acquired by a private investor group, including affiliates of or funds
pital Partners, LLC, Kohlberg Kravis Roberts & Co., BAML Capital Partners and HCA
. Frist, Jr. (collectively, the Investors) and by members of management and certain other
eir investment in Hercules Holding II, LLC, certain of the Investors continue to hold a
our outstanding common stock (approximately 21% as of January 31, 2016). In addition,
lers agreement we entered into with Hercules Holding II, LLC, certain representatives of
continued right to nominate certain of the members of our Board of Directors. As a
nvestors potentially have the ability to influence our decisions to enter into corporate

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) and prevent changes in the composition of our Board of Directors and any transaction
er approval.

stors are in the business of making investments in companies and may acquire and hold
s that compete directly or indirectly with us. One or more of the Investors may also
ortunities that may be complementary to our business and, as a result, those acquisition
be available to us.

l Staff Comments

sts, by state, the number of hospitals (general, acute care, psychiatric and rehabilitation)
wned and operated by us as of December 31, 2015:

	Hospitals	Beds
	1	250
a	5	1,725
	7	2,371
	43	11,540
	7	1,609
	2	484
	1	278
	4	1,360
	2	384
a	4	1,021
pi	1	130
	5	1,014
	3	1,164
npshire	2	295
a	2	772
rolina	3	843
e	13	2,435
	38	11,019
	8	950
	11	3,263
onal		
	6	864
	168	43,771

itals listed in the above table, we directly or indirectly operate 116 freestanding surgery
ate medical office buildings in conjunction with some of our hospitals. These office
y occupied by physicians who practice at our hospitals. Fourteen of our general, acute
of our other properties have been mortgaged to support our obligations under our senior
it facility and first lien secured notes.

quarters in approximately 1,800,000 square feet of space in the Nashville, Tennessee
e headquarters in Nashville, we maintain regional service centers related to our shared
ese service centers are located in markets in which we operate hospitals.

uarters, hospitals and other facilities are suitable for their respective uses and are, in
our present needs. Our properties are subject to various federal, state and local statutes

their operation. Management does not believe that compliance with such statutes and
ally affect our financial position or results of operations.

edings

y regulated and litigious industry. As a result, various lawsuits, claims and legal and
have been and can be expected to be instituted or asserted against us. We are subject to
axes and related interest and penalties. We are also subject to claims and suits arising in
of business, including claims for personal injuries or wrongful restriction of, or
ysicians staff privileges. In certain of these actions the claimants may seek punitive
hich may not be covered by insurance. The resolution of any such lawsuits, claims or
roceedings could have a material, adverse effect on our results of operations, financial

ions, Claims and Litigation

s are subject to numerous investigations by various governmental agencies. Further,
e Claims Act (FCA), private parties have the right to bring *qui tam*, or whistleblower,
s that submit false claims for payments to, or improperly retain overpayments from, the
tes have adopted similar state whistleblower and false claims provisions. Certain of our
ve received, and from time to time, other facilities may receive, government inquiries
ect to investigation by, federal and state agencies. Depending on whether the underlying
ure inquiries or investigations could be considered systemic, their resolution could have
ct on our results of operations, financial position or liquidity.

l Division of the U.S. Attorney s Office in Miami requested information on reviews
necessity of interventional cardiology services provided at any Company facility (other
he Company cooperated with the government s request and produced medical records
lar reviews at eight hospitals, located primarily in Florida. The Company subsequently
rnment s inquiries related to three *qui tam* actions. On February 24, 2015, the United
or the Southern District of Florida unsealed a *qui tam* action that had been filed under
2012 and alleged particular FCA violations relating to two specific facilities that were
the Miami U.S. Attorney s Office investigation. On January 30, 2015, the U.S. Attorney s
istrict Court a formal notice that the Department of Justice declined to intervene in that
bsequently dismissed this *qui tam* action without prejudice. A second *qui tam* action
s was unsealed on March 12, 2015 and dismissed without prejudice by the relator on
rd *qui tam* action, which made allegations relating to another facility that was a subject
orney s Office inquiry was unsealed in December 2015 after the government formally
The Company settled this *qui tam* action on December 17, 2015 with a payment of
olve claims, penalties and attorneys fees. It is the Company s understanding that the
qui tam actions and settlement of the third resolves the investigation of which the
e Company in July 2012.

e UK Competition and Markets Authority (Authority) issued a final report on its
vate health care market in London. It concluded, among other things, that many private
ompetition in central London, and that there are high barriers to entry. As part of its
e Authority ordered HCA to sell either: (a) its London Bridge and Princess Grace
Vellington Hospital, including the Platinum Medical Centre. It also imposed other
n HCA and other private health care providers, including: regulation of incentives to
ncreased access to information about fees and performance; and restrictions on future
private providers and National Health Service private patient units. HCA disagrees with
sment of the competitive conditions for hospitals in London, as well as its proposed
d appealed the decision to the Competition Appeal Tribunal. The Competition Appeal
ertain of the Authority s findings and sent the matter back to the Authority for further
ber 2015,

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on of additional evidence, the Authority issued a Provisional Decision that again found fects on competition in the private hospital market in central London. The Provisional me of the Authority s earlier factual conclusions and acknowledged certain mitigating effects noted in the prior decision. The Provisional Decision also offers some additional d the Authority is now consulting on remedies for the adverse competitive effects. A on Remedies is expected during the first quarter of 2016, with a Final Report anticipated sfied with the Final Report, HCA will have an opportunity to appeal to the Competitive

Litigation

a shareholder action, Schuh v. HCA Holdings, Inc. et al., was filed in the United States Middle District of Tennessee seeking monetary relief. The case sought to include as a acquired the Company s stock pursuant or traceable to the Company s Registration onnection with the March 9, 2011 initial public offering. The lawsuit asserted a claim e Securities Act of 1933 against the Company, certain members of the board of directors, ers in the offering. It further asserted a claim under Section 15 of the Securities Act of e members of the board of directors. The action alleged various deficiencies in the es in the Registration Statement. Subsequently, two additional class action complaints, ings, Inc. et al. and Daniels v. HCA Holdings, Inc. et al., setting forth substantially substantially the same defendants were filed in the same federal court on November 16, 2, 2011, respectively. All three of the cases were consolidated. On May 3, 2012, the England Teamsters & Trucking Industry Pension Fund as Lead Plaintiff for the On July 13, 2012, the lead plaintiff filed an amended complaint asserting claims under 2) of the Securities Act of 1933 against the Company, certain members of the board of underwriters in the offering. It further asserts a claim under Section 15 of the Securities he same members of the board of directors and Hercules Holding II, LLC, a majority mpany at the time of the initial public offering. The consolidated complaint alleges mpany s disclosures in the Registration Statement and Prospectus relating to: (1) the mpany s 2006 recapitalization and 2010 reorganization; (2) the Company s failure to ernal controls relating to its accounting for such transactions; and (3) the Company s id revenue growth rates. The Company and other defendants moved to dismiss the September 11, 2012. The court granted the motion in part on May 28, 2013. The action y on the remaining claims. The plaintiffs motion for class certification was granted on he court certified a class consisting of all persons that acquired HCA stock on or before date of the lawsuit) pursuant to the Registration Statement issued in connection with the public offering. A request to the court of appeals to hear an immediate appeal of this lowing the close of discovery, plaintiffs and defendants each filed motions for summary certain of the expert witnesses. As described below, a preliminary agreement to settle ctions has been reached.

ve described consolidated shareholder class action, on December 8, 2011, a federal action, Sutton v. Bracken, et al., putatively initiated in the name of the Company, was ates District Court for the Middle District of Tennessee against certain officers and ectors of the Company seeking monetary relief. The action alleges breaches of fiduciary fficers and directors in connection with the accounting and earnings claims set forth in actions described above. Setting forth substantially similar claims against substantially an additional federal derivative action, Schroeder v. Bracken, et al., was filed in the Court for the Middle District of Tennessee on December 16, 2011, and a state derivative ken, et al., was filed in Tennessee state court in the Davidson County Circuit Court on he federal derivative actions were consolidated in the Middle District of Tennessee and pments in the shareholder class actions. The state derivative action had also been stayed in the shareholder class actions, but that stay has expired. The plaintiff in the state

sequently filed an amended complaint on September 9, 2013 that added additional
e shareholder class actions. On September 24, 2013, an additional state derivative action,
et al., was filed in Tennessee state court in the Davidson County Circuit Court. This
rd of directors has been consolidated with the earlier filed state derivative action. The
idated action filed a consolidated complaint on December 4, 2013. The Company filed a
ne state derivative action pending developments in the class action, but the court did not

5, the Company reached a preliminary agreement in principle to settle the *Schuh*
on and the *Sutton, Schroeder* and *Bagot* derivative actions. The preliminary settlement
for a resolution of all of the pending claims in the shareholder class action and the
ut any admission or concession of wrongdoing by the Company or the other defendants,
on, among other things, execution of final settlement documents, successful negotiation
ary terms, approval by the Company s Board of Directors, notification to the *Schuh*
l preliminary and final approval of the settlements by the state and federal courts in
ral court gave preliminary approval to the shareholder class action settlement on
vided for class notification, and set a hearing for final approval of the settlement for
te court in *Bagot* gave preliminary approval to the settlement of the derivative claims on
et a hearing for final approval on April 12, 2016.

f the settlement in the *Schuh* case include a payment by HCA of $215 million in return
l claims against all defendants, including the Company, its officers and directors, the
ules Holding II, LLC, a majority shareholder of the Company at the time of the initial
erms of the settlement of the derivative cases include receipt by the Company of $19
ce policies covering the claims asserted in the derivative cases, certain corporate
nd agreement by the Company to pay attorneys fees in the aggregate amount of $5.5
leases of all claims against all defendants. In the fourth quarter of 2015, HCA recorded
of expected insurance recoveries, of $120 million for the expected settlements of the
derivative cases and related costs.

tion

Health Care Foundation of Greater Kansas City, a nonprofit health foundation, filed suit
e Circuit Court of Jackson County, Missouri and alleged that HCA did not fund the level
and uncompensated care agreed to in connection with HCA s purchase of hospitals from
003. The central issue in the case was whether HCA s construction of new hospitals
50 million five-year capital commitment. In addition, the plaintiff alleged that HCA did
apital expenditures in a timely fashion. On January 24, 2013, the court ruled in favor of
ed at least $162 million. The court also ordered a court-supervised accounting of HCA s
as well as of expenditures on charity and uncompensated care during the ten years
. The court also indicated it would award plaintiff attorneys fees, which the parties have
nately $12 million for the trial phase. HCA recorded $175 million of legal claim costs in
012 related to this ruling, and consistent with the judge s order, has been accruing interest
annum. On April 25, 2014, the parties stipulated to an additional $78 million shortfall
xpenditures issue. HCA recorded $78 million of legal claims costs in the first quarter of
stipulation, and accrued interest on that amount at 9% per annum. Pursuant to the terms
parties have preserved their respective rights to contest the judge s underlying ruling,
ns in the trial court or on appeal. On February 9, 2015, the parties reached an agreement
ir dispute relating to charity and uncompensated care for $15 million. The foundation is
nount, net of attorneys fees, for charitable activities in the Kansas City area. The parties
tional amount for attorneys fees for the plaintiff for the accounting phase of the case.
rial motions, on which the court ruled on October 21, 2015. The court denied defendants

ings on liability and damages related to the capital expenditures issue. The court granted for an award of additional pre-judgment interest, but did not specify whether the interest nterest or would be compounded. The court subsequently concluded that interest was to on December 9, 2015, the court entered judgment in the case in the total sum of $434 t continuing to accrue at 9% per annum, compounded annually, from and after ntil the matter is resolved. At December 31, 2015, the Company had an accrued liability damages, costs and interest related to this litigation. On January 15, 2016, the Company al in the Missouri Court of Appeals for the Western District. The schedule for hearing been set.

Disclosures

PART II

Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of

October 2015, our Board of Directors authorized share repurchase programs for up to $1
respectively, of our outstanding common stock. Repurchases made during the fourth
tailed below, were made pursuant to the $1 billion May 2015 (which was completed
the $3 billion October 2015 share repurchase authorizations and were made in the open

rovides certain information with respect to our repurchases of common stock from
gh December 31, 2015 (dollars in millions, except per share amounts).

	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares That May Yet Be Purchased Under Publicly Announced Plans or Programs
gh October 31,	6,469,102	$ 74.18	6,469,102	$ 3,134
ough	2,283,523	$ 68.02	2,283,523	$ 2,979
ough	5,609,305	$ 67.10	5,609,305	$ 2,603
er 2015	14,361,930	$ 70.44	14,361,930	$ 2,603

traded on the New York Stock Exchange (NYSE) (symbol HCA). There were no
ons declared during 2015 or 2014.

orth, for the calendar quarters indicated, the high and low sales prices per share reported
ommon stock.

	Sales Price	
	High	Low
rter	$ 78.44	$ 66.63
Quarter	93.09	73.02
arter	95.49	43.91
uarter	81.39	63.32
rter	$ 52.68	$ 46.02
Quarter	58.55	47.79
arter	73.94	53.61
uarter	75.82	62.50

s on February 12, 2016, there were approximately 350 holders of record of our common

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	3/10/2011	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015
ac.	100.00	71.02	121.66	192.39	295.95	272.72
	100.00	96.44	111.88	148.11	168.39	170.72
e	100.00	108.76	128.21	181.37	227.32	242.98

umulative total return to our stockholders beginning as of March 10, 2011, the day our the NYSE, and through December 31, 2015, in comparison to the cumulative returns of d the S&P Health Care Index. The graph assumes $100 invested on March 10, 2011 in d in each index with the subsequent reinvestment of dividends. The stock performance epresents historical stock performance and is not necessarily indicative of future stock

ancial Data

HCA HOLDINGS, INC.

SELECTED FINANCIAL DATA

AS OF AND FOR THE YEARS ENDED DECEMBER 31

(Dollars in millions, except per share amounts)

	2015	2014	2013	2012	2011
ons:					
sion for doubtful accounts	**$ 43,591**	$ 40,087	$ 38,040	$ 36,783	$ 32,506
accounts	**3,913**	3,169	3,858	3,770	2,824
	39,678	36,918	34,182	33,013	29,682
	18,115	16,641	15,646	15,089	13,440
	6,638	6,262	5,970	5,717	5,179
ses	**7,103**	6,755	6,237	6,048	5,470
d incentive income	**(47)**	(125)	(216)	(336)	(210)
ffiliates	**(46)**	(43)	(29)	(36)	(258)
tization	**1,904**	1,820	1,753	1,679	1,465
	1,665	1,743	1,848	1,798	2,037
of facilities	**5**	(29)	10	(15)	(142)
f debt	**135**	335	17		481
	249	78		175	
controlling interest in					
					(1,522)
ement agreement					181
	35,721	33,437	31,236	30,119	26,121
taxes	**3,957**	3,481	2,946	2,894	3,561
axes	**1,261**	1,108	950	888	719
	2,696	2,373	1,996	2,006	2,842
e to noncontrolling					
	567	498	440	401	377
e to HCA Holdings, Inc.	**$ 2,129**	$ 1,875	$ 1,556	$ 1,605	$ 2,465
ta:					
re	**$ 5.14**	$ 4.30	$ 3.50	$ 3.65	$ 5.17
hare	**$ 4.99**	$ 4.16	$ 3.37	$ 3.49	$ 4.97
ed per share	**$**	$	$	$ 6.50	$
	$ 32,744	$ 30,980	$ 28,594	$ 27,785	$ 26,608
	3,716	3,450	2,342	1,591	1,679
cluding amounts due					
	30,488	29,426	28,139	28,640	26,762
ts	**1,553**	1,396	1,342	1,319	1,244
	(6,046)	(6,498)	(6,928)	(8,341)	(7,014)

ating activities	**$ 4,734**	$ 4,448	$ 3,680	$ 4,175	$ 3,933
activities	**(2,583)**	(2,918)	(2,346)	(2,063)	(2,995)
	(2,375)	(2,176)	(1,943)	(1,862)	(1,679)
activities	**(1,976)**	(1,378)	(1,625)	(1,780)	(976)

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	2015	2014	2013	2012	2011
end of					
	168	166	165	162	163
g					
ters at					
	116	113	115	112	108
ds at					
	43,771	43,356	42,896	41,804	41,594
nsed					
	43,620	43,132	42,133	41,795	39,735
	1,868,800	1,795,300	1,744,100	1,740,700	1,620,400
(d)	**3,122,700**	2,958,700	2,844,700	2,832,100	2,595,900
	4.9	4.8	4.8	4.7	4.8
)	**25,084**	23,835	22,853	22,521	21,123
	58%	55%	54%	54%	53%
s(h)	**8,050,200**	7,450,700	6,968,100	6,912,000	6,143,500
	909,400	891,600	881,900	873,600	799,200
	529,900	518,900	508,800	506,500	484,500
unts					
	53	54	54	51	52
a % of					
	40%	38%	38%	38%	37%

those beds for which a facility has been granted approval to operate from the applicable ncy.
erage number of licensed beds, weighted based on periods owned.
al number of patients admitted to our hospitals and is used by management and certain eral measure of inpatient volume.
sions are used by management and certain investors as a general measure of combined patient volume. Equivalent admissions are computed by multiplying admissions) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing ount by gross inpatient revenue. The equivalent admissions computation equates e to the volume measure (admissions) used to measure inpatient volume, resulting in a f combined inpatient and outpatient volume.
erage number of days admitted patients stay in our hospitals.
erage number of patients in our hospital beds each day.
rcentage of hospital licensed beds occupied by patients. Both average daily census and ovide measures of the utilization of inpatient rooms.
mber of patients treated in our emergency rooms.
mber of surgeries performed on patients who were not admitted to our hospitals. Pain endoscopy procedures are not included in outpatient surgeries.
mber of surgeries performed on patients who have been admitted to our hospitals. and endoscopy procedures are not included in inpatient surgeries.
is calculated by dividing the revenues for the fourth quarter of each year by the days in revenues in accounts receivable is then calculated as accounts receivable, net of the btful accounts, at the end of the period divided by revenues per day. Revenues used in re net of the provision for doubtful accounts.
rcentage of patient revenues related to patients who are not admitted to our hospitals.

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS

t s Discussion and Analysis of Financial Condition and Results of Operations

data and the accompanying consolidated financial statements present certain information
ncial position, results of operations and cash flows of HCA Holdings, Inc. which should
with the following discussion and analysis. The terms HCA, Company, we, our, or us,
o HCA Holdings, Inc. and its affiliates. The term affiliates means direct and indirect
oldings, Inc. and partnerships and joint ventures in which such subsidiaries are partners.

tements

Form 10-K includes certain disclosures which contain forward-looking statements.
ements include statements regarding expected share-based compensation expense,
ditures, expected net claim payments and all other statements that do not relate solely to
cts, and can be identified by the use of words like may, believe, will, expect, project,
te, plan, initiative or continue. These forward-looking statements are based on our current
s and are subject to a number of known and unknown uncertainties and risks, many of
control, which could significantly affect current plans and expectations and our future
results of operations. These factors include, but are not limited to, (1) the impact of our
ess and the ability to refinance such indebtedness on acceptable terms, (2) the effects
entation of the Patient Protection and Affordable Care Act, as amended by the Health
econciliation Act of 2010 (collectively, the Health Reform Law), possible delays in or
to implementation of the Health Reform Law, court challenges, the possible enactment
r state health care reforms and possible changes to the Health Reform Law and other
laws or regulations affecting the health care industry, (3) the effects related to the
tion of the sequestration spending reductions required under the Budget Control Act of
islation extending these reductions, and the potential for future deficit reduction
lter these spending reductions, which include cuts to Medicare payments, or create
ductions, (4) increases in the amount and risk of collectability of uninsured accounts and
yment amounts for insured accounts, (5) the ability to achieve operating and financial
ected levels of patient volumes and control the costs of providing services, (6) possible
Medicaid and other state programs, including Medicaid upper payment limit programs or
at may impact reimbursements to health care providers and insurers, (7) the highly
the health care business, (8) changes in service mix, revenue mix and surgical volumes,
clines in the population covered under managed care agreements, the ability to enter into
are provider agreements on acceptable terms and the impact of consumer driven health
ilization trends and practices, (9) the efforts of insurers, health care providers and others
costs, (10) the outcome of our continuing efforts to monitor, maintain and comply with
ulations, policies and procedures, (11) increases in wages and the ability to attract and
ement and personnel, including affiliated physicians, nurses and medical and technical
2) the availability and terms of capital to fund the expansion of our business and
xisting facilities, (13) changes in accounting practices, (14) changes in general economic
and regionally in our markets, (15) the emergence and effects related to infectious
ivestitures which may result in charges and possible impairments of long-lived assets,
ness strategy or development plans, (18) delays in receiving payments for services
come of pending and any future tax audits, disputes and litigation associated with our tax
l adverse impact of known and unknown government investigations, litigation and other
de against us, (21) our ongoing ability to demonstrate meaningful use of certified EHR
ther risk factors described in this annual

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HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

tements (continued)

As a consequence, current plans, anticipated actions and future financial position and ay differ from those expressed in any forward-looking statements made by or on behalf tioned not to unduly rely on such forward-looking statements when evaluating the in this report.

mary

le to HCA Holdings, Inc. totaled $2.129 billion, or $4.99 per diluted share, for 2015, llion, or $4.16 per diluted share, for 2014. The 2015 results include losses on retirement n, or $0.20 per diluted share, legal claim costs of $249 million, or $0.37 per diluted n sales of facilities of $5 million. The 2014 results include net gains on sales of facilities 04 per diluted share, losses on retirement of debt of $335 million, or $0.47 per diluted costs of $78 million, or $0.11 per diluted share. All per diluted share disclosures are net of the applicable income taxes. Shares used for diluted earnings per share were es and 450.352 million shares for the years ended December 31, 2015 and 2014, 015, we repurchased 31.991 million shares of our common stock.

$39.678 billion for 2015 from $36.918 billion for 2014. Revenues increased 7.5% and n a consolidated basis and on a same facility basis for 2015, compared to 2014. The s increase can be primarily attributed to the combined impact of a 1.8% increase in t admission and a 5.5% increase in equivalent admissions. The same facility revenues arily from a 1.7% increase in same facility revenue per equivalent admission and a 4.6% y equivalent admissions.

ated admissions increased 4.1% and same facility admissions increased 3.4%, compared ical volumes increased 2.1% on both a consolidated and same facility basis during 2015, tpatient surgical volumes increased 2.0% on a consolidated basis and increased 1.6% on uring 2015, compared to 2014. Emergency room visits increased 8.0% on a consolidated 0% on a same facility basis during 2015, compared to 2014.

n for doubtful accounts increased $744 million, compared to 2014. The self-pay revenue y care and uninsured discounts declined $93 million and increased $1.693 billion, compared to 2014. The sum of the provision for doubtful accounts, uninsured percentage of the sum of revenues, the provision for doubtful accounts, uninsured care, was 31.5% for 2015, compared to 30.2% for 2014. Same facility uninsured 4.5% and same facility uninsured emergency room visits increased 1.2% for 2015, me facility uninsured admissions declined 9.4% and same facility uninsured emergency .6% for 2014, compared to 2013. We believe the reversal of the 2014 declines during e to the anniversary of the benefits from the health insurance exchanges and Medicaid at we began realizing during the second quarter of 2014.

d $1.665 billion for 2015, compared to $1.743 billion for 2014. The $78 million decline 2015 was due primarily to a decline in the average interest rate.

ting activities increased $286 million, from $4.448 billion for 2014 to $4.734 billion for
cash flows from operating activities was primarily related to the net impact of an
of $323 million and net negative changes in working capital items of $59 million.

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

providing the communities we serve with high quality, cost-effective health care while , increasing our profitability and creating long-term value for our stockholders. To es, we align our efforts around the following growth agenda:

Existing Markets. We believe we are well positioned in a number of large and growing v us the opportunity to generate long-term, attractive growth through the expansion of narkets. We plan to continue recruiting and strategically collaborating with the physician g attractive service lines such as cardiology, emergency services, oncology and women s omponents of our growth strategy include expanding our footprint through developing cess points, including surgery centers, urgent care clinics, freestanding emergency in clinics.

ing Performance in Clinical and Satisfaction Measures. Achieving high levels of patient tion and clinical quality are central goals of our business model. To achieve these goals, a number of initiatives including infection reduction initiatives, hospitalist programs, rmation technology and evidence-based medicine programs. We routinely analyze from our best-performing hospitals to identify ways to implement organization-wide nents and reduce clinical variation. We believe these initiatives will continue to improve chieve cost efficiencies, grow our revenues and favorably position us in an environment are increasingly focused on quality, efficacy and efficiency.

hysicians to Meet Need for High Quality Health Services. We depend on the quality and th care providers and other team members who serve at our facilities. We believe a our growth strategy is our ability to successfully recruit and strategically collaborate with rofessionals to provide high quality care. We attract and retain physicians by providing ent facilities with advanced technology, by expanding our specialty services and by t operations. We believe our continued investment in the employment, recruitment and will improve the quality of care at our facilities.

Our Scale and Market Positions to Enhance Profitability. We believe there is significant e to grow the profitability of our company by fully leveraging the scale and scope of our ently pursuing next generation performance improvement initiatives such as contracting state basis and expanding our support infrastructure for additional clinical and support sician credentialing, medical transcription and electronic medical recordkeeping. We managed business processes and ability to leverage cost-saving practices across our enable us to continue to manage costs effectively. We continue to invest in our Parallon leverage key components of our support infrastructure, including revenue cycle are group purchasing, supply chain management and staffing functions and are offering to other hospital companies.

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

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HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

ntinued)

ssfully acquiring and integrating hospitals and entering into joint ventures and intend to
s experience.

Policies and Estimates

ur consolidated financial statements requires management to make estimates and
the reported amounts of assets and liabilities, the disclosure of contingent liabilities and
of revenues and expenses. Our estimates are based on historical experience and various
e believe are reasonable under the circumstances. We evaluate our estimates on an
ake changes to the estimates and related disclosures as experience develops or new
nown. Actual results may differ from these estimates.

ng critical accounting policies affect our more significant judgments and estimates used
ur consolidated financial statements.

d during the period the health care services are provided, based upon the estimated
yers. Estimates of contractual allowances under managed care health plans are based
ns specified in the related contractual agreements. Laws and regulations governing the
id programs are complex and subject to interpretation. The estimated reimbursement
payer-specific basis and are recorded based on the best information available regarding
retation of the applicable laws, regulations and contract terms. Management continually
l estimation process to consider and incorporate updates to laws and regulations and the
anaged care contractual terms resulting from contract renegotiations and renewals. We
ant resources to refine and improve our billing systems and the information system data
ual allowance estimates. We have developed standardized calculation processes and
ms to improve the utility of our patient accounting systems.

cal Treatment and Labor Act (EMTALA) requires any hospital participating in the
conduct an appropriate medical screening examination of every person who presents to
ency room for treatment and, if the individual is suffering from an emergency medical
bilize the condition or make an appropriate transfer of the individual to a facility able to
The obligation to screen and stabilize emergency medical conditions exists regardless of
to pay for treatment. Federal and state laws and regulations, including but not limited to
d our commitment to providing quality patient care encourages, the provision of services
ancially unable to pay for the health care services they receive. The Health Reform Law
to reimburse hospitals for emergency services provided to enrollees without prior
out regard to whether a participating provider contract is in place. Further, the Health
s provisions that seek to decrease the number of uninsured individuals, including
ives for individuals to obtain, and large employers to provide, insurance coverage. These
g the financial impact of screening for and stabilizing emergency medical conditions.
s are continuing to develop regarding the impact of the Health Reform Law, including
uninsured individuals will obtain and maintain coverage as a result of the law, the
volume of inpatient and outpatient hospital services that are sought by and provided to
ndividuals and overall changes in the payer mix.

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HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

Policies and Estimates (continued)

ection of amounts related to patients who meet our guidelines to qualify as charity care; t reported in revenues. Patients treated at our hospitals for nonelective care, who have 0% of the federal poverty level, are eligible for charity care. The federal poverty level is ral government and is based on income and family size. We provide discounts from our ured patients who do not qualify for Medicaid or charity care. After the discounts are nable to collect a significant portion of uninsured patients accounts, and we record s for doubtful accounts (based upon our historical collection experience) related to he period the services are provided.

s involved in the classification and documentation of health care services authorized and on of revenues earned and the related reimbursement are often subject to interpretations yments that are different from our estimates. Adjustments to estimated Medicare and nent amounts and disproportionate-share funds, which resulted in net increases to arily to cost reports filed during the respective year were $48 million, $50 million and 2014 and 2013, respectively. The adjustments to estimated reimbursement amounts, ncreases to revenues, related primarily to cost reports filed during previous years were on and $68 million in 2015, 2014 and 2013, respectively. We expect adjustments during ated to Medicare and Medicaid cost report filings and settlements will result in increases imilar to the amounts recorded during these years.

Accounts and the Allowance for Doubtful Accounts

tanding receivables from Medicare, Medicaid, managed care payers, other third-party our primary source of cash and is critical to our operating performance. The primary o uninsured patient accounts, including patient accounts for which the primary insurance mounts covered by the applicable agreement, but patient responsibility amounts yments) remain outstanding. The provision for doubtful accounts and the allowance for te primarily to amounts due directly from patients. An estimated allowance for doubtful or all uninsured accounts, regardless of the aging of those accounts. Accounts are written e internal and external collection efforts have been performed. Our collection policies accounts against certain standard collection criteria, upon completion of our primary rts. Accounts determined to possess positive collectibility attributes are forwarded to a external collection agency and the other accounts are written off. The accounts that are secondary collection agency are written off when secondary collection efforts are ithin 12 months). Writeoffs are based upon specific identification and the writeoff eoff adjustment entry to the patient accounting system. We do not pursue collection of ents that meet our guidelines to qualify as charity care.

ovision for doubtful accounts is based upon management s assessment of historical net collections, business and economic conditions, trends in federal, state, and private coverage and other collection indicators. Management relies on the results of detailed writeoffs and recoveries at facilities that represent a majority of our revenues and me hindsight analysis) as a primary source of information in estimating the collectibility vable. We perform the hindsight analysis quarterly, utilizing rolling twelve-months

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HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

Policies and Estimates (continued)

Accounts and the Allowance for Doubtful Accounts (continued)

and writeoff data. We believe our quarterly updates to the estimated allowance for ach of our hospital facilities provide reasonable valuations of our accounts receivable. ly changes in estimates have not resulted in material adjustments to our allowance for rovision for doubtful accounts or period-to-period comparisons of our results of ber 31, 2015 and 2014, the allowance for doubtful accounts represented approximately billion and 91.4% of the $5.482 billion, respectively, patient due accounts receivable due accounts receivable balance represents the estimated uninsured portion of our The estimated uninsured portion of Medicaid pending and uninsured discount pending our patient due accounts receivable balance.

mpact of and trends related to uninsured accounts, we believe it is beneficial to view the lated to uninsured accounts (charity care and uninsured discounts) and provision for combination, rather than each separately. A summary of these amounts for the years llows (dollars in millions):

	2015	2014	2013
	$ 3,682	$ 3,775	$ 3,497
counts	**10,692**	8,999	8,210
doubtful accounts	**3,913**	3,169	3,858
	$ 18,287	$ 15,943	$ 15,565

ion for doubtful accounts, uninsured discounts and charity care, as a percentage of the provision for doubtful accounts, uninsured discounts and charity care was 31.5% for and 31.3% for 2013. We believe the decline from 2013 to 2014 was primarily due to patients obtaining medical coverage through the health insurance exchanges and programs. We believe the increase from 2014 to 2015 was primarily due to the efits from the health insurance exchanges and Medicaid expansion programs that we 2014.

unts receivable were 53 days, 54 days and 54 days at December 31, 2015, 2014 and nagement expects a continuation of the challenges related to the collection of the patient e changes in the percentage of our patients having adequate health care coverage, sponsibility amounts under certain health care coverages, general economic conditions, vice center operations, payer mix, or trends in federal, state, and private employer health fect the collection of accounts receivable, cash flows and results of operations.

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

Policies and Estimates (continued)

Accounts and the Allowance for Doubtful Accounts (continued)

kdown of accounts receivable by payer classification as of December 31, 2015 and 2014 ving table:

	% of Accounts Receivable		
	Under 91 Days	91 180 Days	Over 180 Days
le aging at 5:			
dicaid	**12%**	**1%**	**1%**
other insurers	**25**	**5**	**5**
	22	**6**	**23**
	59%	**12%**	**29%**
le aging at 4:			
dicaid	13%	1%	2%
other insurers	23	5	5
	17	7	27
	53%	13%	34%

Claims

ly all health care providers, operate in an environment with professional liability risks. ed by our 100% owned insurance subsidiary for losses up to $50 million per occurrence, ion per occurrence self-insured retention. The insurance subsidiary has obtained sional liability risks generally above a retention level of $25 million per occurrence. We rance on a claims-made basis for losses in excess of $50 million per occurrence. elated to professional liability risks were $344 million, $395 million and $314 million cember 31, 2015, 2014 and 2013, respectively.

nal liability risks represent the estimated ultimate cost of all reported and unreported h the respective consolidated balance sheet dates. The estimated ultimate cost includes penses and fees paid to outside counsel and experts, but does not include the general insurance subsidiary or corporate office. Individual case reserves are established based rcumstances of each reported claim and represent our estimates of the future costs that ted claims. Case reserves are reduced as claim payments are made and are adjusted as our estimates regarding the amounts of future losses are revised. Once the case aims are determined, information is stratified by loss layers and retentions, accident and geographic location of our hospitals. Several actuarial methods are employed to oduce estimates of ultimate losses and reserves for incurred but not reported claims,

curred extrapolation methods utilizing paid and incurred loss development to estimate
ency and severity methods utilizing paid and incurred claims development to estimate
quency (number of claims) and ultimate average severity (cost per claim); and
n methods which add expected development to actual paid or incurred experience to
s. These methods use our company-specific historical claims data and other information.
im reporting and payment data collected over an approximate 20-year period is used in
process. This company-specific

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

Policies and Estimates (continued)

Claims (continued)

ation regarding our business, including historical paid losses and loss adjustment nd current case loss reserves, actual and projected hospital statistical data, professional each policy year, geographic information and other data.

ns for professional liability risks are based upon actuarially determined estimates. The es, net of amounts receivable under reinsurance contracts, were $1.294 billion to $1.548 31, 2015 and $1.229 billion to $1.469 billion at December 31, 2014. Our estimated al liability claims may change significantly if future claims differ from expected trends. y analyses which model the volatility of key actuarial assumptions and monitor our relative to all our assumptions in the aggregate. Based on our analysis, we believe the liability reserve ranges represent the reasonably likely outcomes for ultimate losses. We nd severity of claims to be the most significant assumptions in estimating reserves for . A 2% change in the expected frequency trend could be reasonably likely and would timate by $20 million or reduce the reserve estimate by $19 million. A 2% change in the ty trend could be reasonably likely and would increase the reserve estimate by $78 reserve estimate by $73 million. We believe adequate reserves have been recorded for ty claims; however, due to the complexity of the claims, the extended period of time to l the wide range of potential outcomes, our ultimate liability for professional liability y more than the estimated sensitivity amounts and could change materially from our

ssional liability risks cover approximately 2,700 individual claims at both December 31, imates for unreported potential claims. The time period required to resolve these claims on the jurisdiction and whether the claim is settled or litigated. The average time period e and final resolution for our professional liability claims is approximately five years, d circumstances of each individual claim can result in an occurrence-to-resolution from this average. The estimation of the timing of payments beyond a year can vary

nal liability risks were $1.465 billion and $1.407 billion at December 31, 2015 and 2014, ent portion of these reserves, $350 million and $329 million at December 31, 2015 and included in other accrued expenses. Obligations covered by reinsurance and excess included in the reserves for professional liability risks, as we remain liable to the extent nsurance carriers do not meet their obligations. Reserves for professional liability risks and $25 million receivable under reinsurance and excess insurance contracts at d 2014, respectively) were $1.421 billion and $1.382 billion at December 31, 2015 and e estimated total net reserves for professional liability risks at December 31, 2015 and f $863 million and $746 million, respectively, of case reserves for known claims and million, respectively, of reserves for incurred but not reported claims.

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

Policies and Estimates (continued)

Claims (continued)

essional liability reserves, net of reinsurance recoverable, for the years ended marized in the following table (dollars in millions):

	2015	2014	2013
sional liability claims, January 1	**$ 1,382**	$ 1,255	$ 1,248
ear claims	**408**	359	343
e) development related to prior years claims	**(64)**	36	(29)
	344	395	314
ear claims	**7**	13	7
rs claims	**298**	255	300
	305	268	307
sional liability claims, December 31	**$ 1,421**	$ 1,382	$ 1,255

vision for income taxes using the asset and liability method, under which deferred tax e recognized by identifying the temporary differences that arise from the recognition of ods for tax and accounting purposes. Deferred tax assets generally represent the tax pensed in our income statement for which tax deductions will be claimed in future

ve have properly reported taxable income and paid taxes in accordance with applicable international taxing authorities may challenge our tax positions upon audit. Significant n determining and assessing the impact of uncertain tax positions. We report a liability benefits from uncertain tax positions taken or expected to be taken in our income tax porting period, we assess the facts and circumstances related to uncertain tax positions. If cognized tax benefits is deemed probable based upon new facts and circumstances, the the provision for income taxes are reduced in the current period. Final audit results may s.

ls

upon inpatient occupancy levels, the ancillary services and therapy programs ordered by ded to patients, the volume of outpatient procedures and the charge and negotiated

services. Gross charges typically do not reflect what our facilities are actually paid. Our into agreements with third-party payers, including government programs and managed er which the facilities are paid based upon the cost of providing services, predetermined xed per diem rates or discounts from gross charges. We do not pursue collection of ents who meet our guidelines to qualify for charity care; therefore, they are not reported de discounts to uninsured patients who do not qualify for Medicaid or charity care.

5% to $39.678 billion for 2015 from $36.918 billion for 2014 and increased 8.0% for illion for 2013. The increase in revenues in 2015 can be primarily attributed to the

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

s (continued)

ls (continued)

ease in revenue per equivalent admission and a 5.5% increase in equivalent admissions year. The increase in revenues in 2014 can be primarily attributed to the combined ease in revenue per equivalent admission and a 4.0% increase in equivalent admissions recorded $142 million of Medicaid revenues during the second quarter of 2014 related bursements in excess of our estimates for the indigent care component of the Texas gram for the program year ended September 30, 2013. We recorded $94 million of uring the third quarter of 2014 as the settlement amount for certain claims denied by actor (RAC) entities conducting reviews on behalf of CMS and pending in the appeals an administrative agreement to providers willing to withdraw their pending appeals in partial payment (generally, 68% of the claim amount, subject to certain adjustments), uring 2014. All revenue amounts and revenue-related statistics for the year ended clude the impact of these two items that resulted in increases to revenues.

s increased 6.4% for the year ended December 31, 2015 compared to the year ended nd increased 6.9% for the year ended December 31, 2014 compared to the year ended he 6.4% increase for 2015 can be primarily attributed to the combined impact of a 1.7% ity revenue per equivalent admission and a 4.6% increase in same facility equivalent increase for 2014 can be primarily attributed to the combined impact of a 3.9% increase e per equivalent admission and a 2.9% increase in same facility equivalent admissions.

ons increased 4.1% in 2015 compared to 2014 and increased 2.9% in 2014 compared to patient surgeries increased 2.1% and consolidated outpatient surgeries increased 2.0% to 2014. Consolidated inpatient surgeries increased 2.0% and consolidated outpatient % during 2014 compared to 2013. Consolidated emergency room visits increased 8.0% to 2014 and increased 6.9% during 2014 compared to 2013.

ons increased 3.4% in 2015 compared to 2014 and increased 2.1% in 2014 compared to patient surgeries increased 2.1% and same facility outpatient surgeries increased 1.6% to 2014. Same facility inpatient surgeries increased 1.3% and same facility outpatient % during 2014 compared to 2013. Same facility emergency room visits increased 7.0% to 2014 and increased 5.8% during 2014 compared to 2013.

red emergency room visits increased 1.2% and same facility uninsured admissions ng 2015 compared to 2014. We believe these increases were primarily due to the lines experienced during 2014 as some previously uninsured patients obtained medical lth insurance exchanges and Medicaid expansion programs. Same facility uninsured s declined 6.6% and same facility uninsured admissions declined 9.4% during 2014 e believe these declines were primarily due to some previously uninsured patients erage through the health insurance exchanges and Medicaid expansion programs.

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

s (continued)

ls (continued)

entages of our admissions related to Medicare, managed Medicare, Medicaid, managed are and other insurers, and the uninsured for the years ended December 31, 2015, 2014 below.

	Years Ended December 31,		
	2015	**2014**	**2013**
	30%	32%	32%
e	**15**	14	13
	6	7	8
d	**12**	10	9
other insurers	**30**	30	30
	7	7	8
	100%	100%	100%

entages of our inpatient revenues, before provision for doubtful accounts, related to edicare, Medicaid, managed Medicaid, managed care plans and other insurers, and the ended December 31, 2015, 2014 and 2013 are set forth below.

	Years Ended December 31,		
	2015	**2014**	**2013**
	28%	29%	29%
e	**12**	11	10
	6	7	6
d	**5**	5	4
other insurers	**47**	47	46
	2	1	5
	100%	100%	100%

in inpatient revenues related to the uninsured, from 2013 to 2014 and 2015, is primarily scounts provided to the uninsured (uninsured discounts were $10.692 billion, $8.999 on for 2015, 2014 and 2013, respectively).

, we owned and operated 43 hospitals and 33 surgery centers in the state of Florida. Our venues totaled $9.059 billion, $8.336 billion and $7.551 billion for the years ended 014 and 2013, respectively. At December 31, 2015, we owned and operated 38 hospitals in the state of Texas. Our Texas facilities revenues totaled $9.517 billion, $8.706 billion the years ended December 31, 2015, 2014 and 2013, respectively. During 2015, 2014

, 56%, 56% and 55% of our admissions and 47%, 46% and 46% of our revenues were
da and Texas facilities. Uninsured admissions in Florida and Texas represented 68%,
ninsured admissions during 2015, 2014 and 2013, respectively.

nt portion of our revenues from government health programs, principally Medicare and
ghly regulated and subject to frequent and substantial changes. In 2011, the Centers

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

s (continued)

ls (continued)

aid Services (CMS) approved a Medicaid waiver that allows Texas to continue receiving d reimbursement while expanding its Medicaid managed care program. Although Texas Medicaid Waiver Program pursuant to this waiver, the current waiver expires on Texas has submitted an application to extend its Waiver Program, but CMS has not he extension request. We cannot predict whether the Texas Medicaid Waiver Program vised or that revenues recognized from the program will not decline.

ogram includes two primary components: an indigent care component and a Delivery ive Payment (DSRIP) component. Initiatives under the DSRIP program are designed to ments to hospitals and other providers for their investments in delivery system reforms health care, improve the quality of care and enhance the health of patients and families e indigent care services in several communities in the state of Texas, in affiliation with tate of Texas has been involved in efforts to increase the indigent care provided by result of additional indigent care being provided by private hospitals, public hospital Texas have available funds that were previously devoted to indigent care. The public unties are under no contractual or legal obligation to provide such indigent care. The s or counties have elected to transfer some portion of these available funds to the state s uch action is at the sole discretion of the public hospital districts or counties. It is contributions to the state will be matched with federal Medicaid funds. The state then al payments to hospitals in the state for Medicaid services rendered. Hospitals receiving l payments may include those that are providing additional indigent care services. Our ues included $347 million ($95 million DSRIP related and $252 million indigent care ($97 million DSRIP related and $391 million indigent care related) and $393 million lated and $317 million indigent care related) during 2015, 2014 and 2013, respectively, ntal payments.

of 2014, we recorded $142 million of Medicaid revenues related to the receipt of cess of our estimates for the indigent care component of the Texas Medicaid Waiver am year ended September 30, 2013. On October 1, 2014, the Texas Health and Human (THHSC) issued a notice to hospitals participating in the Texas Medicaid Waiver t a review conducted by CMS identified certain local government/hospital affiliations it sistent with the waiver. In addition, CMS notified THHSC that it would defer the federal d payments associated with the affiliations while it completes the review, a measure that During the fourth quarter of 2014, due to the updated information and the receipt of a ng December, we reversed the $68 million reduction to Medicaid revenues recorded in 4.

ve supplemental payments in several other states. We are aware these supplemental currently being reviewed by certain state agencies and some states have made waiver place their existing supplemental payment programs. It is possible these reviews and sult in the restructuring of such supplemental payment programs and could result in the ng reduced or eliminated. Because deliberations about these programs are ongoing, we the financial impact the program structure modifications, if any, may have on our results

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HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

s (continued)

ord Incentive Payments

ery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive
n 2011, for eligible hospitals and professionals that adopt and meaningfully use certified
d (EHR) technology. We recognize income related to Medicare and Medicaid incentive
contingency model that is based upon when our eligible hospitals have demonstrated
tified EHR technology for the applicable period and the cost report information for the
at will determine the final calculation of the incentive payment is available.

ad 2013, respectively, we recognized $47 million, $125 million and $216 million of
d incentive income related to Medicare ($46 million, $118 million and $183 million) and
$7 million and $33 million) incentive programs. For 2016, we estimate EHR incentive
l $10 million.

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

s (continued)

mary

mparative summaries of operating results for the years ended December 31, 2015, 2014
illions):

	2015		2014		2013	
	Amount	Ratio	Amount	Ratio	Amount	Ratio
sion for doubtful						
	$ 43,591		$ 40,087		$ 38,040	
accounts	**3,913**		3,169		3,858	
	39,678	**100.0**	36,918	100.0	34,182	100.0
	18,115	**45.7**	16,641	45.1	15,646	45.8
	6,638	**16.7**	6,262	17.0	5,970	17.5
ses	**7,103**	**17.9**	6,755	18.2	6,237	18.2
d incentive						
	(47)	**(0.1)**	(125)	(0.3)	(216)	(0.6)
ffiliates	**(46)**	**(0.1)**	(43)	(0.1)	(29)	(0.1)
tization	**1,904**	**4.8**	1,820	5.0	1,753	5.1
	1,665	**4.2**	1,743	4.7	1,848	5.4
of facilities	**5**		(29)	(0.1)	10	
f debt	**135**	**0.3**	335	0.9	17	0.1
	249	**0.6**	78	0.2		
	35,721	**90.0**	33,437	90.6	31,236	91.4
taxes	**3,957**	**10.0**	3,481	9.4	2,946	8.6
axes	**1,261**	**3.2**	1,108	3.0	950	2.8
	2,696	**6.8**	2,373	6.4	1,996	5.8
e to						
s	**567**	**1.4**	498	1.3	440	1.2
e to HCA						
	$ 2,129	**5.4**	$ 1,875	5.1	$ 1,556	4.6
year:						
	7.5%		8.0%		3.5%	
taxes	**13.7**		18.2		1.8	
e to HCA						
	13.6		20.5		(3.1)	
	4.1		2.9		0.2	

(b)	**5.5**	4.0	0.4
t admission	**1.8**	3.8	3.1
es from prior			
	6.4	6.9	3.1
	3.4	2.1	0.1
(b)	**4.6**	2.9	0.1
t admission	**1.7**	3.9	3.0

number of patients admitted to our hospitals and is used by management and a general measure of inpatient volume.

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

mation excludes the operations of hospitals and their related facilities that were either or removed from service during the current and prior year.

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

s (continued)

r 31, 2015 and 2014

e to HCA Holdings, Inc. totaled $2.129 billion, or $4.99 per diluted share, for the year 2015 compared to $1.875 billion, or $4.16 per diluted share, for the year ended inancial results for 2015 include losses on retirement of debt of $135 million, or $0.20 al claim costs of $249 million, or $0.37 per diluted share, and net losses on sales of . Financial results for the year ended December 31, 2014 include net gains on sales of n, or $0.04 per diluted share, losses on retirement of debt of $335 million, or $0.47 per l claim costs of $78 million, or $0.11 per diluted share. All per diluted share disclosures ts net of the applicable income taxes. Shares used for diluted earnings per share were es and 450.352 million shares for the years ended December 31, 2015 and 2014, 015, we repurchased 31.991 million shares of our common stock.

ated admissions increased 4.1% and same facility admissions increased 3.4% compared l and same facility inpatient surgeries each increased 2.1% during 2015 compared to tpatient surgeries increased 2.0%, and same facility outpatient surgeries increased 1.6% to 2014. Emergency room visits increased 8.0% on a consolidated basis and increased y basis during 2015 compared to 2014.

ision for doubtful accounts increased 8.7% to $43.591 billion for 2015 from $40.087 provision for doubtful accounts increased $744 million from $3.169 billion in 2014 to 5. The provision for doubtful accounts and the allowance for doubtful accounts relate amounts due directly from patients, including copayment and deductible amounts for alth care coverage. The self-pay revenue deductions for charity care and uninsured 6 million and increased $1.693 billion, respectively, during 2015 compared to 2014. The or doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of on for doubtful accounts, uninsured discounts and charity care, was 31.5% for 2015 or 2014. At December 31, 2015, our allowance for doubtful accounts represented of the $5.636 billion total patient due accounts receivable balance, including accounts, ractual discounts, related to patients for which eligibility for Medicaid coverage or as being evaluated.

5% to $39.678 billion for 2015 from $36.918 billion for 2014. The increase in revenues he combined impact of a 1.8% increase in revenue per equivalent admission and a 5.5% admissions compared to 2014. Same facility revenues increased 6.4% due primarily to f a 1.7% increase in same facility revenue per equivalent admission and a 4.6% increase alent admissions compared to 2014. We recorded $142 million of Medicaid revenues rter of 2014 related to the receipt of reimbursements in excess of our estimates for the ent of the Texas Medicaid Waiver Program for the program year ended September 30, 4 million of Medicare revenues during the third quarter of 2014 as the settlement amount ed by Recovery Audit Contractor (RAC) entities conducting reviews on behalf of CMS eals process. CMS offered an administrative agreement to providers willing to withdraw n exchange for a timely partial payment (generally, 68% of the claim amount, subject to which we accepted during 2014. All revenue amounts and revenue-related statistics for ber 31, 2014 include the impact of these two items that resulted in increases to revenues.

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HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

s (continued)

r 31, 2015 and 2014 (continued)

as a percentage of revenues, were 45.7% in 2015 and 45.1% in 2014. Salaries and admission increased 3.1% in 2015 compared to 2014. Same facility labor rate increases 5 compared to 2014. Share-based compensation expense increased from $163 million in n 2015, and we expect the 2016 expense will increase by approximately $40 million.

age of revenues, were 16.7% in 2015 and 17.0% in 2014. Supply costs per equivalent .4% in 2015 compared to 2014. Supply costs per equivalent admission increased 1.0% d 4.0% for pharmacy supplies and declined 1.0% for general medical and surgical items 014.

ses, as a percentage of revenues, was 17.9% in 2015 and 18.2% in 2014. Other operating y comprised of contract services, professional fees, repairs and maintenance, rents and ance (including professional liability insurance) and nonincome taxes. Provisions for fessional liability risks were $344 million and $395 million for 2015 and 2014, expense decline in 2015 was primarily due to favorable development related to prior

, respectively, we recognized $47 million and $125 million of electronic health record ed to Medicare ($46 million and $118 million) and Medicaid ($1 million and $7 million) We expect that income related to Medicare and Medicaid incentive payments will not 2016.

ffiliates was $46 million for 2015 and $43 million for 2014.

rtization, as a percentage of revenues, was 4.8% in 2015 and 5.0% in 2014. Depreciation llion for 2015 and $1.798 billion for 2014.

ned to $1.665 billion for 2015 from $1.743 billion for 2014. The decline in interest decline in the average interest rate. Our average debt balance was $29.718 billion for 3.529 billion for 2014. The average interest rate for our long-term debt declined from for 2015.

f facilities were $5 million for 2015 and related to sales of real estate and other s on sales of facilities were $29 million for 2014 and related to the sale of a hospital l estate and other investments.

emed all $1.525 billion aggregate principal amount of $7^{3}/_{4}$% senior notes due 2021 and regate principal amount of our outstanding 6.500% senior notes due 2016. We also greement to retire certain of our existing senior secured term loans. The pretax losses on ated to these redemptions were $135 million. During 2014, we redeemed all $1.500 ipal amount of our outstanding $8^{1}/_{2}$% senior secured notes due 2019, all $1.250 billion mount of our outstanding $7^{7}/_{8}$% senior secured notes due 2020, and all $1.400 billion mount of our outstanding $7^{1}/_{4}$% senior secured notes due 2020. The pretax losses on

ed to these redemptions were $335 million.

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

s (continued)

r 31, 2015 and 2014 (continued)

lion of legal claim costs during 2015 to settle a securities class action lawsuit and related e also recorded $129 million of legal claim costs during 2015 related to the Health additional court-awarded interest costs. We recorded $78 million of legal claim costs the Health Midwest litigation.

was 37.2% for both 2015 and 2014. The effective tax rate computations exclude net noncontrolling interests as it relates to consolidated partnerships.

le to noncontrolling interests increased from $498 million for 2014 to $567 million for net income attributable to noncontrolling interests related primarily to joint ventures in market, a Texas market and an Oklahoma market.

r 31, 2014 and 2013

e to HCA Holdings, Inc. totaled $1.875 billion, or $4.16 per diluted share, for the year 2014 compared to $1.556 billion, or $3.37 per diluted share, for the year ended inancial results for 2014 include net gains on sales of facilities of $29 million, or $0.04 s on retirement of debt of $335 million, or $0.47 per diluted share, and legal claim costs 1 per diluted share. Financial results for 2013 include net losses on sales of facilities of per diluted share, and a loss on retirement of debt of $17 million, or $0.02 per diluted share disclosures are based upon amounts net of the applicable income taxes. Shares used er share were 450.352 million shares and 461.913 million shares for the years ended nd 2013, respectively. During 2014, we repurchased 28.583 million shares of our

ated admissions increased 2.9% and same facility admissions increased 2.1% compared inpatient surgeries increased 2.0%, and same facility inpatient surgeries increased 1.3% to 2013. Consolidated outpatient surgeries increased 1.1%, and same facility outpatient 1% during 2014 compared to 2013. Emergency room visits increased 6.9% on a increased 5.8% on a same facility basis during 2014 compared to 2013.

ision for doubtful accounts increased 5.4% to $40.087 billion for 2014 from $38.040 provision for doubtful accounts declined $689 million from $3.858 billion in 2013 to 4. The provision for doubtful accounts and the allowance for doubtful accounts relate amounts due directly from patients, including copayment and deductible amounts for alth care coverage. The self-pay revenue deductions for charity care and uninsured 78 million and $789 million, respectively, during 2014 compared to 2013. The sum of btful accounts, uninsured discounts and charity care, as a percentage of the sum of on for doubtful accounts, uninsured discounts and charity care, was 30.2% for 2014 or 2013. At December 31, 2014, our allowance for doubtful accounts represented of the $5.482 billion total patient due accounts receivable balance, including accounts, ractual discounts, related to patients for which eligibility for Medicaid coverage or as being evaluated.

0% to $36.918 billion for 2014 from $34.182 billion for 2013. The increase in revenues
e combined impact of a 3.8% increase in revenue per equivalent admission and a

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

s (continued)

r 31, 2014 and 2013 (continued)

ivalent admissions compared to 2013. Same facility revenues increased 6.9% due ned impact of a 3.9% increase in same facility revenue per equivalent admission and a e facility equivalent admissions compared to 2013. We recorded $142 million of ring the second quarter of 2014 related to the receipt of reimbursements in excess of our ent care component of the Texas Medicaid Waiver Program for the program year ended We recorded $94 million of Medicare revenues during the third quarter of 2014 as the amount for certain claims denied by Recovery Audit Contractor (RAC) entities n behalf of CMS and pending in the appeals process. CMS offered an administrative rs willing to withdraw their pending appeals in exchange for a timely partial payment e claim amount, subject to certain adjustments), which we accepted during 2014. All revenue-related statistics for the year ended December 31, 2014 include the impact of sulted in increases to revenues.

as a percentage of revenues, were 45.1% in 2014 and 45.8% in 2013. Salaries and admission increased 2.3% in 2014 compared to 2013. Same facility labor rate increases 4 compared to 2013. Share-based compensation expense increased from $113 million in n 2014.

age of revenues, were 17.0% in 2014 and 17.5% in 2013. Supply costs per equivalent .9% in 2014 compared to 2013. Supply costs per equivalent admission increased 1.4% .7% for pharmacy supplies and 0.4% for general medical and surgical items in 2014

ses, as a percentage of revenues, was 18.2% in both 2014 and 2013. Other operating comprised of contract services, professional fees, repairs and maintenance, rents and ance (including professional liability insurance) and nonincome taxes. Provisions for fessional liability risks were $395 million and $314 million for 2014 and 2013,

, respectively, we recognized $125 million and $216 million of electronic health record ted to Medicare ($118 million and $183 million) and Medicaid ($7 million and $33 rams. We recognize income related to Medicare and Medicaid incentive payments using del that is based upon when our eligible hospitals have demonstrated meaningful use of gy for the applicable period and the cost report information for the full cost report year final calculation of the incentive payment is available.

ffiliates increased from $29 million for 2013 to $43 million for 2014.

tization, as a percentage of revenues, was 5.0% in 2014 and 5.1% in 2013. Depreciation llion for 2014 and $1.733 billion for 2013.

ned to $1.743 billion for 2014 from $1.848 billion for 2013. The decline in interest decline in the average interest rate. Our average debt balance was $28.529 billion for

3.113 billion for 2013. The average interest rate for our long-term debt declined from
for 2014.

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

s (continued)

r 31, 2014 and 2013 (continued)

acilities were $29 million for 2014 and related to the sale of a hospital facility and sales r investments. Net losses on sales of facilities were $10 million for 2013 and related to acility and sales of real estate and other investments.

eemed all $1.500 billion aggregate principal amount of our outstanding $8^1/_2$% senior 9, all $1.250 billion aggregate principal amount of our outstanding $7^7/_8$% senior secured ll $1.400 billion aggregate principal amount of our outstanding $7^1/_4$% senior secured etax losses on retirement of debt related to these redemptions were $335 million. During ll $201 million aggregate principal amount of our outstanding $9^7/_8$% senior secured 2017. The pretax loss on retirement of debt related to this redemption was $17 million.

ion of legal claim costs during 2014 to increase the estimate of our legal liability with y disclosed lawsuit alleging we did not make the full level of capital expenditures and greed to in connection with the purchase of the hospitals from Health Midwest in 2003.

e was 37.2% and 37.9% for 2014 and 2013, respectively. The effective tax rate e net income attributable to noncontrolling interests as it relates to consolidated

le to noncontrolling interests increased from $440 million for 2013 to $498 million for n net income attributable to noncontrolling interests related primarily to growth in spital joint ventures in two of our Texas markets and our group purchasing organization.

l Resources

irements are paying our operating expenses, servicing our debt, capital expenditures on s, acquisitions of hospitals and other health care entities, repurchases of our common stockholders and distributions to noncontrolling interests. Our primary cash sources are ting activities, issuances of debt and equity securities and dispositions of hospitals and es.

rating activities totaled $4.734 billion in 2015 compared to $4.448 billion in 2014 and 3. Working capital totaled $3.716 billion at December 31, 2015 and $3.450 billion at he $286 million increase in cash provided by operating activities for 2015, compared to elated to the net impact of an increase in net income of $323 million and net negative apital items of $59 million. The $768 million increase in cash provided by operating mpared to 2013, was primarily related to the net impact of an increase in net income of itive changes in working capital items of $150 million, a net benefit of $357 million) on sales of facilities, losses on retirement of debt and legal claim costs, and a negative n related to income taxes. Cash payments for interest and income taxes increased $21 ared to 2014 and increased $289 million for 2014 compared to 2013.

activities was $2.583 billion, $2.918 billion and $2.346 billion in 2015, 2014 and 2013,
g acquisitions, capital expenditures were $2.375 billion in 2015, $2.176 billion in 2014
013. We expended $351 million, $766 million and $481 million for acquisitions of

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

l Resources (continued)

are entities during 2015, 2014 and 2013, respectively. Planned capital expenditures are ate $2.7 billion in 2016. At December 31, 2015, there were projects under construction d additional cost to complete and equip over the next five years of approximately $2.1 inance capital expenditures with internally generated and borrowed funds.

ved cash of $73 million from sales of a hospital, real estate and other investments. We proceeds of $63 million related to net changes in our investments. During 2014, we illion from sales of a hospital, real estate and other investments. We also expended cash to net changes in our investments. During 2013, we received cash of $33 million from estate and other investments. We also received net cash proceeds of $36 million related nvestments.

g activities totaled $1.976 billion in 2015, $1.378 billion in 2014 and $1.625 billion in e had a net increase of $778 million in our indebtedness and used cash of $2.397 billion mon stock. During 2014, we had a net increase of $778 million in our indebtedness and llion for repurchases of common stock. During 2013, we had a decline of $692 million d used cash of $500 million for repurchases of common stock. During 2015, 2014 and butions to noncontrolling interests of $495 million, $442 million and $435 million, debt issuance costs of $50 million, $73 million and $5 million for 2015, 2014 and 2013, 015, 2014 and 2013, we received income tax benefits of $235 million, $134 million and ively, for certain items (primarily exercises of stock options) that were deductible oses, but were recognized as adjustments to stockholders deficit for financial reporting ffiliates, may in the future repurchase portions of our debt or equity securities, subject to m time to time in either the open market or through privately negotiated transactions, in icable SEC and other legal requirements. The timing, prices, and sizes of purchases g trading prices, general economic and market conditions, and other factors, including aws. At December 31, 2015, $2.603 billion of share repurchase authorization remained 3.000 billion share repurchase program authorized by our board of directors during or the repurchase of debt or equity securities have, and are expected to, come primarily om operations and borrowed funds.

ws from operations, available sources of capital include amounts available under our facilities ($2.179 billion as of December 31, 2015 and $2.299 billion as of January 31, access to public and private debt and equity markets.

ofessional liability insurance subsidiaries, to maintain statutory equity and pay claims, nd $558 million at December 31, 2015 and 2014, respectively. The insurance subsidiary s for professional liability risks of $261 million and $347 million at December 31, 2015 . Our facilities are insured by our 100% owned insurance subsidiary for losses up to $50 ce; however, this coverage is subject to a $15 million per occurrence self-insured for the self-insured professional liability risks retained were $1.160 billion and $1.035 1, 2015 and 2014, respectively. Claims payments, net of reinsurance recoveries, during expected to approximate $334 million. We estimate that approximately $284 million of n payments during the next 12 months will relate to claims subject to the self-insured

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HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

l Resources (continued)

aged company with significant debt service requirements. Our debt totaled $30.488
llion at December 31, 2015 and 2014, respectively. Our interest expense was $1.665
.743 billion for 2014.

e issued $3.500 billion aggregate principal amount of notes, comprised of $1.500 billion
nount of 3.75% senior secured notes due 2019 and $2.000 billion aggregate principal
or secured notes due 2024 and repaid at maturity all $500 million aggregate principal
nding 5.75% senior unsecured notes. During April 2014, we used proceeds from the
ance to redeem all $1.500 billion aggregate principal amount of our outstanding $8^{1}/_{2}$%
due 2019 and all $1.250 billion aggregate principal amount of our outstanding $7^{7}/_{8}$%
ue 2020. The pretax loss on retirement of debt related to these redemptions was $226

, we issued $2.000 billion aggregate principal amount of notes, comprised of $600
ncipal amount of 4.25% senior secured notes due 2019 and $1.400 billion aggregate
25% senior secured notes due 2025. During November 2014, we used a portion of the
ober 2014 debt issuance to redeem all $1.400 billion aggregate principal amount of our
nior secured notes due 2020. The pretax loss on retirement of debt related to this
million.

we issued $1.000 billion aggregate principal amount of 5.375% senior notes due 2025.
the net proceeds to repay at maturity our $750 million aggregate principal amount of
ue 2015.

issued $1.600 billion aggregate principal amount of 5.375% senior notes due 2025. We
o redeem all $1.525 billion aggregate principal amount of our outstanding $7^{3}/_{4}$% senior
etax loss on retirement of debt related to this redemption was $122 million.

entered into a joinder agreement to retire certain of our existing senior secured term
rom a new $1.400 billion senior secured term loan credit facility maturing on June 10,
n retirement of debt was $3 million.

15, we issued $1.000 billion aggregate principal amount of 5.875% senior notes due
proceeds to redeem all $1.000 billion aggregate principal amount of our outstanding
due 2016. The pretax loss on retirement of debt related to this redemption was $10

5, we issued $500 million aggregate principal amount of 5.875% senior notes due 2026.
eds for general corporate purposes.

that cash flows from operations, amounts available under our senior secured credit
cipated access to public and private debt markets will be sufficient to meet expected
the next twelve months.

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HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

ons and Off-Balance Sheet Arrangements

2015, maturities of contractual obligations and other commercial commitments are below (dollars in millions):

	Payments Due by Period				
(a)	Total	Current	2-3 Years	4-5 Years	After 5 Years
ng interest, excluding the cilities(b)	$ 32,220	$ 1,422	$ 3,273	$ 7,379	$ 20,146
er the senior secured credit erest(b)	9,404	450	4,704	4,250	
laims(c)	1,465	350	552	305	258
	2,073	283	483	331	976
igations(d)	33	25	8		
ations	$ 45,195	$ 2,530	$ 9,020	$ 12,265	$ 21,380

	Commitment Expiration by Period				
mitments Not Recorded on the heet	Total	Current	2-3 Years	4-5 Years	After 5 Years
	$ 33	$ 26	$ 6	$ 1	$
	41	36	5		
s(g)	37	26	11		
mitments	$ 111	$ 88	$ 22	$ 1	$

ded obligations related to unrecognized tax benefits of $554 million at December 31, t reasonably estimate the timing or amounts of cash payments, if any, at this time.
est payments assume that interest rates and borrowing spreads at December 31, 2015, uring the period presented.
the timing of payments for professional liability claims beyond a year can vary time period required to resolve these claims can vary depending upon the jurisdiction aim is settled or litigated.
future operating lease obligations, purchase obligations and other obligations and are r consolidated balance sheet. Amounts also include physician commitments that are nsolidated balance sheet.
imarily to instances in which we have agreed to indemnify various commercial insurers d surety bonds to cover self-insured workers compensation claims, utility and sits and damages for malpractice cases which were awarded to plaintiffs by the courts. rrently under appeal and the bonds will not be released by the courts until the cases are

imarily to various insurance programs for which we have letters of credit outstanding.
or physicians relocating to the communities in which our hospitals are located and
e in private practice for the benefit of the respective communities, we make advances to
lly over a period of one year, to assist in establishing the physicians practices. The
hese commitments to be advanced often depends upon the financial results of the
e practice during the recruitment agreement payment period. The physician commitments
ed on our maximum exposure on effective agreements at December 31, 2015.

HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

rket risk related to changes in market values of securities. The investments in debt and r 100% owned insurance subsidiaries were $478 million and $4 million, respectively, at hese investments are carried at fair value, with changes in unrealized gains and losses stments to other comprehensive income. At December 31, 2015, we had a net unrealized the insurance subsidiaries investment securities.

rket risk related to market illiquidity. Investments in debt and equity securities of our e subsidiaries could be impaired by the inability to access the capital markets. Should the e subsidiaries require significant amounts of cash in excess of normal cash requirements r expenses on short notice, we may have difficulty selling these investments in a timely o sell them at a price less than what we might otherwise have been able to in a normal We may be required to recognize other-than-temporary impairments on our investment iods should issuers default on interest payments or should the fair market valuations of te due to ratings downgrades or other issue-specific factors.

o market risk related to changes in interest rates, and we periodically enter into interest o manage our exposure to these fluctuations. Our interest rate swap agreements involve and variable rate interest payments between two parties, based on common notional maturity dates. The notional amounts of the swap agreements represent balances used to e of cash flows and are not our assets or liabilities. Our credit risk related to these red low because the swap agreements are with creditworthy financial institutions. The r these agreements are settled on a net basis. These derivatives have been recognized in s at their respective fair values. Changes in the fair value of these derivatives, which are v hedges, are included in other comprehensive income.

erest-bearing liabilities, approximately $4.671 billion of long-term debt at December 31, riable rates of interest, while the remaining balance in long-term debt of $25.817 billion was subject to fixed rates of interest. Both the general level of interest rates and, for the acilities, our leverage affect our variable interest rates. Our variable debt is comprised outstanding under the senior secured credit facilities. Borrowings under the senior s bear interest at a rate equal to an applicable margin plus, at our option, either (a) a base ference to the higher of (1) the federal funds rate plus 0.50% and (2) the prime rate of) a LIBOR rate for the currency of such borrowing for the relevant interest period. The r borrowings under the senior secured credit facilities may fluctuate according to a erage effective interest rate for our long-term debt declined from 6.1% for 2014 to 5.6%

ue of our total long-term debt was $31.411 billion at December 31, 2015. The estimates upon the quoted market prices for the same or similar issues of long-term debt with the d on a hypothetical 1% increase in interest rates, the potential annualized reduction to would be approximately $47 million. To mitigate the impact of fluctuations in interest get a portion of our debt portfolio to be maintained at fixed rates.

rations and the related market risks associated with foreign currencies are currently ults of operations and financial position.

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HCA HOLDINGS, INC.

MENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION

AND RESULTS OF OPERATIONS (continued)

ued)

struments are employed to manage risks, including interest rate exposures, and are not eculative purposes. We recognize derivative instruments, such as interest rate swap nsolidated balance sheets at fair value. Changes in the fair value of derivatives are y either in earnings or in stockholders equity, as a component of other comprehensive whether the derivative financial instrument qualifies for hedge accounting, and if so, a fair value hedge or a cash flow hedge. Gains and losses on derivatives designated as the extent they are effective, are recorded in other comprehensive income, and ed to earnings to offset the impact of the hedged items when they occur.

or received on interest rate swaps is recognized as interest expense. Gains and losses y termination of interest rate swap agreements are deferred and amortized as adjustments naining period of the debt originally covered by the terminated swap.

nd Changing Prices

and local laws have been enacted that, in certain cases, limit our ability to increase eneral, acute care hospital services rendered to Medicare patients are established under t s prospective payment system. Total fee-for-service Medicare revenues were 21.8%, ur revenues for 2015, 2014 and 2013, respectively.

hospital industry operating margins have been, and may continue to be, under significant hanges in payer and service mix and growth in operating expenses in excess of the payments under the Medicare program. In addition, as a result of increasing regulatory ures, our ability to maintain operating margins through price increases to non-Medicare

Division began an audit of HCA Holdings, Inc. s 2011 and 2012 federal income tax e are also subject to examination by state and foreign taxing authorities.

HCA Holdings, Inc., its predecessors and affiliates properly reported taxable income and nce with applicable laws and agreements established with the IRS, state and foreign final resolution of any disputes will not have a material, adverse effect on our results of l position. However, if payments due upon final resolution of any issues exceed our uch resolutions could have a material, adverse effect on our results of operations or

ve and Qualitative Disclosures about Market Risk

ect to this Item is provided under the caption Market Risk under Item 7, Management s is of Financial Condition and Results of Operations.

atements and Supplementary Data

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

and Disagreements with Accountants on Accounting and Financial Disclosure

nd Procedures

ing the Effectiveness of Disclosure Controls and Procedures

and with the participation of our management, including our principal executive officer officer, we conducted an evaluation of our disclosure controls and procedures, as such Rule 13a-15(e) promulgated under the Securities Exchange Act of 1934, as amended (the sed on this evaluation, our principal executive officer and our principal financial officer closure controls and procedures were effective as of the end of the period covered by this

ver Financial Reporting

port on Internal Control Over Financial Reporting

esponsible for establishing and maintaining effective internal control over financial is defined in Exchange Act Rule 13a-15(f). Because of its inherent limitations, internal reporting may not prevent or detect misstatements. Therefore, even those systems ective, can provide only reasonable assurance with respect to financial statement tation.

and with the participation of our management, including our principal executive officer officer, we conducted an assessment of the effectiveness of our internal control over ed on the framework in Internal Control Integrated Framework issued by the Committee tations of the Treadway Commission (2013 framework). Based on our assessment under nal Control Integrated Framework, our management concluded that our internal control g was effective as of December 31, 2015.

he independent registered public accounting firm that audited our consolidated financial this Form 10-K, has issued a report on our internal control over financial reporting, in.

of the Independent Registered Public Accounting Firm

Report of Independent Registered Public Accounting Firm

s and Stockholders

Holdings, Inc. s internal control over financial reporting as of December 31, 2015, based
d in Internal Control Integrated Framework issued by the Committee of Sponsoring
Treadway Commission (2013 framework) (the COSO criteria). HCA Holdings, Inc. s
nsible for maintaining effective internal control over financial reporting, and for its
ectiveness of internal control over financial reporting included in the accompanying
t on Internal Control Over Financial Reporting. Our responsibility is to express an opinion
rnal control over financial reporting based on our audit.

it in accordance with the standards of the Public Company Accounting Oversight Board
e standards require that we plan and perform the audit to obtain reasonable assurance
e internal control over financial reporting was maintained in all material respects. Our
g an understanding of internal control over financial reporting, assessing the risk that a
ists, testing and evaluating the design and operating effectiveness of internal control
d risk, and performing such other procedures as we considered necessary in the
ieve that our audit provides a reasonable basis for our opinion.

control over financial reporting is a process designed to provide reasonable assurance
y of financial reporting and the preparation of financial statements for external purposes
enerally accepted accounting principles. A company s internal control over financial
ose policies and procedures that (1) pertain to the maintenance of records that, in
rately and fairly reflect the transactions and dispositions of the assets of the company;
assurance that transactions are recorded as necessary to permit preparation of financial
ce with generally accepted accounting principles, and that receipts and expenditures of
g made only in accordance with authorizations of management and directors of the
vide reasonable assurance regarding prevention or timely detection of unauthorized
isposition of the company s assets that could have a material effect on the financial

nt limitations, internal control over financial reporting may not prevent or detect
rojections of any evaluation of effectiveness to future periods are subject to the risk that
inadequate because of changes in conditions, or that the degree of compliance with the
may deteriorate.

Holdings, Inc. maintained, in all material respects, effective internal control over
f December 31, 2015, based on the COSO criteria.

in accordance with the standards of the Public Company Accounting Oversight Board
nsolidated balance sheets of HCA Holdings, Inc. as of December 31, 2015 and 2014,
dated statements of income, comprehensive income, stockholders deficit, and cash flows
ears in the period ended December 31, 2015 and our report dated February 26, 2016
ed opinion thereon.

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Control Over Financial Reporting

ter of 2015, there have been no changes in our internal control over financial reporting ffected or are reasonably likely to materially affect our internal control over financial

rmation

PART III

Executive Officers and Corporate Governance

ired by this Item regarding the identity and business experience of our directors and t forth under the heading Election of Directors in the definitive proxy materials of HCA n with our 2016 Annual Meeting of Stockholders with respect to our directors and is set t I of this annual report on Form 10-K with respect to our executive officers. The by this Item contained in such definitive proxy materials is incorporated herein by

eficial ownership reporting for our directors and executive officers required by this Item caption Section 16(a) Beneficial Ownership Reporting Compliance in the definitive filed in connection with our 2016 Annual Meeting of Stockholders and is incorporated

dit and Compliance Committee and Audit Committee Financial Experts required by this er the caption Corporate Governance in the definitive proxy materials to be filed in 016 Annual Meeting of Stockholders and is incorporated herein by reference.

onduct which is applicable to all our directors, officers and employees (the Code of of Conduct is available on the Ethics and Compliance and Corporate Governance pages of cahealthcare.com. To the extent required pursuant to applicable SEC regulations, we ments to or waivers from our Code of Conduct (to the extent applicable to our chief cipal financial officer or principal accounting officer) at this location on our website or Current Report on Form 8-K. Our Code of Conduct is available free of charge upon te Secretary, HCA Holdings, Inc., One Park Plaza, Nashville, TN 37203.

Compensation

uired by this Item is set forth under the headings Executive Compensation and nittee Interlocks and Insider Participation in the definitive proxy materials to be filed in 2016 Annual Meeting of Stockholders, which information is incorporated herein by

Ownership of Certain Beneficial Owners and Management and Related Stockholder

urity ownership of certain beneficial owners required by this Item is set forth under the nership of Certain Beneficial Owners and Management and Related Stockholder Matters y materials to be filed in connection with our 2016 Annual Meeting of Stockholders, ncorporated herein by reference.

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ertain information as of December 31, 2015 with respect to our equity compensation

EQUITY COMPENSATION PLAN INFORMATION

	(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))
lans			
olders	31,004,900(1)	$ 27.73(1)	36,198,700
lans			
ty			
	31,004,900	$ 27.73	36,198,700

0 restricted share units which vest solely based upon continued employment over a time and 1,740,100 restricted share units and 1,371,300 performance share units which ontinued employment over a specific period of time and the achievement of ancial targets over time. The weighted average exercise price does not take these its and performance share units into account.
ormation concerning our equity compensation plans, see the discussion in Note 2 pensation in the notes to the consolidated financial statements.

lationships and Related Transactions, and Director Independence

red by this Item is set forth under the headings Certain Relationships and Related Party orporate Governance in the definitive proxy materials to be filed in connection with our of Stockholders, which information is incorporated herein by reference.

ccountant Fees and Services

uired by this Item is set forth under the heading Ratification of Appointment of d Public Accounting Firm in the definitive proxy materials to be filed in connection with ing of Stockholders, which information is incorporated herein by reference.

PART IV

d Financial Statement Schedules

part of the report:

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

atement Schedules. All schedules are omitted because the required information is either t in material amounts or presented within the consolidated financial statements.

greement and Plan of Merger, dated July 24, 2006, by and among HCA Inc., Hercules olding II, LLC and Hercules Acquisition Corporation (filed as Exhibit 2.1 to the ompany s Current Report on Form 8-K filed July 25, 2006 (File No. 001-11239), and corporated herein by reference).

erger Agreement, dated November 22, 2010, by and among HCA Inc., HCA Holdings, c., and HCA Merger Sub LLC (filed as Exhibit 2.1 to the Company s Current Report on orm 8-K filed November 24, 2010 (File No. 000-18406), and incorporated herein by ference).

mended and Restated Certificate of Incorporation of the Company (filed as Exhibit 3.1 the Company s Registration Statement on Form S-1 (File No. 333-171369), and corporated herein by reference).

mended and Restated Bylaws of the Company (filed as Exhibit 3.1 to the Company s urrent Report on Form 8-K filed February 19, 2016 (File No. 001-11239), and corporated herein by reference).

pecimen Certificate for shares of Common Stock, par value $0.01 per share, of the ompany. (filed as Exhibit 4.1 to the Company s Registration Statement on Form S-1 ile No. 333-171369), and incorporated herein by reference).

ecurity Agreement, dated as of November 17, 2006, among HCA Inc., the subsidiary rantors party thereto and The Bank of New York, as collateral agent (filed as Exhibit 4.2 the Company s Current Report on Form 8-K filed November 24, 2006 (File No. 01-11239), and incorporated herein by reference).

edge Agreement, dated as of November 17, 2006, among HCA Inc., the subsidiary edgors party thereto and The Bank of New York, as collateral agent (filed as Exhibit 4.3 the Company s Current Report on Form 8-K filed November 24, 2006 (File No. 01-11239), and incorporated herein by reference).

13,550,000,000 1,000,000,000 Credit Agreement, dated as of November 17, 2006, nong HCA Inc., HCA UK Capital Limited, the lending institutions from time to time arties thereto, Banc of America Securities LLC, J.P. Morgan Securities Inc., Citigroup lobal Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint ad arrangers and joint bookrunners, Bank of America, N.A., as administrative agent, PMorgan Chase Bank, N.A. and Citicorp North America, Inc., as co-syndication agents d Merrill Lynch Capital Corporation, as documentation agent (filed as Exhibit 4.8 to the ompany s Current Report on Form 8-K filed November 24, 2006 (File No. 001-11239), d incorporated herein by reference).

mendment No. 1 to the Credit Agreement, dated as of February 16, 2007, among HCA
c., HCA UK Capital Limited, the lending institutions from time to time parties thereto,
ank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and
iticorp North America, Inc., as Co-Syndication Agents, Banc of America Securities,
LC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch,
erce, Fenner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche
ank Securities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill
ynch Capital Corporation, as documentation agent (filed as Exhibit 4.7(b) to the
ompany s Annual Report on Form 10-K for the fiscal year ended December 31, 2006
ile No. 001-11239), and incorporated herein by reference).

mendment No. 2 to the Credit Agreement, dated as of March 2, 2009, among HCA Inc.,
CA UK Capital Limited, the lending institutions from time to time parties thereto, Bank
f America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and Citicorp
orth America, Inc., as Co-Syndication Agents, Banc of America Securities, LLC,
P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce,
enner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche Bank
ecurities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill Lynch
apital Corporation, as documentation agent (filed as Exhibit 4.8(c) to the Company s
nnual Report on Form 10-K for the fiscal year ended December 31, 2008 (File No.
01-11239), and incorporated herein by reference).

mendment No. 3 to the Credit Agreement, dated as of June 18, 2009, among HCA Inc.,
CA UK Capital Limited, the lending institutions from time to time parties thereto, Bank
f America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and Citicorp
orth America, Inc., as Co-Syndication Agents, Banc of America Securities, LLC,
P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce,
enner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche Bank
ecurities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill Lynch
apital Corporation, as documentation agent (filed as Exhibit 4.1 to the Company s
urrent Report on Form 8-K filed June 22, 2009 (File No. 001-11239), and incorporated
erein by reference).

xtension Amendment No. 1 to the Credit Agreement, dated as of April 6, 2010, among
CA Inc., HCA UK Capital Limited, the lending institutions from time to time parties
ereto, Bank of America, N.A., as administrative agent and collateral agent (filed as
xhibit 10.1 to the Company s Current Report on Form 8-K filed April 8, 2010 (File No.
01-11239), and incorporated herein by reference).

mended and Restated Joinder Agreement No. 1, dated as of November 8, 2010, by and
mong each of the financial institutions listed as a Replacement-1 Revolving Credit
ender on Schedule A thereto, HCA Inc., Bank of America, N.A., as Administrative
gent and as Collateral Agent, and the other parties listed on the signature pages thereto
iled as Exhibit 4.1 to the Company s Quarterly Report on Form 10-Q for the quarter
nded September 30, 2010 (File No. 001-11239), and incorporated herein by reference).

estatement Agreement, dated as of May 4, 2011, by and among HCA Inc., HCA UK
apital Limited, the lenders party thereto and Bank of America, N.A., as administrative
gent and collateral agent to the Credit Agreement, dated as of November 17, 2006, as
mended on February 16, 2007, March 2, 2009, June 18, 2009, April 6, 2010 and
ovember 8, 2010 (filed as Exhibit 10.1 to the Company s Current Report on Form 8-K
led May 9, 2011, and incorporated herein by reference).

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).

Joinder Agreement, dated as of April 25, 2013, by and among HCA Inc., as borrower, 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 May 1, 2013, and incorporated herein by reference).

Joinder Agreement No. 2, dated as of May 3, 2013, by and among HCA Inc., as borrower, 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 May 9, 2013, and incorporated herein by reference).

Joinder Agreement No. 3, dated as of May 22, 2013, by and among HCA Inc., as borrower, 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 May 28, 2013, and incorporated herein by reference).

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).

Joinder Agreement No. 1, dated as of June 10, 2015, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed June 15, 2015, and incorporated herein by reference).

Security Agreement, dated as November 17, 2006, and amended and restated as of March 2, 2009, among the Company, the Subsidiary Grantors named therein and Bank of America, N.A., as Collateral Agent (filed as Exhibit 4.10 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008 (File No. 001-11239), and incorporated herein by reference).

Pledge Agreement, dated as of November 17, 2006, and amended and restated as of March 2, 2009, among the Company, the Subsidiary Pledgors named therein and Bank of America, N.A., as Collateral Agent (filed as Exhibit 4.11 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008 (File No. 001-11239), and incorporated herein by reference).

$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).

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).

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).

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).

General Intercreditor Agreement, dated as of November 17, 2006, between Bank of America, N.A., as First Lien Collateral Agent, and The Bank of New York, as Junior Lien Collateral Agent (filed as Exhibit 4.13(a) to the Company s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

Receivables Intercreditor Agreement, dated as of November 17, 2006, among Bank of America, N.A., as ABL Collateral Agent, Bank of America, N.A., as CF Collateral Agent and The Bank of New York, as Bonds Collateral Agent (filed as Exhibit 4.13(b) to the Company s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

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).

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).

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).

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).

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).

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).

Registration Rights Agreement, dated as of November 22, 2010, among HCA Holdings, Inc., Hercules Holding II, LLC and certain other parties thereto (filed as Exhibit 4.4 to the Company s Current Report on Form 8-K filed November 24, 2010 (File No. 000-18406), and incorporated herein by reference).

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).

Assignment and Assumption Agreement, dated as of February 10, 1994, between HCA-Hospital Corporation of America and the Company relating to the Registration Rights Agreement, as amended (filed as Exhibit 4.15 to the Company s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

Indenture, dated as of December 16, 1993 between the Company and The First National Bank of Chicago, as Trustee (filed as Exhibit 4.16(a) to the Company s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

First Supplemental Indenture, dated as of May 25, 2000 between the Company and Bank One Trust Company, N.A., as Trustee (filed as Exhibit 4.16(b) to the Company s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

Second Supplemental Indenture, dated as of July 1, 2001 between the Company and Bank One Trust Company, N.A., as Trustee (filed as Exhibit 4.16(c) to the Company s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

Third Supplemental Indenture, dated as of December 5, 2001 between the Company and The Bank of New York, as Trustee (filed as Exhibit 4.16(d) to the Company s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

Fourth Supplemental Indenture, dated as of November 14, 2006, between the Company and The Bank of New York, as Trustee (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed November 16, 2006 (File No. 001-11239), and incorporated herein by reference).

Form of 7.5% Debentures due 2023 (filed as Exhibit 4.17 to the Company s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

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).

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).

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).

Form of 7.69% Note due 2025 (filed as Exhibit 4.10 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2004 (File No. 001-11239), and incorporated herein by reference).

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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).

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).

7.50% Note due 2033 in the principal amount of $250,000,000 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed November 6, 2003 (File No. 001-11239), and incorporated herein by reference).

6.500% Note due 2016 in the principal amount of $500,000,000 (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed on February 8, 2006 (File No. 001-11239), and incorporated herein by reference).

6.500% Note due 2016 in the principal amount of $500,000,000 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed on February 8, 2006 (File No. 001-11239), and incorporated herein by reference).

Indenture, dated as of November 23, 2010, among HCA Holdings, Inc., Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent, and Law Debenture Trust Company of New York, as trustee (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed November 24, 2010 (File No. 000-18406), and incorporated herein by reference).

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).

Supplemental Indenture No. 1, dated as of August 1, 2011, among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed August 1, 2011, and incorporated herein by reference).

Supplemental Indenture No. 2, dated as of August 1, 2011, among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.3 to the Company s Current Report on Form 8-K filed August 1, 2011, and incorporated herein by reference).

Form of 7.50% Senior Notes Due 2022 (included in Exhibit 4.25).

Form of 6.50% Senior Secured Notes Due 2020 (included in Exhibit 4.26).

Supplemental Indenture No. 3, dated as of October 3, 2011, among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed October 3, 2011, and incorporated herein by reference).

Form of 8.00% Senior Notes Due 2018 (included in Exhibit 4.29).

Supplemental Indenture No. 4, dated as of February 16, 2012, among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed February 16, 2012, and incorporated herein by reference).

Form of 5.875% Senior Secured Notes due 2022 (included in Exhibit 4.31).

plemental Indenture No. 5, dated as of October 23, 2012, among HCA Inc., HCA dings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank t Company Americas, as paying agent, registrar and transfer agent (Unsecured Notes) d as Exhibit 4.3 to the Company s Current Report on Form 8-K filed October 23, 2012, incorporated herein by reference).

plemental Indenture No. 6, dated as of October 23, 2012, among HCA Inc., HCA dings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, strar and transfer agent (Secured Notes) (filed as Exhibit 4.4 to the Company s Current ort on Form 8-K filed October 23, 2012, and incorporated herein by reference).

n of 5.875% Senior Notes due 2023 (included in Exhibit 4.33).

n of 4.75% Senior Secured Notes due 2023 (included in Exhibit 4.34).

nture, dated as of December 6, 2012, among HCA Holdings, Inc., Law Debenture Trust pany of New York, as trustee, and Deutsche Bank Trust Company Americas, as strar, paying agent and transfer agent (filed as Exhibit 4.1 to the Company s Current ort on Form 8-K filed December 6, 2012, and incorporated herein by reference).

plemental Indenture No. 1, dated as of December 6, 2012, among HCA Holdings, Inc., Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company ricas, as registrar, paying agent and transfer agent (filed as Exhibit 4.2 to the Company s ent Report on Form 8-K filed December 6, 2012, and incorporated herein by reference).

n of 6.25% Senior Notes due 2021 (included in Exhibit 4.38).

plemental Indenture No. 7, dated as of March 17, 2014, among HCA Inc., HCA dings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, strar and transfer agent (filed as Exhibit 4.2 to the Company s Current Report on Form filed March 21, 2014, and incorporated herein by reference).

plemental Indenture No. 8, dated as of March 17, 2014, among HCA Inc., HCA dings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, strar and transfer agent (filed as Exhibit 4.3 to the Company s Current Report on Form filed March 21, 2014, and incorporated herein by reference).

n of 3.75% Senior Secured Notes due 2019 (included in Exhibit 4.40).

n of 5.00% Senior Secured Notes due 2024 (included in Exhibit 4.41).

itional Receivables Intercreditor Agreement, dated as of March 17, 2014, by and veen 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 n 8-K filed March 21, 2014, and incorporated herein by reference).

plemental Indenture No. 9, dated as of October 17, 2014, among HCA Inc., HCA dings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, strar and transfer agent (filed as Exhibit 4.2 to the Company s Current Report on Form filed October 17, 2014, and incorporated herein by reference).

plemental Indenture No. 10, dated as of October 17, 2014, among HCA Inc., HCA dings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, strar and transfer agent (filed as Exhibit 4.3 to the Company s Current Report on Form filed October 17, 2014, and incorporated herein by reference).

n of 4.25% Senior Secured Notes due 2019 (included in Exhibit 4.45).

n of 5.25% Senior Secured Notes due 2025 (included in Exhibit 4.46).

itional Receivables Intercreditor Agreement, dated as of October 17, 2014, by and ween 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 n 8-K filed October 17, 2014, and incorporated herein by reference).

plemental Indenture No. 11, dated as of January 16, 2015, among HCA Inc., HCA dings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank t Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 e Company s Current Report on Form 8-K filed January 16, 2015, and incorporated in by reference).

n of 5.375% Senior Notes due 2025 (included in Exhibit 4.50).

plemental Indenture No. 12, dated as of May 20, 2015, among HCA Inc., HCA dings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank t Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.4 e Company s Current Report on Form 8-K filed May 20, 2015, and incorporated herein eference).

plemental Indenture No. 13, dated as of November 13, 2015, among HCA Inc., HCA dings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank t Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 e Company s Current Report on Form 8-K filed November 13, 2015, and incorporated in by reference).

n of 5.875% Senior Notes due 2026 (included in Exhibit 4.53).

plemental Indenture No. 14, dated as of December 8, 2015, among HCA Inc., HCA dings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank t Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.4 e Company s Current Report on Form 8-K filed December 8, 2015, and incorporated in by reference).

A-Hospital Corporation of America Nonqualified Initial Option Plan (filed as Exhibit 4.6 e Company s Registration Statement on Form S-3 (File No. 33-52379), and incorporated in by reference).*

n of Indemnity Agreement with certain officers and directors (filed as Exhibit 10.3 to the pany s Registration Statement on Form S-4 (File No. 333-145054) and incorporated in by reference).

mbia/HCA Healthcare Corporation 2000 Equity Incentive Plan (filed as Exhibit A to Company s Proxy Statement for the Annual Meeting of Stockholders on May 25, 2000 No. 001-11239), and incorporated herein by reference).*

n of Non-Qualified Stock Option Award Agreement (Officers) (filed as Exhibit 99.2 to Company s Current Report on Form 8-K filed February 2, 2005 (File No. 001-11239), incorporated herein by reference).*

HCA 2005 Equity Incentive Plan (filed as Exhibit B to the Company s Proxy Statement or the Annual Meeting of Shareholders on May 26, 2005 (File No. 001-11239), and ncorporated herein by reference).*

Form of 2005 Non-Qualified Stock Option Agreement (Officers) (filed as Exhibit 99.2 to he Company s Current Report on Form 8-K filed October 6, 2005 (File No. 001-11239), nd incorporated herein by reference).*

Form of 2006 Non-Qualified Stock Option Award Agreement (Officers) (filed as Exhibit 10.2 to the Company s Current Report on Form 8-K filed February 1, 2006 (File No. 001-11239), and incorporated herein by reference).*

2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates s 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).*

First Amendment to 2006 Stock Incentive Plan for Key Employees of HCA Holdings, nc. 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 erein by reference).*

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 ncorporated herein by reference).*

Management Stockholder s Agreement dated November 17, 2006 (filed as Exhibit 10.12 o the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006 (File No. 001-11239), and incorporated herein by reference).

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).

Form of Option Rollover Agreement (filed as Exhibit 10.14 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006 (File No. 001-11239), nd incorporated herein by reference).*

Form of Stock Option Agreement (2007) (filed as Exhibit 10.15 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006 (File No. 001-11239), nd incorporated herein by reference).*

Form of Stock Option Agreement (2008) (filed as Exhibit 10.16 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2007 (File No. 001-11239), nd incorporated herein by reference).*

Form of Stock Option Agreement (2009) (filed as Exhibit 10.17 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008 (File No. 001-11239), nd incorporated herein by reference).*

Form of Stock Option Agreement (2010) (filed as Exhibit 10.20 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2009 (File No. 001-11239), nd incorporated herein by reference).*

Form of 2x Time Stock Option Agreement (filed as Exhibit 10.2 to the Company s Quarterly Report on Form 10-Q for the quarter ended September 30, 2009 (File No. 001-11239), and incorporated herein by reference).*

Form of Stock Option Agreement (2011) (filed as Exhibit 10.1 to the Company s Quarterly Report on Form 10-Q for the quarter ended September 30, 2011, and incorporated herein by reference).*

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).*

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).*

Form of Director Restricted Share Unit Agreement (Initial Award) Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.2 to the Company s Current Report on Form 8-K filed February 14, 2012, and incorporated herein by reference).*

Form of Director Restricted Share Unit Agreement (Annual Award) Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.3 to the Company s Current Report on Form 8-K filed February 14, 2012, and incorporated herein by reference).*

Retirement Agreement between the Company and Thomas F. Frist, Jr., M.D. dated as of January 1, 2002 (filed as Exhibit 10.30 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2001 (File No. 001-11239), and incorporated herein by reference).*

Amended and Restated HCA Supplemental Executive Retirement Plan, effective December 22, 2010, except as provided therein (filed as Exhibit 10.26 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2010 (File No. 001-11239), and incorporated herein by reference).*

Amended and Restated HCA Restoration Plan, effective December 22, 2010 (filed as Exhibit 10.27 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2010 (File No. 001-11239), and incorporated herein by reference).*

Employment Agreement dated November 16, 2006 (R. Milton Johnson) (filed as Exhibit 10.27(c) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006 (File No. 001-11239), and incorporated herein by reference).*

Employment Agreement dated November 16, 2006 (Samuel N. Hazen) (filed as Exhibit 10.27(d) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006 (File No. 001-11239), and incorporated herein by reference).*

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).*

Amendment to Employment Agreement effective February 9, 2011 (R. Milton Johnson) (filed as Exhibit 10.29(i) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2010 (File No. 001-11239), and incorporated herein by reference).*

Amendment to Employment Agreement effective February 9, 2011 (Samuel N. Hazen) (filed as Exhibit 10.29(j) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2010 (File No. 001-11239), and incorporated herein by reference).*

Second Amendment to Employment Agreement effective January 1, 2014 (R. Milton Johnson) (filed as Exhibit 10.28(g) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2013, and incorporated herein by reference).*

Third Amendment to Employment Agreement effective December 31, 2014 (R. Milton Johnson) (filed as Exhibit 10.23(h) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2014, and incorporated herein by reference).*

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, and incorporated herein by reference).*

Fourth Amendment to Employment Agreement effective January 27, 2016 (R. Milton Johnson).*

Third Amendment to Employment Agreement effective January 27, 2016 (Samuel N. Hazen).*

Amendment to Employment Agreement effective January 27, 2016 (Charles J. Hall).*

Form of Amended and Restated Limited Liability Company Agreement of Hercules Holding II, LLC dated as of November 17, 2006, among Hercules Holding II, LLC and certain other parties thereto (filed as Exhibit 10.3 to the Company s Registration Statement on Form 8-A, filed April 29, 2008 (File No. 000-18406) and incorporated herein by reference).

Form of Amendment to the Amended and Restated Limited Liability Company Agreement of Hercules Holding II, LLC (filed as Exhibit 10.32(a) to the Company s Registration Statement on Form S-1 (File No. 333-171369), and incorporated herein by reference).

Indemnification Priority and Information Sharing Agreement, dated as of November 1, 2009, between HCA Inc. and certain other parties thereto (filed as Exhibit 10.35 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2009 (File No. 001-11239), and incorporated herein by reference).

Assignment and Assumption Agreement, dated November 22, 2010, by and among HCA Inc., HCA Holdings, Inc. and HCA Merger Sub LLC (filed as Exhibit 10.1 to the Company s Current Report on Form 8-K filed November 24, 2010 (File No. 000-18406), and incorporated herein by reference).

Omnibus Amendment to Various Stock and Option Plans and the Management Stockholders Agreement, dated November 22, 2010 (filed as Exhibit 10.2 to the Company s Current Report on Form 8-K filed November 24, 2010 (File No. 000-18406), and incorporated herein by reference).*

Omnibus Amendment to Stock Option Agreements Issued Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as amended, effective February 16, 2011 (filed as Exhibit 10.38 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2010 (File No. 001-11239), and incorporated herein by reference).*

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).

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).

n of Director Restricted Share Unit Agreement Under the 2006 Stock Incentive Plan for Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as ibit 10.5 to the Company s Quarterly Report on Form 10-Q for the quarter ended ch 31, 2011, and incorporated herein by reference).*

A Holdings, Inc. 2012 Senior Officer Performance Excellence Program (filed as ibit 10.1 to the Company s Current Report on Form 8-K filed April 4, 2012, and rporated herein by reference).*

n of 2012 PEP Restricted Share Unit Agreement (Officers) (filed as Exhibit 10.2 to the npany s Current Report on Form 8-K filed April 4, 2012, and incorporated herein by rence).*

e Repurchase Agreement, dated as of October 28, 2013, by and between HCA Holdings, and Hercules Holding II, LLC (filed as Exhibit 10.1 to the Company s Current Report on n 8-K filed November 1, 2013, and incorporated herein by reference).

A Holdings, Inc. 2013 Senior Officer Performance Excellence Program (filed as Exhibit 4 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, , and incorporated herein by reference).*

n of 2013 PEP Restricted Share Unit Agreement (Officers) (filed as Exhibit 10.45 to the npany s Annual Report on Form 10-K for the fiscal year ended December 31, 2013, and rporated herein by reference).*

cutive Severance Policy (filed as Exhibit 10.46 to the Company s Annual Report on Form K for the fiscal year ended December 31, 2013, and incorporated herein by reference).*

n of Director Restricted Share Unit Agreement (Initial Award) under the 2006 Stock ntive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and ated (filed as Exhibit 10.48 to the Company s Annual Report on Form 10-K for the fiscal ended December 31, 2013, and incorporated herein by reference).*

n of Director Restricted Share Unit Agreement (Annual Award) under the 2006 Stock ntive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and ated (filed as Exhibit 10.49 to the Company s Annual Report on Form 10-K for the fiscal ended December 31, 2013, and incorporated herein by reference).*

A Holdings, Inc. 2014 Senior Officer Performance Excellence Program (filed as Exhibit to the Company s Current Report on Form 8-K filed April 3, 2014, and incorporated in by reference).*

n of 2014 PEP Restricted Share Unit Agreement (Officers) (filed as Exhibit 10.2 to the npany s Current Report on Form 8-K filed April 3, 2014, and incorporated herein by rence).*

A Holdings, Inc. Employee Stock Purchase Plan (filed as Exhibit 10.1 to the Company s ent Report on Form 8-K filed April 25, 2014, and incorporated herein by reference).*

e Repurchase Agreement, dated as of May 14, 2014, by and between HCA Holdings, and Hercules Holding II, LLC (filed as Exhibit 10.1 to the Company s Current Report on n 8-K filed May 20, 2014, and incorporated herein by reference).

e Repurchase Agreement, dated December 5, 2014, among HCA Holdings, Inc. and Capital Integral Investors 2006, LLC, BCIP TCV, LLC and Bain Capital Hercules stors, LLC (filed as Exhibit 10.1 to the Company s Current Report on Form 8-K filed ember 8, 2014, and incorporated herein by reference).

n of 2015 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated d as Exhibit 10.1 to the Company s Current Report on Form 8-K filed February 4, 2015, incorporated herein by reference).*

n of 2015 Performance Share Unit Award Agreement Under the 2006 Stock Incentive for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated d as Exhibit 10.47 to the Company s Annual Report on Form 10-K for the fiscal year d December 31, 2014, and incorporated herein by reference).*

A Holdings, Inc. 2015 Senior Officer Performance Excellence Program (filed as Exhibit to the Company s Current Report on Form 8-K filed April 2, 2015, and incorporated in by reference).*

n of 2015 PEP Restricted Share Unit Agreement (Officers) (filed as Exhibit 10.2 to the npany s Current Report on Form 8-K filed April 2, 2015, and incorporated herein by rence).*

n of Director Restricted Share Unit Agreement (Annual Award) Under the 2006 Stock ntive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and ated (filed as Exhibit 10.3 to the Company s Quarterly Report on Form 10-Q for the ter ended March 31, 2015, and incorporated herein by reference).*

n of 2016 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and ated.*

n of 2016 Performance Share Unit Award Agreement Under the 2006 Stock Incentive for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and ated.*

of Subsidiaries.

sent of Ernst & Young LLP.

ification of Chief Executive Officer Pursuant to Section 302 of the Sarbanes-Oxley Act 002.

ification of Chief Financial Officer Pursuant to Section 302 of the Sarbanes-Oxley Act 002.

ification Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the anes-Oxley Act of 2002.

following financial information from our annual report on Form 10-K for the year ended ember 31, 2015, filed with the SEC on February 26, 2016, formatted in Extensible ness Reporting Language (XBRL): (i) the consolidated balance sheets at December 31, 5 and 2014, (ii) the consolidated income statements for the years ended December 31, 5, 2014 and 2013, (iii) the consolidated comprehensive income statements for the years d December 31, 2015, 2014 and 2013, (iv) the consolidated statements of stockholders cit for the years ended December 31, 2015, 2014 and 2013, (v) the consolidated ements of cash flows for the years ended December 31, 2015, 2014 and 2013, and the notes to consolidated financial statements.

pensatory plan or arrangement.

SIGNATURES

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

HCA HOLDINGS, INC.

By: /s/ R. MILTON JOHNSON
R. Milton Johnson
Chairman and

Chief Executive Officer

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ements of the Securities Exchange Act of 1934, this report has been signed below by the behalf of the registrant and in the capacities and on the dates indicated.

	Title	Date
OHNSON	Chairman, Chief Executive Officer and	February 26, 2016
son	Director (Principal Executive Officer)	
THERFORD	Executive Vice President and Chief Financial Officer	February 26, 2016
erford	(Principal Financial Officer and	
	Principal Accounting Officer)	
ENNIS	Director	February 26, 2016
nis		
EPARLE	Director	February 26, 2016
Parle		
RIST III	Director	February 26, 2016
t III		
FRIST	Director	February 26, 2016
ist		
MONT	Director	February 26, 2016
nt		
GHT	Director	February 26, 2016
t		
MEYERS	Director	February 26, 2016

yers		
ICHELSON	Director	February 26, 2016
elson		
RILEY	Director	February 26, 2016
ey		
OWE	Director	February 26, 2016
ve		

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HCA HOLDINGS, INC.

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

T OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

s and Stockholders

ccompanying consolidated balance sheets of HCA Holdings, Inc. as of December 31, he related consolidated statements of income, comprehensive income, stockholders s for each of the three years in the period ended December 31, 2015. These financial onsibility of the Company s management. Our responsibility is to express an opinion on nts based on our audits.

its in accordance with the standards of the Public Company Accounting Oversight Board e standards require that we plan and perform the audit to obtain reasonable assurance ancial statements are free of material misstatement. An audit includes examining, on a pporting the amounts and disclosures in the financial statements. An audit also includes ng principles used and significant estimates made by management, as well as evaluating tatement presentation. We believe that our audits provide a reasonable basis for our

inancial statements referred to above present fairly, in all material respects, the position of HCA Holdings, Inc. at December 31, 2015 and 2014, and the consolidated s and its cash flows for each of the three years in the period ended December 31, 2015, . generally accepted accounting principles.

to the consolidated financial statements, the Company changed its presentation of debt sult of the adoption of FASB Accounting Standards Update 2015-03, *Simplifying the ssuance Costs*, and the Company changed the classification of all deferred tax assets and nt on the December 31, 2015 consolidated balance sheet as a result of the adoption of ndards Update 2015-17, *Balance Sheet Classification of Deferred Taxes*.

in accordance with the standards of the Public Company Accounting Oversight Board Holdings, Inc. s internal control over financial reporting as of December 31, 2015, based d in Internal Control Integrated Framework issued by the Committee of Sponsoring Treadway Commission (2013 framework), and our report dated February 26, 2016 ed opinion thereon.

HCA HOLDINGS, INC.

CONSOLIDATED INCOME STATEMENTS

OR THE YEARS ENDED DECEMBER 31, 2015, 2014 AND 2013

(Dollars in millions, except per share amounts)

	2015	2014	2013
rovision for doubtful accounts	**$ 43,591**	$ 40,087	$ 38,040
accounts	**3,913**	3,169	3,858
	39,678	36,918	34,182
	18,115	16,641	15,646
	6,638	6,262	5,970
ses	**7,103**	6,755	6,237
d incentive income	**(47)**	(125)	(216)
ffiliates	**(46)**	(43)	(29)
tization	**1,904**	1,820	1,753
	1,665	1,743	1,848
of facilities	**5**	(29)	10
f debt	**135**	335	17
	249	78	
	35,721	33,437	31,236
taxes	**3,957**	3,481	2,946
axes	**1,261**	1,108	950
	2,696	2,373	1,996
e to noncontrolling interests	**567**	498	440
e to HCA Holdings, Inc.	**$ 2,129**	$ 1,875	$ 1,556
re	**$ 5.14**	$ 4.30	$ 3.50
hare	**$ 4.99**	$ 4.16	$ 3.37
s per share calculations (in millions):			
	414.193	435.668	445.066
	426.721	450.352	461.913

mpanying notes are an integral part of the consolidated financial statements.

HCA HOLDINGS, INC.

ONSOLIDATED COMPREHENSIVE INCOME STATEMENTS

OR THE YEARS ENDED DECEMBER 31, 2015, 2014 AND 2013

(Dollars in millions)

	2015	2014	2013
	$ 2,696	$ 2,373	$ 1,996
ncome (loss) before taxes:			
lation	**(63)**	(74)	18
es) on available-for-sale securities	**1**	9	(7)
	30	(158)	134
in salaries and benefits	**32**	21	38
	62	(137)	172
f derivative financial instruments	**(36)**	(36)	3
in interest expense	**125**	132	131
	89	96	134
ncome (loss) before taxes	**89**	(106)	317
) related to other comprehensive income items	**31**	(40)	117
ncome (loss)	**58**	(66)	200
e	**2,754**	2,307	2,196
e attributable to noncontrolling interests	**567**	498	440
e attributable to HCA Holdings, Inc.	**$ 2,187**	$ 1,809	$ 1,756

mpanying notes are an integral part of the consolidated financial statements.

HCA HOLDINGS, INC.

CONSOLIDATED BALANCE SHEETS

DECEMBER 31, 2015 AND 2014

(Dollars in millions)

	2015	2014
ASSETS		
ents	**$ 741**	$ 566
ess allowance for doubtful accounts of $5,326 and $5,011	**5,889**	5,694
	1,439	1,279
		366
	1,163	1,025
	9,232	8,930
nt, at cost:		
	1,524	1,524
	12,533	11,941
	19,335	18,496
ss	**1,222**	1,019
	34,614	32,980
tion	**(19,600)**	(18,625)
	15,014	14,355
ce subsidiaries	**432**	494
vances to affiliates	**178**	165
angible assets	**6,731**	6,416
	1,157	620
	$ 32,744	$ 30,980
ITIES AND STOCKHOLDERS DEFICIT		
	$ 2,170	$ 2,035
	1,233	1,370
s	**1,880**	1,737
thin one year	**233**	338
	5,516	5,480
et debt issuance costs of $167 and $219	**30,255**	29,088
sks	**1,115**	1,078
r liabilities	**1,904**	1,832
par; authorized 1,800,000,000 shares; outstanding 2015 and 420,477,900 shares 2014	**4**	4
mprehensive loss	**(265)**	(323)
	(7,338)	(7,575)

ttributable to HCA Holdings, Inc.	**(7,599)**	(7,894)
ts	**1,553**	1,396
	(6,046)	(6,498)
	$ 32,744	$ 30,980

mpanying notes are an integral part of the consolidated financial statements.

HCA HOLDINGS, INC.

NSOLIDATED STATEMENTS OF STOCKHOLDERS DEFICIT

OR THE YEARS ENDED DECEMBER 31, 2015, 2014 AND 2013

(Dollars in millions)

	Equity (Deficit) Attributable to HCA Holdings, Inc.						
	Common Stock		Capital in Excess of Par Value	Accumulated Other Comprehensive Loss	Retained Deficit	Equity Attributable to Noncontrolling Interests	Total
	Shares (in millions)	Par Value					
1,							
	443.200	$ 4	$ 1,753	$ (457)	$ (10,960)	$ 1,319	$ (8,341)
e				200	1,556	440	2,196
n							
	(10.656)		(500)				(500)
ans	7.060		139				139
						(435)	(435)
			(6)		1	18	13
1,							
	439.604	4	1,386	(257)	(9,403)	1,342	(6,928)
e				(66)	1,875	498	2,307
n							
	(28.583)		(1,701)		(49)		(1,750)
ans	9.457		321				321
						(442)	(442)
			(6)		2	(2)	(6)
1,							
	420.478	4		(323)	(7,575)	1,396	(6,498)
e				**58**	**2,129**	**567**	**2,754**
n							
	(31.991)		**(505)**		**(1,892)**		**(2,397)**
ans	**10.252**		**523**				**523**
						(495)	**(495)**
						85	**85**
			(18)				**(18)**
1,							
	398.739	**$ 4**	**$**	**$ (265)**	**$ (7,338)**	**$ 1,553**	**$ (6,046)**

mpanying notes are an integral part of the consolidated financial statements.

HCA HOLDINGS, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

OR THE YEARS ENDED DECEMBER 31, 2015, 2014 AND 2013

(Dollars in millions)

	2015	2014	2013
rating activities:			
	$ 2,696	$ 2,373	$ 1,996
ile net income to net cash provided by operating			
cash from operating assets and liabilities:			
	(4,114)	(3,645)	(4,395)
accounts	**3,913**	3,169	3,858
et	**(201)**	(476)	(537)
ssets	**(314)**	(232)	(19)
accrued expenses	**192**	444	142
tization	**1,904**	1,820	1,753
	(160)	(83)	143
of facilities	**5**	(29)	10
f debt	**135**	335	17
	149	78	
ssuance costs	**35**	42	55
tion	**239**	163	113
	54	13	7
perating activities	**4,734**	4,448	3,680
sting activities:			
nd equipment	**(2,375)**	(2,176)	(1,943)
s and health care entities	**(351)**	(766)	(481)
nd health care entities	**73**	51	33
	63	(37)	36
	7	10	9
ing activities	**(2,583)**	(2,918)	(2,346)
ncing activities:			
debt	**5,548**	5,502	
g bank credit facilities	**150**	440	970
m debt	**(4,920)**	(5,164)	(1,662)
ntrolling interests	**(495)**	(442)	(435)
ce costs	**(50)**	(73)	(5)
on stock	**(2,397)**	(1,750)	(500)
	235	134	113
	(47)	(25)	(106)
cing activities	**(1,976)**	(1,378)	(1,625)

sh equivalents	**175**	152	(291)
ents at beginning of period	**566**	414	705
ents at end of period	**$ 741**	$ 566	$ 414
	$ 1,650	$ 1,758	$ 1,832
net	**$ 1,186**	$ 1,057	$ 694

mpanying notes are an integral part of the consolidated financial statements.

HCA HOLDINGS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

TING POLICIES

a holding company whose affiliates own and operate hospitals and related health care
filiates includes direct and indirect subsidiaries of HCA Holdings, Inc. and partnerships
which such subsidiaries are partners. At December 31, 2015, these affiliates owned and
s, 116 freestanding surgery centers and provided extensive outpatient and ancillary
gs, Inc. s facilities are located in 20 states and England. The terms Company, HCA, we,
d herein and unless otherwise stated or indicated by context, refer to HCA Holdings, Inc. and
facilities or hospitals refer to entities owned and operated by affiliates of HCA and the
ers to employees of affiliates of HCA.

ancial statements in conformity with generally accepted accounting principles requires
estimates and assumptions that affect the amounts reported in the consolidated financial
panying notes. Actual results could differ from those estimates.

ncial statements include all subsidiaries and entities controlled by HCA. We generally
ownership of a majority of the voting interest of an entity. The consolidated financial
ities in which we absorb a majority of the entity s expected losses, receive a majority of
esidual returns, or both, as a result of ownership, contractual or other financial interests in
intercompany transactions have been eliminated. Investments in entities we do not
we have a substantial ownership interest and can exercise significant influence, are
e equity method.

arious acquisitions and joint venture transactions. The accounts of these entities have
onsolidated financial statements for periods subsequent to our acquisition of controlling
of our expenses are cost of revenue items. Costs that could be classified as general and
our corporate office costs, which were $327 million, $285 million and $287 million for
ber 31, 2015, 2014 and 2013, respectively.

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

TING POLICIES (continued)

narily of net patient service revenues that are recorded based upon established billing for contractual adjustments. Revenues are recorded during the period the health care d, based upon the estimated amounts due from the patients and third-party payers. lude federal and state agencies (under the Medicare and Medicaid programs), managed cludes plans offered through the health insurance exchanges, beginning in 2014), companies and employers. Estimates of contractual allowances under managed care upon the payment terms specified in the related contractual agreements. Contractual aged care agreements are generally based upon predetermined rates per diagnosis, per ed fee-for-service rates. Revenues related to uninsured patients and uninsured copayment ts for patients who have health care coverage may have discounts applied (uninsured tual discounts). We also record a provision for doubtful accounts (based primarily on xperience) related to these uninsured accounts to record net self pay revenues at the expect to collect. Our revenues from third party payers, the uninsured and other for the 31, are summarized in the following table (dollars in millions):

	Years Ended December 31,					
	2015	**Ratio**	**2014**	**Ratio**	**2013**	**Ratio**
	$ 8,654	**21.8%**	$ 8,354	22.6%	$ 7,951	23.3%
	4,133	**10.4**	3,614	9.8	3,279	9.6
	1,705	**4.3**	1,848	5.0	1,480	4.3
	2,234	**5.6**	1,923	5.2	1,570	4.6
r insurers	**21,882**	**55.2**	20,066	54.4	18,654	54.6
l care and other	**1,295**	**3.3**	1,311	3.6	1,175	3.4
	39,903	**100.6**	37,116	100.6	34,109	99.8
	1,927	**4.9**	1,494	4.0	2,677	7.8
	1,761	**4.4**	1,477	4.0	1,254	3.7
sion for doubtful	**43,591**	**109.9**	40,087	108.6	38,040	111.3
accounts	**(3,913)**	**(9.9)**	(3,169)	(8.6)	(3,858)	(11.3)
	$ 39,678	**100.0%**	$ 36,918	100.0%	$ 34,182	100.0%

s governing the Medicare and Medicaid programs are complex and subject to ult, there is at least a reasonable possibility recorded estimates will change by a material mbursement amounts are adjusted in subsequent periods as cost reports are prepared and ements are determined (in relation to certain government programs, primarily Medicare, red to as the cost report filing and settlement process). The adjustments to estimated aid reimbursement amounts and disproportionate-share funds, which resulted in net related primarily to cost reports filed during the respective year were $48 million, $50 n in 2015, 2014 and 2013, respectively. The adjustments to estimated reimbursement ed in net increases to revenues, related primarily to cost reports filed during previous

, $53 million and $68 million in 2015, 2014 and 2013, respectively.

cal Treatment and Labor Act (EMTALA) requires any hospital participating in the conduct an appropriate medical screening examination of every person who presents to ency room for treatment and, if the individual is suffering from an emergency medical

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

TING POLICIES (continued)

ondition or make an appropriate transfer of the individual to a facility able to handle the ation to screen and stabilize emergency medical conditions exists regardless of an pay for treatment. Federal and state laws and regulations require, and our commitment to ent care encourages, us to provide services to patients who are financially unable to pay ices they receive. Because we do not pursue collection of amounts determined to qualify e not reported in revenues. Patients treated at hospitals for nonelective care, who have 0% of the federal poverty level, are eligible for charity care. The federal poverty level is deral government and is based on income and family size. We provide discounts to o do not qualify for Medicaid or charity care. In implementing the uninsured discount ttempt to provide assistance to uninsured patients to help determine whether they may other federal or state assistance or charity care. If an uninsured patient does not qualify uninsured discount is applied.

mpact of and trends related to uninsured accounts, we believe it is beneficial to view d discounts and the provision for doubtful accounts in combination, rather than each of these amounts for the years ended December 31, follows (dollars in millions):

	2015	Ratio	2014	Ratio	2013	Ratio
	$ 3,682	**20%**	$ 3,775	24%	$ 3,497	22%
	10,692	**59**	8,999	56	8,210	53
accounts	**3,913**	**21**	3,169	20	3,858	25
care	**$ 18,287**	**100%**	$ 15,943	100%	$ 15,565	100%

imated cost of total uncompensated care for the years ended December 31, follows

	2015	2014	2013
ries and benefits, supplies, other d depreciation and amortization)	**$ 33,760**	$ 31,478	$ 29,606
patient care costs as percentage of gross	**14.5%**	15.5%	16.3%
care	**$ 18,287**	$ 15,943	$ 15,565
-charges ratio	**14.5%**	15.5%	16.3%
uncompensated care	**$ 2,652**	$ 2,471	$ 2,537

re, uninsured discounts and the provision for doubtful accounts, as a percentage of the
rity care, uninsured discounts and the provision for doubtful accounts was 31.5% for
and 31.3% for 2013.

ts

ncial Accounting Standards Board (FASB) and the International Accounting Standards
converged, principles-based standard on revenue recognition. Companies across all
ve-step model to recognize revenue from customer contracts. The new standard, which

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

TING POLICIES (continued)

ts (continued)

xisting United States Generally Accepted Accounting Principles (US GAAP) and
Reporting Standards revenue recognition guidance, will require significant management
o changing the way many companies recognize revenue in their financial statements.
inally scheduled to become effective for public entities for annual and interim periods
mber 15, 2016. Early adoption was originally not to be permitted under US GAAP. In
decided to defer the effective date of the new revenue standard by one year, but will
t one year earlier if they choose (i.e., the original effective date). The FASB decided,
o various stakeholders and forthcoming exposure drafts, which amend the new revenue
l was necessary to provide adequate time to effectively implement the new standard. We
uate the effects the adoption of this standard will have on our financial statements and

SB issued Accounting Standards Update 2015-03, *Simplifying the Presentation of Debt*
U 2015-03), which requires that debt issuance costs be presented in the balance sheet as a
the carrying amount of that debt liability. The guidance in the new standard is limited to
t issuance costs. The recognition and measurement guidance for debt issuance costs are
015-03. We elected to adopt the new presentation in 2015, and the applicable prior year
lassified in accordance with ASU 2015-03.

e FASB issued Accounting Standards Update 2015-17, *Balance Sheet Classification of*
U 2015-17), which requires that all deferred tax assets and liabilities be classified as
nce sheet instead of separating deferred taxes into current and noncurrent amounts. The
this simplification could reduce cost and complexity without decreasing the usefulness
d to financial statement users. We elected to adopt the new presentation prospectively at
d the applicable prior period amounts were not retrospectively adjusted.

lents

lents include highly liquid investments with a maturity of three months or less when
nce subsidiaries cash equivalent investments in excess of the amounts required to pay
al liability claims during the next twelve months are not included in cash and cash
nds are not available for general corporate purposes. Carrying values of cash and cash
te fair value due to the short-term nature of these instruments.

nt system provides for daily investment of available balances and the funding of
hen presented for payment. Outstanding, but unpresented, checks totaling $517 million
ecember 31, 2015 and 2014, respectively, have been included in accounts payable in the
heets. Upon presentation for payment, these checks are funded through available cash
facility.

for services rendered from federal and state agencies (under the Medicare and Medicaid
care health plans, commercial insurance companies, employers and patients. We
s and receivables from government agencies are significant to our operations, but do not
ficant credit risks associated with these government agencies. We do not believe there

ant concentrations of revenues from any particular payer that would subject us to any
in the collection of our accounts receivable.

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

TING POLICIES (continued)

continued)

ance for doubtful accounts are made by means of the provision for doubtful accounts. s uncollectible are deducted from the allowance for doubtful accounts and subsequent . The amount of the provision for doubtful accounts is based upon management s l and expected net collections, business and economic conditions, trends in federal, state ealth care coverage and other collection indicators. The provision for doubtful accounts doubtful accounts relate to uninsured amounts due directly from patients (including tible amounts from patients who have health care coverage). Accounts are written off ternal and external collection efforts have been performed. We consider the return of an dary collection agency to be the culmination of our reasonable collection efforts and the ng off the account balance. Writeoffs are based upon specific identification and the es a writeoff adjustment entry to the patient accounting system. Management relies on eviews of historical writeoffs and recoveries at facilities that represent a majority of our s receivable (the hindsight analysis) as a primary source of information to utilize in bility of our accounts receivable. We perform the hindsight analysis quarterly, utilizing accounts receivable collection and writeoff data. At December 31, 2015 and 2014, the l accounts represented approximately 94.5% and 91.4%, respectively, of the $5.636 lion, respectively, patient due accounts receivable balance. The patient due accounts presents the estimated uninsured portion of our accounts receivable. The estimated Medicaid pending and uninsured discount pending accounts is included in our patient due alance. Days revenues in accounts receivable were 53 days, 54 days and 54 days at 014 and 2013, respectively. Changes in general economic conditions, patient accounting ons, payer mix, or federal or state governmental health care coverage could affect our receivable, cash flows and results of operations.

t the lower of cost (first-in, first-out) or market.

nt

computed using the straight-line method, was $1.880 billion in 2015, $1.798 billion in on in 2013. Buildings and improvements are depreciated over estimated useful lives m 10 to 40 years. Estimated useful lives of equipment vary generally from four to 10

stances or operating results indicate the carrying values of certain long-lived assets d used, might be impaired, we prepare projections of the undiscounted future cash flows m the use of the assets and their eventual disposition. If the projections indicate the not expected to be recoverable, such amounts are reduced to estimated fair value. Fair d based upon internal evaluations that include quantitative analyses of revenues and cash nt sales of similar facilities and independent appraisals.

e disposed of are reported at the lower of their carrying amounts or fair value less costs stimates of fair value are usually based upon recent sales of similar assets and market discussions with and offers received from potential buyers.

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

TING POLICIES (continued)

ce Subsidiaries

and 2014, the investments of our 100% owned insurance subsidiaries were classified as
s defined in Accounting Standards Codification (ASC) No. 320, *Investments Debt and*
re recorded at fair value. The investment securities are held for the purpose of providing
ay liability claims covered by the insurance subsidiaries. We perform quarterly
ual investment securities to determine whether declines in market value are temporary or
Our investment securities evaluation process involves multiple subjective judgments,
ting the outcome of future events, and requires a significant level of professional
ng whether an impairment has occurred. We evaluate, among other things, the financial
prospects of the issuer, conditions in the issuer s industry, liquidity of the investment,
or timing of expected future cash flows from the investment, and recent downgrades of
agency, to determine if, and when, a decline in the fair value of an investment below
dered other-than-temporary. The length of time and extent to which the fair value of the
n amortized cost and our ability and intent to retain the investment, to allow for any
of the investment s fair value, are important components of our investment securities

le Assets

tized but is subject to annual impairment tests. In addition to the annual impairment
views are performed whenever circumstances indicate a possible impairment may exist.
r goodwill is done at the reporting unit level. Reporting units are one level below the
l, and our impairment testing is performed at the operating division level. We compare
eporting unit assets to the carrying amount, on at least an annual basis, to determine if
irment. If the fair value of the reporting unit assets is less than their carrying value, we
e of the goodwill to its carrying value. If the fair value of the goodwill is less than its
airment loss is recognized. Fair value is estimated based upon internal evaluations of
t include quantitative analyses of market multiples, revenues and cash flows and reviews
lar facilities. No goodwill impairments were recognized during 2015, 2014 and 2013.
we have recognized total goodwill impairments of $102 million in the aggregate. None
rments related to evaluations of goodwill at the reporting unit level, as all recognized
during this period related to goodwill allocated to asset disposal groups.

l increased by $323 million related to acquisitions and declined by $2 million related to
ation and other adjustments. During 2014, goodwill increased by $542 million related to
ed by $13 million related to foreign currency translation and other adjustments.

ble intangible assets increased by $22 million related to acquisitions and declined by $22
zation, foreign currency translation and other adjustments. During 2014, identifiable
ed by $22 million due to amortization. Identifiable intangible assets are amortized over
g generally from three to 10 years. The gross carrying amount of identifiable intangible
, 2015 and 2014 was $184 million and $162 million, respectively, and accumulated
0 million and $38 million, respectively. During 2015, indefinite-lived identifiable
ed by $6 million related to a reclassification. During 2014, indefinite-lived identifiable
ased by $6 million related to acquisitions. The gross carrying amount of indefinite-lived
assets at December 31, 2015 and 2014 was $269 million and $275 million, respectively.
fiable intangible assets are not amortized but are subject to annual impairment tests, and

e performed whenever circumstances indicate a possible impairment may exist.

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

TING POLICIES (continued)

e amortized based upon the terms of the respective debt obligations. The gross carrying ance costs at December 31, 2015 and 2014 was $318 million and $375 million, mulated amortization was $151 million and $156 million, respectively. Amortization of ncluded in interest expense and was $35 million, $42 million and $55 million for 2015, tively.

Claims

nal liability risks were $1.465 billion and $1.407 billion at December 31, 2015 and 2014, ent portion of the reserves, $350 million and $329 million at December 31, 2015 and included in other accrued expenses in the consolidated balance sheets. Provisions for ssional liability risks were $344 million, $395 million and $314 million for 2015, 2014 , and are included in other operating expenses in our consolidated income statements. related to professional liability risks are based upon actuarially determined estimates. reserves represent the estimated ultimate net cost of all reported and unreported losses respective consolidated balance sheet dates. The reserves for unpaid losses and loss d using individual case-basis valuations and actuarial analyses. Those estimates are of trends in loss severity and frequency. The estimates are continually reviewed and ded as experience develops or new information becomes known. Adjustments to the unts are included in current operating results. The reserves for professional liability risks 2,700 individual claims at both December 31, 2015 and 2014 and estimates for laims. The time period required to resolve these claims can vary depending upon the r the claim is settled or litigated. During 2015 and 2014, $305 million and $268 million, yments were made for professional and general liability claims. The estimation of the eyond a year can vary significantly. Although considerable variability is inherent in reserve estimates, we believe the reserves for losses and loss expenses are adequate; no assurance the ultimate liability will not exceed our estimates.

ssional liability risks is insured through a 100% owned insurance subsidiary. Subject to a rence self-insured retention, our facilities are insured by our 100% owned insurance p to $50 million per occurrence. The insurance subsidiary has obtained reinsurance for isks generally above a retention level of $25 million per occurrence. We also maintain nsurance with unrelated commercial carriers for losses in excess of amounts insured by y.

red by reinsurance and excess insurance contracts are included in the reserves for sks, as we remain liable to the extent the reinsurers and excess insurance carriers do not under the reinsurance and excess insurance contracts. The amounts receivable under the include $35 million and $20 million at December 31, 2015 and 2014, respectively, ets, and $9 million and $5 million at December 31, 2015 and 2014, respectively, recorded s.

nstruments are employed to manage interest rate risks, and are not used for trading or We recognize our interest rate swap derivative instruments in the consolidated balance

anges in the fair value of derivatives are recognized periodically in stockholders equity,
er comprehensive income (loss), provided the derivative financial instrument qualifies

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

TING POLICIES (continued)

(continued)

ins and losses on derivatives designated as cash flow hedges, to the extent they are d in other comprehensive income (loss), and subsequently reclassified to earnings to he forecasted transactions when they occur. In the event the forecasted transaction to dge relates is no longer likely, the amount in other comprehensive income (loss) is and generally the derivative is terminated.

or received on interest rate swaps is recognized as interest expense. Gains and losses y termination of interest rate swap agreements are deferred and amortized as adjustments r the remaining term of the debt originally associated with the terminated swap.

ord Incentive Payments

ery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive hospitals and professionals that adopt and meaningfully use certified electronic health ology. We recognize income related to Medicare and Medicaid incentive payments using a el that is based upon when our eligible hospitals have demonstrated meaningful use of gy for the applicable period and the cost report information for the full cost report year final calculation of the incentive payment is available.

illion ($46 million Medicare and $1 million Medicaid), $125 million ($118 million on Medicaid) and $216 million ($183 million Medicare and $33 million Medicaid) of ord incentive income during the years ended December 31, 2015, 2014 and 2013, mber 31, 2014, we had $39 million (none at December 31, 2015) of deferred EHR ch represented initial incentive payments received for which EHR incentive income had

ts in Consolidated Entities

ncial statements include all assets, liabilities, revenues and expenses of less than 100% e control. Accordingly, we have recorded noncontrolling interests in the earnings and

unts have been reclassified to conform to the 2015 presentation.

ASED COMPENSATION

ive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and ncentive Plan), is designed to promote the long term financial interests and growth of the g and retaining management and other personnel and to motivate them to achieve long er the alignment of interests of participants with those of our stockholders through eased stock, or stock-based, ownership in the Company. Portions of the options, stock

ARs) and restricted share units (RSUs) granted under the Stock Incentive Plan vest

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

ASED COMPENSATION (continued)

ontinued)

inued employment over a specific period of time, and portions of the options, SARs and nance share units (PSUs) vest based both upon continued employment over a specific on the achievement of predetermined financial targets over time. We granted 1,746,300 nd 3,105,000 and 3,832,100 RSUs and PSUs under the Stock Incentive Plan during 2015 . At December 31, 2015, there were 15,291,000 stock options and SARs outstanding and were 25,386,000 shares available for future grants under the Stock Incentive Plan.

ase Plan

nc. Employee Stock Purchase Plan (ESPP) was approved by the stockholders of the April 2014 Annual Meeting with 12,000,000 shares of our common stock reserved for The ESPP provides our participating employees an opportunity to obtain shares of our scount (through payroll deductions over three-month periods). At December 31, 2015, common stock were reserved for issuance under the ESPP provisions. During 2015 and ecognized $8 million and $2 million of compensation expense related to the ESPP,

U and PSU Activity

stock option and SAR award is estimated on the grant date, using valuation models and assumptions indicated in the following table. Awards under the Stock Incentive Plan on continued employment (Time Stock Options and SARs and Time RSUs) and based yment and the achievement of certain financial targets (Performance Stock Options and e RSUs and PSUs). PSUs have a three-year cumulative earnings per share target, and the d can vary from zero (for actual performance of less than 80% of target) to two times the r actual performance of 120% or more of target). Each grant is valued as a single award equal to the average expected term of the component vesting tranches. We use historical and other factors to estimate the expected term of the options and SARs. The expected ed award is limited by the contractual term, and employee post-vesting termination d in the historical exercise behavior data.

recognized on the straight-line attribution method. The straight-line attribution method pensation expense recognized must at least equal the vested portion of the grant-date fair latility is derived using historical stock price information for our common stock and that ompanies. The risk-free interest rate is the approximate yield on United States Treasury ual to the expected share-based award life on the date of grant. The expected life is an of years a share-based award will be held before it is exercised.

	2015	2014	2013
rest rate	**1.59%**	1.96%	1.20%
tility	**36%**	37%	45%
in years	**6.25**	6.25	6.25
dend yield			

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

ASED COMPENSATION (continued)

U and PSU Activity (continued)

g Time Stock Options and SARs and Performance Stock Options and SARs activity 2013 is summarized below (share amounts in thousands):

	Time Stock Options and SARs	Performance Stock Options and SARs	Total Stock Options and SARs	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value (dollars in millions)
nding,						
	19,191	22,051	41,242	$ 11.56		
	2,432	2,432	4,864	37.49		
	(4,498)	(5,843)	(10,341)	8.49		
	(316)	(263)	(579)	25.50		
nding,						
	16,809	18,377	35,186	15.82		
	1,723	1,722	3,445	48.56		
	(3,322)	(5,234)	(8,556)	9.15		
	(159)	(121)	(280)	29.54		
nding,						
	15,051	14,744	29,795	21.39		
	1,746		1,746	69.16		
	(4,093)	(3,988)	(8,081)	12.77		
	(539)	(329)	(868)	32.59		
nding,						
	12,165	10,427	22,592	27.73	5.3 years	$ 950
sable,						
	7,648	7,643	15,291	$ 18.74	4.2 years	$ 780

fair values of stock options and SARs granted during 2015, 2014 and 2013 were $26.10, share, respectively. The total intrinsic value of stock options and SARs exercised in the 31, 2015 was $544 million. As of December 31, 2015, the unrecognized compensation ed stock options and SARs was $87 million.

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

ASED COMPENSATION (continued)

U and PSU Activity (continued)

g Time RSUs, Performance RSUs and PSUs activity during 2015, 2014 and 2013 is are amounts in thousands):

	Time RSUs	Performance RSUs	PSUs	Total RSUs and PSUs	Weighted Average Grant Date Fair Value
nding,					
	3,074	1,410		4,484	$ 27.03
	3,305	1,554		4,859	37.43
	(831)	(352)		(1,183)	27.30
	(449)	(213)		(662)	31.91
nding,					
	5,099	2,399		7,498	33.30
	2,603	1,229		3,832	48.53
	(1,423)	(692)		(2,115)	32.56
	(384)	(155)		(539)	38.30
nding,					
	5,895	2,781		8,676	39.89
	1,694		1,411	3,105	69.43
	(1,953)	(928)		(2,881)	37.61
	(334)	(113)	(40)	(487)	47.26
nding,					
	5,302	1,740	1,371	8,413	51.15

015, the unrecognized compensation cost related to RSUs and PSUs was $342 million.

TIONS AND DISPOSITIONS

$15 million to acquire a hospital, and we paid $336 million to acquire nonhospital health 2014, we paid $161 million to acquire three hospitals, and we paid $605 million to alth care entities. During 2013, we paid $146 million to acquire three hospitals, and we cquire nonhospital health care entities. Purchase price amounts have been allocated to ired and liabilities assumed based upon their respective fair values. The purchase price air value of identifiable net assets of these acquired entities aggregated $323 million, 3 million in 2015, 2014 and 2013, respectively. The consolidated financial statements nd operations of the acquired entities subsequent to the respective acquisition dates. The hese acquired entities on our results of operations for periods prior to the respective not significant.

ved proceeds of $73 million and recognized a net pretax loss of $5 million ($3 million
e sale of a hospital facility and sales of real estate and other investments. During 2014,
of $51 million and recognized a net pretax gain of $29 million ($18 million after tax)
hospital facility and sales of real estate and other investments. During 2013, we received
n and recognized a net pretax loss of $10 million ($7 million after tax) related to the sale
d sales of real estate and other investments.

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

TAXES

me taxes consists of the following (dollars in millions):

2015	2014	2013
$ 1,259	$ 916	$ 827
119	102	86
40	52	44
(163)	3	(53)
(27)	(5)	20
33	40	26
$ 1,261	$ 1,108	$ 950

ome taxes reflects $10 million and $9 million ($7 million and $6 million net of tax, t expense related to taxing authority examinations and $4 million ($3 million net of tax) t related to taxing authority examinations for the years ended December 31, 2015, 2014 . Our foreign pretax income was $178 million, $238 million and $187 million for the 31, 2015, 2014 and 2013, respectively.

federal statutory rate to the effective income tax rate follows:

	2015	2014	2013
	35.0%	35.0%	35.0%
of federal tax benefit	**1.6**	2.3	2.3
uncertain tax positions	**0.2**	0.5	0.5
come	**(0.1)**	(0.1)	(0.2)
	0.5	(0.5)	0.3
ate on income applicable to HCA Holdings, Inc.	**37.2**	37.2	37.9
noncontrolling interests from consolidated	**(5.3)**	(5.4)	(5.7)
ate on income before income taxes	**31.9%**	31.8%	32.2%

ns comprising the deferred tax assets and liabilities at December 31 follows (dollars in

2015		2014	
Assets	Liabilities	Assets	Liabilities

asset basis differences	**$**	**$ 222**	$	$ 226
sional liability and other risks	**443**		403	
	363		341	
	334		272	
	845	**820**	756	745
	$ 1,985	**$ 1,042**	$ 1,772	$ 971

5, federal and state net operating loss carryforwards (expiring in years 2018 through set future taxable income approximated $105 million and $144 million, respectively. ating loss carryforwards in any one year may be limited.

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

TAXES (continued)

mmarizes the activity related to our unrecognized tax benefits (dollars in millions):

	2015	2014
t January 1	**$ 503**	$ 445
s based on tax positions related to the current year	**13**	3
s for tax positions of prior years	**22**	72
ns for tax positions of prior years	**(45)**	(11)
nts		(1)
applicable statutes of limitations	**(6)**	(5)
t December 31	**$ 487**	$ 503

Examination Division began an audit of HCA Holding s Inc. s 2011 and 2012 federal e are also subject to examination by state and foreign taxing authorities.

ognized tax benefits was $554 million, including accrued interest of $73 million and that was recorded as reductions of the related deferred tax assets, as of December 31, 58 million and $13 million, respectively, as of December 31, 2014). Unrecognized tax n ($205 million as of December 31, 2014) would affect the effective rate, if recognized.

olution of any IRS, state and foreign tax disputes, the completion of examinations by gn taxing authorities, or the expiration of statutes of limitation for specific taxing eve it is reasonably possible that our liability for unrecognized tax benefits may or decrease within the next 12 months. However, we are currently unable to estimate the hange.

GS PER SHARE

nings per share using the weighted average number of common shares outstanding. We gs per share using the weighted average number of common shares outstanding plus the standing stock options, SARs, RSUs and PSUs, computed using the treasury stock 2014 and 2013, we repurchased 31,991,200 shares, 28,583,200 shares and 10,656,400 our common stock. The following table sets forth the computations of basic and diluted the years ended December 31, 2015, 2014 and 2013 (dollars and shares in millions, nts):

	2015	2014	2013
tributable to HCA	**$ 2,129**	$ 1,875	$ 1,556
rage common shares	**414.193**	435.668	445.066
ive incremental shares	**12.528**	14.684	16.847

or diluted earnings per share	**426.721**	450.352	461.913
share:			
s per share	**$ 5.14**	$ 4.30	$ 3.50
gs per share	**$ 4.99**	$ 4.16	$ 3.37

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

IENTS OF INSURANCE SUBSIDIARIES

rance subsidiaries investments at December 31 follows (dollars in millions):

	2015			
	Amortized Cost	Unrealized Amounts Gains	Losses	Fair Value
palities	**$ 428**	**$ 17**	**$ (1)**	**$ 444**
ds	**34**			**34**
	462	**17**	**(1)**	**478**
		4		**4**
	$ 462	**$ 21**	**$ (1)**	**482**
d as current assets				**(50)**
g value				**$ 432**

	2014			
	Amortized Cost	Unrealized Amounts Gains	Losses	Fair Value
palities	$ 477	$ 18	$ (1)	$ 494
ds	61			61
	538	18	(1)	555
	1	2		3
	$ 539	$ 20	$ (1)	558
d as current assets				(64)
g value				$ 494

15 and 2014, the investments of our insurance subsidiaries were classified as Changes in temporary unrealized gains and losses are recorded as adjustments to other (loss).

of investments in debt securities at December 31, 2015 were as follows (dollars in

	Amortized Cost	Fair Value
e year or less	$ 94	$ 94
one year through five years	162	166
five years through ten years	125	133
ten years	81	85
	$ 462	$ 478

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

IENTS OF INSURANCE SUBSIDIARIES (continued)

l maturity of the investments in debt securities at December 31, 2015 was 3.8 years, age scheduled maturity of 5.4 years. Expected and scheduled maturities may differ certain securities have the right to call, prepay or otherwise redeem such obligations l maturity date.

AL INSTRUMENTS

reements

interest rate swap agreements to manage our exposure to fluctuations in interest rates. ts involve the exchange of fixed and variable rate interest payments between two parties ional principal amounts and maturity dates. Pay-fixed interest rate swaps effectively d variable rate obligations to fixed interest rate obligations. The interest payments under ettled on a net basis. The net interest payments, based on the notional amounts in these match the timing of the related liabilities, for the interest rate swap agreements which as cash flow hedges. The notional amounts of the swap agreements represent amounts xchange of cash flows and are not our assets or liabilities. Our credit risk related to these ed low because the swap agreements are with creditworthy financial institutions.

ets forth our interest rate swap agreements, which have been designated as cash flow 1, 2015 (dollars in millions):

	Notional Amount	Maturity Date	Fair Value
rest rate swaps	$ 3,000	December 2016	$ (85)
rest rate swaps	1,000	December 2017	(25)

onths, we estimate $101 million will be reclassified from other comprehensive income pense.

f Operations

esents the effect of our interest rate swaps on our results of operations for the year ended ollars in millions):

Flow Hedging Relationships	Amount of Loss 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
	$ 22	Interest expense	$ 125

ntingent Features

with each of our derivative counterparties that contain a provision where we could be our derivative obligations if repayment of the underlying indebtedness is accelerated by efault on the indebtedness. As of December 31, 2015, we have not been required to post to these agreements. If we had breached these provisions at December 31, 2015, we uired to settle our obligations under the agreements at their aggregate, estimated 12 million.

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

ND LIABILITIES MEASURED AT FAIR VALUE

Codification 820, *Fair Value Measurements and Disclosures* (ASC 820) emphasizes t-based measurement, not an entity-specific measurement. Therefore, a fair value be determined based on the assumptions market participants would use in pricing the basis for considering market participant assumptions in fair value measurements, ASC e hierarchy that distinguishes between market participant assumptions based on market urces independent of the reporting entity (observable inputs classified within Levels 1) and the reporting entity s own assumptions about market participant assumptions lassified within Level 3 of the hierarchy).

quoted prices (unadjusted) in active markets for identical assets or liabilities. Level 2 r than quoted prices included in Level 1 that are observable for the asset or liability, ectly. Level 2 inputs may include quoted prices for similar assets and liabilities in active uts observable for the asset or liability (other than quoted prices), such as interest rates, es, and yield curves observable at commonly quoted intervals. Level 3 inputs are r the asset or liability, which are typically based on an entity s own assumptions, as there market activity. In instances where the determination of the fair value measurement is different levels of the fair value hierarchy, the level in the fair value hierarchy within alue measurement falls is based on the lowest level input significant to the fair value ntirety. Our assessment of the significance of a particular input to the fair value irety requires judgment, and considers factors specific to the asset or liability.

nts

tments are generally classified within Level 1 or Level 2 of the fair value hierarchy d using quoted market prices, broker or dealer quotations, or alternative pricing sources s of price transparency. Certain types of cash traded instruments are classified within lue hierarchy because they trade infrequently and therefore have little or no price ation of these securities involves management s judgment, after consideration of market e of market transparency, market liquidity and observable inputs.

nstruments

interest rate swap agreements to manage our exposure to fluctuations in interest rates. e instruments is determined using widely accepted valuation techniques, including analysis on the expected cash flows of each derivative. This analysis reflects the e derivatives, including the period to maturity, and uses observable market-based inputs, curves and implied volatilities. We incorporate credit valuation adjustments to reflect formance risk and the respective counterparty s nonperformance risk in the fair value instruments.

ed the majority of the inputs used to value our derivatives fall within Level 2 of the fair edit valuation adjustments associated with our derivatives utilize Level 3 inputs, such as redit spreads to evaluate the likelihood of default by us and our counterparties. We nce of the impact of the credit valuation adjustments on the overall valuation of our nd at December 31, 2015 and 2014, we determined the credit valuation adjustments were verall valuation of our derivatives.

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

ND LIABILITIES MEASURED AT FAIR VALUE (continued)

nstruments (continued)

summarize our assets and liabilities measured at fair value on a recurring basis as of and 2014, aggregated by the level in the fair value hierarchy within which those lars in millions):

	December 31, 2015 Fair Value Measurements Using			
	Fair Value	Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
ce subsidiaries:				
es	$ 444	$	$ 438	$ 6
	34	34		
	478	34	438	6
	4	4		
ce subsidiaries	482	38	438	6
d as current assets	(50)	(34)	(16)	
	$ 432	$ 4	$ 422	$ 6
come taxes and other liabilities)	$ 110	$	$ 110	$

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HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

ND LIABILITIES MEASURED AT FAIR VALUE (continued)

nstruments (continued)

	December 31, 2014 Fair Value Measurements Using			
	Fair Value	Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
ce subsidiaries:				
es	$ 494	$	$ 488	$ 6
	61	61		
	555	61	488	6
	3	3		
ce subsidiaries	558	64	488	6
d as current assets	(64)	(61)	(3)	
	$ 494	$ 3	$ 485	$ 6
come taxes and other liabilities)	$ 199	$	$ 199	$

ue of our long-term debt was $31.411 billion and $30.861 billion at December 31, 2015 , compared to carrying amounts, excluding net debt issuance costs, aggregating $30.655 illion, respectively. The estimates of fair value are generally based upon the quoted d market prices for similar issues of long-term debt with the same maturities.

ERM DEBT

rm debt at December 31, including related interest rates at December 31, 2015, follows

	2015	2014
ased revolving credit facility (effective interest rate of 1.8%)	**$ 3,030**	$ 2,880
ng credit facility		
an facilities (effective interest rate of 5.0%)	**5,639**	5,517
effective interest rate of 5.5%)	**11,100**	11,100
ebt (effective interest rate of 5.8%)	**634**	573
	20,403	20,070

s (effective interest rate of 6.5%)	**10,252**	9,575
s	**(167)**	(219)
e of 6.2 years, rates averaging 5.4%)	**30,488**	29,426
in one year	**233**	338
	$ 30,255	$ 29,088

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

ERM DEBT (continued)

5, we issued $500 million aggregate principal amount of 5.875% senior notes due 2026. eds for general corporate purposes.

15, we issued $1.000 billion aggregate principal amount of 5.875% senior notes due t proceeds to redeem all $1.000 billion aggregate principal amount of our outstanding due 2016. The pretax loss on retirement of debt related to this redemption was $10

e entered into a joinder agreement to retire certain of our existing senior secured term rom a new $1.400 billion senior secured term loan credit facility maturing on June 10, on retirement of debt was $3 million.

issued $1.600 billion aggregate principal amount of 5.375% senior notes due 2025. We o redeem all $1.525 billion aggregate principal amount of our outstanding 7 $^{3}/_{4}$% senior etax loss on retirement of debt related to this redemption was $122 million.

we issued $1.000 billion aggregate principal amount of 5.375% senior notes due 2025. the net proceeds to repay at maturity our $750 million aggregate principal amount of ed notes due 2015.

we issued $600 million aggregate principal amount of 4.25% senior secured notes due ion aggregate principal amount of 5.25% senior secured notes due 2025. During sed a portion of the proceeds from the October 2014 debt issuances to redeem all $1.400 ipal amount of our outstanding 7 $^{1}/_{4}$% senior secured notes due 2020. The pretax loss on ed to this redemption was $109 million.

ve issued $1.500 billion aggregate principal amount of 3.75% senior secured notes due on aggregate principal amount of 5.00% senior secured notes due 2024, and repaid at on aggregate principal amount of our outstanding 5.75% senior unsecured notes. During proceeds from the March 2014 debt issuance to redeem all $1.500 billion aggregate ur outstanding 8 $^{1}/_{2}$% senior secured notes due 2019 and all $1.250 billion aggregate r outstanding 7 $^{7}/_{8}$% senior secured notes due 2020. The pretax loss on retirement of debt tions was $226 million.

Facilities And Other Senior Secured Debt

the following senior secured credit facilities: (i) a $3.250 billion asset-based revolving ng on March 7, 2019 with a borrowing base of 85% of eligible accounts receivable, eserves and eligibility criteria ($3.030 billion outstanding at December 31, 2015) (the); (ii) a $2.000 billion senior secured revolving credit facility maturing on February 26, g at December 31, 2015 without giving effect to certain outstanding letters of credit); enior secured term loan A-5 facility maturing on June 10, 2020; (iv) a $2.319 billion an B-4 facility maturing on May 1, 2018; and (v) a $1.955 billion senior secured term

ring on March 31, 2017. We refer to the facilities described under (ii) through (v) above,
sh flow credit facility and, together with the ABL credit facility, the senior secured credit

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

ERM DEBT (continued)

Facilities And Other Senior Secured Debt (continued)

senior secured credit facilities bear interest at a rate equal to, at our option, either (a) a y reference to the higher of (1) the federal funds rate plus 0.50% or (2) the prime rate of) a LIBOR rate for the currency of such borrowing for the relevant interest period, plus, cable margin. The applicable margin for borrowings under the senior secured credit ed subject to attaining certain leverage ratios.

edit facilities contain a number of covenants that restrict, subject to certain exceptions, of our subsidiaries) ability to incur additional indebtedness, repay subordinated liens on assets, sell assets, make investments, loans or advances, engage in certain ates, pay dividends and distributions, and enter into sale and leaseback transactions. In ed to satisfy and maintain a maximum total leverage ratio covenant under the cash flow certain situations under the ABL credit facility, a minimum interest coverage ratio

consists of (i) $3.000 billion aggregate principal amount of 6.50% first lien notes due on aggregate principal amount of 5.875% first lien notes due 2022; (iii) $1.250 billion nount of 4.75% first lien notes due 2023; (iv) $1.500 billion aggregate principal amount es due 2019; (v) $2.000 billion aggregate principal amount of 5.00% first lien notes due n aggregate principal amount of 4.25% first lien notes due 2019; and (vii) $1.400 billion nount of 5.25% first lien notes due 2025. Capital leases and other secured debt totaled ber 31, 2015.

swap agreements to manage the variable rate exposure of our debt portfolio. At e had entered into effective interest rate swap agreements, in a total notional amount of r to hedge a portion of our exposure to variable rate interest payments associated with it facilities. The effect of the interest rate swaps is reflected in the effective interest rates credit facilities.

es

s consist of (i) $8.391 billion aggregate principal amount of senior notes with maturities 2033; (ii) an aggregate principal amount of $125 million medium-term notes maturing te principal amount of $736 million debentures with maturities ranging from 2023 to gate principal amount of $1.000 billion senior notes due 2021.

ion

edit facilities and senior secured notes are fully and unconditionally guaranteed by ng and future, direct and indirect, 100% owned material domestic subsidiaries that are iaries under our Indenture (the 1993 Indenture) dated December 16, 1993 (except for subsidiaries that only guarantee and pledge their assets under our ABL credit facility).

the ABL credit facility, and the guarantees of those obligations, are secured, subject to ther exceptions, by a first-priority lien on substantially all of the receivables of the arantor under such ABL credit facility (the Receivables Collateral).

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

ERM DEBT (continued)

ion (continued)

he cash flow credit facility and the guarantees of such obligations are secured, subject to er exceptions, by:

lien on the capital stock owned by HCA Inc., or by any U.S. guarantor, in each of their t-tier subsidiaries;

lien on substantially all present and future assets of HCA Inc. and of each U.S. er than (i) Principal Properties (as defined in the 1993 Indenture), (ii) certain other real l (iii) deposit accounts, other bank or securities accounts, cash, leaseholds, s and certain other exceptions; and

rity lien on certain of the Receivables Collateral.

otes and the related guarantees are secured by first-priority liens, subject to permitted ubsidiary guarantors assets, subject to certain exceptions, that secure our cash flow credit ity basis and are secured by second-priority liens, subject to permitted liens, on our and ors assets that secure our ABL credit facility on a first-priority basis and our other cash a second-priority basis.

n debt in years 2017 through 2020, excluding amounts under the ABL credit facility, are billion, $2.227 billion and $4.125 billion, respectively.

GENCIES AND LEGAL CLAIM COSTS

y regulated and litigious industry. As a result, various lawsuits, claims and legal and have been and can be expected to be instituted or asserted against us. We are subject to axes and related interest and penalties. We are also subject to claims and suits arising in of business, including claims for personal injuries or wrongful restriction of, or ysicians staff privileges. In certain of these actions the claimants may seek punitive hich may not be covered by insurance. The resolution of any such lawsuits, claims or roceedings could have a material, adverse effect on our results of operations, financial

ions, Claims and Litigation

s are subject to numerous investigations by various governmental agencies. Further, e Claims Act (FCA), private parties have the right to bring *qui tam*, or whistleblower, s that submit false claims for payments to, or improperly retain overpayments from, the tes have adopted similar state whistleblower and false claims provisions. Certain of our ve received, and from time to time, other facilities may receive, government inquiries ect to investigation by, federal and state agencies. Depending on whether the underlying

ure inquiries or investigations could be considered systemic, their resolution could have ect on our results of operations, financial position or liquidity.

l Division of the U.S. Attorney s Office in Miami requested information on reviews necessity of interventional cardiology services provided at any Company facility (other he Company cooperated with the government s request and produced medical records lar reviews at eight hospitals, located primarily in Florida. The Company subsequently

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

GENCIES AND LEGAL CLAIM COSTS (continued)

ions, Claims and Litigation (continued)

rnment s inquiries related to three *qui tam* actions. On February 24, 2015, the United or the Southern District of Florida unsealed a *qui tam* action that had been filed under 2012 and alleged particular FCA violations relating to two specific facilities that were the Miami U.S. Attorney s Office investigation. On January 30, 2015, the U.S. Attorney s District Court a formal notice that the Department of Justice declined to intervene in that bsequently dismissed this *qui tam* action without prejudice. A second *qui tam* action s was unsealed on March 12, 2015 and dismissed without prejudice by the relator on rd *qui tam* action, which made allegations relating to another facility that was a subject orney s Office inquiry, was unsealed in December 2015 after the government formally The Company settled this *qui tam* action on December 17, 2015 with a payment of olve claims, penalties and attorneys fees. It is the Company s understanding that the *qui tam* actions and settlement of the third resolves the investigation of which the e Company in July 2012.

e UK Competition and Markets Authority (Authority) issued a final report on its vate health care market in London. It concluded, among other things, that many private ompetition in central London, and that there are high barriers to entry. As part of its e Authority ordered HCA to sell either: (a) its London Bridge and Princess Grace Vellington Hospital, including the Platinum Medical Centre. It also imposed other n HCA and other private health care providers, including: regulation of incentives to ncreased access to information about fees and performance; and restrictions on future private providers and National Health Service private patient units. HCA disagrees with sment of the competitive conditions for hospitals in London, as well as its proposed d appealed the decision to the Competition Appeal Tribunal. The Competition Appeal ertain of the Authority s findings and sent the matter back to the Authority for further mber 2015, following consideration of additional evidence, the Authority issued a hat again found there were adverse effects on competition in the private hospital market e Provisional Decision modified some of the Authority s earlier factual conclusions and mitigating factors for some of the effects noted in the prior decision. The Provisional ome additional potential remedies, and the Authority is now consulting on remedies for ve effects. A Provisional Decision on Remedies is expected during the first quarter of port anticipated in May 2016. If dissatisfied with the Final Report, HCA will have an o the Competitive Appeal Tribunal.

Litigation

a shareholder action, Schuh v. HCA Holdings, Inc. et al., was filed in the United States Middle District of Tennessee seeking monetary relief. The case sought to include as a acquired the Company s stock pursuant or traceable to the Company s Registration onnection with the March 9, 2011 initial public offering. The lawsuit asserted a claim e Securities Act of 1933 against the Company, certain members of the board of directors, rs in the offering. It further asserted a claim under Section 15 of the Securities Act of e members of the board of directors. The action alleged various deficiencies in the es in the Registration Statement. Subsequently, two additional class action complaints, ings, Inc. et al. and Daniels v. HCA Holdings, Inc. et al., setting forth substantially substantially the same defendants were filed in the same federal court on November 16,

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HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

GENCIES AND LEGAL CLAIM COSTS (continued)

Litigation (continued)

ll three of the cases were consolidated. On May 3, 2012, the court appointed New Trucking Industry Pension Fund as Lead Plaintiff for the consolidated action. On plaintiff filed an amended complaint asserting claims under Sections 11 and 12(a)(2) of 1933 against the Company, certain members of the board of directors, and certain ering. It further asserts a claim under Section 15 of the Securities Act of 1933 against the oard of directors and Hercules Holding II, LLC, a majority shareholder of the Company al public offering. The consolidated complaint alleges deficiencies in the Company s stration Statement and Prospectus relating to: (1) the accounting for the Company s 2006 010 reorganization; (2) the Company s failure to maintain effective internal controls ng for such transactions; and (3) the Company s Medicare and Medicaid revenue growth nd other defendants moved to dismiss the amended complaint on September 11, 2012. motion in part on May 28, 2013. The action proceeded to discovery on the remaining motion for class certification was granted on September 22, 2014. The court certified a persons that acquired HCA stock on or before October 28, 2011 (the date of the lawsuit) ration Statement issued in connection with the March 9, 2011 initial public offering. A appeals to hear an immediate appeal of this ruling was denied. Following the close of nd defendants each filed motions for summary judgment and to strike certain of the escribed below, a preliminary agreement to settle the shareholder class actions has been

ve described consolidated shareholder class action, on December 8, 2011, a federal action, Sutton v. Bracken, et al., putatively initiated in the name of the Company, was ates District Court for the Middle District of Tennessee against certain officers and ectors of the Company seeking monetary relief. The action alleges breaches of fiduciary fficers and directors in connection with the accounting and earnings claims set forth in actions described above. Setting forth substantially similar claims against substantially an additional federal derivative action, Schroeder v. Bracken, et al., was filed in the Court for the Middle District of Tennessee on December 16, 2011, and a state derivative ken, et al., was filed in Tennessee state court in the Davidson County Circuit Court on he federal derivative actions were consolidated in the Middle District of Tennessee and pments in the shareholder class actions. The state derivative action had also been stayed s in the shareholder class actions, but that stay has expired. The plaintiff in the state sequently filed an amended complaint on September 9, 2013 that added additional e shareholder class actions. On September 24, 2013, an additional state derivative action, et al., was filed in Tennessee state court in the Davidson County Circuit Court. This rd of directors has been consolidated with the earlier filed state derivative action. The idated action filed a consolidated complaint on December 4, 2013. The Company filed a he state derivative action pending developments in the class action, but the court did not

5, the Company reached a preliminary agreement in principle to settle the *Schuh* on and the *Sutton, Schroeder* and *Bagot* derivative actions. The preliminary settlement for a resolution of all of the pending claims in the shareholder class action and the ut any admission or concession of wrongdoing by the Company or the other defendants, on, among other things, execution of final settlement documents, successful negotiation ary terms, approval by the Company s Board of Directors, notification to the *Schuh* d preliminary and final approval of the settlements by the state and federal courts in

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

GENCIES AND LEGAL CLAIM COSTS (continued)

Litigation (continued)

approval to the shareholder class action settlement on January 13, 2016, provided for set a hearing for final approval of the settlement for April 11, 2016. The state court in ry approval to the settlement of the derivative claims on January 28, 2016 and set a val on April 12, 2016.

f the settlement in the *Schuh* case include a payment by HCA of $215 million in return l claims against all defendants, including the Company, its officers and directors, the ules Holding II, LLC, a majority shareholder of the Company at the time of the initial erms of the settlement of the derivative cases include receipt by the Company of $19 ce policies covering the claims asserted in the derivative cases, certain corporate nd agreement by the Company to pay attorneys fees in the aggregate amount of $5.5 leases of all claims against all defendants. In the fourth quarter of 2015, HCA recorded of expected insurance recoveries, of $120 million for the expected settlements of the derivative cases and related costs.

tion

Health Care Foundation of Greater Kansas City, a nonprofit health foundation, filed suit e Circuit Court of Jackson County, Missouri and alleged that HCA did not fund the level and uncompensated care agreed to in connection with HCA s purchase of hospitals from 003. The central issue in the case was whether HCA s construction of new hospitals 50 million five-year capital commitment. In addition, the plaintiff alleged that HCA did apital expenditures in a timely fashion. On January 24, 2013, the court ruled in favor of ed at least $162 million. The court also ordered a court-supervised accounting of HCA s as well as of expenditures on charity and uncompensated care during the ten years . The court also indicated it would award plaintiff attorneys fees, which the parties have nately $12 million for the trial phase. HCA recorded $175 million of legal claim costs in 012 related to this ruling, and consistent with the judge s order, has been accruing interest annum. On April 25, 2014, the parties stipulated to an additional $78 million shortfall xpenditures issue. HCA recorded $78 million of legal claims costs in the first quarter of stipulation, and accrued interest on that amount at 9% per annum. Pursuant to the terms parties have preserved their respective rights to contest the judge s underlying ruling, ns in the trial court or on appeal. On February 9, 2015, the parties reached an agreement ir dispute relating to charity and uncompensated care for $15 million. The foundation is nount, net of attorneys fees, for charitable activities in the Kansas City area. The parties tional amount for attorneys fees for the plaintiff for the accounting phase of the case. rial motions, on which the court ruled on October 21, 2015. The court denied defendants rt change its rulings on liability and damages related to the capital expenditures issue. plaintiff s motion for an award of additional pre-judgment interest, but did not specify arded was simple interest or would be compounded. The court subsequently concluded compounded, and on December 9, 2015, the court entered judgment in the case in the ion, with interest continuing to accrue at 9% per annum, compounded annually, from 9, 2015, until the matter is resolved. At December 31, 2015, the Company had an 38 million for the damages, costs and interest related to this litigation. On January 15, ed a Notice of Appeal in the Missouri Court of Appeals for the Western District. The e appeal has not yet been set.

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

ce buildings and certain equipment under operating lease agreements. Commitments
ble operating leases for each of the next five years and thereafter are as follows (dollars

he Year Ended December 31,	
	$ 283
	267
	216
	182
	149
eafter	976
	2,073
sublease income	(18)
	$ 2,055

L STOCK

ated certificate of incorporation authorizes the Company to issue up to 1,800,000,000
ck, and our amended and restated by-laws set the number of directors constituting the
he Company at not less than three members, the exact number to be determined from
ion adopted by the affirmative vote of a majority of the total number of directors then in

nsactions

, May 2015 and February 2015, our board of directors authorized share repurchase
0 billion, $1.0 billion and $1.0 billion, respectively, of our outstanding common stock.
e Company entered into an agreement to repurchase 3,806,500 shares of its common
ed by affiliates of Bain Capital Investors, LLC (the Bain Entities) and certain charitable
ived shares of common stock as charitable contributions from certain partners and other
n Entities at a purchase price of $77.26 per share, the closing price of the Company s
e New York Stock Exchange on April 17, 2015, less a discount of 1% (the Share
are Repurchase was made pursuant to the February 2015 authorization. During 2015, we
00 shares of our common stock at an average price of $74.62 per share through market
in total repurchases pursuant to the October 2015, May 2015 and February 2015
991,200 shares of our common stock at an average price of $74.93 per share. At
e had no repurchase authorization remaining under the $1.0 billion May 2015 and $1.0
authorizations and $2.603 billion of repurchase authorization available under the $3.0
uthorization.

4, the Company entered into an agreement to repurchase 7,612,900 shares of its common
ed by affiliates of Bain Capital Investors, LLC at a purchase price of $73.26 per share,
Company s common stock on the New York Stock Exchange on December 5, 2014, less

e repurchase was made pursuant to the Company s $1.0 billion repurchase program
ny s board of directors in October 2014 which was completed during the fourth quarter
ket purchases of an additional 6,415,700 shares of our common stock at an average
96 per share (14,028,600 total shares repurchased at an average purchase price of $71.29

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

L STOCK (continued)

nsactions (continued)

rtain of the Company s stockholders, consisting principally of affiliates of, or funds pital Partners, LLC and Kohlberg Kravis Roberts & Co. (the Selling Stockholders), sold ondary offering, 15 million shares from their holdings of the Company s common stock. ders received all the proceeds from this offering. Concurrent with the closing of the e repurchased approximately $750 million of additional shares (14,554,600 shares) of m the Selling Stockholders at the net offering price ($51.53 per share).

13, the Selling Stockholders sold, in an underwritten secondary offering, 30 million dings of the Company s common stock. The Selling Stockholders received all of the ffering. Concurrent with the closing of the secondary offering, we repurchased illion of additional shares (10,656,400 shares) of our common stock from the Selling offering price ($46.92 per share).

YEE BENEFIT PLANS

ory, defined contribution benefit plans that are available to employees who meet certain ts. Certain of the plans require that we match specified percentages of participant rtain maximum levels (generally, 100% of the first 3% to 9%, depending upon years of mpensation deferred by participants). The cost of these plans totaled $432 million for 2014 and $374 million for 2013. Our contributions are funded periodically during each

ontributory, nonqualified Restoration Plan to provide certain retirement benefits for igibility for the Restoration Plan is based upon earning eligible compensation in excess Wage Base and attaining 1,000 or more hours of service during the plan year. Company s account balances (the Restoration Plan is not funded) depend upon participants f vesting service and certain IRS limitations related to the HCA 401(k) plan. Benefits n was $20 million for 2015, $31 million for 2014 and $29 million for 2013. Accrued nder this plan totaled $164 million at December 31, 2015 and $156 million at

emental Executive Retirement Plan (SERP) for certain executives (the SERP is not esigned to ensure that upon retirement the participant receives the value of a prescribed combination of the SERP and our other benefit plans. Benefits expense under the plan 015, $31 million for 2014 and $43 million for 2013. Accrued benefits liabilities under million at December 31, 2015 and $231 million at December 31, 2014.

benefit pension plans which resulted from certain hospital acquisitions in prior years. r these plans was $25 million for 2015, $13 million for 2014, and $37 million for 2013. lities under these plans totaled $131 million at December 31, 2015 and $172 million at

NT AND GEOGRAPHIC INFORMATION

of business, which is operating hospitals and related health care entities. We operate in
ganized groups: the National and American Groups. At December 31, 2015, the National
pitals located in Alaska, California, Florida, southern Georgia, Idaho, Indiana, northern

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NT AND GEOGRAPHIC INFORMATION (continued)

w Hampshire, South Carolina, Utah and Virginia, and the American Group included 78 lorado, northern Georgia, Kansas, southern Kentucky, Louisiana, Mississippi, Missouri, and Texas. We also operate six hospitals in England, and these facilities are included in r group.

TDA is defined as income before depreciation and amortization, interest expense, losses cilities, losses on retirement of debt, legal claim costs, income taxes and net income ntrolling interests. We use adjusted segment EBITDA as an analytical indicator for g resources to geographic areas and assessing their performance. Adjusted segment y used as an analytical indicator within the health care industry, and also serves as a apacity and debt service ability. Adjusted segment EBITDA should not be considered as performance under generally accepted accounting principles, and the items excluded nt EBITDA are significant components in understanding and assessing financial e adjusted segment EBITDA is not a measurement determined in accordance with counting principles and is thus susceptible to varying calculations, adjusted segment d, may not be comparable to other similarly titled measures of other companies. The ons of our revenues, equity in earnings of affiliates, adjusted segment EBITDA, tization, assets and goodwill and other intangible assets are summarized in the following ns):

	For the Years Ended December 31,		
	2015	**2014**	**2013**
up	**$ 18,756**	$ 17,335	$ 15,975
oup	**18,872**	17,532	16,487
l other	**2,050**	2,051	1,720
	$ 39,678	$ 36,918	$ 34,182
ings of affiliates:			
up	**$ (7)**	$ (15)	$ (9)
oup	**(32)**	(31)	(24)
l other	**(7)**	3	4
	$ (46)	$ (43)	$ (29)
ment EBITDA:			
up	**$ 4,271**	$ 3,848	$ 3,303
oup	**4,207**	4,025	3,662
l other	**(563)**	(445)	(391)
	$ 7,915	$ 7,428	$ 6,574
and amortization:			
up	**$ 769**	$ 749	$ 718

up	**886**	840	835
l other	**249**	231	200
	$ 1,904	$ 1,820	$ 1,753

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NT AND GEOGRAPHIC INFORMATION (continued)

	For the Years Ended December 31,		
	2015	**2014**	**2013**
ment EBITDA	**$ 7,915**	$ 7,428	$ 6,574
and amortization	**1,904**	1,820	1,753
se	**1,665**	1,743	1,848
) on sales of facilities	**5**	(29)	10
rement of debt	**135**	335	17
osts	**249**	78	
e income taxes	**$ 3,957**	$ 3,481	$ 2,946

	December 31,		
	2015	**2014**	**2013**
up	**$ 11,332**	$ 10,590	$ 10,208
oup	**15,240**	15,091	13,911
l other	**6,172**	5,299	4,475
	$ 32,744	$ 30,980	$ 28,594

	National Group	**American Group**	**Corporate and Other**	**Total**
angible assets:				
31, 2012	$ 1,035	$ 4,189	$ 315	$ 5,539
	68	13	297	378
lation, amortization and other	1	(12)	(3)	(14)
31, 2013	1,104	4,190	609	5,903
	72	428	48	548
lation, amortization and other	(6)	(4)	(25)	(35)
31, 2014	1,170	4,614	632	6,416
	318	**27**		**345**
lation, amortization and other	**(7)**	**(3)**	**(20)**	**(30)**
31, 2015	**$ 1,481**	**$ 4,638**	**$ 612**	**$ 6,731**

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

COMPREHENSIVE LOSS

cumulated other comprehensive loss are as follows (dollars in millions):

	Unrealized Gains on Available-for-Sale Securities	Foreign Currency Translation Adjustments	Defined Benefit Plans	Change in Fair Value of Derivative Instruments	Total
31, 2012	$ 11	$ (1)	$ (196)	$ (271)	$ (457)
vailable-for-sale					
come tax benefit	(4)				(4)
lation adjustments,					
xes		12			12
net of $50 of income					
			84		84
f derivative					
of income taxes				2	2
to operations from					
ncome, net of $14					
income tax benefits			24	82	106
31, 2013	7	11	(88)	(187)	(257)
ailable-for-sale					
income taxes	6				6
lation adjustments,					
benefit		(47)			(47)
net of $59 income					
			(99)		(99)
f derivative					
income tax benefit				(23)	(23)
to operations from					
ncome, net of $8 and					
me tax benefits			13	84	97
31, 2014	13	(36)	(174)	(126)	(323)
ailable-for-sale					
income taxes					
lation adjustments,					
benefit		**(38)**			**(38)**
net of $11 of income					
			19		**19**
f derivative					
income tax benefit				**(22)**	**(22)**
to operations from					
ncome, net of $12					
income tax benefits			**20**	**79**	**99**
31, 2015	**$ 13**	**$ (74)**	**$ (135)**	**$ (69)**	**$ (265)**

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

ED EXPENSES AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

crued expenses at December 31 follows (dollars in millions):

	2015	2014
nal liability risks	**$ 350**	$ 329
	365	357
er than income	**277**	255
	888	796
	$ 1,880	$ 1,737

for the allowance of doubtful accounts follows (dollars in millions):

	Balance at Beginning of Year	Provision for Doubtful Accounts	Accounts Written off, Net of Recoveries	Balance at End of Year
r doubtful accounts:				
ecember 31, 2013	$ 4,846	$ 3,858	$ (3,216)	$ 5,488
ecember 31, 2014	5,488	3,169	(3,646)	5,011
ecember 31, 2015	5,011	3,913	(3,598)	5,326

MENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND RAL-RELATED INFORMATION

wned direct subsidiary of HCA Holdings, Inc. On November 23, 2010, HCA Holdings, ion aggregate principal amount of 7 $^{3}/_{4}$% senior unsecured notes due 2021, which were g May 2015. On December 6, 2012, HCA Holdings, Inc. issued $1.000 billion aggregate 25% senior unsecured notes due 2021. These notes are senior unsecured obligations and any of our subsidiaries.

dit facilities and senior secured notes described in Note 9 are jointly and severally, and lly guaranteed by substantially all existing and future, direct and indirect, 100% owned idiaries that are Unrestricted Subsidiaries under our Indenture dated December 16, 1993 ecial purpose subsidiaries that only guarantee and pledge their assets under our ABL

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

MENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND RAL-RELATED INFORMATION (continued)

lidating balance sheets at December 31, 2015 and 2014 and condensed consolidating ehensive income and cash flows for each of the three years in the period ended egregating HCA Holdings, Inc. issuer, HCA Inc. issuer, the subsidiary guarantors, the tors and eliminations, follow.

HCA HOLDINGS, INC.

SED CONSOLIDATING COMPREHENSIVE INCOME STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2015

(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
sion for						
	$	$	$ 22,272	$ 21,319	$	$ 43,591
accounts			2,099	1,814		3,913
			20,173	19,505		39,678
			9,131	8,984		18,115
			3,464	3,174		6,638
ses	(2)		3,324	3,781		7,103
d						
			(31)	(16)		(47)
ffiliates	(2,352)		(6)	(40)	2,352	(46)
tization			915	989		1,904
	115	2,445	(766)	(129)		1,665
of						
			(2)	7		5
f debt	122	13				135
	120	129				249
			(676)	676		
	(1,997)	2,587	15,353	17,426	2,352	35,721
ncome						
	1,997	(2,587)	4,820	2,079	(2,352)	3,957
income						
	(132)	(962)	1,758	597		1,261
	2,129	(1,625)	3,062	1,482	(2,352)	2,696

e to s			92	475		567
butable	$ 2,129	$ (1,625)	$ 2,970	$ 1,007	$ (2,352)	$ 2,129
e (loss) oldings,	$ 2,187	$ (1,568)	$ 3,009	$ 969	$ (2,410)	$ 2,187

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

MENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND RAL-RELATED INFORMATION (continued)

HCA HOLDINGS, INC.

SED CONSOLIDATING COMPREHENSIVE INCOME STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2014

(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
	$	$	$ 20,533	$ 19,554	$	$ 40,087
			1,777	1,392		3,169
			18,756	18,162		36,918
			8,574	8,067		16,641
			3,280	2,982		6,262
ses d	20		3,138	3,597		6,755
			(85)	(40)		(125)
	(2,003)		(7)	(36)	2,003	(43)
			888	932		1,820
	184	2,175	(559)	(57)		1,743
ties f			(25)	(4)		(29)
		335				335
		78				78
			(662)	662		
	(1,799)	2,588	14,542	16,103	2,003	33,437
	1,799	(2,588)	4,214	2,059	(2,003)	3,481
	(76)	(961)	1,533	612		1,108
	1,875	(1,627)	2,681	1,447	(2,003)	2,373
e to s			87	411		498

$ 1,875	$ (1,627)	$ 2,594	$ 1,036	$ (2,003)	$ 1,875
e CA						
$ 1,809	$ (1,566)	$ 2,508	$ 995	$ (1,937)	$ 1,809

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

MENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND RAL-RELATED INFORMATION (continued)

HCA HOLDINGS, INC.

SED CONSOLIDATING COMPREHENSIVE INCOME STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2013

(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
sion for	$	$	$ 20,042	$ 17,998	$	$ 38,040
accounts			2,262	1,596		3,858
			17,780	16,402		34,182
			8,387	7,259		15,646
			3,158	2,812		5,970
ses	8	(2)	2,998	3,233		6,237
d						
			(142)	(74)		(216)
ffiliates	(1,675)		(2)	(27)	1,675	(29)
tization			855	898		1,753
	184	2,253	(523)	(66)		1,848
of						
			20	(10)		10
debt		17				17
			(632)	632		
	(1,483)	2,268	14,119	14,657	1,675	31,236
ncome						
	1,483	(2,268)	3,661	1,745	(1,675)	2,946
income						
	(73)	(860)	1,362	521		950
	1,556	(1,408)	2,299	1,224	(1,675)	1,996
e to						
s			69	371		440
butable						
	$ 1,556	$ (1,408)	$ 2,230	$ 853	$ (1,675)	$ 1,556

e (loss) oldings,						
$ 1,756	$ (1,324)	$ 2,338	$ 861	$ (1,875)	$ 1,756	

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

MENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND RAL-RELATED INFORMATION (continued)

HCA HOLDINGS, INC.

CONDENSED CONSOLIDATING BALANCE SHEET

DECEMBER 31, 2015

(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
ents	$	$	$ 155	$ 586	$	$ 741
et			2,982	2,907		5,889
			852	587		1,439
	223		403	537		1,163
	223		4,392	4,617		9,232
t, net ce			8,328	6,686		15,014
				432		432
vances to						
	24,380		14	164	(24,380)	178
angible						
			1,703	5,028		6,731
	943		19	195		1,157
	$ 25,546	$	$ 14,456	$ 17,122	$ (24,380)	$ 32,744
ND RS						
	$ 2	$	$ 1,375	$ 793	$	$ 2,170
			712	521		1,233
s	172	340	458	910		1,880
thin one						
		114	65	54		233
	174	454	2,610	2,278		5,516
	984	28,756	226	289		30,255

	31,432	(11,171)	(23,435)	3,174		
sks				1,115		1,115
r						
	555	548	417	384		1,904
	33,145	18,587	(20,182)	7,240		38,790
) equity						
oldings,						
	(7,599)	(18,587)	34,510	8,457	(24,380)	(7,599)
ts			128	1,425		1,553
	(7,599)	(18,587)	34,638	9,882	(24,380)	(6,046)
	$ 25,546	$	$ 14,456	$ 17,122	$ (24,380)	$ 32,744

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

MENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND RAL-RELATED INFORMATION (continued)

HCA HOLDINGS, INC.

CONDENSED CONSOLIDATING BALANCE SHEET

DECEMBER 31, 2014

(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
ents	$	$	$ 87	$ 479	$	$ 566
et			2,812	2,882		5,694
			756	523		1,279
	366					366
	118		376	531		1,025
	484		4,031	4,415		8,930
t, net			7,871	6,484		14,355
ce						
				494		494
vances to						
	21,970		16	149	(21,970)	165
angible						
			1,705	4,711		6,416
	435		27	158		620
	$ 22,889	$	$ 13,650	$ 16,411	$ (21,970)	$ 30,980
ND RS						
	$ 1	$	$ 1,272	$ 762	$	$ 2,035
			783	587		1,370
s	45	317	517	858		1,737
thin one						
		231	56	51		338
	46	548	2,628	2,258		5,480

	2,499	26,124	185	280		29,088
	27,685	(10,141)	(21,405)	3,861		
sks				1,078		1,078
r						
	553	487	605	187		1,832
	30,783	17,018	(17,987)	7,664		37,478
) equity						
oldings,						
	(7,894)	(17,018)	31,516	7,472	(21,970)	(7,894)
ts			121	1,275		1,396
	(7,894)	(17,018)	31,637	8,747	(21,970)	(6,498)
	$ 22,889	$	$ 13,650	$ 16,411	$ (21,970)	$ 30,980

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

MENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND RAL-RELATED INFORMATION (continued)

HCA HOLDINGS, INC.

NDENSED CONSOLIDATING STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED DECEMBER 31, 2015

(Dating in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
rating						
	$ 2,129	$ (1,625)	$ 3,062	$ 1,482	$ (2,352)	$ 2,696
ile net sh						
sets and	(12)	44	(2,537)	(1,731)		(4,236)
			2,099	1,814		3,913
tization			915	989		1,904
	(160)					(160)
of			(2)	7		5
f debt	122	13				135
	20	129				149
ssuance	3	32				35
tion	239					239
ffiliates	(2,352)				2,352	
	66	3	(4)	(11)		54
used in)	55	(1,404)	3,533	2,550		4,734
sting						
nd			(1,248)	(1,127)		(2,375)
s and			(51)	(300)		(351)
nd			48	25		73

			9	54		63
			(6)	13		7
ing						
			(1,248)	(1,335)		(2,583)
ncing						
debt		5,548				5,548
g bank						
		150				150
m debt	(1,632)	(3,189)	(59)	(40)		(4,920)
ntrolling						
			(85)	(410)		(495)
ce costs		(50)				(50)
on stock	(2,397)					(2,397)
	235					235
ny						
, net	3,767	(1,055)	(2,073)	(639)		
	(28)			(19)		(47)
vided by						
	(55)	1,404	(2,217)	(1,108)		(1,976)
sh						
			68	107		175
ents at						
			87	479		566
ents at						
	$	$	$ 155	$ 586	$	$ 741

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

MENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND RAL-RELATED INFORMATION (continued)

HCA HOLDINGS, INC.

NDENSED CONSOLIDATING STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED DECEMBER 31, 2014

(Dating in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
rating						
	$ 1,875	$ (1,627)	$ 2,681	$ 1,447	$ (2,003)	$ 2,373
ile net sh						
sets and	(11)	(12)	(1,972)	(1,438)		(3,433)
			1,777	1,392		3,169
tization			888	932		1,820
	(83)					(83)
ties			(25)	(4)		(29)
f debt		335				335
		78				78
ssuance	3	39				42
tion	163					163
ffiliates	(2,003)				2,003	
		18		(5)		13
vided by	(56)	(1,169)	3,349	2,324		4,448
sting						
nd			(1,189)	(987)		(2,176)
s and			(34)	(732)		(766)
nd			41	10		51
			32	(69)		(37)

				10		10
ing						
			(1,150)	(1,768)		(2,918)
ncing						
debt		5,500		2		5,502
g bank						
		440				440
m debt		(5,086)	(50)	(28)		(5,164)
ntrolling						
			(65)	(377)		(442)
ce costs		(73)				(73)
on stock	(1,750)					(1,750)
	134					134
ny						
, net	1,678	388	(2,109)	43		
	(6)			(19)		(25)
used in)						
	56	1,169	(2,224)	(379)		(1,378)
sh						
			(25)	177		152
ents at						
			112	302		414
ents at						
	$	$	$ 87	$ 479	$	$ 566

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

MENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND RAL-RELATED INFORMATION (continued)

HCA HOLDINGS, INC.

NDENSED CONSOLIDATING STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED DECEMBER 31, 2013

(Dating in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
rating						
	$ 1,556	$ (1,408)	$ 2,299	$ 1,224	$ (1,675)	$ 1,996
ile net sh						
sets and	(11)	17	(2,320)	(1,958)		(4,272)
			2,262	1,596		3,858
tization			855	898		1,753
	143					143
of			20	(10)		10
debt		17				17
ssuance	3	52				55
tion	113					113
ffiliates	(1,675)				1,675	
		9	2	(4)		7
used in)	129	(1,313)	3,118	1,746		3,680
sting						
nd			(921)	(1,022)		(1,943)
s and				(481)		(481)
nd			17	16		33
			(16)	52		36

			9			9
ing						
			(920)	(1,426)		(2,346)
ncing						
g bank						
		970				970
m debt		(1,254)	(34)	(374)		(1,662)
ntrolling						
			(71)	(364)		(435)
nce costs		(5)				(5)
on stock	(500)					(500)
	113					113
ny						
, net	342	1,602	(2,364)	420		
	(106)					(106)
vided by						
	(151)	1,313	(2,469)	(318)		(1,625)
sh						
	(22)		(271)	2		(291)
ents at						
	22		383	300		705
ents at						
	$	$	$ 112	$ 302	$	$ 414

HCA HOLDINGS, INC.

S TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

MENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND RAL-RELATED INFORMATION (continued)

e Hospital Company (Healthtrust) is the first-tier subsidiary of HCA Inc. The common as been pledged as collateral for the senior secured credit facilities and senior secured e 9. Rule 3-16 of Regulation S-X under the Securities Act requires the filing of separate or any affiliate of the registrant whose securities constitute a substantial portion of the of securities registered or being registered. We believe the separate financial statements Healthtrust due to the pledge of its common stock as collateral for the senior secured orate structure relationship of HCA and Healthtrust, HCA s operating subsidiaries are bsidiaries of Healthtrust. The corporate structure relationship, combined with the own accounting in Healthtrust s consolidated financial statements related to HCA s debt nts, results in the consolidated financial statements of Healthtrust being substantially idated financial statements of HCA. The consolidated financial statements of HCA and he identical amounts for revenues, expenses, net income, assets, liabilities, total net cash provided by operating activities, net cash used in investing activities and net cash ities. Certain individual line items in the HCA consolidated statements of stockholders to one line item in the Healthtrust consolidated statements of stockholder s deficit.

HCA Holdings, Inc. Consolidated Statements of Stockholders Deficit presentation to the Hospital Company Consolidated Statements of Stockholder s Deficit presentation for the 31, 2015, 2014 and 2013 are as follows (dollars in millions):

	2015	2014	2013
oldings, Inc. Consolidated Statements of Stockholders			
ans	**$ 523**	$ 321	$ 139
	(18)	(6)	(6)
rust, Inc. The Hospital Company Consolidated Statements			
cit:			
A Holdings, Inc., net of contributions to HCA Holdings,	**$ 505**	$ 315	$ 133

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

HCA HOLDINGS, INC.

UARTERLY CONSOLIDATED FINANCIAL INFORMATION

(UNAUDITED)

(Dollars in millions)

	2015			
	First	**Second**	**Third**	**Fourth**
	$ 9,676	**$ 9,897**	**$ 9,856**	**$ 10,249**
	$ 720(a)	**$ 665(b)**	**$ 573(c)**	**$ 738(d)**
table to HCA				
	$ 591(a)	**$ 507(b)**	**$ 449(c)**	**$ 582(d)**
share	**$ 1.41**	**$ 1.22**	**$ 1.08**	**$ 1.44**
er share	**$ 1.36**	**$ 1.18**	**$ 1.05**	**$ 1.40**

	2014			
	First	**Second**	**Third**	**Fourth**
	$ 8,832	$ 9,230	$ 9,220	$ 9,636
	$ 454(e)	$ 632(f)	$ 611(g)	$ 676(h)
table to HCA				
	$ 347(e)	$ 483(f)	$ 518(g)	$ 527(h)
share	$ 0.78	$ 1.10	$ 1.20	$ 1.22
er share	$ 0.76	$ 1.07	$ 1.16	$ 1.19

s include $6 million of gains on sales of facilities (See Note 3 of the notes to cial statements).

ults include $3 million of losses on sales of facilities (See Note 3 of the notes to cial statements) and $79 million of losses on retirement of debt (See Note 9 of the notes ancial statements).

lts include $2 million of losses on sales of facilities (See Note 3 of the notes to cial statements) and $49 million of legal claim costs (See Note 10 of the notes to cial statements).

ults include $4 million of losses on sales of facilities (See Note 3 of the notes to cial statements), $7 million of loss on retirement of debt (See Note 9 of the notes to cial statements) and $108 million of legal claim costs (See Note 10 of the notes to cial statements).

s include $13 million of gains on sales of facilities (See Note 3 of the notes to cial statements) and $49 million of legal claim costs (See Note 10 of the notes to cial statements).

ults include $7 million of gains on sales of facilities (See Note 3 of the notes to cial statements) and $143 million of losses on retirement of debt (See Note 9 of the ted financial statements).

lts include $9 million of losses on sales of facilities (See Note 3 of the notes to cial statements).

ults include $7 million of gains on sales of facilities (See Note 3 of the notes to cial statements) and $68 million of loss on retirement of debt (See Note 9 of the notes to cial statements).