August 10, 2012

On August 7, the New York Times published a lengthy story about HCA. We understand that a second story may soon be published. Based on questions the Times has asked us, it appears the upcoming story may address several topics that did not appear in the first story.

ACEP MODEL ADOPTION

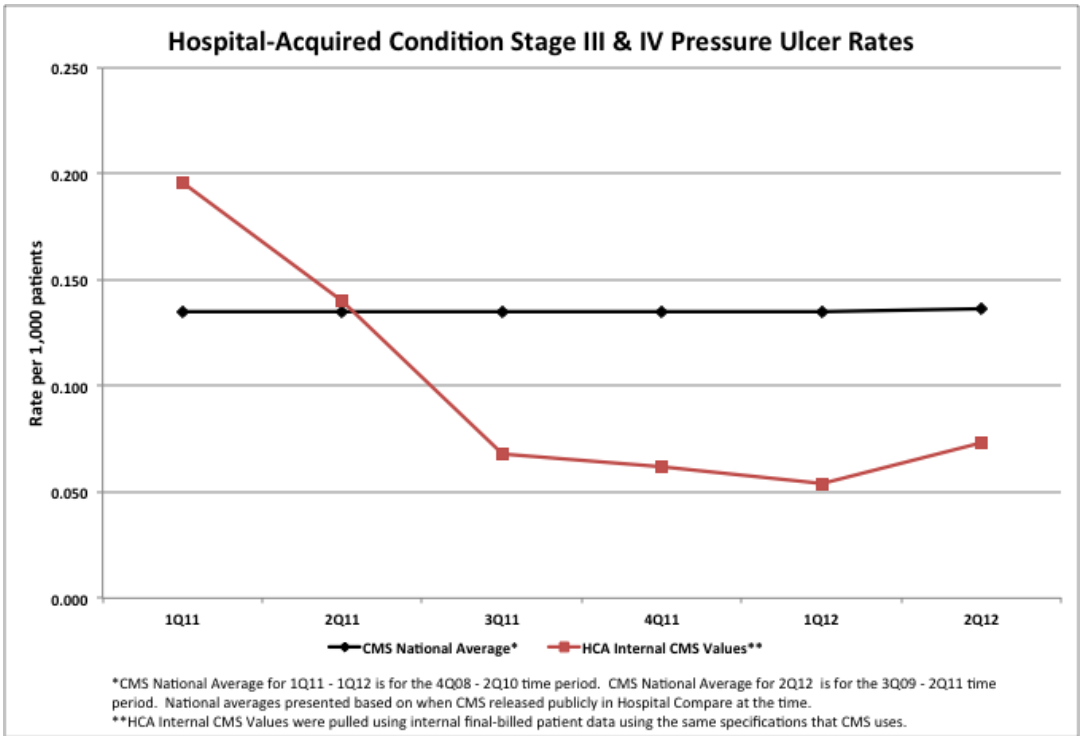
The Times has raised questions about our adoption of the American College of Emergency Physicians (ACEP) evaluation and management guidelines for the purpose of reimbursement. We have been very open about our adoption of this model, having explained it in our public releases in 2009. The system uses interventions, like IVs and cardiac monitoring as a proxy for the acuity of the patient and the resources involved in the evaluation and management of the patient. We implemented this system, which is used by many hospitals, because it provides for greater consistency and simplicity than the point system HCA had previously used. We know of no better organization than the American College of Emergency Physicians to establish a model that provides a national standard for more consistent classification of emergency visits for reimbursement purposes. After several years of using this model we believe our classifications are generally consistent with national averages.

ER SERVICES

Another topic the story may address relates to determining the emergency status of visitors to emergency rooms. Many ERs in America have adopted a variety of systems to determine when a patient in fact needs emergency care. About half of HCA affiliated hospitals have done so and they typically have two caregivers, usually a triage nurse and a physician, make that determination. In 2011 HCA affiliated hospitals had 6,143,500 ER visits. Of that number, 80,000, or only about one in 100, were determined not to have an emergency condition, were offered information on more appropriate care settings and chose to seek alternative options.

PRESSURE ULCERS

The Times also has asked about the rate of pressure ulcers for HCA-affiliated hospitals. As noted in the chart below, this rate is lower than the CMS national average.



PRIVATE EQUITY INVESTMENT

Since 2006, Bain Capital, the Frist Family and KKR have had a significant ownership position and governance role in HCA. During this time, HCA has enjoyed favorable growth and made significant improvement in our clinical care and patient services agendas. KKR and Bain Capital, as well as the Frist Family, have been valued partners, and we look forward to their continued involvement with the company.

During this time, HCA has provided an average of approximately $7.9 billion annually – more than $47 billion total - in charity care, uninsured discounts and other uncompensated care. Our capital expenditures over this same period have been approximately $1.5 billion annually, a total of more than $9 billion. These investments help ensure hospitals are up to date and have the latest equipment and technology. Additionally during this time, the company has added approximately 16,500 jobs not counting acquisitions and divestitures. Quality improvement has also been a significant focus during this time and more than 90 percent of HCA hospitals are now in the top quartile nationally on CMS Core Measures, which is one of the most widely-accepted sets of clinical quality measures, and is publicly available on CMS's Hospital Compare web site.

The company undertakes no duty to update or further comment on this matter.

August 6, 2012

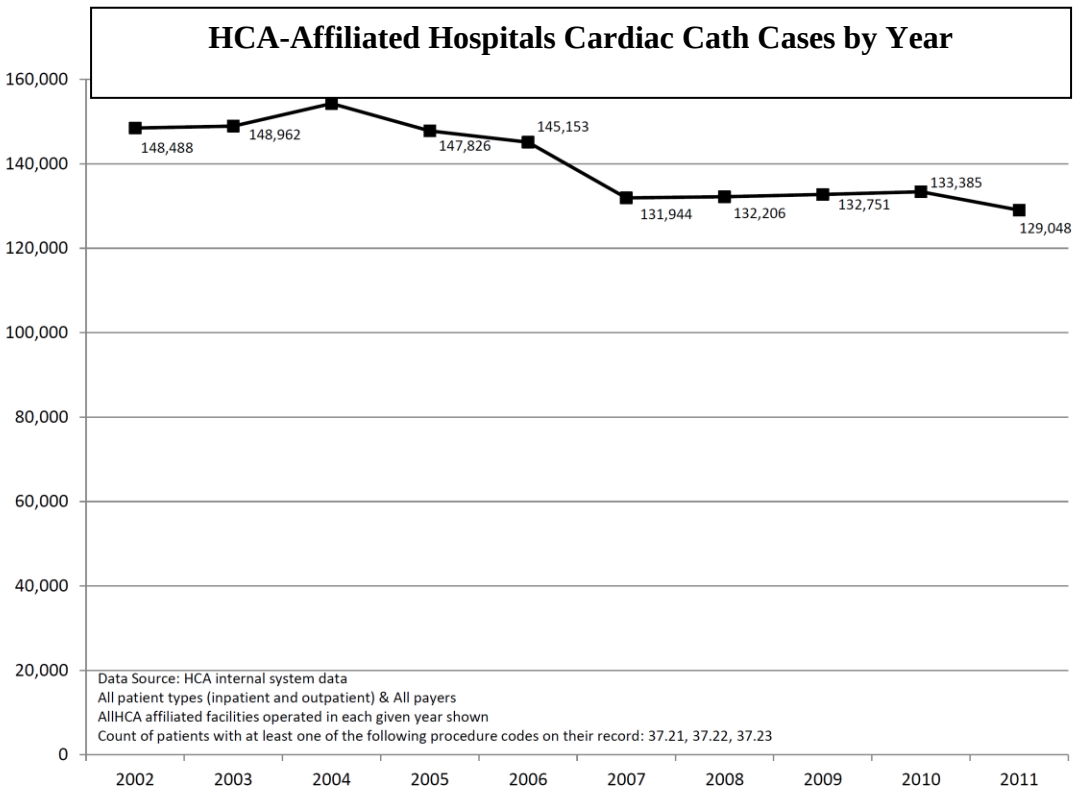
We understand that The New York Times may be publishing one or more articles about the company. Based upon its questions, the Times appears to be making broad points concerning patient care provided at our company's affiliated hospitals. As a result, we would like to share some background information.

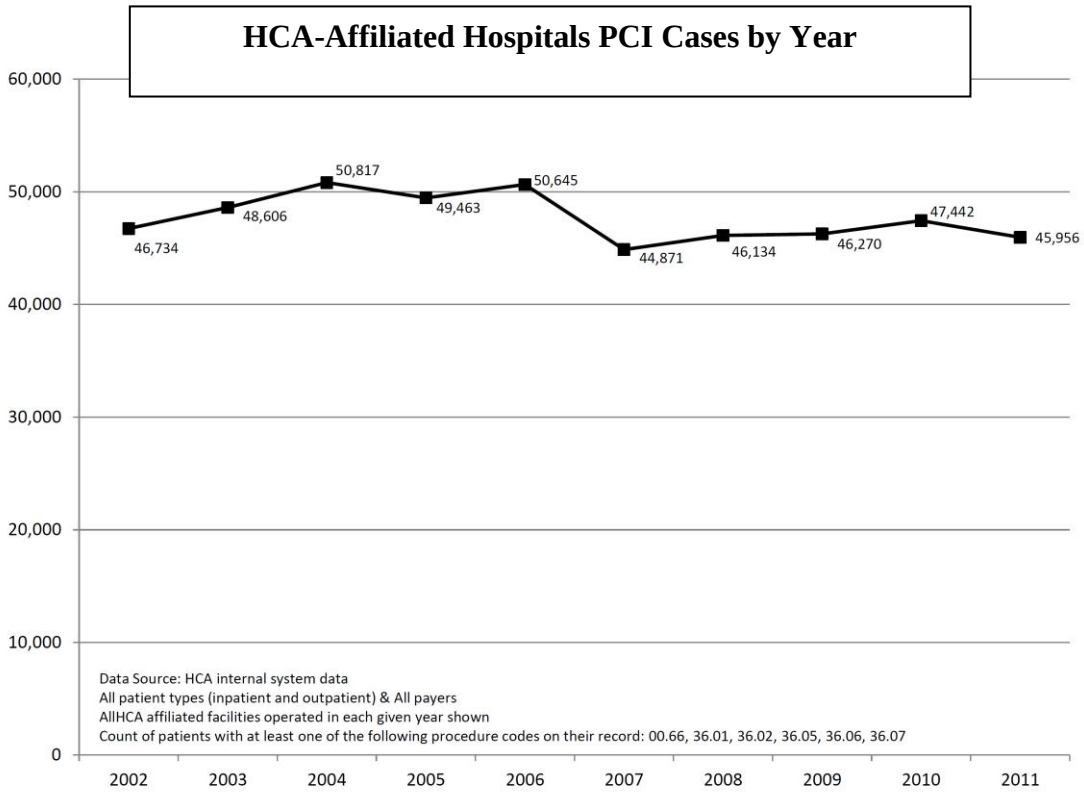
Cardiac Procedures:

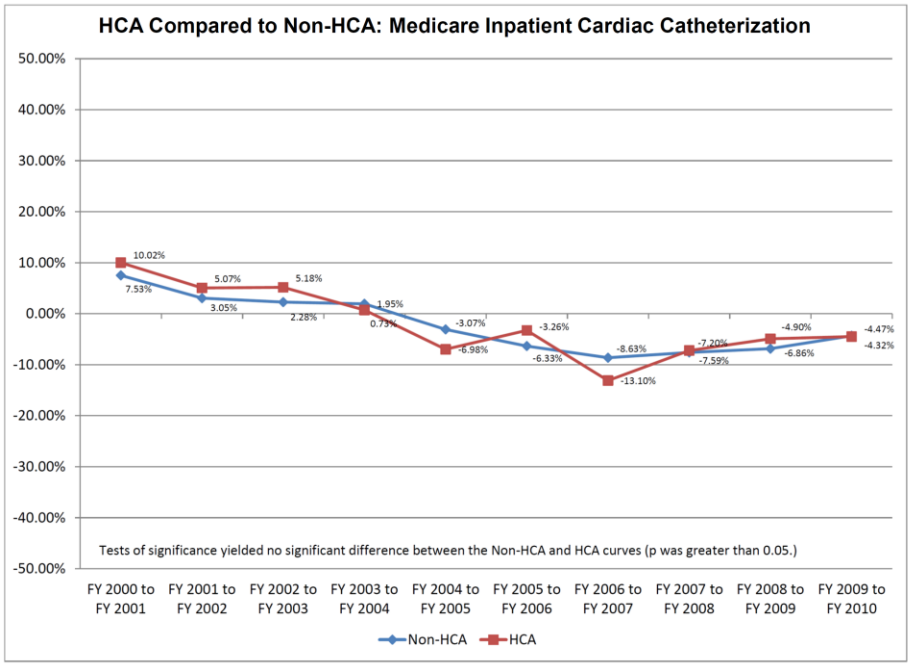
One topic we believe may be addressed is how physician decisions are made regarding when it is medically necessary to perform cardiac procedures, such as cardiac catheterizations and percutaneous coronary interventions (PCI). These physician-driven decisions have been and are the subject of much debate within the cardiology community. Accordingly, there is variation across the country, between regions, within regions, and even within the same medical staff or medical group regarding this issue. In addition, even when expert outside reviewers are engaged, they themselves may disagree on the same patient data. Thus, variation and disagreement among physicians indicates the difficulty in determining the medical necessity of these procedures.

Another topic which may be addressed is the volume of cardiac catheterizations and PCIs. Based upon Medicare inpatient data, trends for HCA-affiliated hospitals are similar to the rest of the nation for these procedures. Moreover, our data indicate that the number of both cardiac catheterizations and PCIs performed at HCA-affiliated facilities has declined over the last decade.

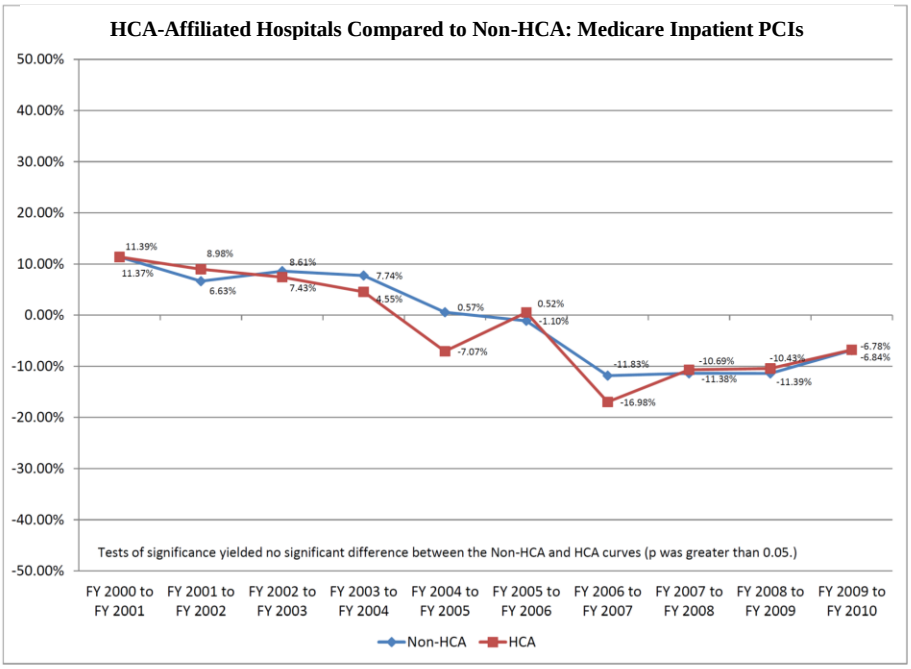
Below are four charts that demonstrate these trends:







The Medicare Provider Analysis and Review (MedPAR) file, published by CMS, contains records of Medicare-covered inpatient discharges.
This graph includes fee-for-service beneficiaries only.
FY = Federal fiscal year, October 1 through September 30. Most recently available data shown.
Count of patients with at least one of the following procedure codes on their record: 37.21, 37.22, 37.23.



The Medicare Provider Analysis and Review (MedPAR) file, published by CMS, contains records of Medicare-covered inpatient discharges.
This graph includes fee-for-service beneficiaries only.
FY = Federal fiscal year, October 1 through September 30. Most recently available data shown.
Count of patients with at least one of the following procedure codes on their record: 00.66, 36.01, 36.02, 36.05, 36.06, 36.07.

Patient Care Outcomes:

In its communications with us, The Times has given us examples where they assert that individual patients may have had adverse outcomes from the care they received at HCA-affiliated facilities. While there were approximately 20 million visits to our facilities last year, we deeply regret any adverse occurrences to even one of our patients. HCA-affiliated physicians and employees strive to provide the highest quality care and minimize adverse outcomes.

One of the most widely-accepted sets of clinical quality measures is the "Core Measures," published on the CMS Hospital Compare website. More than 90 percent of HCA hospitals are in the top quartile nationally on Core Measures, and more than 80 percent are in the top 10 percent. Approximately half of our U.S. hospitals are on the Joint Commission's list of 405 Top Performers in key quality measures of evidence-based care.

Emergency Services:

The Times also has raised questions about our adoption of the American College of Emergency Physicians (ACEP) evaluation and management guidelines for the purpose of reimbursement. As HCA explained in our public releases in 2009, the ACEP model provides a national standard for more consistent classification of emergency visits for reimbursement purposes. We believe our classifications are generally consistent with national averages.

Care for the Uninsured:

We believe the Times may also address the topic of uninsured care. HCA-affiliated hospitals in aggregate are one of, if not the largest, providers of care for the uninsured in the United States, as well as one of the largest providers for Medicaid patients. More than one in five emergency visits to our facilities – 23 percent - is by uninsured patients. Furthermore, from 2006-2011, our affiliated hospitals have seen growth in uninsured emergency room visits of approximately 25 percent. This compares with a growth of only approximately 18 percent in overall emergency room visits during that same period.

In addition, we have charity care and discount programs for the indigent and uninsured that we believe are industry-leadership models. Patients who earn less than 200 percent of the Federal poverty guideline are regarded as charity patients in our hospitals, and their care is free of charge. Any patient who is uninsured qualifies for an uninsured discount, which will reduce the bill to be in line with the bill expected by an insured patient.

The company undertakes no duty to update or further comment on this matter.