

BROOKWOOD MEDICAL CENTER OF GULFPORT INC

Form 424B3

March 01, 2010

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Filed Pursuant to Rule 424(b)(3)

Registration Nos. 333-159511 and 333-159511-01 to 333-159511-184

HCA INC.

SUPPLEMENT NO. 10 TO

MARKET MAKING PROSPECTUS DATED

JULY 10, 2009

THE DATE OF THIS SUPPLEMENT IS MARCH 1, 2010

On March 1, 2010, HCA Inc. filed the attached Annual Report on Form 10-K

for the fiscal year ended December 31, 2009

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

Form 10-K

(Mark One)

- ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES
EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2009**
- OR**
- TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES
EXCHANGE ACT OF 1934
For the transition period from _____ to _____**

Commission File Number 1-11239

HCA INC.
(Exact Name of Registrant as Specified in its Charter)

Delaware (State or Other Jurisdiction of Incorporation or Organization)	75-2497104 (I.R.S. Employer Identification No.)
One Park Plaza Nashville, Tennessee (Address of Principal Executive Offices)	37203 (Zip Code)
Registrant's telephone number, including area code: (615) 344-9551	

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

Securities Registered Pursuant to Section 12(g) of the Act: Common Stock, \$0.01 Par Value

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

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

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

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files). Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, 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.

Large accelerated
filer

Accelerated filer

Non-accelerated filer
(Do not check if a smaller reporting
company)

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

As of February 28, 2010, there were approximately 94,652,100 shares of Registrant's common stock outstanding. There is not a market for the Registrant's common stock; therefore, the aggregate market value of the Registrant's common stock held by non-affiliates is not calculable.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive Information Statement in connection with its action on written consent of stockholders in lieu of an annual meeting are incorporated by reference into Part III hereof.

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PART I

Item 1. *Business*

General

HCA Inc. is one of the leading health care services companies in the United States. At December 31, 2009, we operated 163 hospitals, comprised of 157 general, acute care hospitals; five psychiatric hospitals; and one rehabilitation hospital. The 163 hospital total includes eight hospitals (seven general, acute care hospitals and one rehabilitation hospital) owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. In addition, we operated 105 freestanding surgery centers, eight of which are owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. Our facilities are located in 20 states and England. The terms Company, HCA, we, our or us, as herein, refer to HCA Inc. and its affiliates unless otherwise stated or indicated by context. The term affiliates means direct and indirect subsidiaries of HCA Inc. and partnerships and joint ventures in which such subsidiaries are partners. The terms facilities or hospitals refer to entities owned and operated by affiliates of HCA and the term employees refers to employees of affiliates of HCA.

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

The Company was incorporated in Nevada in January 1990 and reincorporated in Delaware in September 1993. Our principal executive offices are located at One Park Plaza, Nashville, Tennessee 37203, and our telephone number is (615) 344-9551.

On November 17, 2006, HCA Inc. completed its merger (the Merger) with Hercules Acquisition Corporation, pursuant to which the Company was acquired by Hercules Holding II, LLC (Hercules Holding), a Delaware limited liability company owned by a private investor group comprised of affiliates of Bain Capital Partners, Kohlberg Kravis Roberts & Co., Merrill Lynch Global Private Equity (each a Sponsor), affiliates of Citigroup Inc. and Bank of America Corporation (the Sponsor Assignees) and affiliates of HCA founder, Dr. Thomas F. Frist Jr., (the Frist Entities, and together with the Sponsors and the Sponsor Assignees, the Investors), and by members of management and certain other investors. The Merger, the financing transactions related to the Merger and other related transactions are collectively referred to in this annual report as the Recapitalization. The Merger was accounted for as a recapitalization in our financial statements, with no adjustments to the historical basis of our assets and liabilities. As a result of the Recapitalization, our outstanding capital stock is owned by the Investors, certain members of management and key employees. On April 29, 2008, we registered our common stock pursuant to Section 12(g) of the Securities Exchange Act of 1934, as amended, thus subjecting us to the reporting requirements of Section 13(a) of the Securities Exchange Act of 1934, as amended. Our common stock is not traded on a national securities exchange.

Available Information

We file certain reports with the Securities and Exchange Commission (the SEC), including annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. The public may read and copy any materials we file with the SEC at the SEC s Public Reference Room at 100 F Street, N.E., Washington, DC 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. We are an electronic filer, and the SEC maintains an Internet site at <http://www.sec.gov> that contains the reports, proxy and information statements and other information we file electronically. Our website address is www.hcahealthcare.com. Please note that our website address is provided as an inactive textual reference only. We make available free of charge, through our website, our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and all amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act, as soon as reasonably practicable after such material is electronically

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filed with or furnished to the SEC. The information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

Our Code of Conduct is available free of charge upon request to our Corporate Secretary, HCA Inc., One Park Plaza, Nashville, Tennessee 37203.

Business Strategy

We are committed to providing the communities we serve high quality, cost-effective health care while complying fully with our ethics policy, governmental regulations and guidelines and industry standards. As a part of this strategy, management focuses on the following principal elements:

maintain our dedication to the care and improvement of human life;

maintain our commitment to ethics and compliance;

leverage our leading local market positions;

expand our presence in key markets;

continue to leverage our scale;

continue to develop physician relationships; and

become the health care employer of choice.

Health Care Facilities

We currently own, manage or operate hospitals; freestanding surgery centers; diagnostic and imaging centers; radiation and oncology therapy centers; comprehensive rehabilitation and physical therapy centers; and various other facilities.

At December 31, 2009, we owned and operated 150 general, acute care hospitals with 38,349 licensed beds, and an additional seven general, acute care hospitals with 2,269 licensed beds are operated through joint ventures, which are accounted for using the equity method. Most of our general, acute care hospitals provide medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic services and emergency services. The general, acute care hospitals also provide outpatient services such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology and physical therapy. Each hospital has an organized medical staff and a local board of trustees or governing board, made up of members of the local community.

Our hospitals do not typically engage in extensive medical research and education programs. However, some of our hospitals are affiliated with medical schools and may participate in the clinical rotation of medical interns and residents and other education programs.

At December 31, 2009, we operated five psychiatric hospitals with 490 licensed beds. Our psychiatric hospitals provide therapeutic programs including child, adolescent and adult psychiatric care, adult and adolescent alcohol and drug abuse treatment and counseling.

We also operate outpatient health care facilities which include freestanding surgery centers, diagnostic and imaging centers, comprehensive outpatient rehabilitation and physical therapy centers, outpatient radiation and oncology therapy centers and various other facilities. These outpatient services are an integral component of our strategy to develop comprehensive health care networks in select communities. A majority of our surgery centers are operated through partnerships or limited liability companies, with majority ownership of each partnership or limited liability company typically held by a general partner or subsidiary that is an affiliate of HCA.

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

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

We receive payment for patient services from the federal government under the Medicare program, state governments under their respective Medicaid or similar programs, managed care plans, private insurers and directly from patients. The approximate percentages of our revenues from such sources were as follows:

	Year Ended December 31,		
	2009	2008	2007
Medicare	23%	23%	24%
Managed Medicare	7	6	5
Medicaid	6	5	5
Managed Medicaid	4	3	3
Managed care and other insurers	52	53	54
Uninsured	8	10	9
Total	100%	100%	100%

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

Our hospitals generally offer discounts from established charges to certain group purchasers of health care services, including private insurance companies, employers, HMOs, PPOs and other managed care plans. These discount programs generally limit our ability to increase revenues in response to increasing costs. See Item 1, Business Competition. Patients are generally not responsible for the total difference between established hospital gross charges and amounts reimbursed for such services under Medicare, Medicaid, HMOs or PPOs and other managed care plans, but are responsible to the extent of any exclusions, deductibles or coinsurance features of their coverage. The amount of such exclusions, deductibles and coinsurance continues to increase. Collection of amounts due from individuals is typically more difficult than from governmental or third-party payers. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care under our charity care policy. These discounts are similar to those provided to many local managed care plans. In implementing the discount policy, we attempt to qualify uninsured patients for Medicaid, other federal or state assistance or charity care under our charity care policy. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Medicare

Inpatient Acute Care

Under the Medicare program, we receive reimbursement under a prospective payment system (PPS) for general, acute care hospital inpatient services. Under the hospital inpatient PPS, fixed payment amounts per inpatient discharge are established based on the patient s assigned Medicare severity diagnosis-related group (MS-DRG). The Centers for Medicare & Medicaid Services (CMS) recently completed a two-year transition to full implementation of MS-DRGs to replace the previously used Medicare diagnosis related groups in an effort to better recognize severity of illness in Medicare payment rates. MS-DRGs classify treatments for illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. MS-DRG weights

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represent the average resources for a given MS-DRG relative to the average resources for all MS-DRGs. MS-DRG payments are adjusted for area wage differentials. Hospitals, other than those defined as new, receive PPS reimbursement for inpatient capital costs based on MS-DRG weights multiplied by a geographically adjusted federal rate. When the cost to treat certain patients falls well outside the normal distribution, providers typically receive additional outlier payments.

MS-DRG rates are updated and MS-DRG weights are recalibrated using cost relative weights each federal fiscal year (which begins October 1). The index used to update the MS-DRG rates (the market basket) gives consideration to the inflation experienced by hospitals and entities outside the health care industry in purchasing goods and services. In federal fiscal year 2009, the MS-DRG rate was increased by the full market basket of 3.6%. For the federal fiscal year 2010, CMS has set the MS-DRG rate increase at the full market basket of 2.1%. A decrease in payments rates or an increase in rates that is below the increase in our costs may adversely affect the results of our operations.

In federal fiscal years 2008 and 2009, CMS reduced payments to hospitals through a documentation and coding adjustment intended to account for changes in payments under the MS-DRG system that are not related to changes in patient case mix. In addition, CMS has the authority to determine retrospectively whether the documentation and coding adjustment levels for federal fiscal years 2008 and 2009 were adequate to account for changes in payments not related to changes in case mix. CMS has not imposed an adjustment for federal fiscal year 2010, but has announced its intent to impose reductions to payments in federal fiscal years 2011 and 2012 because of what CMS has determined to be an inadequate adjustment in federal fiscal year 2008. Such payment adjustments may adversely affect the results of our operations.

Further realignments in the MS-DRG system could also reduce the payments we receive for certain specialties, including cardiology and orthopedics. CMS has focused on payment levels for such specialties in recent years in part because of the proliferation of specialty hospitals. Changes in the payments received for specialty services could have an adverse effect on our results of operations.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides for rate increases at the full market basket if data for patient care quality indicators are submitted to the Secretary of the Department of Health and Human Services (HHS). As required by the Deficit Reduction Act of 2005 (DRA 2005), CMS has expanded, through a series of rulemakings, the number of quality measures that must be reported to receive a full market basket update. CMS currently requires hospitals to report 46 quality measures in order to qualify for the full market basket update to the inpatient prospective payment system in federal fiscal year 2011. Failure to submit the required quality indicators will result in a two percentage point reduction to the market basket update. All of our hospitals paid under Medicare inpatient MS-DRG PPS are participating in the quality initiative by submitting the requested quality data. While we will endeavor to comply with all data submission requirements as additional requirements continue to be added, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals.

As part of CMS's goal of transforming Medicare from a passive payer to an active purchaser of quality goods and services, for discharges occurring after October 1, 2008, Medicare no longer assigns an inpatient hospital discharge to a higher paying MS-DRG if a selected hospital-acquired condition (HAC) was not present on admission. In this situation, the case is paid as though the secondary diagnosis was not present. Currently, there are ten categories of conditions on the list of HACs. Furthermore, on January 15, 2009, CMS announced three National Coverage Determinations (NCDs) that prohibit Medicare reimbursement for erroneous surgical procedures performed on an inpatient or outpatient basis. These three erroneous surgical procedures are in addition to the HACs designated in CMS regulations. These changes are not expected to have a material effect on our revenues or cash flows.

Historically, the Medicare program has set aside 5.10% of Medicare inpatient payments to pay for outlier cases. CMS estimates that outlier payments accounted for 4.8% of total operating DRG payments for federal fiscal year 2008. For federal fiscal year 2009, CMS established an outlier threshold of \$20,045, and for federal fiscal year 2010, CMS has increased the outlier threshold to \$23,140. We do not anticipate the increase to the outlier threshold for federal fiscal year 2010 will have a material impact on our results of operations.

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Outpatient

CMS reimburses hospital outpatient services (and certain Medicare Part B services furnished to hospital inpatients who have no Part A coverage) on a PPS basis. CMS continues to use fee schedules to pay for physical, occupational and speech therapies, durable medical equipment, clinical diagnostic laboratory services and nonimplantable orthotics and prosthetics, freestanding surgery centers services and services provided by independent diagnostic testing facilities.

Hospital outpatient services paid under PPS are classified into groups called ambulatory payment classifications (APCs). Services for each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit. The APC payment rates were updated for calendar years 2008 and 2009 by market baskets of 3.30% and 3.60%, respectively. On November 20, 2009, CMS published a final rule that updated payment rates for calendar year 2010 by the full market basket of 2.1%. CMS continues to require hospitals to submit quality data relating to outpatient care to receive the full market basket increase under the outpatient PPS in calendar year 2010. CMS required hospitals to report data on eleven quality measures in calendar year 2009 for the payment determination in calendar year 2010 and will continue to require hospitals to report the existing eleven quality measures in calendar year 2010 for the 2011 payment determination. Hospitals that fail to submit such data will receive the market basket update minus two percentage points for the outpatient PPS.

Rehabilitation

CMS reimburses inpatient rehabilitation facilities (IRFs) on a PPS basis. Under IRF PPS, patients are classified into case mix groups based upon impairment, age, comorbidities (additional diseases or disorders from which the patient suffers) and functional capability. IRFs are paid a predetermined amount per discharge that reflects the patient's case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. The Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Reauthorization Act of 2007 eliminated the market basket update for federal fiscal year 2009. However, CMS issued a final rule setting the market basket update at 2.5% for fiscal year 2010. As of December 31, 2009, we had one rehabilitation hospital, which is operated through a joint venture, and 46 hospital rehabilitation units.

On May 7, 2004, CMS published a final rule to change the criteria for being classified as an IRF. Pursuant to that final rule, 75% of a facility's inpatients over a given year had to have been treated for at least one of 10 specified conditions, and a subsequent regulation expanded the number of specified conditions to 13. Since then, several statutory and regulatory adjustments have been made to the rule, including adjustments to the percentage of a facility's patients that must be treated for one of the 13 specified conditions. Currently, the compliance threshold is set by statute at 60%. Implementation of this 60% threshold has reduced our IRF admissions and can be expected to continue to restrict the treatment of patients whose medical conditions do not meet any of the 13 approved conditions. In addition, effective January 1, 2010, IRFs must meet additional coverage criteria, including patient selection and care requirements relating to pre-admission screenings, post-admission evaluations, ongoing coordination of care and involvement of rehabilitation physicians. A facility that fails to meet the 60% threshold or other criteria to be classified as an IRF will be paid under the acute care hospital inpatient or outpatient PPS, which generally provide for lower payment amounts.

Psychiatric

Inpatient hospital services furnished in psychiatric hospitals and psychiatric units of general, acute care hospitals and critical access hospitals are reimbursed under a prospective payment system (IPF PPS), a per diem payment, with adjustments to account for certain patient and facility characteristics. IPF PPS contains an outlier policy for extraordinarily costly cases and an adjustment to a facility's base payment if it maintains a full-service emergency

department. CMS has established the IPF PPS payment rate in a manner intended to be budget neutral and has adopted a July 1 update cycle. The rehabilitation, psychiatric and long-term care (RPL) market basket update is used to update the IPF PPS. The annual RPL market basket update for rate year 2010 is 2.1%. As of December 31, 2009, we had five psychiatric hospitals and 32 hospital psychiatric units.

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Ambulatory Surgery Centers

CMS reimburses ambulatory surgery centers (ASCs) using a predetermined fee schedule. Reimbursements for ASC overhead costs are limited to no more than the overhead costs paid to hospital outpatient departments under the Medicare hospital outpatient PPS for the same procedure. Effective January 1, 2008, ASC payment groups increased from nine clinically disparate payment groups to an extensive list of covered surgical procedures among the APCs used under the outpatient PPS for these surgical services. Because the new payment system has a significant impact on payments for certain procedures, CMS has established a four-year transition period for implementing the required payment rates. Moreover, if CMS determines that a procedure is commonly performed in a physician's office, the ASC reimbursement for that procedure is limited to the reimbursement allowable under the Medicare Part B Physician Fee Schedule, with limited exceptions. In addition, all surgical procedures, other than those that pose a significant safety risk or generally require an overnight stay, are payable as ASC procedures. As a result, more Medicare procedures now performed in hospitals may be moved to ASCs, reducing surgical volume in our hospitals. Also, more Medicare procedures now performed in ASCs may be moved to physicians' offices. Commercial third-party payers may adopt similar policies.

Other

Under PPS, the payment rates are adjusted for the area differences in wage levels by a factor (wage index) reflecting the relative wage level in the geographic area compared to the national average wage level. Beginning in federal fiscal year 2007, CMS adjusted 100% of the wage index factor for occupational mix. The redistributive impact of wage index changes, while slightly negative in the aggregate, is not anticipated to have a material financial impact for 2010.

As required by the MMA, CMS is implementing contractor reform whereby CMS has competitively bid the Medicare fiscal intermediary and Medicare carrier functions to 15 Medicare Administrative Contractors (MACs), which are geographically assigned. CMS has awarded contracts to all 15 MAC jurisdictions; as a result of filed protests, CMS is taking corrective action regarding the contracts in several jurisdictions. While chain providers had the option of having all hospitals use one home office MAC, HCA chose to use the MACs assigned to the geographic areas in which our hospitals are located. The individual MAC jurisdictions are in varying phases of transition. For the transition periods and for a potentially unforeseen period thereafter, all of these changes could impact claims processing functions and the resulting cash flow; however, we are unable to predict the impact at this time.

The MMA established the Recovery Audit Contractor (RAC) three-year demonstration program to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The Tax Relief and Health Care Act of 2006 made the RAC program permanent and mandated its nationwide expansion by 2010. CMS has awarded contracts to four RACs that are implementing the permanent RAC program on a nationwide basis.

Managed Medicare

Managed Medicare plans relate to situations where a private company contracts with CMS to provide members with Medicare Part A, Part B and Part D benefits. Managed Medicare plans can be structured as HMOs, PPOs or private fee-for-service plans. The Medicare program allows beneficiaries to choose enrollment in certain managed Medicare plans. In 2003, MMA increased reimbursement to managed Medicare plans and expanded Medicare beneficiaries healthcare options. Since 2003, the number of beneficiaries choosing to receive their Medicare benefits through such plans has increased. However, the Medicare Improvements for Patients and Providers Act of 2008 imposed new restrictions and implemented focused cuts to certain managed Medicare plans. In addition, some health care reform proposals would reduce payments to managed Medicare plans. In light of the current economic downturn and the political climate, managed Medicare plans may experience reduced premium payments, which may lead to decreased

enrollment in such plans.

Medicaid

Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid program payments are made under a PPS or are based on negotiated

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payment levels with individual hospitals. Medicaid reimbursement is often less than a hospital's cost of services. The federal government and many states are currently considering altering the level of Medicaid funding (including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. As permitted by law, certain states in which we operate have adopted broad-based provider taxes to fund their Medicaid programs.

Since most states must operate with balanced budgets and since the Medicaid program is often the state's largest program, states can be expected to adopt or consider adopting legislation designed to reduce their Medicaid expenditures. The current economic downturn has increased the budgetary pressures on most states, and these budgetary pressures have resulted and likely will continue to result in decreased spending for Medicaid programs in many states. Further, many states have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems.

Through DRA 2005, Congress has expanded the federal government's involvement in fighting fraud, waste and abuse in the Medicaid program by creating the Medicaid Integrity Program. Among other things, this legislation requires CMS to employ private contractors, referred to as Medicaid Integrity Contractors (MICs), to perform post-payment audits of Medicaid claims and identify overpayments. MICs are assigned to five geographic regions and have commenced audits in several of the states assigned to those regions. Throughout 2010, MIC audits will continue to expand to other states. In addition to MICs, several other contractors, including the state Medicaid agencies, have increased their review activities. Future legislation or other changes in the administration or interpretation of government health programs could have a material, adverse effect on our financial position and results of operations.

Managed Medicaid

Managed Medicaid programs enable states to contract with one or more entities for patient enrollment, care management and claims adjudication. The states usually do not relinquish program responsibilities for financing, eligibility criteria and core benefit plan design. We generally contract directly with one of the designated entities, usually a managed care organization. The provisions of these programs are state-specific.

Enrollment in managed Medicaid plans has increased in recent years, as state governments seek to control the cost of Medicaid programs. However, general economic conditions in the states in which we operate may require reductions in premium payments to these plans and may reduce enrollment in these plans.

TRICARE

TRICARE is the Department of Defense's health care program for members of the armed forces. On May 1, 2009, the Department of Defense implemented a prospective payment system for hospital outpatient services furnished to TRICARE beneficiaries similar to that utilized for services furnished to Medicare beneficiaries. Because the Medicare outpatient prospective payment system APC rates have historically been below TRICARE rates, the adoption of this payment methodology for TRICARE beneficiaries reduces our reimbursement; however, TRICARE outpatient services do not represent a significant portion of our patient volumes.

Annual Cost Reports

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

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

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Managed Care and Other Discounted Plans

Most of our hospitals offer discounts from established charges to certain large group purchasers of health care services, including managed care plans and private insurance companies. Admissions reimbursed by commercial managed care and other insurers were 34%, 35% and 37% of our total admissions for the years ended December 31, 2009, 2008 and 2007, respectively. Managed care contracts are typically negotiated for terms between one and three years. While we generally received annual average yield increases of 6% to 7% from managed care payers during 2009, there can be no assurance that we will continue to receive increases in the future.

Uninsured and Self-Pay Patients

A high percentage of our uninsured patients are initially admitted through our emergency rooms. For the year ended December 31, 2009, approximately 81% of our admissions of uninsured patients occurred through our emergency rooms. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the individual to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment.

We are taking proactive measures to reduce our provision for doubtful accounts by, among other things:

screening all patients, including the uninsured, through our emergency screening protocol, to determine the appropriate care setting in light of their condition, while reducing the potential for bad debt; and

increasing up-front collections from patients subject to co-pay and deductible requirements and uninsured patients.

Hospital Utilization

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

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

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periods and increases in the cold weather months. The data set forth in this table includes only those facilities that are consolidated for financial reporting purposes.

	Years Ended December 31,				
	2009	2008	2007	2006	2005
Number of hospitals at end of period(a)	155	158	161	166	175
Number of freestanding outpatient surgery centers at end of period(b)	97	97	99	98	87
Number of licensed beds at end of period(c)	38,839	38,504	38,405	39,354	41,265
Weighted average licensed beds(d)	38,825	38,422	39,065	40,653	41,902
Admissions(e)	1,556,500	1,541,800	1,552,700	1,610,100	1,647,800
Equivalent admissions(f)	2,439,000	2,363,600	2,352,400	2,416,700	2,476,600
Average length of stay (days)(g)	4.8	4.9	4.9	4.9	4.9
Average daily census(h)	20,650	20,795	21,049	21,688	22,225
Occupancy rate(i)	53%	54%	54%	53%	53%
Emergency room visits(j)	5,593,500	5,246,400	5,116,100	5,213,500	5,415,200
Outpatient surgeries(k)	794,600	797,400	804,900	820,900	836,600
Inpatient surgeries(l)	494,500	493,100	516,500	533,100	541,400

- (a) Excludes eight facilities in 2009, 2008 and 2007 and seven facilities in 2006 and 2005 that are not consolidated (accounted for using the equity method) for financial reporting purposes.
- (b) Excludes eight facilities in 2009 and 2008, nine facilities in 2007 and 2006 and seven facilities in 2005 that are not consolidated (accounted for using the equity method) for financial reporting purposes.
- (c) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.
- (d) Weighted average licensed beds represents the average number of licensed beds, weighted based on periods owned.
- (e) Represents the total number of patients admitted to our hospitals and is used by management and certain investors as a general measure of inpatient volume.
- (f) Equivalent admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Equivalent admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The equivalent admissions computation equates outpatient revenue to the volume measure (admissions) used to measure inpatient volume, resulting in a general measure of combined inpatient and outpatient volume.
- (g) Represents the average number of days admitted patients stay in our hospitals.

- (h) Represents the average number of patients in our hospital beds each day.
- (i) Represents the percentage of hospital licensed beds occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.
- (j) Represents the number of patients treated in our emergency rooms.
- (k) Represents the number of surgeries performed on patients who were not admitted to our hospitals. Pain management and endoscopy procedures are not included in outpatient surgeries.
- (l) Represents the number of surgeries performed on patients who have been admitted to our hospitals. Pain management and endoscopy procedures are not included in inpatient surgeries.

Competition

Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. Additionally, in recent years the number of freestanding surgery centers and diagnostic centers (including facilities owned by physicians) in the geographic areas in which we operate has

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increased significantly. As a result, most of our hospitals operate in a highly competitive environment. In some cases, competing hospitals are more established than our hospitals. Some competing hospitals are owned by tax-supported government agencies and many others are owned by not-for-profit entities that may be supported by endowments, charitable contributions and/or tax revenues and are exempt from sales, property and income taxes. Such exemptions and support are not available to our hospitals. In certain localities there are large teaching hospitals that provide highly specialized facilities, equipment and services which may not be available at most of our hospitals. We are facing increasing competition from physician-owned specialty hospitals and both our own and unaffiliated freestanding surgery centers for market share in high margin services.

Psychiatric hospitals frequently attract patients from areas outside their immediate locale and, therefore, our psychiatric hospitals compete with both local and regional hospitals, including the psychiatric units of general, acute care hospitals.

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

Two of the most significant factors to the competitive position of a hospital are the number and quality of physicians affiliated with the hospital. Although physicians may at any time terminate their affiliation with a hospital we operate, our hospitals seek to retain physicians with varied specialties on the hospitals' medical staffs and to attract other qualified physicians. We believe physicians refer patients to a hospital on the basis of the quality and scope of services it renders to patients and physicians, the quality of physicians on the medical staff, the location of the hospital and the quality of the hospital's facilities, equipment and employees. Accordingly, we strive to maintain and provide quality facilities, equipment, employees and services for physicians and patients.

Another major factor in the competitive position of a hospital is our ability to negotiate service contracts with purchasers of group health care services. Managed care plans attempt to direct and control the use of hospital services and obtain discounts from hospitals' established gross charges. In addition, employers and traditional health insurers continue to attempt to contain costs through negotiations with hospitals for managed care programs and discounts from established gross charges. Generally, hospitals compete for service contracts with group health care services purchasers on the basis of price, market reputation, geographic location, quality and range of services, quality of the medical staff and convenience. Our future success will depend, in part, on our ability to retain and renew our managed care contracts and enter into new managed care contracts on favorable terms. Other health care providers may impact our ability to enter into managed care contracts or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. The trend toward consolidation among non-government payers tends to increase their bargaining power over fee structures. The importance of obtaining contracts with managed care organizations varies from community to community, depending on the market strength of such organizations.