HCA Holdings, Inc.
Form S-1
December 22, 2010

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As filed with the Securities and Exchange Commission on December 22, 2010
Registration No. 333-

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

Form S-1
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933

HCA Holdings, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**8062**	**27-3865930**
(State or other jurisdiction of incorporation or organization)	*(Primary Standard Industrial Classification Code Number)*	*(I.R.S. Employer Identification Number)*

One Park Plaza
Nashville, Tennessee 37203
(615) 344-9551
(Address, including zip code, and telephone number, including area code, of registrant s principal executive offices)

John M. Franck II, Esq.
HCA Holdings, Inc.
Vice President and Corporate Secretary
One Park Plaza
Nashville, Tennessee 37203
(615) 344-9551
(Name, address, including zip code, and telephone number, including area code, of agent for service)
With copies to:

Joseph H. Kaufman, Esq. **John C. Ericson, Esq.** **Simpson Thacher & Bartlett LLP** **425 Lexington Avenue** **New York, New York 10017-3954** **(212) 455-2000**	**J. Page Davidson, Esq.** **Ryan D. Thomas, Esq.** **Bass, Berry & Sims PLC** **150 Third Avenue South, Suite 2800** **Nashville, Tennessee 37201-2017** **(615) 742-6200**	**James J. Clark, Esq.** **Jonathan A. Schaffzin, Esq.** **William J. Miller, Esq.** **Cahill Gordon & Reindel llp** **Eighty Pine Street** **New York, New York 10005-1702**

(212) 701-3000

Approximate date of commencement of proposed sale to the public: As soon as practicable after this Registration Statement is declared effective.

If any of the securities being registered on this Form are to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933, check the following box. o

If this Form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, please check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

If this Form is a post-effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

If this Form is a post-effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

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 o	Accelerated filer o	Non-accelerated filer þ (Do not check if a smaller reporting company)	Smaller reporting company o

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	**Proposed Maximum Aggregate Offering Price(1)(2)**	**Amount of Registration Fee(3)**
Common Stock, par value $0.01 per share	$ 4,600,000,000	$ 327,980

(1) Includes shares to be sold upon exercise of the underwriters option. See Underwriting.

(2) Estimated solely for the purpose of calculating the amount of the registration fee pursuant to Rule 457(o) under the Securities Act of 1933, as amended.

(3) A filing fee of $327,980 has already been paid with respect to unissued securities under HCA Inc. s Registration Statement on Form S-1 (File No. 333-166610) filed on May 7, 2010. Pursuant to 457(p) under the Securities Act of 1933, as amended, all of these unused filing fees are being used to offset against the registration fee due for this offering.

The registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933, as amended, or until the Registration Statement shall become effective on such date as the Securities and Exchange Commission, acting pursuant to said Section 8(a), may determine.

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EXPLANATORY NOTE

This registration statement is being filed by HCA Holdings, Inc. (the Registrant) following completion of a corporate reorganization on November 22, 2010, pursuant to which the Registrant became the direct parent company of, and successor issuer to, HCA Inc. Concurrently with this filing, HCA Inc. is filing a request to withdraw its Registration Statement on Form S-1 (File No. 333-166610), together with all exhibits thereto, initially filed on May 7, 2010, which registration statement related to a comparable offering to the offering contemplated by this registration statement. The Registrant is filing this registration statement, and HCA Inc. is requesting withdrawal of its registration statement, pursuant to the representations made by HCA Inc. in connection with no action relief granted by the staff of the Division of Corporation Finance of the U.S. Securities and Exchange Commission by letter dated November 22, 2010 in connection with the corporate reorganization.

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The information in this preliminary prospectus is not complete and may be changed. We and the selling stockholders may not sell these securities until the registration statement filed with the Securities and Exchange Commission is effective. This preliminary prospectus is not an offer to sell these securities, and it is not soliciting an offer to buy these securities in any jurisdiction where the offer or sale is not permitted.

SUBJECT TO COMPLETION, DATED DECEMBER 22, 2010

PRELIMINARY PROSPECTUS

HCA Holdings, Inc.

Shares

Common Stock
$ per share

We are offering shares of our common stock, and the selling stockholders named in this prospectus are offering shares of our common stock. We will not receive any proceeds from the sale of the shares by the selling stockholders.

This is an initial public offering of our common stock. Since November 2006 and prior to this offering, there has been no public market for our common stock. We currently expect the initial public offering price will be between $ and $ per share. We intend to apply to list the common stock on the New York Stock Exchange under the symbol HCA.

Investing in our common stock involves a high degree of risk. See Risk Factors beginning on page 15 of this prospectus to read about factors you should consider before buying shares of our common stock.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or passed upon the adequacy or accuracy of this prospectus. Any representation to the contrary is a criminal offense.

	Per Share	Total
Initial price to public	$	$
Underwriting discount	$	$
Proceeds, before expenses, to HCA Holdings, Inc.	$	$
Proceeds, before expenses, to the selling stockholders	$	$

To the extent that the underwriters sell more than shares of common stock, the underwriters have the option to purchase up to an additional shares from us and the selling stockholders at the initial price to the public less the underwriting discount.

The underwriters expect to deliver the shares against payment in New York, New York on or about , 2011.

Joint Book-Running Managers

BofA Merrill Lynch **Citi** **J.P. Morgan**

Barclays Capital

Credit Suisse

Deutsche Bank Securities

Goldman, Sachs & Co.

Morgan Stanley

Wells Fargo Securities

Prospectus dated , 2011.

You should rely only on the information contained in this prospectus or in any free writing prospectus that we authorize be delivered to you. Neither we nor the underwriters have authorized anyone to provide you with additional or different information. If anyone provides you with additional, different or inconsistent information, you should not rely on it. We and the underwriters are not making an offer to sell these securities in any jurisdiction where an offer or sale is not permitted. You should assume that the information in this prospectus is accurate only as of the date on the front cover, regardless of the time of delivery of this prospectus or of any sale of our common stock. Our business, prospects, financial condition and results of operations may have changed since that date.

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MARKET, RANKING AND OTHER INDUSTRY DATA

The data included in this prospectus regarding markets and ranking, including the size of certain markets and our position and the position of our competitors within these markets, are based on reports of government agencies or published industry sources and estimates based on our management s knowledge and experience in the markets in which we operate. These estimates have been based on information obtained from our trade and business

organizations and other contacts in the markets in which we operate. We believe these estimates to be accurate as of the date of this prospectus. However, this information may prove to be inaccurate because of the method by which we obtained some of the data for the estimates or because this information cannot always be verified with complete certainty due to the limits on the availability and reliability of raw data, the voluntary nature of the data gathering process and other limitations and uncertainties. As a result, you should be aware that market, ranking and other similar industry data included in this prospectus, and estimates and beliefs based on that data, may not be reliable. We cannot guarantee the accuracy or completeness of any such information contained in this prospectus.

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PROSPECTUS SUMMARY

This summary highlights significant aspects of our business and this offering, but it is not complete and does not contain all of the information you should consider before making your investment decision. You should carefully read the entire prospectus, including the information presented under the section entitled Risk Factors and the financial statements and related notes, before making an investment decision. This summary contains forward-looking statements that involve risks and uncertainties. Our actual results may differ significantly from the results discussed in the forward-looking statements as a result of certain factors, including those set forth in Risk Factors and Forward-Looking Statements.

As used herein, unless otherwise stated or indicated by context, references to (i) the Issuer refer to HCA Holdings, Inc. and not its affiliates, (ii) HCA Inc. refer to HCA Inc. and its affiliates and (iii) the Company, HCA, we, our refer to HCA Inc. and its affiliates prior to the Corporate Reorganization (as defined below) and to HCA Holdings, Inc. and its affiliates after the Corporate Reorganization. The term affiliates means direct and indirect subsidiaries of HCA Holdings, 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.

The Issuer

We are a Delaware corporation and the parent company of HCA Inc., formed in connection with HCA Inc. s Corporate Reorganization. We do not have any independent operations. Accordingly, no separate historical financial statements of HCA Holdings, Inc. on a stand-alone basis are included or incorporated by reference in this prospectus.

Our Company

We are the largest non-governmental hospital operator in the U.S. and a leading comprehensive, integrated provider of health care and related services. We provide these services through a network of acute care hospitals, outpatient facilities, clinics and other patient care delivery settings. As of September 30, 2010, we operated a diversified portfolio of 162 hospitals (with approximately 41,000 beds) and 104 freestanding surgery centers across 20 states throughout the U.S. and in England. As a result of our efforts to establish significant market share in large and growing urban markets with attractive demographic and economic profiles, we currently have a substantial market presence in 14 of the top 25 fastest growing markets in the U.S. and currently maintain the first or second position, based on inpatient admissions, in many of our key markets. We believe our ability to successfully position and grow our assets in attractive markets and execute our operating plan has contributed to the strength of our financial performance over the last several years. For the year ended December 31, 2009, we generated revenues of $30.052 billion, net income attributable to HCA Inc. of $1.054 billion and Adjusted EBITDA of $5.472 billion. For the nine months ended September 30, 2010, we generated revenues of $22.947 billion, net income attributable to HCA Inc. of $924 million and Adjusted EBITDA of $4.421 billion.

Our patient-first strategy is to provide high quality health care services in a cost-efficient manner. We intend to build upon our history of profitable growth by maintaining our dedication to quality care, increasing our presence in key markets through organic expansion and strategic acquisitions, leveraging our scale and infrastructure, and further developing our physician and employee relationships. We believe pursuing these core elements of our strategy helps us develop a faster-growing, more stable and more profitable business and increases our relevance to patients, physicians, payers and employers.

Using our scale, significant resources and over 40 years of operating experience we have developed a significant management and support infrastructure. Some of the key components of our support infrastructure include a revenue cycle management organization, a health care group purchasing organization, or GPO, an information technology and services provider, a nurse staffing agency and a medical malpractice insurance underwriter. These shared services have helped us to maximize our cash collection efficiency, achieve savings in purchasing through our scale, more rapidly deploy information technology upgrades, more effectively manage our labor pool and achieve greater stability in malpractice insurance premiums. Collectively, these components have helped us to further enhance our operating effectiveness, cost efficiency and overall financial results.

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Since the founding of our business in 1968 as a single-facility hospital company, we have demonstrated an ability to consistently innovate and sustain growth during varying economic and regulatory climates. Under the leadership of an experienced senior management team, whose tenure at HCA averages over 20 years, we have established an extensive record of providing high quality care, profitably growing our business, making and integrating strategic acquisitions and efficiently and strategically allocating capital spending.

On November 17, 2006, HCA Inc. was acquired by a private investor group comprised of affiliates of or funds sponsored by Bain Capital Partners, LLC (Bain Capital), Kohlberg Kravis Roberts & Co. (KKR), Merrill Lynch Global Private Equity (MLGPE), now BAML Capital Partners (each a Sponsor), Citigroup Inc., Bank of America Corporation (the Sponsor Assignees) and HCA founder Dr. Thomas F. Frist, Jr. (the Frist Entities), a group we collectively refer to as the Investors, and by members of management and certain other investors. We refer to the merger, the financing transactions related to the merger and other related transactions collectively as the Recapitalization.

Since the Recapitalization, we have achieved substantial operational and financial progress. During this time, we have made significant investments in expanding our service lines and expanding our alignment with highly specialized and primary care physicians. In addition, we have enhanced our operating efficiencies through a number of corporate cost-saving initiatives and an expansion of our support infrastructure. We have made investments in information technology to optimize our facilities and systems. We have also undertaken a number of initiatives to improve clinical quality and patient satisfaction. As a result of these initiatives, our financial performance has improved significantly from the year ended December 31, 2007, the first full year following the Recapitalization, to the year ended December 31, 2009, with revenues growing by $3.194 billion, net income attributable to HCA Inc. increasing by $180 million and Adjusted EBITDA increasing by $880 million. This represents compounded annual growth rates on these key metrics of 5.8%, 9.8% and 9.2%, respectively.

Our Industry

We believe well-capitalized, comprehensive and integrated health care delivery providers are well-positioned to benefit from the current industry trends, some of which include:

Aging Population and Continued Growth in the Need for Health Care Services. According to the U.S. Census Bureau, the demographic age group of persons aged 65 and over is expected to experience compounded annual growth of 3.0% over the next 20 years, and constitute 19.3% of the total U.S. population by 2030. The Centers for Medicare & Medicaid Services, or CMS, projects continued increases in hospital services based on the aging of the U.S. population, advances in medical procedures, expansion of health coverage, increasing consumer demand for expanded medical services and increased prevalence of chronic conditions such as diabetes, heart disease and obesity. We believe these factors will continue to drive increased utilization of health care services and the need for comprehensive, integrated hospital networks that can provide a wide array of essential and sophisticated health care.

Continued Evolution of Quality-Based Reimbursement Favors Large-Scale, Comprehensive and Integrated Providers. We believe the U.S. health care system is continuing to evolve in ways that favor large-scale, comprehensive and integrated providers that provide high levels of quality care. Specifically, we believe there are a number of initiatives that will continue to gain importance in the foreseeable future, including: introduction of value-based payment methodologies tied to performance, quality and coordination of care, implementation of integrated electronic health records and information, and an increasing ability for patients and consumers to make choices about all aspects of health care. We believe our company is well positioned to respond to these emerging trends and has the resources, expertise and flexibility necessary to adapt in a timely manner to the changing health care regulatory and reimbursement environment.

Impact of Health Reform Law. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the Health Reform Law), will change how health care services are covered, delivered and reimbursed. It will do so through expanded coverage of uninsured individuals, significant reductions in the growth of Medicare program payments, material decreases in Medicare and Medicaid disproportionate share hospital (DSH) payments, and the establishment of

programs where reimbursement is tied in part to quality and integration. The Health Reform Law, as enacted, is expected to expand health insurance coverage to approximately 32 to 34 million additional individuals through a combination of public program expansion and private sector health insurance reforms. We believe the expansion of private sector and Medicaid coverage will, over time, increase our reimbursement related to providing services to individuals who were previously uninsured. On the other hand, the reductions in the growth in Medicare payments and the decreases in DSH payments will adversely affect our government reimbursement. Because of the many variables involved, including court challenges to the constitutionality of the law and the potential for changes to the law as a result, we are unable to predict the net impact of the Health Reform Law on us; however, we believe our experienced management team, emphasis on quality care and diverse service offerings will enable us to capitalize on the opportunities presented by the Health Reform Law, as well as adapt in a timely manner to its challenges.

Our Competitive Strengths

We believe our key competitive strengths include:

Largest Comprehensive, Integrated Health Care Delivery System. We are the largest non-governmental hospital operator in the U.S., providing approximately 4% to 5% of all U.S. hospital services through our national footprint. The scope and scale of our operations, evidenced by the types of facilities we operate, the diverse medical specialties we offer and the numerous patient care access points we provide enable us to provide a comprehensive range of health care services in a cost-effective manner. As a result, we believe the breadth of our platform is a competitive advantage in the marketplace enabling us to attract patients, physicians and clinical staff while also providing significant economies of scale and increasing our relevance with commercial payers.

Reputation for High Quality Patient-Centered Care. Since our founding, we have maintained an unwavering focus on patients and clinical outcomes. We believe clinical quality influences physician and patient choices about health care delivery. We align our quality initiatives throughout the organization by engaging corporate, local, physician and nurse leaders to share best practices and develop standards for delivering high quality care. We have invested extensively in quality of care initiatives, with an emphasis on implementing information technology and adopting industry-wide best practices and clinical protocols. As a result of these efforts, we have achieved significant progress in clinical quality, as measured by the CMS clinical core measures reported on the CMS Hospital Compare website, HCA s HQA Grand Composite Score (based on publicly available data for the twelve months ended December 31, 2009) wherein our hospitals achieved 98.1% of the CMS core measures versus the national average of 95.0%, making us among the top performing major health systems in the U.S. Similarly, based upon our hospitals core measure set composite scores, 86% are in the top quartile and 73% are in the top decile based on publicly available data for the three months ended September 30, 2010. In addition, the Health Reform Law establishes a value-based purchasing system and adjusts hospital payment rates based on hospital-acquired conditions and hospital readmissions. We also believe our quality initiatives favorably position us in a payment environment that is increasingly performance-based.

Leading Local Market Positions in Large, Growing, Urban Markets. Over our history, we have sought to selectively expand and upgrade our asset base to create a premium portfolio of assets in attractive growing markets. As a result, we have a strong market presence in 14 of the top 25 fastest growing markets in the U.S. We currently operate in 29 markets, 17 of which have populations of 1 million or more, with all but one of these markets projecting growth above the national average from 2009 to 2014. Our inpatient market share places us first or second in many of our key markets. In addition, we operate in markets that have demonstrated relative economic stability, with the unemployment rate in a majority of our markets below the national average as of September 2010. We believe the strength and stability of these market positions will create organic growth opportunities and allow us to develop long-term relationships with patients, physicians, large employers and third-party payers.

Diversified Revenue Base and Payer Mix. We believe our broad geographic footprint, varied service lines and diverse revenue base mitigate our risks in numerous ways. Our diversification limits our exposure to

competitive dynamics and economic conditions in any single local market, reimbursement changes in specific service lines and disruptions with respect to payers such as state Medicaid programs or large commercial insurers. We have a diverse portfolio of assets with no single facility contributing more than 2.4% of our revenues and no single metropolitan statistical area contributing more than 7.8% of revenues for the year ended December 31, 2009. We have also developed a highly diversified payer base, including approximately 3,000 managed care contracts, with no single commercial payer representing more than 8% of revenues for the year ended December 31, 2009. In addition, we are one of the country s largest providers of outpatient services, which accounted for approximately 38% of our revenues for the year ended December 31, 2009. We believe the geographic diversity of our markets and the scope of our inpatient and outpatient operations help reduce volatility in our operating results.

Scale and Infrastructure Drives Cost Savings and Efficiencies. Our scale allows us to leverage our support infrastructure to achieve significant cost savings and operating efficiencies, thereby driving margin expansion. We strategically manage our supply chain through centralized purchasing and supply warehouses, as well as our revenue cycle through centralized billing, collections and health information management functions. We also manage the provision of information technology through a combination of centralized systems with regional service support as well as centralize many other clinical and corporate functions, creating economies of scale in managing expenses and business processes. In addition to the cost savings and operating efficiencies, this support infrastructure simultaneously generates revenue from third parties that utilize our services.

Well-Capitalized Portfolio of High Quality Assets. In order to expand the range and improve the quality of services provided at our facilities, we invested over $7.8 billion in our facilities and information technology systems over the five-year period ended December 31, 2009. We believe our significant capital investments in these areas will continue to attract new and returning patients, attract and retain high-quality physicians, maximize cost efficiencies and address the health care needs of our local communities. Furthermore, we believe our platform as well as electronic health record infrastructure, national research and physician management capabilities provide a strategic advantage by enhancing our ability to capitalize on anticipated incentives through the HITECH provisions of the American Recovery and Reinvestment Act of 2009 and positions us well in an environment that increasingly emphasizes quality, transparency and coordination of care.

Strong Operating Results and Cash Flows. Our leading scale, diversification, favorable market positions, dedication to clinical quality and focus on operational efficiency have enabled us to achieve attractive historical financial performance even during the most recent economic period. In the year ended December 31, 2009, we generated net income attributable to HCA Inc. of $1.054 billion, Adjusted EBITDA of $5.472 billion and cash flows from operating activities of $2.747 billion, while for the nine months ended September 30, 2010, we generated net income attributable to HCA Inc. of $924 million, Adjusted EBITDA of $4.421 billion and cash flows from operating activities of $2.611 billion. Our ability to generate strong and consistent cash flow from operations has enabled us to invest in our operations, reduce our debt, enhance earnings per share and continue to pursue attractive growth opportunities.

Proven and Experienced Management Team. We believe the extensive experience and depth of our management team are a distinct competitive advantage in the complicated and evolving industry in which we compete. Our CEO and Chairman of the Board of Directors, Richard M. Bracken, began his career with our company over 28 years ago and has held various executive positions with us over that period, including, most recently, as our President and Chief Operating Officer. Our Executive Vice President, Chief Financial Officer and Director, R. Milton Johnson, joined our company over 27 years ago and has held various positions in our financial operations since that time. Our six Group Presidents average over 20 years of experience with our company. Members of our senior management hold significant equity interests in our company, further aligning their long-term interests with those of our stockholders.

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Our Growth Strategy

We are committed to providing the communities we serve with high quality, cost-effective health care while growing our business, increasing our profitability and creating long-term value for our stockholders. To achieve these objectives, we align our efforts around the following growth agenda:

Grow Our Presence in Existing Markets. We believe we are well positioned in a number of large and growing markets that will allow us the opportunity to generate long-term, attractive growth through the expansion of our presence in these markets. We plan to continue recruiting and strategically collaborating with the physician community and adding attractive service lines such as cardiology, emergency services, oncology and women s services. Additional components of our growth strategy include expanding our footprint through developing various outpatient access points, including surgery centers, rural outreach, freestanding emergency departments and walk-in clinics. Since our Recapitalization, we have invested significant capital into these markets and expect to continue to see the benefit of this investment.

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

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

Continue to Leverage Our Scale and Market Positions to Enhance Profitability. We believe there is significant opportunity to continue to grow the profitability of our company by fully leveraging the scale and scope of our franchise. We are currently pursuing next generation performance improvement initiatives such as contracting for services on a multistate basis and expanding our support infrastructure for additional clinical and support functions, such as physician credentialing, medical transcription and electronic medical recordkeeping. We believe our centrally managed business processes and ability to leverage cost-saving practices across our extensive network will enable us to continue to manage costs effectively.

Selectively Pursue a Disciplined Development Strategy. We continue to believe there are significant growth opportunities in our markets. We will continue to provide financial and operational resources to successfully execute on our in-market opportunities. To complement our in-market growth agenda, we intend to focus on selectively developing and acquiring new hospitals, outpatient facilities and other health care service providers. We believe the challenges faced by the hospital industry may spur consolidation and we believe our size, scale, national presence and access to capital will position us well to participate in any such consolidation. We have a strong record of successfully acquiring and integrating hospitals and entering into joint ventures and intend to continue leveraging this experience.

Recent Developments

On November 8, 2010, an amended and restated joinder agreement was entered into with respect to the cash flow credit facility to establish a new replacement revolving credit series, which will mature on November 17, 2015. Under the amended and restated joinder agreement, these replacement revolving credit commitments will become effective, subject to certain conditions, upon the earlier of (i) our or HCA Inc. s

initial public offering and (ii) May 17, 2012, subject to the satisfaction of certain other conditions. See Description of Indebtedness.

On November 23, 2010, our Board of Directors declared a distribution (the December 2010 distribution) to the Company s stockholders and holders of stock options of approximately $2.1 billion in the aggregate.

On November 23, 2010, we issued $1.525 billion aggregate principal amount of 73/4% senior notes due 2021. We used the proceeds, together with borrowings by HCA Inc. under its senior secured credit facilities, to fund the December 2010 distribution.

Corporate Reorganization

On November 22, 2010, HCA Inc. reorganized by creating a new holding company structure (the Corporate Reorganization). We are the new parent company, and HCA Inc. is now our wholly owned direct subsidiary. As part of the Corporate Reorganization, HCA Inc. s outstanding shares of capital stock were automatically converted, on a share for share basis, into identical shares of our common stock. Our amended and restated certificate of incorporation, amended and restated by-laws, executive officers and board of directors are the same as HCA Inc. s in effect immediately prior to the Corporate Reorganization, and the rights, privileges and interests of HCA Inc. s stockholders remain the same with respect to us as the new holding company. Additionally, as a result of the Corporate Reorganization, we are deemed the successor registrant to HCA Inc. under the Securities and Exchange Act of 1934, as amended (the Exchange Act), and shares of our common stock are deemed registered under Section 12(g) of the Exchange Act. As part of the Corporate Reorganization, we will become a guarantor but will not assume the debt of HCA Inc. s outstanding secured notes. See Description of Indebtedness.

We have assumed all of HCA Inc. s obligations with respect to the outstanding shares previously registered on Form S-8 for distribution pursuant to HCA Inc. s stock incentive plan and have also assumed HCA Inc. s other equity incentive plans that provide for the right to acquire HCA Inc. s common stock, whether or not exercisable. We have also assumed and agreed to perform HCA Inc. s obligations under its other compensation plans and agreements pursuant to which HCA Inc. is to issue equity securities to its directors, officers, or employees. The agreements and plans we assumed were each deemed to be automatically amended as necessary to provide that references therein to HCA Inc. now refer to HCA Holdings, Inc. Consequently, following the Corporate Reorganization, the right to receive HCA Inc. s common stock under its various compensation plans and agreements automatically converted into rights for the same number of shares of our common stock, with the same rights and conditions as the corresponding HCA Inc. rights prior to the Corporate Reorganization.

Risk Factors

Investing in our common stock involves substantial risk, and our ability to successfully operate our business is subject to numerous risks, including those that are generally associated with operating in the health care industry. Any of the factors set forth under Risk Factors may limit our ability to successfully execute our business strategy. You should carefully consider all of the information set forth in this prospectus and, in particular, should evaluate the specific factors set forth under Risk Factors in deciding whether to invest in our common stock. Among these important risks are the following:

- our substantial debt could limit our ability to pursue our growth strategy;
- our debt agreements contain restrictions that may limit our flexibility in operating our business;
- the current economic climate and general economic factors may adversely affect our performance;

we face intense competition that could limit our growth opportunities;

we are required to comply with extensive laws and regulations that could impact our operations;

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legal proceedings and governmental investigations could negatively impact our business; and

uninsured and patient due accounts could adversely affect our results of operations.

In addition, it is difficult to predict the impact on our company of the Health Reform Law due to the law s complexity, lack of implementing regulations or interpretive guidance, gradual and potentially delayed implementation, pending court challenges, and possible amendment, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the law. Because of the many variables involved, we are unable to predict the net effect on the Company of the Health Reform Law s planned reductions in the growth of Medicare payments, the expected increases in our revenues from providing care to previously uninsured individuals, and numerous other provisions in the law that may affect us.

Through our predecessors, we commenced operations in 1968. HCA Inc. was incorporated in Nevada in January 1990 and reincorporated in Delaware in September 1993. HCA Holdings, Inc. was incorporated in Delaware in October 2010. Our principal executive offices are located at One Park Plaza, Nashville, Tennessee 37203, and our telephone number is (615) 344-9551. Our website address is *www.hcahealthcare.com*. The information on our website is not part of this prospectus.

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The Offering

Common stock offered by HCA	shares
Common stock offered by selling stockholders	shares
Common stock to be outstanding after this offering	shares (shares if the underwriters exercise their option in full)
Use of Proceeds	We estimate that the net proceeds to us from this offering, after deducting underwriting discounts and estimated offering expenses, will be approximately $ billion, assuming the shares are offered at $ per share, which is the mid-point of the estimated offering price range set forth on the cover page of this prospectus. We intend to use the anticipated net proceeds to repay certain of our existing indebtedness, as will be determined prior to our offering, and for general corporate purposes. As a result of this application of proceeds, this offering is subject to the conflict of interest provisions of Rule 5121 of the Financial Industry Regulatory Authority, Inc. Conduct Rules (FINRA Rule 5121). We will not receive any proceeds from the sale of shares of our common stock by the selling stockholders.
Underwriters option	We and the selling stockholders have granted the underwriters a 30-day option to purchase up to additional shares of our common stock at the initial public offering price.
Dividend policy	We do not intend to pay dividends on our common stock for the foreseeable future following completion of the offering.
Risk Factors	You should carefully read and consider the information set forth under Risk Factors beginning on page 15 of this prospectus and all other information set forth in this prospectus before investing in our common stock.
Conflicts of Interest	Certain of the underwriters and their respective affiliates have, from time to time, performed, and may in the future perform, various financial advisory, investment banking, commercial banking and other services for us for which they received or will receive customary fees and expenses. See Underwriting. Merrill Lynch, Pierce, Fenner & Smith Incorporated and/or its affiliates indirectly own in excess of 10% of our issued and outstanding common stock, and is therefore deemed to be one of our affiliates and have a conflict of interest within the meaning of FINRA Rule 5121. Additionally, because we expect that more than 5% of the net proceeds of this offering

may be received by certain underwriters in this offering or their affiliates that are lenders under the senior secured credit facilities, this offering is being conducted in accordance with FINRA Rule 5121 regarding the underwriting of securities. FINRA Rule 5121 requires that a qualified independent underwriter as defined by the FINRA rules participate in the preparation of the registration statement of which this prospectus forms a part and perform its usual standard of due diligence with

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	respect thereto. Barclays Capital Inc. (Barclays Capital) has agreed to serve as the qualified independent underwriter for the offering. In addition, in accordance with FINRA Rule 5121, if Merrill Lynch, Pierce, Fenner & Smith Incorporated and/or its affiliates receives more than 5% of the net proceeds from this offering, it will not confirm sales to discretionary accounts without the prior written consent of its customers. See Underwriting Conflicts of Interest.
Proposed NYSE ticker symbol	HCA

Unless we indicate otherwise or the context requires, all information in this prospectus:

assumes (1) no exercise of the underwriters option to purchase additional shares of our common stock; and (2) an initial public offering price of $ per share, the midpoint of the initial public offering range indicated on the cover of this prospectus;

reflects the to 1 stock split that we will effectuate prior to the consummation of this offering; and

does not reflect (1) shares of our common stock issuable upon the exercise of outstanding stock options at a weighted average exercise price of $ per share as of , of which were then exercisable; and (2) shares of our common stock reserved for future grants under our stock incentive plans effective upon the consummation of this offering.

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Summary Financial Data

The following table sets forth HCA Inc. s summary financial data as of and for the periods indicated. The financial data as of December 31, 2009 and 2008 and for each of the three years ended December 31, 2009 have been derived from HCA Inc. s consolidated financial statements included elsewhere in this prospectus, which have been audited by Ernst & Young LLP. The financial data as of December 31, 2007 have been derived from HCA Inc. s consolidated financial statements audited by Ernst & Young LLP that are not included herein.

The summary financial data as of September 30, 2010 and for the nine months ended September 30, 2010 and 2009 have been derived from HCA Inc. s unaudited condensed consolidated financial statements included elsewhere in this prospectus. The summary financial data as of September 30, 2009 have been derived from HCA Inc. s unaudited condensed consolidated financial statements that are not included in this prospectus. The unaudited financial data presented have been prepared on a basis consistent with our audited consolidated financial statements. In the opinion of management, such unaudited financial data reflect all adjustments, consisting only of normal and recurring adjustments, necessary for a fair presentation of the results for those periods. The results of operations for the interim periods are not necessarily indicative of the results to be expected for the full year or any future period.

The summary financial data should be read in conjunction with, and are qualified by reference to, Selected Financial Data, Management s Discussion and Analysis of Financial Condition and Results of Operations, the consolidated financial statements and the related notes thereto and the unaudited condensed consolidated financial statements and related notes thereto appearing elsewhere in this prospectus.

	As of and for the Years Ended December 31,			As of and for the Nine Months Ended September 30,	
	2009	2008	2007	2010	2009
				(Unaudited)	
	(Dollars in millions, except per share amounts)				
Income Statement Data:					
Revenues	$ 30,052	$ 28,374	$ 26,858	$ 22,947	$ 22,447
Salaries and benefits	11,958	11,440	10,714	9,282	8,880
Supplies	4,868	4,620	4,395	3,685	3,627
Other operating expenses	4,724	4,554	4,233	3,696	3,410
Provision for doubtful accounts	3,276	3,409	3,130	2,073	2,583
Equity in earnings of affiliates	(246)	(223)	(206)	(210)	(182)
Depreciation and amortization	1,425	1,416	1,426	1,062	1,067
Interest expense	1,987	2,021	2,215	1,571	1,487
Losses (gains) on sales of facilities	15	(97)	(471)	2	8
Impairments of long-lived assets	43	64	24	119	16
	28,050	27,204	25,460	21,280	20,896
Income before income taxes	2,002	1,170	1,398	1,667	1,551
Provision for income taxes	627	268	316	488	480
Net income	1,375	902	1,082	1,179	1,071

Net income attributable to noncontrolling interests	321	229	208	255	233
Net income attributable to HCA Inc.	$ 1,054	$ 673	$ 874	$ 924	$ 838

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	As of and for the Years Ended December 31,			As of and for the Nine Months Ended September 30,	
	2009	2008	2007	2010	2009
				(Unaudited)	
	(Dollars in millions, except per share amounts)				
Earnings per share:					
Basic	$ 11.16	$ 7.16	$ 9.31	$ 9.80	$ 8.88
Diluted	10.99	7.04	9.15	9.55	8.75
Weighted average shares (shares in thousands):					
Basic	94,465	94,051	93,840	94,293	94,409
Diluted	95,945	95,668	95,453	96,718	95,761
Statement of Cash Flows Data:					
Cash flows provided by operating activities	$ 2,747	$ 1,990	$ 1,564	$ 2,611	$ 2,315
Cash flows used in investing activities	(1,035)	(1,467)	(479)	(398)	(807)
Cash flows used in financing activities	(1,865)	(451)	(1,326)	(2,148)	(1,530)
Other Financial Data:					
EBITDA(1)	$ 5,093	$ 4,378	$ 4,831	$ 4,045	$ 3,872
Adjusted EBITDA(1)	5,472	4,574	4,592	4,421	4,129
Capital expenditures	1,317	1,600	1,444	860	915
Operating Data(2):					
Number of hospitals at end of period(3)	155	158	161	154	155
Number of freestanding outpatient surgical centers at end of period(4)	97	97	99	96	97
Number of licensed beds at end of period(5)	38,839	38,504	38,405	38,636	38,829
Weighted average licensed beds(6)	38,825	38,422	39,065	38,646	38,819
Admissions(7)	1,556,500	1,541,800	1,552,700	1,167,900	1,171,200
Equivalent admissions(8)	2,439,000	2,363,600	2,352,400	1,851,100	1,835,200
Average length of stay (days)(9)	4.8	4.9	4.9	4.8	4.8
Average daily census(10)	20,650	20,795	21,049	20,647	20,782
Occupancy(11)	53%	54%	54%	53%	54%
Emergency room visits(12)	5,593,500	5,246,400	5,116,100	4,260,400	4,198,900
Outpatient surgeries(13)	794,600	797,400	804,900	583,400	593,700
Inpatient surgeries(14)	494,500	493,100	516,500	365,900	372,300
Days revenues in accounts receivable(15)	45	49	53	43	43
Gross patient revenues(16)	$ 115,682	$ 102,843	$ 92,429	$ 92,432	$ 85,582

Outpatient revenues as a percentage of patient revenues(17)	38%	37%	37%	38%	38%

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	As of and for the Years Ended December 31,			As of and for the Nine Months Ended September 30,	
	2009	2008	2007	2010	2009
				(Unaudited)	
	(Dollars in millions, except per share amounts)				
Balance Sheet Data:					
Working capital(18)	$ 2,264	$ 2,391	$ 2,356	$ 2,221	$ 2,197
Property, plant and equipment, net	11,427	11,529	11,442	11,136	11,351
Cash and cash equivalents	312	465	393	377	443
Total assets	24,131	24,280	24,025	23,253	24,120
Total debt	25,670	26,989	27,308	26,079	25,914
Equity securities with contingent redemption rights	147	155	164	144	147
Stockholders deficit attributable to HCA Inc.	(8,986)	(10,255)	(10,538)	(10,259)	(9,279)
Noncontrolling interests	1,008	995	938	1,017	990
Total stockholders deficit	(7,978)	(9,260)	(9,600)	(9,242)	(8,289)

(1) EBITDA, a measure used by management to evaluate operating performance, is defined as net income attributable to HCA Inc. plus (i) provision for income taxes, (ii) interest expense and (iii) depreciation and amortization. EBITDA is not a recognized term under GAAP and does not purport to be an alternative to net income as a measure of operating performance or to cash flows from operating activities as a measure of liquidity. Additionally, EBITDA is not intended to be a measure of free cash flow available for management s discretionary use, as it does not consider certain cash requirements such as interest payments, tax payments and other debt service requirements. Management believes EBITDA is helpful to investors and our management in highlighting trends because EBITDA excludes the results of decisions outside the control of operating management and that can differ significantly from company to company depending on long-term strategic decisions regarding capital structure, the tax jurisdictions in which companies operate and capital investments. Management compensates for the limitations of using non-GAAP financial measures by using them to supplement GAAP results to provide a more complete understanding of the factors and trends affecting the business than GAAP results alone. Because not all companies use identical calculations, our presentation of EBITDA may not be comparable to similarly titled measures of other companies.

Adjusted EBITDA is defined as EBITDA, adjusted to exclude net income attributable to noncontrolling interests, losses (gains) on sales of facilities and impairments of long-lived assets. We believe Adjusted EBITDA is an important measure that supplements discussions and analysis of our results of operations. We believe it is useful to investors to provide disclosures of our results of operations on the same basis used by management. Management relies upon Adjusted EBITDA as the primary measure to review and assess operating performance of its hospital facilities and their management teams. Adjusted EBITDA target amounts are the performance measures utilized in our annual incentive compensation programs and are vesting conditions for a portion of our stock option grants. Management and investors review both the overall performance (GAAP net income attributable to HCA Inc.) and operating performance (Adjusted EBITDA) of our health care facilities. Adjusted EBITDA and the Adjusted EBITDA margin (Adjusted EBITDA divided by revenues) are utilized by management and investors to compare our current operating results with the corresponding periods during the previous year and to compare our operating results with other companies in the health care industry. It is reasonable to expect that losses (gains) on sales of facilities and impairment of long-lived assets will occur in

future periods, but the amounts recognized can vary significantly from period to period, do not directly relate to the ongoing operations of our health care facilities and complicate period comparisons of our results of operations and operations comparisons with other health care companies. Adjusted EBITDA is not a measure of financial performance under accounting principles generally accepted in the United States, and should not be considered an alternative

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to net income attributable to HCA Inc. as a measure of operating performance or cash flows from operating, investing and financing activities as a measure of liquidity. Because Adjusted EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is susceptible to varying calculations, Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures presented by other companies.

EBITDA and Adjusted EBITDA are calculated as follows:

	Years Ended December 31,			Nine Months Ended September 30,	
	2009	2008	2007	2010	2009
				(Unaudited)	
	(Dollars in millions)				
Net income attributable to HCA Inc.	$ 1,054	$ 673	$ 874	$ 924	$ 838
Provision for income taxes	627	268	316	488	480
Interest expense	1,987	2,021	2,215	1,571	1,487
Depreciation and amortization	1,425	1,416	1,426	1,062	1,067
EBITDA	5,093	4,378	4,831	4,045	3,872
Net income attributable to noncontrolling interests(i)	321	229	208	255	233
Losses (gains) on sales of facilities(ii)	15	(97)	(471)	2	8
Impairments of long-lived assets(iii)	43	64	24	119	16
Adjusted EBITDA	$ 5,472	$ 4,574	$ 4,592	$ 4,421	$ 4,129

(i) Represents the add-back of net income attributable to noncontrolling interests.

(ii) Represents the elimination of losses (gains) on sales of facilities.

(iii) Represents the add-back of impairments of long-lived assets.

(2) The operating data set forth in this table includes only those facilities that are consolidated for financial reporting purposes.

(3) Excludes eight facilities in 2010, 2009, 2008 and 2007 that are not consolidated (accounted for using the equity method) for financial reporting purposes.

(4) Excludes eight facilities in 2010, 2009 and 2008 and nine facilities in 2007 that are not consolidated (accounted for using the equity method) for financial reporting purposes.

(5) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(6) Weighted average licensed beds represents the average number of licensed beds, weighted based on periods owned.

(7) 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.

(8) 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 revenues and gross outpatient revenues and then dividing the resulting amount by gross inpatient revenues. The equivalent admissions computation equates outpatient revenues to the volume measure (admissions) used to measure inpatient volume, resulting in a general measure of combined inpatient and outpatient volume.

(9) Represents the average number of days admitted patients stay in our hospitals.

(10) Represents the average number of patients in our hospital beds each day.

(11) 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.

(12) Represents the number of patients treated in our emergency rooms.

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(13) 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.

(14) 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.

(15) Revenues per day is calculated by dividing the revenues for the period by the days in the period. Days revenues in accounts receivable is then calculated as accounts receivable, net of the allowance for doubtful accounts, at the end of the period divided by revenues per day.

(16) Gross patient revenues are based upon our standard charge listing. Gross charges/revenues do not reflect what our hospital facilities are paid. Gross charges/revenues are reduced by contractual adjustments, discounts and charity care to determine reported revenues.

(17) Represents the percentage of patient revenues related to patients who are not admitted to our hospitals.

(18) We define working capital as current assets minus current liabilities.

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RISK FACTORS

An investment in our common stock involves risk. You should carefully consider the following risks as well as the other information included in this prospectus, including Management s Discussion and Analysis of Financial Condition and Results of Operations and the financial statements and related notes included elsewhere in this prospectus, before investing in our common stock. Any of the following risks could materially and adversely affect our business, financial condition or results of operations. However, the selected risks described below are not the only risks facing us. Additional risks and uncertainties not currently known to us or those we currently view to be immaterial may also materially and adversely affect our business, financial condition or results of operations. In such a case, the trading price of the common stock could decline, and you may lose all or part of your investment in us.

Risks Related to Our Business

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

The health care business is highly competitive, and competition among hospitals and other health care providers for patients has intensified in recent years. Generally, other hospitals in the local communities we serve provide services similar to those offered by our hospitals. In addition, CMS publicizes on its Medicare website performance data related to quality measures and data on patient satisfaction surveys hospitals submit in connection with their Medicare reimbursement. Federal law provides for the future expansion of the number of quality measures that must be reported. Additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes. Further, the Health Reform Law requires all hospitals to annually establish, update and make public a list of the hospital s standard charges for items and services. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures or on patient satisfaction surveys or if our standard charges are higher than our competitors, our patient volumes could decline.

In addition, the number of freestanding specialty hospitals, surgery centers and diagnostic and imaging centers in the geographic areas in which we operate has increased significantly. As a result, most of our hospitals operate in a highly competitive environment. Some of the facilities that compete with our hospitals are owned by governmental agencies or not-for-profit corporations supported by endowments, charitable contributions and/or tax revenues and can finance capital expenditures and operations on a tax-exempt basis. Our hospitals are facing increasing competition from specialty hospitals, some of which are physician-owned, and from both our own and unaffiliated freestanding surgery centers for market share in high margin services and for quality physicians and personnel. If ambulatory surgery centers are better able to compete in this environment than our hospitals, our hospitals may experience a decline in patient volume, and we may experience a decrease in margin, even if those patients use our ambulatory surgery centers. In states that do not require a Certificate of Need (CON) for the purchase, construction or expansion of health care facilities or services, competition in the form of new services, facilities and capital spending is more prevalent. Further, if our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than our hospitals and ambulatory surgery centers, we may experience an overall decline in patient volume. See Business Competition.

The growth of uninsured and patient due accounts and a deterioration in the collectibility of these accounts could adversely affect our results of operations.

The primary collection risks of our accounts receivable relate to the uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. The provision for doubtful accounts relates

primarily to amounts due directly from patients.

The amount of the provision for doubtful accounts is based upon management s assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal and state governmental and private employer health care coverage, the rate of growth in uninsured patient admissions and other collection indicators. At September 30, 2010, our allowance for doubtful accounts represented

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approximately 93% of the $4.615 billion patient due accounts receivable balance. The sum of the provision for doubtful accounts, uninsured discounts and charity care increased from $6.134 billion for 2007 to $7.009 billion for 2008 and to $8.362 billion for 2009.

A continuation of the trends that have resulted in an increasing proportion of accounts receivable being comprised of uninsured accounts and a deterioration in the collectibility of these accounts will adversely affect our collection of accounts receivable, cash flows and results of operations. Prior to the Health Reform Law being fully implemented, our facilities may experience growth in bad debts, uninsured discounts and charity care as a result of a number of factors, including the economic downturn and increase in unemployment. As enacted, the Health Reform Law seeks to decrease, over time, the number of uninsured individuals. Among other things, the Health Reform Law will, effective January 1, 2014, expand Medicaid and incentivize employers to offer, and require individuals to carry, health insurance or be subject to penalties. However, there have been more than 20 court challenges to the law, which are in various procedural stages. A federal district court recently ruled that the requirement for individuals to carry health insurance is unconstitutional. This ruling is subject to appeal as are other cases that have been dismissed or ruled the law constitutional. It is difficult to predict the full impact of the Health Reform Law due to the law s complexity, lack of implementing regulations or interpretive guidance, gradual and potentially delayed implementation, pending court challenges, and possible amendment, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the law. In addition, even after implementation of the Health Reform Law, we may continue to experience bad debts and have to provide uninsured discounts and charity care for undocumented aliens who are not permitted to enroll in a health insurance exchange or government health care programs.

Changes in government health care programs may reduce our revenues.

A significant portion of our patient volume is derived from government health care programs, principally Medicare and Medicaid. Specifically, we derived approximately 40% of our revenues from the Medicare and Medicaid programs in 2009. Changes in government health care programs may reduce the reimbursement we receive and could adversely affect our business and results of operations.

In recent years, legislative and regulatory changes have resulted in limitations on and, in some cases, reductions in levels of payments to health care providers for certain services under the Medicare program. For example, CMS completed a two-year transition to full implementation of the Medicare severity diagnosis-related group (MS-DRG) system, which represents a refinement to the existing diagnosis-related group system. Future realignments in the MS-DRG system could impact the margins we receive for certain services. Further, the Health Reform Law provides for material reductions in the growth of Medicare program spending, including reductions in Medicare market basket updates, and Medicare DSH funding. Medicare payments in federal fiscal year 2011 for inpatient hospital services are expected to be slightly lower than payments for the same services in federal fiscal year 2010 because of reductions resulting from the Health Reform Law and the MS-DRG implementation.

Since most states must operate with balanced budgets and since the Medicaid program is often a state s largest program, some states can be expected to enact or consider enacting legislation designed to reduce their Medicaid expenditures. The current economic downturn has increased the budgetary pressures on many states, and these budgetary pressures have resulted, and likely will continue to result, in decreased spending for Medicaid programs and the Children s Health Insurance Program (CHIP) in many states. Further, many states have also adopted, or are considering, legislation designed to reduce coverage, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems. Effective March 23, 2010, the Health Reform Law requires states to at least maintain Medicaid eligibility standards established prior to the enactment of the law for adults until January 1, 2014 and for children until October 1, 2019. However, states with budget deficits may seek exceptions from this requirement to address eligibility standards that apply to adults making more than 133% of the federal poverty level. The Health Reform Law provides for material reductions to Medicare

DSH funding. The Health Reform Law also provides for significant expansions to the Medicaid program, but these changes are not required until 2014. In addition, the Health Reform Law will result in increased state legislative and regulatory changes in

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order for states to comply with new federal mandates, such as the requirement to establish health insurance exchanges, and to participate in grants and other incentive opportunities.

In some cases, commercial third-party payers rely on all or portions of the MS-DRG system to determine payment rates, which may result in decreased reimbursement from some commercial third-party payers. Other changes to government health care programs may negatively impact payments from commercial third-party payers.

Current or future health care reform efforts, changes in laws or regulations regarding government health care programs, other changes in the administration of government health care programs and changes to commercial third-party payers in response to health care reform and other changes to government health care programs could have a material, adverse effect on our financial position and results of operations.

We are unable to predict the impact of the Health Reform Law, which represents a significant change to the health care industry.

As enacted, the Health Reform Law will change how health care services are covered, delivered, and reimbursed through expanded coverage of uninsured individuals, reduced growth in Medicare program spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. In addition, the law reforms certain aspects of health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality, and contains provisions intended to strengthen fraud and abuse enforcement.

The expansion of health insurance coverage under the Health Reform Law may result in a material increase in the number of patients using our facilities who have either private or public program coverage. In addition, a disproportionately large percentage of the new Medicaid coverage is likely to be in states that currently have relatively low income eligibility requirements. Two such states are Texas and Florida, where about one-half of our licensed beds are located. We also have a significant presence in other relatively low income eligibility states, including Georgia, Kansas, Louisiana, Missouri, Oklahoma and Virginia. Further, the Health Reform Law provides for a value-based purchasing program, the establishment of Accountable Care Organizations (ACOs) and bundled payment pilot programs, which will create possible sources of additional revenue.

However, it is difficult to predict the size of our potential revenue gains as a result of these elements of the Health Reform Law, because of uncertainty surrounding a number of material factors, including the following:

- how many previously uninsured individuals will obtain coverage as a result of the Health Reform Law (while the Congressional Budget Office (CBO) estimates 32 million, CMS estimates almost 34 million; both agencies made a number of assumptions to derive that figure, including how many individuals will ignore substantial subsidies and decide to pay the penalty rather than obtain health insurance and what percentage of people in the future will meet the new Medicaid income eligibility requirements);

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

- the extent to which states will enroll new Medicaid participants in managed care programs;

- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;

- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;

the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created American Health Benefit Exchanges (Exchanges) and those who might be covered under the Medicaid program under contracts with the state;

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- the rate paid by state governments under the Medicaid program for newly covered individuals;

- how the value-based purchasing and other quality programs will be implemented;

- the percentage of individuals in the Exchanges who select the high deductible plans, since health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;

- whether the net effect of the Health Reform Law, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and

- the possibility that implementation of provisions expanding health insurance coverage will be delayed or even blocked due to court challenges or revised or eliminated as a result of court challenges and efforts to repeal or amend the new law. More than twenty challenges to the Health Reform Law have been filed in federal courts. Although some federal district courts have upheld the constitutionality of the Health Reform Law or dismissed cases on procedural grounds, on December 13, 2010, a Virginia federal district court held the requirement that individuals maintain health insurance or pay a penalty to be unconstitutional, while leaving the remainder of the Health Reform Law intact. These lawsuits are subject to appeal.

On the other hand, the Health Reform Law provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. Since approximately 40% of our revenues in 2009 were from Medicare and Medicaid, reductions to these programs may significantly impact us and could offset any positive effects of the Health Reform Law. It is difficult to predict the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from Medicare and Medicaid business when the reductions are implemented;

- whether reductions required by the Health Reform Law will be changed by statute prior to becoming effective;

- the size of the Health Reform Law s annual productivity adjustment to the market basket beginning in 2012 payment years;

- the amount of the Medicare DSH reductions that will be made, commencing in federal fiscal year 2014;

- the allocation to our hospitals of the Medicaid DSH reductions, commencing in federal fiscal year 2014;

- what the losses in revenues will be, if any, from the Health Reform Law s quality initiatives;

- how successful ACOs, in which we participate, will be at coordinating care and reducing costs or whether they will decrease reimbursement;

- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs;

whether our revenues from upper payment limit (UPL) programs will be adversely affected, because there may be fewer indigent, non-Medicaid patients for whom the Company provides services pursuant to UPL programs; and

reductions to Medicare payments CMS may impose for excessive readmissions.

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Because of the many variables involved, we are unable to predict the net effect on us of the expected increases in insured individuals using our facilities, the reductions in Medicare spending, reductions in Medicare and Medicaid DSH funding, and numerous other provisions in the Health Reform Law that may affect us. Further, it is unclear how federal lawsuits challenging the constitutionality of the Health Reform Law will be resolved or what the impact will be of any resulting changes to the law. For example, should the requirement that individuals maintain health insurance ultimately be deemed unconstitutional but the prohibition on health insurers excluding coverage due to pre-existing conditions be maintained, significant disruption to the health insurance industry could result, which could impact our revenues and operations.

If we are unable to retain and negotiate favorable contracts with nongovernment payers, including managed care plans, our revenues may be reduced.

Our ability to obtain favorable contracts with nongovernment payers, including health maintenance organizations, preferred provider organizations and other managed care plans significantly affects the revenues and operating results of our facilities. Revenues derived from these entities and other insurers accounted for 53%, 52% and 53% of our patient revenues for the nine months ended September 30, 2010 and the years ended December 31, 2009 and December 31, 2008, respectively. Nongovernment payers, including managed care payers, continue to demand discounted fee structures, and the trend toward consolidation among nongovernment payers tends to increase their bargaining power over fee structures. As various provisions of the Health Reform Law are implemented, including the establishment of the Exchanges, nongovernment payers increasingly may demand reduced fees. 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 terms favorable to us. 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. It is not clear what impact, if any, the increased obligations on managed care payers and other payers imposed by the Health Reform Law will have on our ability to negotiate reimbursement increases. If we are unable to retain and negotiate favorable contracts with managed care plans or experience reductions in payment increases or amounts received from nongovernment payers, our revenues may be reduced.

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

The success of our hospitals depends in part on the number and quality of the physicians on the medical staffs of our hospitals, the admitting practices of those physicians and maintaining good relations with those physicians. Although we employ some physicians, physicians are often not employees of the hospitals at which they practice and, in many of the markets we serve, most physicians have admitting privileges at other hospitals in addition to our hospitals. Such physicians may terminate their affiliation with our hospitals at any time. If we are unable to provide adequate support personnel or technologically advanced equipment and hospital facilities that meet the needs of those physicians and their patients, they may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline.

Our hospitals face competition for staffing, which may increase labor costs and reduce profitability.

Our operations are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians, as well as our physicians. We compete with other health care providers in recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our hospitals, including nurses and other nonphysician health care professionals. In some markets, the availability of nurses and other medical support personnel has been a significant operating issue to health care providers. We may be required to continue to enhance wages and benefits to recruit and retain nurses and other

medical support personnel or to hire more expensive temporary or contract personnel. As a result, our labor costs could increase. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Certain proposed changes in federal labor laws, including the Employee Free Choice Act, could increase the likelihood of employee unionization attempts. To the extent a significant portion of our employee base unionizes, it is possible our

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labor costs could increase materially. When negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur during the negotiation process, and our continued operation during any strikes could increase our labor costs. In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control labor costs, could have a material, adverse effect on our results of operations.

If we fail to comply with extensive laws and government regulations, we could suffer penalties or be required to make significant changes to our operations.

The health care industry is required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things:

billing and coding for services and properly handling overpayments;

relationships with physicians and other referral sources;

necessity and adequacy of medical care;

quality of medical equipment and services;

qualifications of medical and support personnel;

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

the screening, stabilization and transfer of individuals who have emergency medical conditions;

licensure and certification;

hospital rate or budget review;

preparing and filing of cost reports;

operating policies and procedures;

activities regarding competitors; and

addition of facilities and services.

Among these laws are the federal Anti-kickback Statute, the federal physician self-referral law (commonly called the Stark Law), the federal False Claims Act (FCA) and similar state laws. We have a variety of financial relationships with physicians and others who either refer or influence the referral of patients to our hospitals and other health care facilities, and these laws govern those relationships. The Office of Inspector General of the Department of Health and Human Services (OIG) has enacted safe harbor regulations that outline practices deemed protected from prosecution

under the Anti-kickback Statute. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements, including joint ventures and financial relationships with physicians and other referral sources and persons and entities to which we refer patients, do not qualify for safe harbor protection. Failure to qualify for a safe harbor does not mean the arrangement necessarily violates the Anti-kickback Statute, but may subject the arrangement to greater scrutiny. However, we cannot offer assurance that practices outside of a safe harbor will not be found to violate the Anti-kickback Statute. Allegations of violations of the Anti-kickback Statute may be brought under the federal Civil Monetary Penalty Law, which requires a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute.

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Our financial relationships with referring physicians and their immediate family members must comply with the Stark Law by meeting an exception. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot provide assurance that every relationship complies fully with the Stark Law. Unlike the Anti-kickback Statute, failure to meet an exception under the Stark Law results in a violation of the Stark Law, even if such violation is technical in nature.

Additionally, if we violate the Anti-kickback Statute or Stark Law, or if we improperly bill for our services, we may be found to violate the FCA, either under a suit brought by the government or by a private person under a *qui tam*, or whistleblower, suit.

If we fail to comply with the Anti-kickback Statute, the Stark Law, the FCA or other applicable laws and regulations, we could be subjected to liabilities, including civil penalties (including the loss of our licenses to operate one or more facilities), exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs and, for violations of certain laws and regulations, criminal penalties. See Regulation and Other Factors.

Because many of these laws and their implementing regulations are relatively new, we do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. In the future, different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material, adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly. In addition, other legislation or regulations at the federal or state level may be adopted that adversely affect our business.

We have been and could become the subject of governmental investigations, claims and litigation.

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

Governmental agencies and their agents, such as the Medicare Administrative Contractors, fiscal intermediaries and carriers, as well as the OIG, CMS and state Medicaid programs, conduct audits of our health care operations. Private payers may conduct similar post-payment audits, and we also perform internal audits and monitoring. Depending on the nature of the conduct found in such audits and whether the underlying conduct could be considered systemic, the resolution of these audits could have a material, adverse effect on our financial position, results of operations and liquidity.

As required by statute, CMS is in the process of implementing the Recovery Audit Contractor (RAC) program on a nationwide basis. Under the program, CMS contracts with RACs to conduct post-payment reviews to detect and correct improper payments in the Medicare program. The Health Reform Law expands the RAC program s scope to include managed Medicare and to include Medicaid claims by requiring all states to establish programs to contract with RACs by December 31, 2010. In addition, CMS employs Medicaid Integrity Contractors (MICs) to perform post-payment audits of Medicaid claims and identify overpayments. The Health Reform Law increases federal funding for the MIC program for federal fiscal year 2011 and later years. In addition to RACs and MICs, the state

Medicaid agencies and other contractors have increased their review activities.

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Should we be found out of compliance with any of these laws, regulations or programs, depending on the nature of the findings, our business, our financial position and our results of operations could be negatively impacted. See Business Legal Proceedings Government Investigations, Claims and Litigation.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare, managed Medicare, Medicaid, managed Medicaid and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as utilization review, have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by health plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. For example, the Health Reform Law potentially expands the use of prepayment review by Medicare contractors by eliminating statutory restrictions on their use. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

Our overall business results may suffer from the economic downturn.

During periods of high unemployment, governmental entities often experience budget deficits as a result of increased costs and lower than expected tax collections. These budget deficits at federal, state and local government entities have decreased, and may continue to decrease, spending for health and human service programs, including Medicare, Medicaid and similar programs, which represent significant payer sources for our hospitals. Other risks we face during periods of high unemployment include potential declines in the population covered under managed care agreements, patient decisions to postpone or cancel elective and non-emergency health care procedures, potential increases in the uninsured and underinsured populations and further difficulties in our collecting patient co-payment and deductible receivables.

The industry trend towards value-based purchasing may negatively impact our revenues.

There is a trend in the health care industry toward value-based purchasing of health care services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events (also called never events). Many large commercial payers currently require hospitals to report quality data, and several commercial payers do not reimburse hospitals for certain preventable adverse events. Further, we have implemented a policy pursuant to which we do not bill patients or third-party payers for fees or expenses incurred due to certain preventable adverse events.

The Health Reform Law contains a number of provisions intended to promote value-based purchasing. Effective July 1, 2011, the Health Reform Law will prohibit the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat hospital acquired conditions (HACs). Beginning in federal fiscal year 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. Hospitals with excessive readmissions for conditions designated by the Department of Health and Human Services (HHS) will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard.

The Health Reform Law also requires HHS to implement a value-based purchasing program for inpatient hospital services. The Health Reform Law requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1% in federal fiscal year 2013 and increasing by 0.25% each fiscal year up to 2% in federal fiscal year 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance

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standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenues.

Our operations could be impaired by a failure of our information systems.

Any system failure that causes an interruption in service or availability of our systems could adversely affect operations or delay the collection of revenues. Even though we have implemented network security measures, our servers are vulnerable to computer viruses, break-ins and similar disruptions from unauthorized tampering. The occurrence of any of these events could result in interruptions, delays, the loss or corruption of data, cessations in the availability of systems or liability under privacy and security laws, all of which could have a material adverse effect on our financial position and results of operations and harm our business reputation.

The performance of our information technology and systems is critical to our business operations. In addition to our shared services initiatives, our information systems are essential to a number of critical areas of our operations, including:

accounting and financial reporting;

billing and collecting accounts;

coding and compliance;

clinical systems;

medical records and document storage;

inventory management;

negotiating, pricing and administering managed care contracts and supply contracts; and

monitoring quality of care and collecting data on quality measures necessary for full Medicare payment updates.

If we fail to effectively and timely implement electronic health record systems, our operations could be adversely affected.

As required by the American Recovery and Reinvestment Act of 2009, the Secretary of the Department of HHS is in the process of developing and implementing an incentive payment program for eligible hospitals and health care professionals that adopt and meaningfully use certified electronic health record (EHR) technology. HHS intends to use the Provider Enrollment, Chain and Ownership System (PECOS) to verify Medicare enrollment prior to making EHR incentive program payments. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, including having an enrollment record in PECOS, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. Further, beginning in federal fiscal year 2015, eligible hospitals and professionals that fail to demonstrate meaningful use of certified EHR technology will be subject to reduced payments from Medicare. Failure to implement EHR systems

effectively and in a timely manner could have a material, adverse effect on our financial position and results of operations.

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

Some states, particularly in the eastern part of the country, require health care providers to obtain prior approval, known as a CON, for the purchase, construction or expansion of health care facilities, to make

certain capital expenditures or to make changes in services or bed capacity. In giving approval, these states consider the need for additional or expanded health care facilities or services. We currently operate health care facilities in a number of states with CON laws. The failure to obtain any requested CON could impair our ability to operate or expand operations. Any such failure could, in turn, adversely affect our ability to attract patients to our facilities and grow our revenues, which would have an adverse effect on our results of operations.

Our facilities are heavily concentrated in Florida and Texas, which makes us sensitive to regulatory, economic, environmental and competitive conditions and changes in those states.

We operated 162 hospitals at September 30, 2010, and 72 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities combined revenues represented approximately 52% and 51%, respectively, of our consolidated revenues for the nine months ended September 30, 2010 and year ended December 31, 2009. This concentration makes us particularly sensitive to regulatory, economic, environmental and competitive conditions and changes in those states. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in those states could have a disproportionate effect on our overall business results.

In addition, our hospitals in Florida and Texas and other areas across the Gulf Coast are located in hurricane-prone areas. In the recent past, hurricanes have had a disruptive effect on the operations of our hospitals in Florida, Texas and other coastal states, and the patient populations in those states. Our business activities could be harmed by a particularly active hurricane season or even a single storm, and the property insurance we obtain may not be adequate to cover losses from future hurricanes or other natural disasters.

We may be subject to liabilities from claims by the Internal Revenue Service.

We are currently contesting, before the Internal Revenue Service (IRS) Appeals Division, certain claimed deficiencies and adjustments proposed by the IRS Examination Division in connection with its audit of HCA Inc. s 2005 and 2006 federal income tax returns. The disputed items include the timing of recognition of certain patient service revenues, the deductibility of certain debt retirement costs and our method for calculating the tax allowance for doubtful accounts. In addition, eight taxable periods of HCA Inc. and its predecessors ended in 1997 through 2004, for which the primary remaining issue is the computation of the tax allowance for doubtful accounts, are currently pending before the IRS Examination Division. The IRS Examination Division began an audit of HCA Inc. s 2007, 2008 and 2009 federal income tax returns in December 2010.

Management believes HCA Inc., its predecessors, subsidiaries and affiliates properly reported taxable income and paid taxes in accordance with applicable laws and agreements established with the IRS and final resolution of these disputes will not have a material, adverse effect on our results of operations or financial position. However, if payments due upon final resolution of these issues exceed our recorded estimates, such resolutions could have a material, adverse effect on our results of operations or financial position.

We may be subject to liabilities from claims brought against our facilities.

We are subject to litigation relating to our business practices, including claims and legal actions by patients and others in the ordinary course of business alleging malpractice, product liability or other legal theories. See Business Legal Proceedings. Many of these actions involve large claims and significant defense costs. We insure a portion of our professional liability risks through a wholly owned subsidiary. Management believes our reserves for self-insured retentions and insurance coverage are sufficient to cover insured claims arising out of the operation of our facilities. Our wholly owned insurance subsidiary has entered into certain reinsurance contracts, and the obligations covered by the reinsurance contracts are included in its reserves for professional liability risks, as the subsidiary remains liable to the extent that the reinsurers do not meet their obligations under the reinsurance contracts. If payments for claims

exceed actuarially determined estimates, are not covered by insurance, or reinsurers, if any, fail to meet their obligations, our results of operations and financial position could be adversely affected.

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We are exposed to market risks related to changes in the market values of securities and interest rate changes.

We are exposed to market risk related to changes in market values of securities. The investments in debt and equity securities of our wholly owned insurance subsidiary were $790 million and $8 million, respectively, at September 30, 2010. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At September 30, 2010, we had a net unrealized gain of $16 million on the insurance subsidiary s investment securities.

We are exposed to market risk related to market illiquidity. Liquidity of the investments in debt and equity securities of our wholly owned insurance subsidiary could be impaired by the inability to access the capital markets. Should the wholly owned insurance subsidiary require significant amounts of cash in excess of normal cash requirements to pay claims and other expenses on short notice, we may have difficulty selling these investments in a timely manner or be forced to sell them at a price less than what we might otherwise have been able to in a normal market environment. At September 30, 2010, our wholly owned insurance subsidiary had invested $260 million ($261 million par value) in tax-exempt student loan auction rate securities that continue to experience market illiquidity. It is uncertain if auction-related market liquidity will resume for these securities. We may be required to recognize other-than-temporary impairments on these long-term investments in future periods should issuers default on interest payments or should the fair market valuations of the securities deteriorate due to ratings downgrades or other issue specific factors.

We are also exposed to market risk related to changes in interest rates, and we periodically enter into interest rate swap agreements to manage our exposure to these fluctuations. Our interest rate swap agreements involve the exchange of fixed and variable rate interest payments between two parties, based on common notional principal amounts and maturity dates. The notional amounts of the swap agreements represent balances used to calculate the exchange of cash flows and are not our assets or liabilities. See Management s Discussion and Analysis of Financial Condition and Results of Operations Market Risk.

Risks Related to Our Indebtedness

Our substantial leverage could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of our variable rate debt and prevent us from meeting our obligations.

We are highly leveraged. As of September 30, 2010, our total indebtedness was $26.079 billion and, on November 23, 2010, we issued an additional $1.525 billion of senior notes. Our high degree of leverage could have important consequences, including:

- increasing our vulnerability to downturns or adverse changes in general economic, industry or competitive conditions and adverse changes in government regulations;
- requiring a substantial portion of cash flow from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flow to fund our operations, capital expenditures and future business opportunities;
- exposing us to the risk of increased interest rates as certain of our unhedged borrowings are at variable rates of interest;
- limiting our ability to make strategic acquisitions or causing us to make nonstrategic divestitures;

limiting our ability to obtain additional financing for working capital, capital expenditures, product or service line development, debt service requirements, acquisitions and general corporate or other purposes; and

limiting our ability to adjust to changing market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged.

We and our subsidiaries have the ability to incur additional indebtedness in the future, subject to the restrictions contained in HCA Inc. s senior secured credit facilities and the indentures governing our and HCA

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Inc. s outstanding notes. If new indebtedness is added to our current debt levels, the related risks that we now face could intensify.

We may not be able to generate sufficient cash to service all of our indebtedness and may not be able to refinance our indebtedness on favorable terms. If we are unable to do so, we may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which are subject to prevailing economic and competitive conditions and to certain financial, business and other factors beyond our control. We cannot assure you we will maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness.

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

We may find it necessary or prudent to refinance our outstanding indebtedness with longer-maturity debt at a higher interest rate. In February, April and August of 2009 and, in March of 2010, for example, HCA Inc. issued $310 million in aggregate principal amount of 97/8% second lien notes due 2017, $1.500 billion in aggregate principal amount of 81/2% first lien notes due 2019, $1.250 billion in aggregate principal amount of 77/8% first lien notes due 2020 and $1.400 billion in aggregate principal amount of 71/4% first lien notes due 2020, respectively. The net proceeds of those offerings were used to prepay term loans under HCA Inc. s cash flow credit facility, which currently bears interest at a lower floating rate. Our ability to refinance our indebtedness on favorable terms, or at all, is directly affected by the current global economic and financial conditions. In addition, our ability to incur secured indebtedness (which would generally enable us to achieve better pricing than the incurrence of unsecured indebtedness) depends in part on the value of our assets, which depends, in turn, on the strength of our cash flows and results of operations, and on economic and market conditions and other factors.

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

Our and HCA Inc. s debt agreements contain restrictions that limit our flexibility in operating our business.

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

- incur additional indebtedness or issue certain preferred shares;

pay dividends on, repurchase or make distributions in respect of our capital stock or make other restricted payments;

make certain investments;

sell or transfer assets;

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create liens;

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

enter into certain transactions with our affiliates.

Under HCA Inc. s asset-based revolving credit facility, when (and for as long as) the combined availability under HCA Inc. s asset-based revolving credit facility and HCA Inc. s senior secured revolving credit facility is less than a specified amount for a certain period of time or, if a payment or bankruptcy event of default has occurred and is continuing, funds deposited into any of HCA Inc. s depository accounts will be transferred on a daily basis into a blocked account with the administrative agent and applied to prepay loans under the asset-based revolving credit facility and to cash collateralize letters of credit issued thereunder.

Under HCA Inc. s senior secured credit facilities, HCA Inc. is required to satisfy and maintain specified financial ratios. Its ability to meet those financial ratios can be affected by events beyond our control, and there can be no assurance HCA Inc. will continue to meet those ratios. A breach of any of these covenants could result in a default under both the cash flow credit facility and the asset-based revolving credit facility. Upon the occurrence of an event of default under the senior secured credit facilities, the lenders thereunder could elect to declare all amounts outstanding under the senior secured credit facilities to be immediately due and payable and terminate all commitments to extend further credit. If HCA Inc. were unable to repay those amounts, the lenders under the senior secured credit facilities could proceed against the collateral granted to them to secure such indebtedness. HCA Inc. has pledged a significant portion of its assets as collateral under HCA Inc. s senior secured credit facilities, and that collateral (other than certain European collateral securing HCA Inc. s senior secured European term loan facility) is also pledged as collateral under HCA Inc. s first lien notes. If any of the lenders under the senior secured credit facilities accelerate the repayment of borrowings, there can be no assurance there will be sufficient assets to repay the senior secured credit facilities, the first lien notes and our senior notes.

Risks Related to this Offering and Ownership of Our Common Stock

An active, liquid trading market for our common stock may not develop.

After our Recapitalization and prior to this offering, there has not been a public market for our common stock. We cannot predict the extent to which investor interest in our company will lead to the development of a trading market on the New York Stock Exchange or otherwise or how active and liquid that market may become. If an active and liquid trading market does not develop, you may have difficulty selling any of our common stock that you purchase. The initial public offering price for the shares will be determined by negotiations between us and the underwriters and may not be indicative of prices that will prevail in the open market following this offering. The market price of our common stock may decline below the initial offering price, and you may not be able to sell your shares of our common stock at or above the price you paid in this offering, or at all.

You will incur immediate and substantial dilution in the net tangible book value of the shares you purchase in this offering.

Prior investors have paid substantially less per share of our common stock than the price in this offering. The initial public offering price of our common stock is substantially higher than the net tangible book value per share of outstanding common stock prior to completion of the offering. Based on our net tangible book value as of September 30, 2010 and upon the issuance and sale of shares of common stock by us at an assumed initial public offering price of $ per share (the midpoint of the initial public offering price range indicated on the cover of

this prospectus), if you purchase our common stock in this offering, you will pay more for your shares than the amounts paid by our existing stockholders for their shares and you will suffer immediate dilution of approximately $ per share in net tangible book value. We also have a large number of outstanding stock options to purchase common stock with exercise prices that are below the estimated initial public offering price of our common stock. To the extent that these options are exercised, you will experience further dilution. See Dilution.

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Our stock price may change significantly following the offering, and you could lose all or part of your investment as a result.

We and the underwriters will negotiate to determine the initial public offering price. You may not be able to resell your shares at or above the initial public offering price due to a number of factors such as those listed in Risks Related to Our Business and the following, some of which are beyond our control:

- quarterly variations in our results of operations;
- results of operations that vary from the expectations of securities analysts and investors;
- results of operations that vary from those of our competitors;
- changes in expectations as to our future financial performance, including financial estimates by securities analysts and investors;
- announcements by us, our competitors or our vendors of significant contracts, acquisitions, joint marketing relationships, joint ventures or capital commitments;
- announcements by third parties or governmental entities of significant claims or proceedings against us;
- new laws and governmental regulations applicable to the health care industry, including the Health Reform Law;
- a default under the agreements governing our indebtedness;
- future sales of our common stock by us, directors, executives and significant stockholders; and
- changes in domestic and international economic and political conditions and regionally in our markets.

Furthermore, the stock market has recently experienced extreme volatility that, in some cases, has been unrelated or disproportionate to the operating performance of particular companies. These broad market and industry fluctuations may adversely affect the market price of our common stock, regardless of our actual operating performance.

In the past, following periods of market volatility, stockholders have instituted securities class action litigation. If we were involved in securities litigation, it could have a substantial cost and divert resources and the attention of executive management from our business regardless of the outcome of such litigation.

If we or our existing investors sell additional shares of our common stock after this offering, the market price of our common stock could decline.

The market price of our common stock could decline as a result of sales of a large number of shares of common stock in the market after this offering, or the perception that such sales could occur. These sales, or the possibility that these sales may occur, also might make it more difficult for us to sell equity securities in the future at a time and at a price that we deem appropriate. After the completion of this offering, we will have million shares of common stock outstanding (million shares if the underwriters exercise their option to purchase additional shares in full). This number includes million shares that are being sold in this offering, which may be resold immediately in the public market.

We and the selling stockholders, our executive officers and directors and the Investors have agreed not to sell or transfer any common stock or securities convertible into, exchangeable for, exercisable for, or repayable with common stock, for 180 days after the date of this prospectus without first obtaining the written consent of two of the representatives of the underwriters. In addition, pursuant to stockholders agreements, we have granted certain members of our management and other stockholders the right to cause us, in certain instances, at our expense, to file registration statements under the Securities Act of 1933, as amended (the Securities Act) covering resales of our common stock held by them. These shares will represent approximately % of our outstanding common stock after this offering, or % if the underwriters exercise their option to purchase additional shares in full. These shares also may be sold pursuant to Rule 144 under the Securities Act, depending on their holding period and subject to restrictions in the case of shares held by persons deemed to be our affiliates. As restrictions on resale end or if these stockholders exercise their registration rights, the market price of our stock could decline if the holders of restricted shares sell them or are perceived by the market as intending to sell them. See Certain Relationships and Related Party Transactions Stockholder

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Agreements Management Stockholder s Agreement, Certain Relationships and Related Party Transactions Registration Rights Agreement, Shares Eligible for Future Sale and Underwriting.

As of , 2010, shares of our common stock were outstanding, shares were issuable upon the exercise of outstanding vested stock options under our stock incentive plans, shares were subject to outstanding unvested stock options under our stock incentive plans, and shares were reserved for future grant under our stock incentive plans. Shares acquired upon the exercise of vested options under our stock incentive plan will first become eligible for resale days after the date of this prospectus. Sales of a substantial number of shares of our common stock following the vesting of outstanding stock options could cause the market price of our common stock to decline.

Because we do not currently intend to pay cash dividends on our common stock for the foreseeable future, you may not receive any return on investment unless you sell your common stock for a price greater than that which you paid for it.

We currently intend to retain future earnings, if any, for future operation, expansion and debt repayment and do not intend to pay any cash dividends for the foreseeable future. Any decision to declare and pay dividends in the future will be made at the discretion of our board of directors (the Board or the Board of Directors) and will depend on, among other things, our results of operations, financial condition, cash requirements, contractual restrictions and other factors that our Board of Directors may deem relevant. In addition, our ability to pay dividends may be limited by covenants of any existing and future outstanding indebtedness we or our subsidiaries incur, including our senior secured credit facilities and the indentures governing our notes. As a result, you may not receive any return on an investment in our common stock unless you sell our common stock for a price greater than that which you paid for it.

Some provisions of Delaware law and our governing documents could discourage a takeover that stockholders may consider favorable.

In addition to the Investors ownership of a controlling percentage of our common stock, Delaware law and provisions contained in our amended and restated certificate of incorporation and amended and restated by-laws as we expect them to be in effect upon completion of this offering could make it difficult for a third party to acquire us, even if doing so might be beneficial to our stockholders. For example, our amended and restated certificate of incorporation authorizes our Board of Directors to determine the rights, preferences, privileges and restrictions of unissued preferred stock, without any vote or action by our stockholders. As a result, our Board could authorize and issue shares of preferred stock with voting or conversion rights that could adversely affect the voting or other rights of holders of our common stock or with other terms that could impede the completion of a merger, tender offer or other takeover attempt. In addition, as described under Description of Capital Stock Delaware Anti-Takeover Statutes elsewhere in this prospectus, we are subject to certain provisions of Delaware law that may discourage potential acquisition proposals and may delay, deter or prevent a change of control of our company, including through transactions, and, in particular, unsolicited transactions, that some or all of our stockholders might consider to be desirable. As a result, efforts by our stockholders to change the direction or management of our company may be unsuccessful.

The Investors will continue to have significant influence over us after this offering, including control over decisions that require the approval of stockholders, which could limit your ability to influence the outcome of key transactions, including a change of control.

We are controlled, and after this offering is completed will continue to be controlled, by the Investors. The Investors will indirectly own through their investment in Hercules Holding II, LLC (Hercules Holding) approximately % of our common stock (or % if the underwriters exercise their option to purchase additional shares in full) after the completion of this offering. In addition, representatives of the Investors will have the right to designate a majority of the seats on our Board of Directors. As a result, the Investors will have control over our decisions to enter into any

corporate transaction (and the terms thereof) and the ability to prevent any change in the composition of our Board of Directors and any transaction that requires stockholder approval regardless of whether others believe that such change or transaction is in our best

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interests. So long as the Investors continue to indirectly hold a majority of our outstanding common stock, they will have the ability to control the vote in any election of directors, amend our amended and restated certificate of incorporation or amended and restated by-laws or take other actions requiring the vote of our stockholders. Even if such amount is less than 50%, the Investors will continue to be able to strongly influence or effectively control our decisions.

Additionally, Bain Capital, KKR, and BAML Capital Partners, the successor organization to MLGPE (each a Sponsor, collectively, the Sponsors), are in the business of making investments in companies and may acquire and hold interests in businesses that compete directly or indirectly with us. One or more of the Sponsors may also pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us.

We are a controlled company within the meaning of the New York Stock Exchange rules and, as a result, will qualify for, and intend to rely on, exemptions from certain corporate governance requirements. You will not have the same protections afforded to stockholders of companies that are subject to such requirements.

After completion of this offering, the Investors will continue to control a majority of the voting power of our outstanding common stock. As a result, we are a controlled company within the meaning of the corporate governance standards of the New York Stock Exchange. Under these rules, a company of which more than 50% of the voting power is held by an individual, group or another company is a controlled company and may elect not to comply with certain corporate governance requirements, including:

- the requirement that a majority of the Board of Directors consist of independent directors;
- the requirement that we have a nominating/corporate governance committee that is composed entirely of independent directors with a written charter addressing the committee s purpose and responsibilities;
- the requirement that we have a compensation committee that is composed entirely of independent directors with a written charter addressing the committee s purpose and responsibilities; and
- the requirement for an annual performance evaluation of the nominating/corporate governance and compensation committees.

Following this offering, we intend to utilize these exemptions. As a result, we will not have a majority of independent directors, our nominating and corporate governance committee, if any, and compensation committee will not consist entirely of independent directors and such committees will not be subject to annual performance evaluations. Accordingly, you will not have the same protections afforded to stockholders of companies that are subject to all of the corporate governance requirements of the New York Stock Exchange.

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FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements within the meaning of the federal securities laws, which involve risks and uncertainties. Forward-looking statements include all statements that do not relate solely to historical or current facts, and you can identify forward-looking statements because they contain words such as believes, expects, may, will, should, seeks, approximately, intends, plans, estimates, projects, continue, initiative expressions that concern our prospects, objectives, strategies, plans or intentions. All statements made relating to our estimated and projected earnings, margins, costs, expenditures, cash flows, growth rates, operating and growth strategies, ability to repay or refinance our substantial existing indebtedness and financial results or to the impact of existing or proposed laws or regulations (including the Health Reform Law) described in this prospectus are forward-looking statements. These forward-looking statements are subject to risks and uncertainties that may change at any time, and, therefore, our actual results may differ materially from those expected. We derive many of our forward-looking statements from our operating budgets and forecasts, which are based upon many detailed assumptions. While we believe our assumptions are reasonable, it is very difficult to predict the impact of known factors, and, of course, it is impossible to anticipate all factors that could affect our actual results. These factors include, but are not limited to:

- the ability to recognize the benefits of the Recapitalization;
- the impact of the substantial indebtedness incurred to finance the Recapitalization and distributions to stockholders and the ability to refinance such indebtedness on acceptable terms;
- the effects related to the enactment of the Health Reform Law and the possible enactment of additional federal or state health care reform and changes in federal, state or local laws or regulations affecting the health care industry;
- increases in the amount and risk of collectibility of uninsured accounts, and deductibles and copayment amounts for insured accounts;
- the ability to achieve operating and financial targets, attain expected levels of patient volumes and control the costs of providing services;
- possible changes in the Medicare, Medicaid and other state programs, including Medicaid supplemental payments pursuant to UPL programs, that may impact reimbursements to health care providers and insurers;
- the highly competitive nature of the health care business;
- changes in revenue mix, including potential declines in the population covered under managed care agreements, and the ability to enter into and renew managed care provider agreements on acceptable terms;
- the efforts of insurers, health care providers and others to contain health care costs;
- the outcome of our continuing efforts to monitor, maintain and comply with appropriate laws, regulations, policies and procedures;
- increases in wages and the ability to attract and retain qualified management and personnel, including affiliated physicians, nurses and medical and technical support personnel;

the availability and terms of capital to fund the expansion of our business and improvements to our existing facilities;

changes in accounting practices;

changes in general economic conditions nationally and regionally in our markets;

future divestitures of assets, which may result in charges, and possible impairments of long-lived assets;

changes in business strategy or development plans;

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delays in receiving payments for services provided;

the outcome of pending and any future tax audits, appeals and litigation associated with our tax positions;

potential liabilities and other claims that may be asserted against us; and

other risk factors described in this prospectus.

All subsequent written and oral forward-looking statements attributable to us, or persons acting on our behalf, are expressly qualified in their entirety by these cautionary statements.

We caution you that the important factors discussed above may not contain all of the material factors that are important to you. The forward-looking statements included in this prospectus are made only as of the date hereof. We undertake no obligation to publicly update or revise any forward-looking statement as a result of new information, future events or otherwise, except as otherwise required by law.

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USE OF PROCEEDS

We estimate that the gross proceeds we will receive from the sale of shares of our common stock sold by us in this offering, excluding the underwriters option to purchase additional shares, will be $ billion. We estimate that the net proceeds we will receive from the sale of shares of our common stock in this offering, after deducting underwriter discounts and commissions and estimated expenses payable by us, will be approximately $ billion (or $ billion if the underwriters exercise the option to purchase additional shares in full). This estimate assumes an initial public offering price of $ per share, the midpoint of the range set forth on the cover page of this prospectus. A $1.00 increase (decrease) in the assumed initial public offering price of $ per share would increase (decrease) the net proceeds to us from this offering by $ million, assuming the number of shares offered by us, as set forth on the cover page of this prospectus, remains the same and after deducting the estimated underwriting discounts and commissions and estimated expenses payable by us. We will not receive any proceeds from the sale of shares of our common stock by the selling stockholders.

We intend to use the anticipated net proceeds from this offering to repay certain of our existing indebtedness, as will be determined prior to this offering, and for general corporate purposes.

Affiliates of certain of the underwriters are lenders under our senior secured credit facilities and, accordingly, may receive a portion of the net proceeds from this offering through repayment of such indebtedness. See Underwriting Conflicts of Interest.

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DIVIDEND POLICY

Following completion of the offering, we do not intend to pay any cash dividends on our common stock for the foreseeable future and instead may retain earnings, if any, for future operation and expansion and debt repayment. Any decision to declare and pay dividends in the future will be made at the discretion of our Board of Directors and will depend on, among other things, our results of operations, cash requirements, financial condition, contractual restrictions and other factors that our Board of Directors may deem relevant. In addition, our ability to pay dividends is limited by covenants in our senior secured credit facilities and in the indentures governing certain of our notes. See Description of Indebtedness and Note 9 to our consolidated financial statements for restrictions on our ability to pay dividends.

On January 27, 2010, HCA Inc. s Board of Directors declared a distribution to its stockholders and holders of vested stock options of $1.751 billion in the aggregate. On May 5, 2010, HCA Inc. s Board of Directors declared a distribution to its stockholders and holders of vested stock options of $500 million in the aggregate. On November 23, 2010, our Board of Directors declared a distribution to our stockholders and holders of stock options of approximately $2.1 billion.

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CAPITALIZATION

The following table sets forth our capitalization as of September 30, 2010:

on an actual basis; and

on an as adjusted basis to give effect to (1) the issuance of common stock in this offering and the application of proceeds from the offering as described in Use of Proceeds as if each had occurred on September 30, 2010, (2) the to 1 stock split that will be effectuated prior to the consummation of this offering, (3) our $1.525 billion senior notes issued in November 2010, (4) our $2.080 billion distribution declared in November 2010 and (5) the payment of approximately $ million in fees under our management agreement with the Sponsors in connection with its termination. See Certain Relationships and Related Party Transactions Sponsor Management Agreement.

You should read this table in conjunction with Use of Proceeds, Selected Financial Data, and Management s Discussion and Analysis of Financial Condition and Results of Operations and the financial statements and notes thereto, included elsewhere in this prospectus.

	September 30, 2010	
	Actual	As Adjusted
	(In millions)	
Cash and cash equivalents	$ 377	$
Long-term obligations:		
Senior secured credit facilities(1)	$ 9,316	$
Senior secured first lien notes(2)	4,073	
Senior secured second lien notes(3)	6,079	
Other secured indebtedness	331	
Unsecured indebtedness(4)	6,280	
Total long-term obligations	26,079	
Equity securities with contingent redemption rights	144	
Stockholders deficit:		
Common stock: $.01 par value; authorized shares; 94,644,100 and outstanding shares, actual and as adjusted	1	
Capital in excess of par value	324	
Accumulated other comprehensive loss	(494)	
Retained deficit	(10,090)	
Stockholders deficit attributable to HCA Inc.	(10,259)	
Noncontrolling interests	1,017	
Total stockholders deficit	(9,242)	

Total capitalization(5)	$ 16,981	$

(1) Consists of, (i) a $2.000 billion asset-based revolving credit facility maturing on November 16, 2012 (the asset-based revolving credit facility) ($1.750 billion outstanding at September 30, 2010); (ii) a $2.000 billion senior secured revolving credit facility maturing on November 17, 2012 and to be extended to November 17, 2015 pursuant to the amended and restated joinder agreement entered into on November 8, 2010 (see Description of Indebtedness) (the senior secured revolving credit facility) (none outstanding at September 30, 2010, without giving effect to outstanding letters of credit and, for purposes of the As Adjusted column only, $ million outstanding); (iii) a $2.750 billion senior secured term loan A facility maturing on November 17, 2012 ($1.618 billion outstanding at September 30, 2010); (iv) an $8.800 billion senior secured term loan B facility consisting of a $6.800 billion senior secured term loan B-1 facility maturing on November 17, 2013 and a $2.000 billion senior secured term loan B-2 facility maturing on

March 31, 2017 ($3.525 billion outstanding under term loan B-1 facility at September 30, 2010 and $2.000 billion outstanding under term loan B-2 facility at September 30, 2010); and (v) a 1.000 billion senior secured European term loan facility maturing on November 17, 2013 (311 million, or $423 million-equivalent, outstanding at September 30, 2010). We refer to the facilities described under (ii) through (v) above, collectively, as the cash flow credit facility and, together with the asset-based revolving credit facility, the senior secured credit facilities.

(2) In April 2009, HCA Inc. issued $1.500 billion aggregate principal amount of first lien notes at a price of 96.755% of their face value, resulting in $1.451 billion of gross proceeds, which were used to repay obligations under our cash flow credit facility after the payment of related fees and expenses. In August 2009, HCA Inc. issued $1.250 billion aggregate principal amount of first lien notes at a price of 98.254% of their face value, resulting in $1.228 billion of gross proceeds, which were used to repay obligations under our cash flow credit facility after the payment of related fees and expenses. In March 2010, HCA Inc. issued $1.400 billion aggregate principal amount of first lien notes at a price of 99.095% of their face value, resulting in approximately $1.387 billion of gross proceeds, which were used to repay obligations under its cash flow credit facility after the payment of related fees and expenses. In each case, the discount will accrete and be included in interest expense until the applicable first lien notes mature. As of September 30, 2010, there was $77 million of unamortized discount.

(3) Consists of $4.200 billion of second lien notes (comprised of $1.000 billion of 91/8% notes due 2014 and $3.200 billion of 91/4% notes due 2016) and $1.578 billion of 95/8%/103/8% second lien toggle notes (which allow HCA Inc., at its option, to pay interest in kind during the first five years at the higher interest rate of 103/8%) due 2016. In addition, in February 2009 we issued $310 million aggregate principal amount of 97/8% second lien notes due 2017 at a price of 96.673% of their face value, resulting in $300 million of gross proceeds, which were used to repay obligations under its cash flow credit facility after payment of related fees and expenses. The discount on the 2009 second lien notes will accrete and be included in interest expense until those 2009 second lien notes mature. As of September 30, 2010, there was $9 million of unamortized discount.

(4) Consists of (i) an aggregate principal amount of $246 million medium-term notes with maturities in 2014 and 2025 and a weighted average interest rate of 8.28%; (ii) an aggregate principal amount of $886 million debentures with maturities ranging from 2015 to 2095 and a weighted average interest rate of 7.55%; (iii) an aggregate principal amount of $4.967 billion senior notes with maturities ranging from 2011 to 2033 and a weighted average interest rate of 6.62%; (iv) £121 million ($190 million-equivalent at September 30, 2010) aggregate principal amount of 8.75% senior notes due 2010; (v) $9 million of unamortized debt discounts that reduce the existing indebtedness and (vi) for purposes of the As Adjusted column only, $1.525 billion of 73/4% senior notes due 2021. For more information regarding our unsecured and other indebtedness, see Description of Indebtedness.

(5) A $1.00 increase (decrease) in the assumed initial public offering price of $ per share would increase (decrease) each of cash and cash equivalents, equity and total capitalization by $, $ and $, respectively, assuming the number of shares offered by us, as set forth on the cover page of this prospectus, remains the same and after deducting the estimated underwriting discounts and commissions and estimated expenses payable by us.

The table set forth above is based on the number of shares of our common stock outstanding as of September 30, 2010. This table does not reflect:

shares of our common stock issuable upon the exercise of outstanding stock options at a weighted average exercise price of $ per share as of September 30, 2010, of which were then exercisable; and

shares of our common stock reserved for future grants under our stock incentive plans.

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DILUTION

If you invest in our common stock, your interest will be diluted to the extent of the difference between the initial public offering price per share of our common stock and the net tangible book value per share of our common stock after this offering. Dilution results from the fact that the initial public offering price per share of common stock is substantially in excess of the net tangible book value per share of our common stock attributable to the existing stockholders for our presently outstanding shares of common stock. We calculate net tangible book value per share of our common stock by dividing the net tangible book value (total consolidated tangible assets less total consolidated liabilities) by the number of outstanding shares of our common stock.

Our net tangible book value as of September 30, 2010 was a deficit of $(12.1) billion or $ per share of our common stock, based on shares of our common stock outstanding. Dilution is determined by subtracting net tangible book value per share of our common stock from the assumed initial public offering price per share of our common stock.

Without taking into account any other changes in such net tangible book value after September 30, 2010, after giving effect to the sale of shares of our common stock in this offering assuming an initial public offering price of $ per share, less the underwriting discounts and commissions and the estimated offering expenses payable by us, our pro forma as adjusted net tangible book value at September 30, 2010 would have been $, or $ per share. This represents an immediate increase in net tangible book value of $ per share of our common stock to the existing stockholders and an immediate dilution in net tangible book value of $ per share of our common stock, to investors purchasing shares of our common stock in this offering. The following table illustrates such dilution per share of our common stock:

Assumed initial public offering price per share of our common stock	$
Net tangible book value per share of our common stock as of September 30, 2010	
Pro forma net tangible book value per share of our common stock after giving effect to this offering	
Amount of dilution in net tangible book value per share of our common stock to new investors in this offering	

If the underwriters exercise their overallotment option in full, the adjusted net tangible book value per share of our common stock after giving effect to the offering would be $ per share of our common stock. This represents an increase in adjusted net tangible book value of $ per share of our common stock to existing stockholders and dilution in adjusted net tangible book value of $ per share of our common stock to new investors.

A $1.00 increase (decrease) in the assumed initial public offering price of $ per share of our common stock would increase (decrease) our net tangible book value after giving to the offering by $ million, or by $ per share of our common stock, assuming no change to the number of shares of our common stock offered by us as set forth on the cover page of this prospectus, and after deducting the estimated underwriting discounts and estimated expenses payable by us.

The following table summarizes, on a pro forma basis as of September 30, 2010, the total number of shares of our common stock purchased from us, the total cash consideration paid to us and the average price per share of our common stock paid by purchasers of such shares and by new investors purchasing shares of our common stock in this offering.

	Shares of our Common Stock Purchased		Total Consideration		Average Price Per Share of our Common Stock
	Number	Percent	Amount	Percent	
Prior purchasers		%	$	%	$
New investors		%	$	%	$
Total		%	$	%	$

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If the underwriters were to fully exercise their overallotment option to purchase additional shares of our common stock from us and the selling stockholders, the percentage of shares of our common stock held by existing stockholders who are directors, officers or affiliated persons would be %, and the percentage of shares of shares of our common stock held by new investors would be %.

To the extent that we grant options to our employees or directors in the future, and those options or existing options are exercised or other issuances of shares of our common stock are made, there will be further dilution to new investors.

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SELECTED FINANCIAL DATA

The following table sets forth selected financial data of HCA Inc. as of the dates and for the periods indicated. The selected financial data as of December 31, 2009 and 2008 and for each of the three years ended December 31, 2009 have been derived from HCA Inc. s consolidated financial statements appearing elsewhere in this prospectus, which have been audited by Ernst & Young LLP. The selected financial data as of December 31, 2007, 2006 and 2005 and for each of the two years in the period ended December 31, 2006 presented in this table have been derived from HCA Inc. s consolidated financial statements audited by Ernst & Young LLP that are not included in this prospectus.

The selected financial data as of September 30, 2010 and for the nine months ended September 30, 2010 and 2009 have been derived from HCA Inc. s unaudited condensed consolidated financial statements included elsewhere in this prospectus. The selected financial data as of September 30, 2009 have been derived from HCA Inc. s unaudited condensed consolidated financial statements that are not included in this prospectus. The unaudited financial data presented have been prepared on a basis consistent with our audited consolidated financial statements. In the opinion of management, such unaudited financial data reflect all adjustments, consisting only of normal and recurring adjustments, necessary for a fair presentation of the results for those periods. The results of operations for the interim periods are not necessarily indicative of the results to be expected for the full year or any future period.

The selected financial data set forth below should be read in conjunction with, and are qualified by reference to, Management s Discussion and Analysis of Financial Condition and Results of Operations, the consolidated financial statements and the related notes thereto and the unaudited condensed consolidated financial statements and related notes thereto appearing elsewhere in this prospectus.

	As of and for the Years Ended December 31,					As of and for the Nine Months Ended September 30,	
	2009	2008	2007	2006	2005	2010	2009
						(Unaudited)	
	(Dollars in millions, except per share amounts)						
Summary of Operations:							
Revenues	$ 30,052	$ 28,374	$ 26,858	$ 25,477	$ 24,455	$ 22,947	$ 22,447
Salaries and benefits	11,958	11,440	10,714	10,409	9,928	9,282	8,880
Supplies	4,868	4,620	4,395	4,322	4,126	3,685	3,627
Other operating expenses	4,724	4,554	4,233	4,056	4,034	3,696	3,410
Provision for doubtful accounts	3,276	3,409	3,130	2,660	2,358	2,073	2,583
Equity in earnings of affiliates	(246)	(223)	(206)	(197)	(221)	(210)	(182)
Gains on sales of investments				(243)	(53)		
Depreciation and amortization	1,425	1,416	1,426	1,391	1,374	1,062	1,067
Interest expense	1,987	2,021	2,215	955	655	1,571	1,487
	15	(97)	(471)	(205)	(78)	2	8

Losses (gains) on sales of facilities							
Impairments of long-lived assets	43	64	24	24		119	16
Transaction costs				442			
	28,050	27,204	25,460	23,614	22,123	21,280	20,896
Income before income taxes	2,002	1,170	1,398	1,863	2,332	1,667	1,551
Provision for income taxes	627	268	316	626	730	488	480
Net income	1,375	902	1,082	1,237	1,602	1,179	1,071
Net income attributable to noncontrolling interests	321	229	208	201	178	255	233
Net income attributable to HCA Inc.	$ 1,054	$ 673	$ 874	$ 1,036	$ 1,424	$ 924	$ 838

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	As of and for the Years Ended December 31,					As of and for the Nine Months Ended September 30,	
	2009	2008	2007	2006	2005	2010	2009
						(Unaudited)	
	(Dollars in millions, except per share amounts)						
gs per share:							
	$ 11.16	$ 7.16	$ 9.31	(a)	(a)	$ 9.80	$ 8
d	10.99	7.04	9.15	(a)	(a)	9.55	8
ted average shares s in thousands):							
	94,465	94,051	93,840	(a)	(a)	94,293	94,4
d	95,945	95,668	95,453	(a)	(a)	96,718	95,7
cial Position:							
	$ 24,131	$ 24,280	$ 24,025	$ 23,675	$ 22,225	$ 23,253	$ 24,
ng capital	2,264	2,391	2,356	2,502	1,320	2,221	2,
term debt, including ts due within one	25,670	26,989	27,308	28,408	10,475	26,079	25,9
securities with gent redemption	147	155	164	125		144	
ntrolling interests	1,008	995	938	907	828	1,017	9
holders (deficit)	(7,978)	(9,260)	(9,600)	(10,467)	5,691	(9,242)	(8,2
Flow Data:							
provided by ing activities	$ 2,747	$ 1,990	$ 1,564	$ 1,988	$ 3,162	$ 2,611	$ 2,3
sed in investing ies	(1,035)	(1,467)	(479)	(1,307)	(1,681)	(398)	(8
l expenditures	(1,317)	(1,600)	(1,444)	(1,865)	(1,592)	(860)	(9
sed in financing ies	(1,865)	(451)	(1,326)	(383)	(1,403)	(2,148)	(1,3
ating Data:							
er of hospitals at period(b)	155	158	161	166	175	154	
er of freestanding ient surgical centers of period(c)	97	97	99	98	87	96	
er of licensed beds of period(d)	38,839	38,504	38,405	39,354	41,265	38,636	38,8
ted average ed beds(e)	38,825	38,422	39,065	40,653	41,902	38,646	38,8
ssions(f)	1,556,500	1,541,800	1,552,700	1,610,100	1,647,800	1,167,900	1,171,2
alent admissions(g)	2,439,000	2,363,600	2,352,400	2,416,700	2,476,600	1,851,100	1,835,2
	4.8	4.9	4.9	4.9	4.9	4.8	

ge length of stay (h)							
ge daily census(i)	20,650	20,795	21,049	21,688	22,225	20,647	20,
ancy(j)	53%	54%	54%	53%	53%	53%	
gency room visits(k)	5,593,500	5,246,400	5,116,100	5,213,500	5,415,200	4,260,400	4,198,
tient surgeries(l)	794,600	797,400	804,900	820,900	836,600	583,400	593,
ent surgeries(m)	494,500	493,100	516,500	533,100	541,400	365,900	372,
evenues in nts receivable(n)	45	49	53	53	50	43	
patient revenues(o)	$ 115,682	$ 102,843	$ 92,429	$ 84,913	$ 78,662	$ 92,432	$ 85,
tient revenues as a patient revenues(p)	38%	37%	37%	36%	36%	38%	

(a) Due to our November 2006 merger and Recapitalization, our capital structure and share-based compensation plans for periods before and after the Recapitalization are not comparable, therefore we are presenting earnings per share information only for periods subsequent to the Recapitalization.

(b) Excludes eight facilities in 2010, 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.

(c) Excludes eight facilities in 2010, 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.

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(d) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(e) Weighted average licensed beds represents the average number of licensed beds, weighted based on periods owned.

(f) 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.

(g) 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.

(h) Represents the average number of days admitted patients stay in our hospitals.

(i) Represents the average number of patients in our hospital beds each day.

(j) 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.

(k) Represents the number of patients treated in our emergency rooms.

(l) 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.

(m) 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.

(n) Revenues per day is calculated by dividing the revenues for the period by the days in the period. Days revenues in accounts receivable is then calculated as accounts receivable, net of the allowance for doubtful accounts, at the end of the period divided by revenues per day.

(o) Gross patient revenues are based upon our standard charge listing. Gross charges/revenues do not reflect what our hospital facilities are paid. Gross charges/revenues are reduced by contractual adjustments, discounts and charity care to determine reported revenues.

(p) Represents the percentage of patient revenues related to patients who are not admitted to our hospitals.

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MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

You should read the following discussion of our results of operations and financial condition with Selected Financial Data and the consolidated financial statements and related notes included elsewhere in this prospectus. This discussion contains forward-looking statements and involves numerous risks and uncertainties, including, but not limited to, those described in the Risk Factors section of this prospectus. Actual results may differ materially from those contained in any forward-looking statements.

You also should read the following discussion of our results of operations and financial condition with Business Business Drivers and Measures for a discussion of certain of our important financial policies and objectives; performance measures and operational factors we use to evaluate our financial condition and operating performance; and our business segments.

Overview

We are the largest non-governmental hospital operator in the U.S. and a leading comprehensive, integrated provider of health care and related services. At September 30, 2010, we operated 162 hospitals, comprised of 156 general, acute care hospitals; five psychiatric hospitals; and one rehabilitation hospital. The 162 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 104 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. For the year ended December 31, 2009, we generated revenues of $30.052 billion and net income attributable to HCA Inc. of $1.054 billion, and for the nine months ended September 30, 2010, we generated revenues of $22.947 billion and net income attributable to HCA Inc. of $924 million.

On November 17, 2006, HCA Inc. was acquired by a private investor group comprised of affiliates of or funds sponsored by Bain Capital, KKR, MLGPE (now BAML Capital Partners), Citigroup Inc., Bank of America Corporation and HCA founder Dr. Thomas F. Frist, Jr., and by members of management and certain other investors. We refer to the merger, the financing transactions related to the merger and other related transactions collectively as the Recapitalization.

Nine Months Ended September 30, 2010 Operations Summary

Net income attributable to HCA Inc. totaled $924 million in the nine months ended September 30, 2010, compared to $838 million in the nine months ended September 30, 2009. Revenues increased to $22.947 billion in the nine months ended September 30, 2010 from $22.447 billion in the first nine months of 2009. Losses on sales of facilities were $2 million and impairments of long-lived assets were $119 million for the nine months ended September 30, 2010. Losses on sales of facilities were $8 million and impairments of long-lived assets were $16 million for the nine months ended September 30, 2009.

Revenues increased 2.2% on a consolidated basis and 2.3% on a same facility basis for the nine months ended September 30, 2010 compared to the nine months ended September 30, 2009. The increase in consolidated revenues can be attributed to the combined impact of a 1.3% increase in revenue per equivalent admission and a 0.9% increase in equivalent admissions. The same facility revenues increase resulted from the combined impact of a 1.2% increase in same facility revenue per equivalent admission and a 1.1% increase in same facility equivalent admissions.

During the nine months ended September 30, 2010, consolidated admissions declined 0.3% and same facility admissions were flat compared to the nine months ended September 30, 2009. Inpatient surgeries declined 1.7% on both a consolidated basis and a same facility basis during the nine months ended September 30, 2010, compared to the nine months ended September 30, 2009. Outpatient surgeries declined 1.7% on a consolidated basis and declined 1.5% on a same facility basis during the nine months ended September 30, 2010, compared to the nine months ended September 30, 2009. Emergency department visits increased

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1.5% on a consolidated basis and increased 1.7% on a same facility basis during the nine months ended September 30, 2010, compared to the nine months ended September 30, 2009.

For the nine months ended September 30, 2010, the provision for doubtful accounts declined $510 million to 9.0% of revenues, from 11.5% of revenues for the nine months ended September 30, 2009. The self-pay revenue deductions for charity care and uninsured discounts increased $113 million and $1.316 billion (we increased our uninsured discount percentages during August 2009), respectively, during the first nine months of 2010, compared to the first nine months of 2009. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of revenues, uninsured discounts and charity care, was 25.3% for the first nine months of 2010, compared to 23.7% for the first nine months of 2009. Same facility uninsured admissions increased 4.2% and same facility uninsured emergency room visits increased 0.6% for the nine months ended September 30, 2010, compared to the nine months ended September 30, 2009.

The increases in the self-pay revenue deductions resulted in reductions to both the provision for doubtful accounts and revenues, and were the primary contributing factors to the lower growth rates we experienced in revenues and revenue per equivalent admission during the nine months ended September 30, 2010.

Interest expense increased $84 million to $1.571 billion for the nine months ended September 30, 2010, from $1.487 billion for the nine months ended September 30, 2009. The additional interest expense was due primarily to an increase in the average effective interest rate.

Cash flows from operating activities increased $296 million, from $2.315 billion for the first nine months of 2009 to $2.611 billion for the first nine months of 2010. The increase related primarily to a decline in income tax payments, changes in working capital items and an increase in net income.

2009 Operations Summary

Net income attributable to HCA Inc. totaled $1.054 billion for 2009, compared to $673 million for 2008. The 2009 results include losses on sales of facilities of $15 million and impairments of long-lived assets of $43 million. The 2008 results include gains on sales of facilities of $97 million and impairments of long-lived assets of $64 million.

Revenues increased to $30.052 billion for 2009 from $28.374 billion for 2008. Revenues increased 5.9% on a consolidated basis and 6.1% on a same facility basis for 2009, compared to 2008. The consolidated revenues increase can be attributed to the combined impact of a 2.6% increase in revenue per equivalent admission and a 3.2% increase in equivalent admissions. The same facility revenues increase resulted from a 2.6% increase in same facility revenue per equivalent admission and a 3.4% increase in same facility equivalent admissions.

During 2009, consolidated admissions increased 1.0% and same facility admissions increased 1.2%, compared to 2008. Inpatient surgical volumes increased 0.3% on a consolidated basis and increased 0.5% on a same facility basis during 2009, compared to 2008. Outpatient surgical volumes declined 0.4% on a consolidated basis and declined 0.1% on a same facility basis during 2009, compared to 2008. Emergency department visits increased 6.6% on a consolidated basis and increased 7.0% on a same facility basis during 2009, compared to 2008.

For 2009, the provision for doubtful accounts declined to 10.9% of revenues from 12.0% of revenues for 2008. The combined self-pay revenue deductions for charity care and uninsured discounts increased $1.486 billion for 2009, compared to 2008. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of net revenues, uninsured discounts and charity care, was 23.8% for 2009, compared to 21.9% for 2008. Same facility uninsured admissions increased 4.7% and same facility uninsured emergency room visits increased 6.5% for 2009, compared to 2008.

Interest expense totaled $1.987 billion for 2009, compared to $2.021 billion for 2008. The $34 million decline in interest expense for 2009 was due to a reduction in the average debt balance offsetting an increase in the average interest rate.

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Critical Accounting Policies and Estimates

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

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

Revenues

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

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires any hospital participating in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital s emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize the condition or make an appropriate transfer of the individual to a facility able to handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual s ability to pay for treatment. Federal and state laws and regulations, including but not limited to EMTALA, require, and our commitment to providing quality patient care encourages, the provision of services to patients who are financially unable to pay for the health care services they receive. The Health Reform Law requires health plans offered through an Exchange to reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place. Further, as enacted, the Health Reform Law contains provisions that seek to decrease the number of uninsured individuals, including requirements or incentives, which do not become effective until 2014, for individuals to obtain, and large employers to provide, insurance coverage. These mandates may reduce the financial impact of screening for and stabilizing emergency medical conditions. However, many factors are unknown regarding the impact of the Health Reform Law, including the outcome of court challenges to the constitutionality of the law, how many previously uninsured individuals will obtain coverage as a result of the new law or the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals.

We do not pursue collection of amounts related to patients who meet our guidelines to qualify as charity care; therefore, they are not reported in revenues. Patients treated at our hospitals for nonelective care, who have income at or below 200% of the federal poverty level, are eligible for charity care. The federal poverty level is established by the federal government and is based on income and family size. We provide discounts from our gross charges to uninsured patients who do not qualify for Medicaid or charity care. These discounts are similar to those provided to

many local managed care plans.

Due to the complexities involved in the classification and documentation of health care services authorized and provided, the estimation of revenues earned and the related reimbursement are often subject to interpretations that could result in payments that are different from our estimates. Adjustments to estimated Medicare and Medicaid reimbursement amounts and disproportionate-share funds, which resulted in net

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increases to revenues, related primarily to cost reports filed during the respective year were $40 million, $32 million and $47 million in 2009, 2008 and 2007, respectively. The adjustments to estimated reimbursement amounts, which resulted in net increases to revenues, related primarily to cost reports filed during previous years were $60 million, $35 million and $83 million in 2009, 2008 and 2007, respectively. We expect adjustments during the next 12 months related to Medicare and Medicaid cost report filings and settlements and disproportionate-share funds will result in increases to revenues within generally similar ranges.

Provision for Doubtful Accounts and the Allowance for Doubtful Accounts

The collection of outstanding receivables from Medicare, managed care payers, other third-party payers and patients is our primary source of cash and is critical to our operating performance. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to amounts due directly from patients. An estimated allowance for doubtful accounts is recorded for all uninsured accounts, regardless of the aging of those accounts. Accounts are written off when all reasonable internal and external collection efforts have been performed. Our collection policies include a review of all accounts against certain standard collection criteria, upon completion of our internal collection efforts. Accounts determined to possess positive collectibility attributes are forwarded to a secondary external collection agency and the other accounts are written off. The accounts that are not collected by the secondary external collection agency are written off when they are returned to us by the collection agency (usually within 12 months). Writeoffs are based upon specific identification and the writeoff process requires a writeoff adjustment entry to the patient accounting system. We do not pursue collection of amounts related to patients that meet our guidelines to qualify as charity care.

The amount of the provision for doubtful accounts is based upon management s assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal, state, and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical writeoffs and recoveries at facilities that represent a majority of our revenues and accounts receivable (the hindsight analysis) as a primary source of information in estimating the collectibility of our accounts receivable. We perform the hindsight analysis quarterly, utilizing rolling twelve-months accounts receivable collection and writeoff data. We believe our quarterly updates to the estimated allowance for doubtful accounts at each of our hospital facilities provide reasonable valuations of our accounts receivable. These routine, quarterly changes in estimates have not resulted in material adjustments to our allowance for doubtful accounts, provision for doubtful accounts or period-to-period comparisons of our results of operations. At September 30, 2010 and 2009, the allowance for doubtful accounts represented approximately 93% and 94%, respectively, of the $4.615 billion and $5.454 billion, respectively, patient due accounts receivable balance. At December 31, 2009 and 2008, the allowance for doubtful accounts represented approximately 94% and 92%, respectively, of the $5.176 billion and $5.148 billion, respectively, patient due accounts receivable balance. The patient due accounts receivable balance represents the estimated uninsured portion of our accounts receivable. The estimated uninsured portion of Medicaid pending and uninsured discount pending accounts is included in our patient due accounts receivable balance.

The revenue deductions related to uninsured accounts (charity care and uninsured discounts) generally have the inverse effect on the provision for doubtful accounts. To quantify the total impact of and trends related to uninsured accounts, we believe it is beneficial to view these revenue deductions and provision for doubtful accounts in combination, rather than each separately. A summary of these amounts for the years

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ended December 31, 2009, 2008 and 2007 and for the nine months ended September 30, 2010 and 2009 follows (dollars in millions):

	Years Ended December 31,			Nine Months Ended September 30,	
	2009	2008	2007	2010	2009
Provision for doubtful accounts	$ 3,276	$ 3,409	$ 3,130	$ 2,073	$ 2,583
Uninsured discounts	2,935	1,853	1,474	3,285	1,969
Charity care	2,151	1,747	1,530	1,730	1,617
Totals	$ 8,362	$ 7,009	$ 6,134	$ 7,088	$ 6,169

The provision for doubtful accounts, as a percentage of revenues, increased from 11.7% for 2007 to 12.0% for 2008 and declined to 10.9% for 2009. However, the sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of net revenues, uninsured discounts and charity care increased from 20.5% for 2007 to 21.9% for 2008 and to 23.8% for 2009.

Days revenues in accounts receivable were 43 days at both September 30, 2010 and 2009, and 45 days, 49 days and 53 days at December 31, 2009, 2008 and 2007, respectively. Management expects a continuation of the challenges related to the collection of the patient due accounts. Adverse changes in the percentage of our patients having adequate health care coverage, general economic conditions, patient accounting service center operations, payer mix, or trends in federal, state, and private employer health care coverage could affect the collection of accounts receivable, cash flows and results of operations.

The approximate breakdown of accounts receivable by payer classification as of September 30, 2010, December 31, 2009 and 2008 is set forth in the following table:

	% of Accounts Receivable		
	Under 91 Days	91 180 Days	Over 180 Days
Accounts receivable aging at September 30, 2010:			
Medicare and Medicaid	13%	1%	1%
Managed care and other insurers	19	4	4
Uninsured	19	7	32
Total	51%	12%	37%
Accounts receivable aging at December 31, 2009:			
Medicare and Medicaid	12%	1%	1%
Managed care and other insurers	18	4	4
Uninsured	13	8	39
Total	43%	13%	44%

Accounts receivable aging at December 31, 2008:			
Medicare and Medicaid	10%	1%	2%
Managed care and other insurers	17	4	3
Uninsured	21	9	33
Total	48%	14%	38%

Professional Liability Claims

We, along with virtually all health care providers, operate in an environment with professional liability risks. Our facilities are insured by our wholly-owned insurance subsidiary for losses up to $50 million per occurrence, subject to a $5 million per occurrence self-insured retention. We purchase excess insurance on a claims-made basis for losses in excess of $50 million per occurrence. Our professional liability reserves, net of receivables under reinsurance contracts, do not include amounts for any estimated losses covered by our excess

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insurance coverage. Provisions for losses related to professional liability risks were $167 million and $154 million for the nine months ended September 30, 2010 and 2009, respectively, and $211 million, $175 million and $163 million for the years ended December 31, 2009, 2008 and 2007, respectively.

Reserves for professional liability risks represent the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The estimated ultimate cost includes estimates of direct expenses and fees paid to outside counsel and experts, but does not include the general overhead costs of our insurance subsidiary or corporate office. Individual case reserves are established based upon the particular circumstances of each reported claim and represent our estimates of the future costs that will be paid on reported claims. Case reserves are reduced as claim payments are made and are adjusted upward or downward as our estimates regarding the amounts of future losses are revised. Once the case reserves for known claims are determined, information is stratified by loss layers and retentions, accident years, reported years, and geographic location of our hospitals. Several actuarial methods are employed to utilize this data to produce estimates of ultimate losses and reserves for incurred but not reported claims, including: paid and incurred extrapolation methods utilizing paid and incurred loss development to estimate ultimate losses; frequency and severity methods utilizing paid and incurred claims development to estimate ultimate average frequency (number of claims) and ultimate average severity (cost per claim); and Bornhuetter-Ferguson methods which add expected development to actual paid or incurred experience to estimate ultimate losses. These methods use our company-specific historical claims data and other information. Company-specific claim reporting and settlement data collected over an approximate 20-year period is used in our reserve estimation process. This company-specific data includes information regarding our business, including historical paid losses and loss adjustment expenses, historical and current case loss reserves, actual and projected hospital statistical data, professional liability retentions for each policy year, geographic information and other data.

Reserves and provisions for professional liability risks are based upon actuarially determined estimates. The estimated reserve ranges, net of amounts receivable under reinsurance contracts, were $1.024 billion to $1.270 billion at December 31, 2009 and $1.102 billion to $1.332 billion at December 31, 2008. Our estimated reserves for professional liability claims may change significantly if future claims differ from expected trends. We perform sensitivity analyses which model the volatility of key actuarial assumptions and monitor our reserves for adequacy relative to all our assumptions in the aggregate. Based on our analysis, we believe the estimated professional liability reserve ranges represent the reasonably likely outcomes for ultimate losses. We consider the number and severity of claims to be the most significant assumptions in estimating reserves for professional liabilities. A 2% change in the expected frequency trend could be reasonable likely and would increase the reserve estimate by $16 million or reduce the reserve estimate by $15 million. A 2% change in the expected claim severity trend could be reasonably likely and would increase the reserve estimate by $69 million or reduce the reserve estimate by $63 million. We believe adequate reserves have been recorded for our professional liability claims; however, due to the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes, our ultimate liability for professional liability claims could change by more than the estimated sensitivity amounts and could change materially from our current estimates.

The reserves for professional liability risks cover approximately 2,600 and 2,800 individual claims at December 31, 2009 and 2008, respectively, and estimates for unreported potential claims. The time period required to resolve these claims can vary depending upon the jurisdiction and whether the claim is settled or litigated. The average time period between the occurrence and payment of final settlement for our professional liability claims is approximately five years, although the facts and circumstances of each individual claim can result in an occurrence-to-settlement timeframe that varies from this average. The estimation of the timing of payments beyond a year can vary significantly.

Reserves for professional liability risks were $1.293 billion, $1.322 billion and $1.387 billion at September 30, 2010, December 31, 2009 and 2008, respectively. The current portion of these reserves, $266 million, $265 million and

$279 million at September 30, 2010, December 31, 2009 and 2008, respectively, is included in other accrued expenses. Obligations covered by reinsurance contracts are included in the reserves for professional liability risks, as the insurance subsidiary remains liable to the extent reinsurers do not meet their obligations. Reserves for professional liability risks (net of $14 million, $53 million

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and $57 million receivable under reinsurance contracts at September 30, 2010, December 31, 2009 and 2008, respectively) were $1.279 billion, $1.269 billion and $1.330 billion at September 30, 2010, December 31, 2009 and 2008, respectively. The estimated total net reserves for professional liability risks at September 30, 2010, December 31, 2009 and 2008 are comprised of $765 million, $680 million and $724 million, respectively, of case reserves for known claims and $514 million, $589 million and $606 million, respectively, of reserves for incurred but not reported claims.

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

	2009	2008	2007
Net reserves for professional liability claims, January 1	$ 1,330	$ 1,469	$ 1,542
Provision for current year claims	258	239	214
Favorable development related to prior years claims	(47)	(64)	(51)
Total provision	211	175	163
Payments for current year claims	4	7	4
Payments for prior years claims	268	307	232
Total claim payments	272	314	236
Net reserves for professional liability claims, December 31	$ 1,269	$ 1,330	$ 1,469

The favorable development related to prior years claims resulted from declining claim frequency and moderating claim severity trends. We believe these favorable trends are primarily attributable to tort reforms enacted in key states, particularly Texas, and our risk management and patient safety initiatives, particularly in the area of obstetrics.

Income Taxes

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

Although we believe we have properly reported taxable income and paid taxes in accordance with applicable laws, federal, state or international taxing authorities may challenge our tax positions upon audit. Significant judgment is required in determining and assessing the impact of uncertain tax positions. We report a liability for unrecognized tax benefits from uncertain tax positions taken or expected to be taken in our income tax return. During each reporting period, we assess the facts and circumstances related to uncertain tax positions. If the realization of unrecognized tax benefits is deemed probable based upon new facts and circumstances, the estimated liability and the provision for income taxes are reduced in the current period. Final audit results may vary from our estimates.

Results of Operations

Revenue/Volume Trends

Our revenues depend upon inpatient occupancy levels, the ancillary services and therapy programs ordered by physicians and provided to patients, the volume of outpatient procedures and the charge and negotiated payment rates for such services. Gross charges typically do not reflect what our facilities are actually paid. Our facilities have entered into agreements with third-party payers, including government programs and managed care health plans, under which the facilities are paid based upon the cost of providing services, predetermined rates per diagnosis, fixed per diem rates or discounts from gross charges. We do not pursue collection of amounts related to patients who meet our guidelines to qualify for charity care; therefore, they are not reported in revenues. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care that are similar to the discounts provided to many local managed care plans.

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Revenues increased 2.2% from $22.447 billion for the nine months ended September 30, 2009 to $22.947 billion for the nine months ended September 30, 2010. The increase in consolidated revenues can be attributed to the combined impact of revenue per equivalent admission growth of 1.3% and an increase of 0.9% in equivalent admissions. Same facility revenues increased 2.3% from $22.217 billion for the nine months ended September 30, 2009 to $22.730 billion for the nine months ended September 30, 2010. The increase in same facility revenues can be attributed to the combined impact of a 1.2% increase in same facility revenue per equivalent admission and a 1.1% increase in same facility equivalent admissions. The increases in the self-pay revenue deductions (charity care and uninsured discounts) resulted in reductions to both the provision for doubtful accounts and revenues, and were the primary contributing factors to the low growth rates we experienced in revenues and revenue per equivalent admission during the nine months ended September 30, 2010.

Revenues increased 5.9% to $30.052 billion for 2009 from $28.374 billion for 2008 and increased 5.6% for 2008 from $26.858 billion for 2007. The increase in revenues in 2009 can be primarily attributed to the combined impact of a 2.6% increase in revenue per equivalent admission and a 3.2% increase in equivalent admissions compared to the prior year. The increase in revenues in 2008 can be primarily attributed to the combined impact of a 5.2% increase in revenue per equivalent admission and a 0.5% increase in equivalent admissions compared to 2007.

Same facility revenues increased 6.1% for the year ended December 31, 2009 compared to the year ended December 31, 2008 and increased 7.0% for the year ended December 31, 2008 compared to the year ended December 31, 2007. The 6.1% increase for 2009 can be primarily attributed to the combined impact of a 2.6% increase in same facility revenue per equivalent admission and a 3.4% increase in same facility equivalent admissions. The 7.0% increase for 2008 can be primarily attributed to the combined impact of a 5.1% increase in same facility revenue per equivalent admission and a 1.9% increase in same facility equivalent admissions.

For the first nine months of 2010, consolidated admissions declined 0.3% and same facility admissions remained unchanged, compared to the first nine months of 2009. Outpatient surgical volumes declined 1.7% and 1.5% on a consolidated basis and a same facility basis, respectively, during the first nine months of 2010, compared to the first nine months of 2009. Inpatient surgeries declined 1.7% on both a consolidated basis and same facility basis during the first nine months of 2010, compared to the first nine months of 2009. Emergency department visits increased 1.5% on a consolidated basis and increased 1.7% on a same facility basis during the nine months ended September 30, 2010, compared to the nine months ended September 30, 2009.

Consolidated admissions increased 1.0% in 2009 compared to 2008 and declined 0.7% in 2008 compared to 2007. Consolidated inpatient surgeries increased 0.3% and consolidated outpatient surgeries declined 0.4% during 2009 compared to 2008. Consolidated inpatient surgeries declined 4.5% and consolidated outpatient surgeries declined 0.9% during 2008 compared to 2007. Consolidated emergency department visits increased 6.6% during 2009 compared to 2008 and increased 2.5% during 2008 compared to 2007.

Same facility admissions increased 1.2% in 2009 compared to 2008 and increased 0.9% in 2008 compared to 2007. Same facility inpatient surgeries increased 0.5% and same facility outpatient surgeries declined 0.1% during 2009 compared to 2008. Same facility inpatient surgeries declined 0.5% and same facility outpatient surgeries declined 0.2% during 2008 compared to 2007. Same facility emergency department visits increased 7.0% during 2009 compared to 2008 and increased 3.6% during 2008 compared to 2007.

Same facility uninsured emergency room visits increased 0.6% and same facility uninsured admissions increased by 4.2% for the first nine months ended September 30, 2010, compared to the same period in 2009. Same facility uninsured emergency room visits increased 6.5% and same facility uninsured admissions increased 4.7% during 2009 compared to 2008. Same facility uninsured emergency room visits increased 4.5% and same facility uninsured admissions increased 1.7% during 2008 compared to 2007. Management believes same facility uninsured emergency

department visits and same facility uninsured admissions could continue to increase during 2010 if the adverse general economic and unemployment trends continue.

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The approximate percentages of our admissions related to Medicare, managed Medicare, Medicaid, managed Medicaid, managed care and other insurers and the uninsured for the years ended December 31, 2009, 2008 and 2007 and for the nine months ended September 30, 2010 and 2009 are set forth in the following table.

	Years Ended December 31,			Nine Months Ended September 30,	
	2009	2008	2007	2010	2009
Medicare	34%	35%	35%	34%	34%
Managed Medicare	10	9	7	10	10
Medicaid	9	8	8	9	9
Managed Medicaid	7	7	7	8	7
Managed care and other insurers	34	35	37	32	33
Uninsured	6	6	6	7	7
	100%	100%	100%	100%	100%

The approximate percentages of our inpatient revenues related to Medicare, managed Medicare, Medicaid, managed Medicaid, managed care and other insurers and the uninsured for the years ended December 31, 2009, 2008 and 2007 and for the nine months ended September 30, 2010 and 2009 are set forth below.

	Years Ended December 31,			Nine Months Ended September 30,	
	2009	2008	2007	2010	2009
Medicare	31%	31%	32%	31%	31%
Managed Medicare	8	8	7	9	8
Medicaid	8	7	7	9	8
Managed Medicaid	4	4	4	4	4
Managed care and other insurers	44	44	44	44	44
Uninsured	5	6	6	3	5
	100%	100%	100%	100%	100%

The increases in uninsured discounts have caused reductions in the percentage of inpatient revenues related to the uninsured, as the percentage of uninsured admissions compared to total admissions has been constant.

At September 30, 2010, we owned and operated 38 hospitals and 32 surgery centers in the state of Florida. Our Florida facilities revenues totaled $5.628 billion, $7.343 billion and $7.099 billion for the nine months ended September 30, 2010 and for the years ended December 31, 2009 and 2008, respectively. At September 30, 2010, we owned and operated 34 hospitals and 23 surgery centers in the state of Texas. Our Texas facilities revenues totaled $6.232 billion, $8.042 billion and $7.351 billion for the nine months ended September 30, 2010 and for the years ended December 31, 2009 and 2008, respectively. During the first nine months ended September 30, 2010 and during

2009 and 2008, 57%, 57% and 55%, respectively, of our admissions and 52%, 51% and 51% of our revenues were generated by our Florida and Texas facilities. Uninsured admissions in Florida and Texas represented 63%, 64% and 63% of our uninsured admissions during the first nine months ended September 30, 2010 and during 2009 and 2008, respectively.

We provided $1.730 billion and $1.617 billion of charity care (amounts are based upon our gross charges) during the nine months ended September 30, 2010 and 2009, respectively, and $2.151 billion, $1.747 billion and $1.530 billion of charity care during the years ended December 31, 2009, 2008 and 2007, respectively. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care. These discounts are similar to those provided to many local managed care plans and totaled $3.285 billion and $1.969 billion for the nine months ended September 30, 2010 and 2009, respectively, and $2.935 billion, $1.853 billion and $1.474 billion for the years ended December 31, 2009, 2008 and 2007, respectively.

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We receive a significant portion of our revenues from government health programs, principally Medicare and Medicaid, which are highly regulated and subject to frequent and substantial changes. We have increased the indigent care services we provide in several communities in the state of Texas, in affiliation with other hospitals. The state of Texas has been involved in the effort to increase the indigent care provided by private hospitals. As a result of this additional indigent care provided by private hospitals, public hospital districts or counties in Texas have available funds that were previously devoted to indigent care. The public hospital districts or counties are under no contractual or legal obligation to provide such indigent care. The public hospital districts or counties have elected to transfer some portion of these available funds to the state s Medicaid program. Such action is at the sole discretion of the public hospital districts or counties. It is anticipated that these contributions to the state will be matched with federal Medicaid funds. The state then may make supplemental payments to hospitals in the state for Medicaid services rendered. Hospitals receiving Medicaid supplemental payments may include those that are providing additional indigent care services. Such payments must be within the federal UPL established by federal regulation. Our Texas Medicaid revenues included $486 million and $276 million for the nine months ended September 30, 2010 and 2009, respectively, and $474 million, $262 million and $232 million for the years ended December 31, 2009, 2008 and 2007, respectively, of Medicaid supplemental payments pursuant to UPL programs.

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Operating Results Summary

The following are comparative summaries of operating results for the years ended December 31, 2009, 2008 and 2007 and for the nine months ended September 30, 2010 and 2009 (dollars in millions):

	Years Ended December 31						Nine Months Ended September 3			
	2009		2008		2007		2010		2009	
	Amount	Ratio	Amount	Ratio	Amount	Ratio	Amount	Ratio	Amount	
							(Unaudited)			
s	$ 30,052	100.0	$ 28,374	100.0	$ 26,858	100.0	$ 22,947	100.0	$ 22,447	
and benefits	11,958	39.8	11,440	40.3	10,714	39.9	9,282	40.4	8,880	
	4,868	16.2	4,620	16.3	4,395	16.4	3,685	16.1	3,627	
erating expenses	4,724	15.7	4,554	16.1	4,233	15.7	3,696	16.1	3,410	
n for doubtful	3,276	10.9	3,409	12.0	3,130	11.7	2,073	9.0	2,583	
earnings of	(246)	(0.8)	(223)	(0.8)	(206)	(0.8)	(210)	(0.9)	(182)	
tion and tion	1,425	4.8	1,416	5.0	1,426	5.4	1,062	4.7	1,067	
xpense	1,987	6.6	2,021	7.1	2,215	8.2	1,571	6.8	1,487	
gains) on sales of	15		(97)	(0.3)	(471)	(1.8)	2		8	
ents of long-lived	43	0.1	64	0.2	24	0.1	119	0.5	16	
	28,050	93.3	27,204	95.9	25,460	94.8	21,280	92.7	20,896	
before income	2,002	6.7	1,170	4.1	1,398	5.2	1,667	7.3	1,551	
n for income	627	2.1	268	0.9	316	1.1	488	2.2	480	
me	1,375	4.6	902	3.2	1,082	4.1	1,179	5.1	1,071	
me attributable to olling interests	321	1.1	229	0.8	208	0.8	255	1.1	233	
me attributable to .	$ 1,054	3.5	$ 673	2.4	$ 874	3.3	$ 924	4.0	$ 838	
es from prior										
s	5.9%		5.6%		5.4%		2.2%		6.3%	
before income	71.1		(16.3)		(25.0)		7.5		96.1	
me attributable to .	56.7		(23.0)		(15.7)		10.3		110.9	

ons(a)	1.0	(0.7)	(3.6)	(0.3)	0.8
nt admissions(b)	3.2	0.5	(2.7)	0.9	3.3
per equivalent					
n	2.6	5.2	8.3	1.3	2.9
ility % changes					
or year(c):					
s	6.1	7.0	7.4	2.3	6.7
ons(a)	1.2	0.9	(1.3)		1.2
nt admissions(b)	3.4	1.9	(0.7)	1.1	3.8
per equivalent					
n	2.6	5.1	8.1	1.2	2.8

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

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

(c) Same facility information excludes the operations of hospitals and their related facilities which were either acquired or divested during the current and prior period.

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Supplemental Non-GAAP Disclosures
Operating Measures on a Cash Revenues Basis
(Dollars in millions)

The results from operations presented on a cash revenues basis for the nine months ended September 30, 2010 and 2009 follow:

	2010			2009		
	Amount	Non-GAAP % of Cash Revenues Ratios(b)	GAAP % of Revenues Ratios(b)	Amount	Non-GAAP % of Cash Revenues Ratios(b)	GAAP % of Revenues Ratios(b)
Revenues	$ 22,947		100.0	$ 22,447		100.0
Provision for doubtful accounts	2,073			2,583		
Cash revenues(a)	20,874	100.0		19,864	100.0	
Salaries and benefits	9,282	44.5	40.4	8,880	44.7	39.6
Supplies	3,685	17.7	16.1	3,627	18.3	16.2
Other operating expenses	3,696	17.6	16.1	3,410	17.1	15.1
% changes from prior year:						
Revenues	2.2%					
Cash revenues	5.1					
Revenue per equivalent admission	1.3					
Cash revenue per equivalent admission	4.2					

(a) Cash revenues is defined as reported revenues less the provision for doubtful accounts. We use cash revenues as an analytical indicator for purposes of assessing the effect of uninsured patient volumes, adjusted for the effect of both the revenue deductions related to uninsured accounts (charity care and uninsured discounts) and the provision for doubtful accounts (which relates primarily to uninsured accounts), on our revenues and certain operating expenses, as a percentage of cash revenues. Variations in the revenue deductions related to uninsured accounts generally have the inverse effect on the provision for doubtful accounts. We increased our uninsured discount percentages during August 2009 and the resulting effects, for the first nine months of 2010, were an increase in uninsured discounts of $1.316 billion and a decline in the provision for doubtful accounts of $510 million, compared to the same periods for 2009. Cash revenues is commonly used as an analytical indicator within the health care industry. Cash revenues should not be considered as a measure of financial performance under generally accepted accounting principles. Because cash revenues is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, cash revenues, as presented, may not be comparable to other similarly titled measures of other health care companies.

(b) Salaries and benefits, supplies and other operating expenses, as a percentage of cash revenues (a non-GAAP financial measure), present the impact on these ratios due to the adjustment of deducting the provision for

doubtful accounts from reported revenues and results in these ratios being non-GAAP financial measures. We believe these non-GAAP financial measures are useful to investors to provide disclosures of our results of operations on the same basis as that used by management. Management uses this information to compare certain operating expense categories as a percentage of cash revenues. Management finds this information useful to evaluate certain expense category trends without the influence of whether adjustments related to revenues for uninsured accounts are recorded as revenue adjustments (charity care and uninsured discounts) or operating expenses (provision for doubtful accounts), and thus the expense category trends are generally analyzed as a percentage of cash revenues. These non-GAAP financial measures should not be considered alternatives to GAAP financial measures. We believe this supplemental information provides management and the users of our financial statements with useful information for period-to-period comparisons. Investors are encouraged to use GAAP measures when evaluating our overall financial performance.

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Nine Months Ended September 30, 2010 and 2009

Net income attributable to HCA Inc. totaled $924 million in the nine months ended September 30, 2010 compared to $838 million in the nine months ended September 30, 2009. Revenues increased 2.2% due to the combined impact of revenue per equivalent admission growth of 1.3% and an increase of 0.9% in equivalent admissions for the first nine months of 2010 compared to the first nine months of 2009. Cash revenues (reported revenues less the provision for doubtful accounts) increased 5.1% in the nine months ended September 30, 2010 compared to the nine months ended September 30, 2009.

For the first nine months of 2010, consolidated admissions declined 0.3% and same facility admissions remained unchanged, compared to the first nine months of 2009. Outpatient surgical volumes declined 1.7% and 1.5% on a consolidated basis and a same facility basis, respectively, during the first nine months of 2010, compared to the first nine months of 2009. Inpatient surgeries declined 1.7% both on both a consolidated basis and same facility basis during the first nine months of 2010, compared to the first nine months of 2009. Emergency department visits increased 1.5% on a consolidated basis and increased 1.7% on a same facility basis during the nine months ended September 30, 2010, compared to the nine months ended September 30, 2009.

Salaries and benefits, as a percentage of revenues, were 40.4% in the first nine months of 2010 and 39.6% in the first nine months of 2009. Salaries and benefits, as a percentage of cash revenues, were 44.5% in the first nine months of 2010 and 44.7% in the first nine months of 2009. Salaries and benefits per equivalent admission increased 3.6% in the first nine months of 2010 compared to the first nine months of 2009. Same facility labor rate increases averaged 2.9% for the first nine months of 2010 compared to the first nine months of 2009.

Supplies, as a percentage of revenues, were 16.1% in the first nine months of 2010 and 16.2% in the first nine months of 2009. Supplies, as a percentage of cash revenues, were 17.7% in the first nine months of 2010 and 18.3% in the first nine months of 2009. Supply cost per equivalent admission increased 0.7% in the first nine months of 2010 compared to the first nine months of 2009. Supply costs per equivalent admission increased 2.9% for medical devices and 3.4% for general medical and surgical items, blood products were unchanged and pharmacy supplies declined 1.2% in the first nine months of 2010 compared to the first nine months of 2009.

Other operating expenses, as a percentage of revenues, increased to 16.1% in the first nine months of 2010 from 15.1% in the first nine months of 2009. Other operating expenses, as a percentage of cash revenues, increased to 17.6% in the first nine months of 2010 from 17.1% in the first nine months of 2009. Other operating expenses is primarily comprised of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and nonincome taxes. Other operating expenses includes $268 million and $145 million of indigent care costs in certain Texas markets during the first nine months of 2010 and 2009, respectively, and this increase is the primary component of the overall increase in other operating expenses. Provisions for losses related to professional liability risks were $167 million and $154 million for the first nine months of 2010 and 2009, respectively.

Provision for doubtful accounts declined $510 million, from $2.583 billion in the first nine months of 2009 to $2.073 billion in the first nine months of 2010, and as a percentage of revenues, declined to 9.0% in the first nine months of 2010 from 11.5% in the first nine months of 2009. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts due directly from patients. The combined self-pay revenue deductions for charity care and uninsured discounts increased $1.429 billion during the first nine months of 2010, compared to the first nine months of 2009. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of revenues, uninsured discounts and charity care, was 25.3% for the first nine months of 2010, compared to 23.7% for the first nine months of 2009. To quantify the total impact of and trends related to uninsured accounts, we believe it is beneficial to review the related revenue deductions and the provision for

doubtful accounts in combination, rather than separately. At September 30, 2010, our allowance for doubtful accounts represented approximately 93% of the $4.615 billion total patient due accounts receivable balance. The patient due accounts receivable balance represents the estimated uninsured portion of our accounts receivable.

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Equity in earnings of affiliates was $210 million and $182 million in the first nine months of 2010 and 2009, respectively. Equity in earnings of affiliates relates primarily to our Denver, Colorado market joint venture.

Depreciation and amortization declined $5 million, from $1.067 billion in the first nine months of 2009 to $1.062 billion in the first nine months of 2010.

Interest expense increased from $1.487 billion in the first nine months of 2009 to $1.571 billion in the first nine months of 2010, due primarily to an increase in the average effective interest rate. Our average debt balance was $26.525 billion for the first nine months of 2010 compared to $26.452 billion for the first nine months of 2009. The average effective interest rate for our long term debt increased from 7.5% for the first nine months of 2009 to 7.9% for the first nine months of 2010.

During the first nine months of 2010 and 2009, we recorded net losses on sales of facilities of $2 million and $8 million, respectively.

During the first nine months of 2010, we recorded impairments of long-lived assets of $119 million, including impairment charges of $73 million for two hospital facilities and $35 million for capitalized engineering and design costs related to certain building safety requirements (California earthquake standards) that have been revised, to adjust the carrying values to estimated fair value. During the first nine months of 2009, we recorded asset impairment charges of $16 million to adjust the value of certain real estate investments to estimated fair value.

The effective tax rate was 34.6% and 36.4% for the first nine months of 2010 and 2009, respectively. The effective tax rate computations exclude net income attributable to noncontrolling interests as it relates to consolidated partnerships. Our provision for income taxes for the first nine months of 2010 and 2009 was reduced by $50 million and $20 million, respectively, related to reductions in interest expense related to taxing authority examinations. Excluding the effect of these adjustments, the effective tax rate for the first nine months of 2010 and 2009 would have been 38.1% and 37.9%, respectively.

Net income attributable to noncontrolling interests increased from $233 million for the first nine months of 2009 to $255 million for the first nine months of 2010. The increase in net income attributable to noncontrolling interests related primarily to growth in operating results of hospital joint ventures in two Texas markets.

Years Ended December 31, 2009 and 2008

Net income attributable to HCA Inc. totaled $1.054 billion for the year ended December 31, 2009 compared to $673 million for the year ended December 31, 2008. Financial results for 2009 include losses on sales of facilities of $15 million and asset impairment charges of $43 million. Financial results for 2008 include gains on sales of facilities of $97 million and asset impairment charges of $64 million.

Revenues increased 5.9% to $30.052 billion for 2009 from $28.374 billion for 2008. The increase in revenues was due primarily to the combined impact of a 2.6% increase in revenue per equivalent admission and a 3.2% increase in equivalent admissions compared to 2008. Same facility revenues increased 6.1% due primarily to the combined impact of a 2.6% increase in same facility revenue per equivalent admission and a 3.4% increase in same facility equivalent admissions compared to 2008.

During 2009, consolidated admissions increased 1.0% and same facility admissions increased 1.2% for 2009, compared to 2008. Consolidated inpatient surgical volumes increased 0.3%, and same facility inpatient surgeries increased 0.5% during 2009 compared to 2008. Consolidated outpatient surgical volumes declined 0.4%, and same facility outpatient surgeries declined 0.1% during 2009 compared to 2008. Emergency department visits increased

6.6% on a consolidated basis and increased 7.0% on a same facility basis during 2009 compared to 2008.

Salaries and benefits, as a percentage of revenues, were 39.8% in 2009 and 40.3% in 2008. Salaries and benefits per equivalent admission increased 1.3% in 2009 compared to 2008. Same facility labor rate increases averaged 3.7% for 2009 compared to 2008.

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Supplies, as a percentage of revenues, were 16.2% in 2009 and 16.3% in 2008. Supply costs per equivalent admission increased 2.1% in 2009 compared to 2008. Same facility supply costs increased 5.9% for medical devices, 4.0% for pharmacy supplies, 7.1% for blood products and 7.0% for general medical and surgical items in 2009 compared to 2008.

Other operating expenses, as a percentage of revenues, declined to 15.7% in 2009 from 16.1% in 2008. Other operating expenses are primarily comprised of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and nonincome taxes. The overall decline in other operating expenses, as a percentage of revenues, is comprised of relatively small reductions in several areas, including utilities, employee recruitment and travel and entertainment. Other operating expenses include $248 million and $144 million of indigent care costs in certain Texas markets during 2009 and 2008, respectively. Provisions for losses related to professional liability risks were $211 million and $175 million for 2009 and 2008, respectively.

Provision for doubtful accounts declined $133 million, from $3.409 billion in 2008 to $3.276 billion in 2009, and as a percentage of revenues, declined to 10.9% for 2009 from 12.0% in 2008. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts due directly from patients. The decline in the provision for doubtful accounts can be attributed to the $1.486 billion increase in the combined self-pay revenue deductions for charity care and uninsured discounts during 2009, compared to 2008. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of net revenues, uninsured discounts and charity care, was 23.8% for 2009, compared to 21.9% for 2008. At December 31, 2009, our allowance for doubtful accounts represented approximately 94% of the $5.176 billion total patient due accounts receivable balance, including accounts, net of estimated contractual discounts, related to patients for which eligibility for Medicaid coverage or uninsured discounts was being evaluated.

Equity in earnings of affiliates increased from $223 million for 2008 to $246 million for 2009. Equity in earnings of affiliates relates primarily to our Denver, Colorado market joint venture.

Depreciation and amortization decreased, as a percentage of revenues, to 4.8% in 2009 from 5.0% in 2008. Depreciation expense was $1.419 billion for 2009 and $1.412 billion for 2008.

Interest expense decreased to $1.987 billion for 2009 from $2.021 billion for 2008. The decrease in interest expense was due to reductions in the average debt balance. Our average debt balance was $26.267 billion for 2009 compared to $27.211 billion for 2008. The average interest rate for our long-term debt increased from 7.4% for 2008 to 7.6% for 2009.

Net losses on sales of facilities were $15 million for 2009 and included $8 million of net losses on the sales of three hospital facilities and $7 million of net losses on sales of real estate and other health care entity investments. Gains on sales of facilities were $97 million for 2008 and included $81 million of gains on the sales of two hospital facilities and $16 million of net gains on sales of real estate and other health care entity investments.

Impairments of long-lived assets were $43 million for 2009 and included $19 million related to goodwill and $24 million related to property and equipment. Impairments of long-lived assets were $64 million for 2008 and included $48 million related to goodwill and $16 million related to property and equipment.

The effective tax rate was 37.3% and 28.5% for 2009 and 2008, respectively. The effective tax rate computations exclude net income attributable to noncontrolling interests as it relates to consolidated partnerships. Primarily as a result of reaching a settlement with the IRS Appeals Division and the revision of the amount of a proposed IRS adjustment related to prior taxable periods, we reduced our provision for income taxes by $69 million in 2008. Excluding the effect of these adjustments, the effective tax rate for 2008 would have been 35.8%.

Net income attributable to noncontrolling interests increased from $229 million for 2008 to $321 million for 2009. The increase in net income attributable to noncontrolling interests related primarily to growth in operating results of hospital joint ventures in two Texas markets.

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Years Ended December 31, 2008 and 2007

Net income attributable to HCA Inc. totaled $673 million for the year ended December 31, 2008 compared to $874 million for the year ended December 31, 2007. Financial results for 2008 include gains on sales of facilities of $97 million and asset impairment charges of $64 million. Financial results for 2007 include gains on sales of facilities of $471 million and an asset impairment charge of $24 million.

Revenues increased 5.6% to $28.374 billion for 2008 from $26.858 billion for 2007. The increase in revenues was due primarily to the combined impact of a 5.2% increase in revenue per equivalent admission and a 0.5% increase in equivalent admissions compared to 2007. Same facility revenues increased 7.0% due primarily to the combined impact of a 5.1% increase in same facility revenue per equivalent admission and a 1.9% increase in same facility equivalent admissions compared to 2007.

During 2008, consolidated admissions declined 0.7% and same facility admissions increased 0.9%, compared to 2007. Inpatient surgical volumes declined 4.5% on a consolidated basis and same facility inpatient surgeries declined 0.5% during 2008 compared to 2007. Outpatient surgical volumes declined 0.9% on a consolidated basis and same facility outpatient surgeries declined 0.2% during 2008 compared to 2007. Emergency department visits increased 2.5% on a consolidated basis and increased 3.6% on a same facility basis during 2008 compared to 2007.

Salaries and benefits, as a percentage of revenues, were 40.3% in 2008 and 39.9% in 2007. Salaries and benefits per equivalent admission increased 6.3% in 2008 compared to 2007. Same facility labor rate increases averaged 5.1% for 2008 compared to 2007.

Supplies, as a percentage of revenues, were 16.3% in 2008 and 16.4% in 2007. Supply costs per equivalent admission increased 4.5% in 2008 compared to 2007. Same facility supply costs increased 8.0% for medical devices, 2.8% for pharmacy supplies, 18.7% for blood products and 6.6% for general medical and surgical items in 2008 compared to 2007.

Other operating expenses, as a percentage of revenues, increased to 16.1% in 2008 from 15.7% in 2007. Other operating expenses are primarily comprised of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and nonincome taxes. Increases in professional fees paid to hospitalists, emergency room physicians and anesthesiologists represented 20 basis points of the 2008 increase in other operating expenses. Other operating expenses include $144 million and $187 million of indigent care costs in certain Texas markets during 2008 and 2007, respectively. Provisions for losses related to professional liability risks were $175 million and $163 million for 2008 and 2007, respectively.

Provision for doubtful accounts, as a percentage of revenues, increased to 12.0% for 2008 from 11.7% in 2007. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts due directly from patients. The increase in the provision for doubtful accounts, as a percentage of revenues, can be attributed to an increasing amount of patient financial responsibility under certain managed care plans and same facility increases in uninsured emergency room visits of 4.5% and uninsured admissions of 1.7% in 2008 compared to 2007. At December 31, 2008, our allowance for doubtful accounts represented approximately 92% of the $5.148 billion total patient due accounts receivable balance, including accounts, net of estimated contractual discounts, related to patients for which eligibility for Medicaid coverage or uninsured discounts was being evaluated.

Equity in earnings of affiliates increased from $206 million for 2007 to $223 million for 2008. Equity in earnings of affiliates relates primarily to our Denver, Colorado market joint venture.

Depreciation and amortization declined, as a percentage of revenues, to 5.0% in 2008 from 5.4% in 2007. Depreciation expense was $1.412 billion for 2008 and $1.421 billion for 2007.

Interest expense declined to $2.021 billion for 2008 from $2.215 billion for 2007. The decline in interest expense was due to reductions in both the average debt balance and the average interest rate on long-term debt. Our average debt balance was $27.211 billion for 2008 compared to $27.732 billion for 2007. The average interest rate for our long-term debt declined from 8.0% for 2007 to 7.4% for 2008.

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Gains on sales of facilities were $97 million for 2008 and included $81 million of net gains on the sales of two hospital facilities and $16 million of net gains on sales of real estate and other health care entity investments. Gains on sales of facilities were $471 million for 2007 and included a $312 million gain on the sale of our two Switzerland hospitals, a $131 million gain on the sale of a facility in Florida and $28 million of net gains on sales of real estate and other health care entity investments.

Impairments of long-lived assets were $64 million for 2008 and included $48 million related to goodwill and $16 million related to property and equipment. The $24 million asset impairment for 2007 related to property and equipment.

The effective tax rate was 28.5% for 2008 and 26.6% for 2007, respectively. The effective tax rate computations exclude net income attributable to noncontrolling interests as it relates to consolidated partnerships. Primarily as a result of reaching a settlement with the IRS Appeals Division and the revision of the amount of a proposed IRS adjustment related to prior taxable periods, we reduced our provision for income taxes by $69 million in 2008. Our 2007 provision for income taxes was reduced by $85 million, principally based on receiving new information related to tax positions taken in a prior taxable year, and by an additional $39 million to adjust 2006 state tax accruals to the amounts reported on completed tax returns and based upon an analysis of the Recapitalization costs. Excluding the effect of these adjustments, the effective tax rates for 2008 and 2007 would have been 35.8% and 37.0%, respectively.

Net income attributable to noncontrolling interests increased from $208 million for 2007 to $229 million for 2008. The increase relates primarily to our Austin, Texas market partnership and our group purchasing organization.

Liquidity and Capital Resources

Our primary cash requirements are paying our operating expenses, servicing our debt, capital expenditures on our existing properties, acquisitions of hospitals and other health care entities and distributions to noncontrolling interests. Our primary cash sources are cash flow from operating activities, issuances of debt and equity securities and dispositions of hospitals and other health care entities.

Cash provided by operating activities totaled $2.611 billion for the nine months ended September 30, 2010 compared to $2.315 billion for the nine months ended September 30, 2009. The $296 million increase in cash provided by operating activities in the first nine months of 2010 compared to the first nine months of 2009 was primarily comprised of the net impact of the $108 million increase in net income, a $301 million decline from changes in operating assets and liabilities and the provision for doubtful accounts and a $475 million decrease in income taxes. Working capital totaled $2.221 billion at September 30, 2010.

Cash provided by operating activities totaled $2.747 billion in 2009 compared to $1.990 billion in 2008 and $1.564 billion in 2007. Working capital totaled $2.264 billion at December 31, 2009 and $2.391 billion at December 31, 2008. The $757 million increase in cash provided by operating activities for 2009, compared to 2008, related primarily to the $473 million increase in net income and $143 million improvement from changes in operating assets and liabilities and the provision for doubtful accounts. The $426 million increase in cash provided by operating activities for 2008, compared to 2007, relates primarily to changes in working capital items. The changes in accounts receivable (net of the provision for doubtful accounts), inventories and other assets, and accounts payable and accrued expenses contributed $42 million to cash provided by operating activities for 2008 while changes in these items decreased cash provided by operating activities by $485 million for 2007. The net impact of the cash payments for interest and income taxes was an increase in cash payments of $203 million for 2009 compared to 2008 and an increase of $111 million for 2008 compared to 2007.

Cash used in investing activities was $398 million for the nine months ended September 30, 2010 compared to $807 million for the nine months ended September 30, 2009. Excluding acquisitions, capital expenditures were $860 million in the first nine months of 2010 and $915 million in the first nine months of 2009. We expended $35 million and $42 million for acquisitions of nonhospital health care facilities during the first nine months of 2010 and 2009, respectively. Capital expenditures are expected to approximate $1.400 billion in 2010. At September 30, 2010, there were projects under construction which had estimated

additional costs to complete and equip over the next five years of approximately $1.240 billion. We expect to finance capital expenditures with internally generated and borrowed funds. We received $26 million and $39 million from sales of hospitals and health care entities during the first nine months of 2010 and 2009, respectively. We received net cash flows from our investments of $473 million and $113 million in the first nine months of 2010 and 2009, respectively. During the first nine months of 2010, we liquidated certain investments of the insurance subsidiary in order to distribute $500 million of excess capital to the Company.

Cash used in investing activities was $1.035 billion, $1.467 billion and $479 million in 2009, 2008 and 2007, respectively. Excluding acquisitions, capital expenditures were $1.317 billion in 2009, $1.600 billion in 2008 and $1.444 billion in 2007. We expended $61 million, $85 million and $32 million for acquisitions of hospitals and health care entities during 2009, 2008 and 2007, respectively. Expenditures for acquisitions in all three years were generally comprised of outpatient and ancillary services entities and were funded by a combination of cash flows from operations and the issuance or incurrence of debt.

During 2009, we received cash proceeds of $41 million from dispositions of three hospitals and sales of other health care entities and real estate investments. We also received net cash proceeds of $303 million related to net changes in our investments. During 2008, we received cash proceeds of $143 million from dispositions of two hospitals and $50 million from sales of other health care entities and real estate investments. During 2007, we sold three hospitals for cash proceeds of $661 million, and we also received cash proceeds of $106 million related primarily to the sales of real estate investments and $207 million related to net changes in our investments.

Cash used in financing activities totaled $2.148 billion for the nine months ended September 30, 2010 compared to $1.530 billion for the nine months ended September 30, 2009. During the first nine months of 2010, cash flows used in financing activities included payment of cash distributions to stockholders of $2.251 billion, increases in net borrowings of $402 million, payments of debt issuance costs of $25 million and distributions to noncontrolling interests of $282 million. During the first nine months of 2009, cash flows used in financing activities included reductions in net borrowings of $1.196 billion, payment of debt issuance costs of $68 million and distributions to noncontrolling interests of $254 million.

Cash used in financing activities totaled $1.865 billion in 2009, $451 million in 2008 and $1.326 billion in 2007. During 2009, 2008 and 2007, we used cash proceeds from sales of facilities and available cash provided by operations to make net debt repayments of $1.459 billion, $260 million and $1.270 billion, respectively. During 2009, 2008 and 2007, we made distributions to noncontrolling interests of $330 million, $178 million and $152 million, respectively. We also paid debt issuance costs of $70 million for 2009. We or our affiliates, including affiliates of the Sponsors, may in the future repurchase portions of our debt securities, subject to certain limitations, from time to time in either the open market or through privately negotiated transactions, in accordance with applicable SEC and other legal requirements. The timing, prices, and sizes of purchases depend upon prevailing trading prices, general economic and market conditions, and other factors, including applicable securities laws. Funds for the repurchase of debt securities have, and are expected to, come primarily from cash generated from operations and borrowed funds.

In addition to cash flows from operations, available sources of capital include amounts available under the senior secured credit facilities ($2.157 billion as of September 30, 2010 and $3.181 billion as of December 31, 2009) and anticipated access to public and private debt markets.

On January 27, 2010, HCA Inc. s Board of Directors declared a distribution to its stockholders and holders of vested stock options. The distribution was $17.50 per share and vested stock option, or $1.751 billion in the aggregate. The distribution was paid on February 5, 2010 to holders of record on February 1, 2010. The distribution was funded using funds available under our existing senior secured credit facilities and approximately $100 million of cash on hand.

On May 5, 2010, HCA Inc. s Board of Directors declared a distribution to its stockholders and holders of vested options. The distribution was $5.00 per share and vested stock option, or $500 million in the aggregate. The distribution was paid on May 14, 2010 to holders of record on May 6, 2010. The distribution was funded using funds available under our senior secured credit facilities.

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On November 23, 2010, our Board of Directors declared a distribution to our stockholders and holders of stock options. The distribution was $20.00 per share and vested stock option, or approximately $2.1 billion in the aggregate. The distribution to stockholders and holders of vested options was paid on December 1, 2010 to holders of record on November 24, 2010. The distribution was funded using the proceeds from the November 2010 issuance of $1.525 billion aggregate principal amount of 73/4% senior notes due 2021, together with borrowings by HCA Inc. under its existing senior secured credit facilities.

Investments of our professional liability insurance subsidiary, to maintain statutory equity and pay claims, totaled $798 million, $1.316 billion and $1.622 billion at September 30, 2010, December 31, 2009 and 2008, respectively. Investments were reduced during 2010 as a result of the insurance subsidiary distributing $500 million of excess capital to the Company. The insurance subsidiary maintained net reserves for professional liability risks of $534 million, $590 million and $782 million at September 30, 2010, December 31, 2009 and 2008, respectively. Our facilities are insured by our wholly-owned insurance subsidiary for losses up to $50 million per occurrence; however, since January 2007, this coverage is subject to a $5 million per occurrence self-insured retention. Net reserves for the self-insured professional liability risks retained were $745 million, $679 million and $548 million at September 30, 2010, December 31, 2009 and 2008, respectively. At September 30, 2010, claims payments, net of reinsurance recoveries, during the next 12 months are expected to approximate $263 million. We estimate that approximately $130 million of the expected net claim payments during the next 12 months will relate to claims subject to the self-insured retention.

Financing Activities

We are a highly leveraged company with significant debt service requirements. Our debt totaled $26.079 billion, $25.670 billion and $26.989 billion at September 30, 2010, December 31, 2009 and 2008, respectively. Our interest expense was $1.571 billion and $1.487 billion for the nine months ended September 30, 2010 and 2009, respectively, and $1.987 billion for 2009 and $2.021 billion for 2008.

During February 2009, HCA Inc. issued $310 million aggregate principal amount of 97/8% senior secured second lien notes due 2017 at a price of 96.673% of their face value, resulting in $300 million of gross proceeds. During April 2009, HCA Inc. issued $1.500 billion aggregate principal amount of 81/2% senior secured first lien notes due 2019 at a price of 96.755% of their face value, resulting in $1.451 billion of gross proceeds. During August 2009, HCA Inc. issued $1.250 billion aggregate principal amount of 77/8% senior secured first lien notes due 2020 at a price of 98.254% of their face value, resulting in $1.228 billion of gross proceeds. During March 2010, HCA Inc. issued $1.400 billion aggregate principal amount of 71/4% senior secured first lien notes due 2020 at a price of 99.095% of their face value, resulting in $1.387 billion of gross proceeds. After the payment of related fees and expenses, we used the proceeds from these debt offerings to repay outstanding indebtedness under our senior secured term loan facilities. During November 2010, we issued $1.525 billion aggregate principal amount of 73/4% senior notes due 2021 at a price of 100% of their face value, resulting in $1.525 billion of gross proceeds. After the payment of related fees and expenses, we used the proceeds from this debt offering and borrowings under the senior secured credit facilities to fund a December 2010 distribution of approximately $2.1 billion to our stockholders and holders of vested stock options.

On November 8, 2010, an amended and restated joinder agreement was entered into with respect to the cash flow credit facility to establish a new replacement revolving credit series, which will mature on November 17, 2015. Under the amended and restated joinder agreement, these replacement revolving credit commitments will become effective, subject to certain conditions, upon the earlier of (i) our or HCA Inc. s initial public offering and (ii) May 17, 2012.

Management believes that cash flows from operations, amounts available under our senior secured credit facilities and our anticipated access to public and private debt markets will be sufficient to meet expected liquidity needs during the

next twelve months.

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Contractual Obligations and Off-Balance Sheet Arrangements

As of December 31, 2009, maturities of contractual obligations and other commercial commitments are presented in the table below (dollars in millions):

	Payments Due by Period				
Contractual Obligations(a)	**Total**	**Current**	**2-3 Years**	**4-5 Years**	**After 5 Years**
Long-term debt including interest, excluding the senior secured credit facilities(b)	$ 26,739	$ 2,175	$ 3,780	$ 4,915	$ 15,869
Loans outstanding under the senior secured credit facilities, including interest(b)	11,786	649	3,565	7,410	162
Operating leases(c)	1,190	226	355	223	386
Purchase and other obligations(c)	196	43	33	30	90
Total contractual obligations	$ 39,911	$ 3,093	$ 7,733	$ 12,578	$ 16,507

	Commitment Expiration by Period				
Other Commercial Commitments Not Recorded on the Consolidated Balance Sheet	**Total**	**Current**	**2-3 Years**	**4-5 Years**	**After 5 Years**
Surety bonds(d)	$ 106	$ 105	$ 1	$	$
Letters of credit(e)	100	23	44	33	
Physician commitments(f)	40	30	10		
Guarantees(g)	2				2
Total commercial commitments	$ 248	$ 158	$ 55	$ 33	$ 2

(a) We have not included obligations to pay estimated professional liability claims ($1.322 billion at December 31, 2009) in this table. The estimated professional liability claims, which occurred prior to 2007, are expected to be funded by the designated investment securities that are restricted for this purpose ($1.316 billion at December 31, 2009). We also have not included obligations related to unrecognized tax benefits of $628 million at December 31, 2009, as we cannot reasonably estimate the timing or amounts of additional cash payments, if any, at this time.

(b) Estimates of interest payments assumes that interest rates, borrowing spreads and foreign currency exchange rates at December 31, 2009, remain constant during the period presented.

(c) Amounts relate to future operating lease obligations, purchase obligations and other obligations and are not recorded in our consolidated balance sheet. Amounts also include physician commitments that are recorded in our consolidated balance sheet.

(d)

Amounts relate primarily to instances in which we have agreed to indemnify various commercial insurers who have provided surety bonds to cover damages for malpractice cases which were awarded to plaintiffs by the courts. These cases are currently under appeal and the bonds will not be released by the courts until the cases are closed.

(e) Amounts relate primarily to various employee benefit plan obligations in which we have letters of credit outstanding.

(f) In consideration for physicians relocating to the communities in which our hospitals are located and agreeing to engage in private practice for the benefit of the respective communities, we make advances to physicians, normally over a period of one year, to assist in establishing the physicians practices. The actual amount of these commitments to be advanced often depends upon the financial results of the physicians private practices during the recruitment agreement payment period. The physician commitments reflected were based on our maximum exposure on effective agreements at December 31, 2009.

(g) We have entered into guarantee agreements related to certain leases.

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Market Risk

We are exposed to market risk related to changes in market values of securities. The investments in debt and equity securities of our wholly-owned insurance subsidiary were $790 million and $8 million, respectively, at September 30, 2010. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At September 30, 2010, we had a net unrealized gain of $16 million on the insurance subsidiary s investment securities.

We are exposed to market risk related to market illiquidity. Liquidity of the investments in debt and equity securities of our wholly-owned insurance subsidiary could be impaired by the inability to access the capital markets. Should the wholly-owned insurance subsidiary require significant amounts of cash in excess of normal cash requirements to pay claims and other expenses on short notice, we may have difficulty selling these investments in a timely manner or be forced to sell them at a price less than what we might otherwise have been able to in a normal market environment. At September 30, 2010, our wholly-owned insurance subsidiary had invested $260 million ($261 million par value) in tax-exempt student loan auction rate securities (ARS) that continue to experience market illiquidity. It is uncertain if auction-related market liquidity will resume for these securities. We may be required to recognize other-than-temporary impairments on these long-term investments in future periods should issuers default on interest payments or should the fair market valuations of the securities deteriorate due to ratings downgrades or other issue specific factors.

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

With respect to our interest-bearing liabilities, approximately $2.218 billion of long-term debt at September 30, 2010 was subject to variable rates of interest, while the remaining balance in long-term debt of $23.861 billion at September 30, 2010 was subject to fixed rates of interest. Both the general level of interest rates and, for the senior secured credit facilities, our leverage affect our variable interest rates. Our variable rate debt is comprised primarily of amounts outstanding under the senior secured credit facilities. Borrowings under the senior secured credit facilities bear interest at a rate equal to an applicable margin plus, at our option, either (a) a base rate determined by reference to the higher of (1) the federal funds rate plus 0.50% and (2) the prime rate of Bank of America or (b) a LIBOR rate for the currency of such borrowing for the relevant interest period. The applicable margin for borrowings under the senior secured credit facilities may fluctuate according to a leverage ratio, with the exception of term loan B where the margin is static. The average effective interest rate for our long-term debt increased from 7.5% for the nine months ended September 30, 2009 to 7.9% for the nine months ended September 30, 2010.

On March 2, 2009, the cash flow credit facility was amended to allow for one or more future issuances of additional secured notes, which may include notes that are secured on a pari passu basis or on a junior basis with the obligations under the cash flow credit facility, so long as (1) such notes do not require, subject to certain exceptions, scheduled repayments, payment of principal or redemption prior to the scheduled term loan B-1 maturity date, (2) the terms of such notes, taken as a whole, are not more restrictive than those in the cash flow credit facility and (3) no subsidiary of

HCA Inc. that is not a U.S. guarantor is an obligor of such additional secured notes, and such notes are not secured by any European collateral securing the cash flow credit facility. The U.S. security documents related to the cash flow credit facility were also amended and restated in connection with the amendment in order to give effect to the security interests to be granted to holders of such additional secured notes.

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On March 2, 2009, the asset-based revolving credit facility was amended to allow for one or more future issuances of additional secured notes or loans, which may include notes or loans that are secured on a pari passu basis or on a junior basis with the obligations under the cash flow credit facility, so long as (1) such notes or loans do not require, subject to certain exceptions, scheduled repayments, payment of principal or redemption prior to the scheduled term loan B-1 maturity date, (2) the terms of such notes or loans, as applicable, taken as a whole, are not more restrictive than those in the cash flow credit facility and (3) no subsidiary of HCA Inc. that is not a U.S. guarantor is an obligor of such additional secured notes. The amendment to the asset-based revolving credit facility also altered the excess facility availability requirement to include a separate minimum facility availability requirement applicable to the asset-based revolving credit facility and increased the applicable LIBOR and asset-based revolving margins for all borrowings under the asset-based revolving credit facility by 0.25% each.

On April 6, 2010 the cash flow credit facility was amended to (i) extend the maturity date for $2.0 billion of the tranche B term loans from November 17, 2013 to March 31, 2017 and (ii) increase the ABR margin and LIBOR margin with respect to such extended term loans to 2.25% and 3.25%, respectively.

On June 18, 2009, the cash flow credit facility was further amended to permit the unlimited incurrence of new term loans to refinance the term loans initially incurred as well as any previously incurred refinancing term loans and to permit the establishment of commitments under a replacement cash flow revolver under the cash flow credit facility to replace all or a portion of the revolving commitments initially established under the cash flow credit facility as well as any previously issued replacement revolvers.

On November 8, 2010, an amended and restated joinder agreement was entered into with respect to the cash flow credit facility to establish a new replacement revolving credit series, which will mature on November 17, 2015. The replacement revolving credit commitments will become effective upon the earlier of (i) our receipt of all or a portion of the proceeds (including by way of contribution) from an initial public offering of our or HCA Inc. s common stock (the IPO Proceeds Condition) and (ii) May 17, 2012, subject to the satisfaction of certain other conditions. If the IPO Proceeds Condition has not been satisfied, on May 17, 2012 or, if the IPO Proceeds Condition has been satisfied prior to May 17, 2012, on November 17, 2012, the applicable ABR and LIBOR margins with respect to the replacement revolving loans will be increased from the applicable ABR and LIBOR margins of the existing revolving loans based upon the achievement of a certain leverage ratio, which level will decrease from the levels of the existing revolving loans. The offering contemplated hereby will satisfy the IPO Proceeds Condition.

The estimated fair value of our total long-term debt was $26.658 billion at September 30, 2010. The estimates of fair value are based upon the quoted market prices for the same or similar issues of long-term debt with the same maturities. Based on a hypothetical 1% increase in interest rates, the potential annualized reduction to future pretax earnings would be approximately $22 million. To mitigate the impact of fluctuations in interest rates, we generally target a portion of our debt portfolio to be maintained at fixed rates.

Our international operations and foreign currency denominated loans expose us to market risks associated with foreign currencies. In order to mitigate the currency exposure related to foreign currency denominated debt service obligations, we have entered into cross currency swap agreements. A cross currency swap is an agreement between two parties to exchange a stream of principal and interest payments in one currency for a stream of principal and interest payments in another currency over a specified period. Our credit risk related to these agreements is considered low because the swap agreements are with creditworthy financial institutions.

Financial Instruments

Derivative financial instruments are employed to manage risks, including foreign currency and interest rate exposures, and are not used for trading or speculative purposes. We recognize derivative instruments, such as interest rate swap

agreements and foreign exchange contracts, in the consolidated balance sheets at fair value. Changes in the fair value of derivatives are recognized periodically either in earnings or in stockholders equity, as a component of other comprehensive income, depending on whether the derivative financial instrument qualifies for hedge accounting, and if so, whether it qualifies as a fair value hedge or a cash flow hedge. Gains and losses on derivatives designated as cash flow hedges, to the extent they are effective, are

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recorded in other comprehensive income, and subsequently reclassified to earnings to offset the impact of the hedged items when they occur. Changes in the fair value of derivatives not qualifying as hedges, and for any portion of a hedge that is ineffective, are reported in earnings.

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

Effects of Inflation and Changing Prices

Various federal, state and local laws have been enacted that, in certain cases, limit our ability to increase prices. Revenues for general, acute care hospital services rendered to Medicare patients are established under the federal government s prospective payment system. Total fee-for-service Medicare revenues approximated 23% in 2009, 23% in 2008 and 24% in 2007 of our total patient revenues.

Management believes hospital industry operating margins have been, and may continue to be, under significant pressure because of changes in payer mix and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. In addition, as a result of increasing regulatory and competitive pressures, our ability to maintain operating margins through price increases to non-Medicare patients is limited.

IRS Disputes

At September 30, 2010, we were contesting, before the IRS Appeals Division, certain claimed deficiencies and adjustments proposed by the IRS Examination Division in connection with its audit of our 2005 and 2006 federal income tax returns, including the timing of recognition of certain patient service revenues, the deductibility of certain debt retirement costs and our method for calculating the tax allowance for doubtful accounts. Eight taxable periods of HCA Inc. and its predecessors ended in 1997 through 2004, for which the primary remaining issue is the computation of the tax allowance for doubtful accounts, were pending before the IRS Examination Division as of September 30, 2010. The IRS Examination Division began an audit of HCA Inc. s 2007, 2008 and 2009 federal income tax returns in December 2010.

Management believes HCA Inc., its predecessors and affiliates properly reported taxable income and paid taxes in accordance with applicable laws and agreements established with the IRS and final resolution of these disputes will not have a material, adverse effect on our results of operations or financial position. However, if payments due upon final resolution of these issues exceed our recorded estimates, such resolutions could have a material, adverse effect on our results of operations or financial position.

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BUSINESS

Our Company

We are the largest non-governmental hospital operator in the U.S. and a leading comprehensive, integrated provider of health care and related services. We provide these services through a network of acute care hospitals, outpatient facilities, clinics and other patient care delivery settings. As of September 30, 2010, we operated a diversified portfolio of 162 hospitals (with approximately 41,000 beds) and 104 freestanding surgery centers across 20 states throughout the U.S. and in England. As a result of our efforts to establish significant market share in large and growing urban markets with attractive demographic and economic profiles, we currently have a substantial market presence in 14 of the top 25 fastest growing markets in the U.S. and currently maintain the first or second position, based on inpatient admissions, in many of our key markets. We believe our ability to successfully position and grow our assets in attractive markets and execute our operating plan has contributed to the strength of our financial performance over the last several years. For the year ended December 31, 2009, we generated revenues of $30.052 billion, net income attributable to HCA Inc. of $1.054 billion and Adjusted EBITDA of $5.472 billion. For the nine months ended September 30, 2010, we generated revenues of $22.947 billion, net income attributable to HCA Inc. of $924 million and Adjusted EBITDA of $4.421 billion.

Our patient-first strategy is to provide high quality health care services in a cost-efficient manner. We intend to build upon our history of profitable growth by maintaining our dedication to quality care, increasing our presence in key markets through organic expansion and strategic acquisitions, leveraging our scale and infrastructure, and further developing our physician and employee relationships. We believe pursuing these core elements of our strategy helps us develop a faster-growing, more stable and more profitable business and increases our relevance to patients, physicians, payers and employers.

Using our scale, significant resources and over 40 years of operating experience we have developed a significant management and support infrastructure. Some of the key components of our support infrastructure include a revenue cycle management organization, a health care group purchasing organization, or GPO, an information technology and services provider, a nurse staffing agency and a medical malpractice insurance underwriter. These shared services have helped us to maximize our cash collection efficiency, achieve savings in purchasing through our scale, more rapidly deploy information technology upgrades, more effectively manage our labor pool and achieve greater stability in malpractice insurance premiums. Collectively, these components have helped us to further enhance our operating effectiveness, cost efficiency and overall financial results.

Since the founding of our business in 1968 as a single-facility hospital company, we have demonstrated an ability to consistently innovate and sustain growth during varying economic and regulatory climates. Under the leadership of an experienced senior management team, whose tenure at HCA averages over 20 years, we have established an extensive record of providing high quality care, profitably growing our business, making and integrating strategic acquisitions and efficiently and strategically allocating capital spending.

On November 17, 2006, we were acquired by a private investor group comprised of affiliates of or funds sponsored by Bain Capital, KKR, MLGPE (now BAML Capital Partners) (each a Sponsor), Citigroup Inc., Bank of America Corporation (the Sponsor Assignees) and HCA founder Dr. Thomas F. Frist, Jr. (the Frist Entities), a group we collectively refer to as the Investors, and by members of management and certain other investors. We refer to the merger, the financing transactions related to the merger and other related transactions collectively as the Recapitalization.

Since the Recapitalization, we have achieved substantial operational and financial progress. During this time, we have made significant investments in expanding our service lines and expanding our alignment with highly specialized and primary care physicians. In addition, we have enhanced our operating efficiencies through a number of corporate cost-saving initiatives and an expansion of our support infrastructure. We have made investments in information technology to optimize our facilities and systems. We have also undertaken a number of initiatives to improve clinical quality and patient satisfaction. As a result of these initiatives, our financial performance has improved significantly from the year ended December 31, 2007, the first full year following the Recapitalization, to the year ended December 31, 2009, with revenues growing by $3.194 billion,

net income attributable to HCA Inc. increasing by $180 million and Adjusted EBITDA increasing by $880 million. This represents compounded annual growth rates on these key metrics of 5.8%, 9.8% and 9.2%, respectively.

Our Industry

We believe well-capitalized, comprehensive and integrated health care delivery providers are well-positioned to benefit from the current industry trends, some of which include:

Aging Population and Continued Growth in the Need for Health Care Services. According to the U.S. Census Bureau, the demographic age group of persons aged 65 and over is expected to experience compounded annual growth of 3.0% over the next 20 years, and constitute 19.3% of the total U.S. population by 2030. The Centers for Medicare & Medicaid Services, or CMS, projects continued increases in hospital services based on the aging of the U.S. population, advances in medical procedures, expansion of health coverage, increasing consumer demand for expanded medical services and increased prevalence of chronic conditions such as diabetes, heart disease and obesity. We believe these factors will continue to drive increased utilization of health care services and the need for comprehensive, integrated hospital networks that can provide a wide array of essential and sophisticated health care.

Continued Evolution of Quality-Based Reimbursement Favors Large-Scale, Comprehensive and Integrated Providers. We believe the U.S. health care system is continuing to evolve in ways that favor large-scale, comprehensive and integrated providers that provide high levels of quality care. Specifically, we believe there are a number of initiatives that will continue to gain importance in the foreseeable future, including: introduction of value-based payment methodologies tied to performance, quality and coordination of care, implementation of integrated electronic health records and information, and an increasing ability for patients and consumers to make choices about all aspects of health care. We believe our company is well positioned to respond to these emerging trends and has the resources, expertise and flexibility necessary to adapt in a timely manner to the changing health care regulatory and reimbursement environment.

Impact of Health Reform Law. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the Health Reform Law), will change how health care services are covered, delivered and reimbursed. It will do so through expanded coverage of uninsured individuals, significant reductions in the growth of Medicare program payments, material decreases in Medicare and Medicaid disproportionate share hospital (DSH) payments, and the establishment of programs where reimbursement is tied in part to quality and integration. The Health Reform Law, as enacted, is expected to expand health insurance coverage to approximately 32 to 34 million additional individuals through a combination of public program expansion and private sector health insurance reforms. We believe the expansion of private sector and Medicaid coverage will, over time, increase our reimbursement related to providing services to individuals who were previously uninsured. On the other hand, the reductions in the growth in Medicare payments and the decreases in DSH payments will adversely affect our government reimbursement. Because of the many variables involved, including court challenges to the constitutionality of the law and the potential for changes to the law as a result, we are unable to predict the net impact of the Health Reform Law on us; however, we believe our experienced management team, emphasis on quality care and diverse service offerings will enable us to capitalize on the opportunities presented by the Health Reform Law, as well as adapt in a timely manner to its challenges.

Our Competitive Strengths

We believe our key competitive strengths include:

Largest Comprehensive, Integrated Health Care Delivery System. We are the largest non-governmental hospital operator in the U.S., providing approximately 4% to 5% of all U.S. hospital services through our national footprint.

The scope and scale of our operations, evidenced by the types of facilities we operate, the diverse medical specialties we offer and the numerous patient care access points we provide enable us to provide a comprehensive range of health care services in a cost-effective manner. As a result, we believe the breadth of our platform is a competitive advantage in the marketplace enabling us to attract patients,

physicians and clinical staff while also providing significant economies of scale and increasing our relevance with commercial payers.

Reputation for High Quality Patient-Centered Care. Since our founding, we have maintained an unwavering focus on patients and clinical outcomes. We believe clinical quality influences physician and patient choices about health care delivery. We align our quality initiatives throughout the organization by engaging corporate, local, physician and nurse leaders to share best practices and develop standards for delivering high quality care. We have invested extensively in quality of care initiatives, with an emphasis on implementing information technology and adopting industry-wide best practices and clinical protocols. As a result of these efforts, we have achieved significant progress in clinical quality, as measured by the CMS clinical core measures reported on the CMS Hospital Compare website, HCA s HQA Grand Composite Score (based on publicly available data for the twelve months ended December 31, 2009) wherein our hospitals achieved 98.1% of the CMS core measures versus the national average of 95.0%, making HCA among the top performing major health systems in the U.S. Similarly, based upon our hospitals core measure set composite scores, 86% are in the top quartile and 73% are in the top decile based on publicly available data for the three months ended September 30, 2010. In addition, the Health Reform Law establishes a value-based purchasing system and adjusts hospital payment rates based on hospital-acquired conditions and hospital readmissions. We also believe our quality initiatives favorably position us in a payment environment that is increasingly performance-based.

Leading Local Market Positions in Large, Growing, Urban Markets. Over our history, we have sought to selectively expand and upgrade our asset base to create a premium portfolio of assets in attractive growing markets. As a result, we have a strong market presence in 14 of the top 25 fastest growing markets in the U.S. We currently operate in 29 markets, 17 of which have populations of 1 million or more, with all but one of these markets projecting growth above the national average from 2009 to 2014. Our inpatient market share places us first or second in many of our key markets. In addition, we operate in markets that have demonstrated relative economic stability, with the unemployment rate in a majority of our markets below the national average as of September 2010. We believe the strength and stability of these market positions will create organic growth opportunities and allow us to develop long-term relationships with patients, physicians, large employers and third-party payers.

Diversified Revenue Base and Payer Mix. We believe our broad geographic footprint, varied service lines and diverse revenue base mitigate our risks in numerous ways. Our diversification limits our exposure to competitive dynamics and economic conditions in any single local market, reimbursement changes in specific service lines and disruptions with respect to payers such as state Medicaid programs or large commercial insurers. We have a diverse portfolio of assets with no single facility contributing more than 2.4% of our revenues and no single metropolitan statistical area contributing more than 7.8% of revenues for the year ended December 31, 2009. We have also developed a highly diversified payer base, including approximately 3,000 managed care contracts, with no single commercial payer representing more than 8% of revenues for the year ended December 31, 2009. In addition, we are one of the country s largest providers of outpatient services, which accounted for approximately 38% of our revenues for the year ended December 31, 2009. We believe the geographic diversity of our market positions and the scope of our inpatient and outpatient operations help reduce volatility in our operating results.

Scale and Infrastructure Drives Cost Savings and Efficiencies. Our scale allows us to leverage our support infrastructure to achieve significant cost savings and operating efficiencies, thereby driving margin expansion. We strategically manage our supply chain through centralized purchasing and supply warehouses, as well as our revenue cycle through centralized billing, collections and health information management functions. We also manage the provision of information technology through a combination of centralized systems with regional service support as well as centralize many other clinical and corporate functions, creating economies of scale in managing expenses and business processes. In addition to the cost savings and operating efficiencies, this support infrastructure simultaneously generates revenue from third parties that utilize our services.

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Well-Capitalized Portfolio of High Quality Assets. In order to expand the range and improve the quality of services provided at our facilities, we invested over $7.8 billion in our facilities and information technology systems over the five-year period ended December 31, 2009. We believe our significant capital investments in these areas will continue to attract new and returning patients, attract and retain high-quality physicians, maximize cost efficiencies and address the health care needs of our local communities. Furthermore, we believe our platform as well as electronic health record infrastructure, national research and physician management capabilities provide a strategic advantage by enhancing our anticipated ability to capitalize on incentives through the HITECH provisions of the American Recovery and Reinvestment Act of 2009 and positions us well in an environment that increasingly emphasizes quality, transparency and coordination of care.

Strong Operating Results and Cash Flows. Our leading scale, diversification, favorable market positions, dedication to clinical quality and focus on operational efficiency have enabled us to achieve attractive historical financial performance even during the most recent economic period. In the year ended December 31, 2009, we generated net income attributable to HCA Inc. of $1.054 billion, Adjusted EBITDA of $5.472 billion and cash flows from operating activities of $2.747 billion, while for the nine months ended September 30, 2010, we generated net income attributable to HCA Inc. of $924 million, Adjusted EBITDA of $4.421 billion and cash flows from operating activities of $2.611 billion. Our ability to generate strong and consistent cash flow from operations has enabled us to invest in our operations, reduce our debt, enhance earnings per share and continue to pursue attractive growth opportunities.

Proven and Experienced Management Team. We believe the extensive experience and depth of our management team are a distinct competitive advantage in the complicated and evolving industry in which we compete. Our CEO and Chairman of the Board of Directors, Richard M. Bracken, began his career with our company approximately 30 years ago and has held various executive positions with us over that period, including, most recently, as our President and Chief Operating Officer. Our Executive Vice President, Chief Financial Officer and Director, R. Milton Johnson, joined our company over 27 years ago and has held various positions in our financial operations since that time. Our six Group Presidents average over 20 years of experience with our company. Members of our senior management hold significant equity interests in our company, further aligning their long-term interests with those of our stockholders.

Our Growth Strategy

We are committed to providing the communities we serve with high quality, cost-effective health care while growing our business, increasing our profitability and creating long-term value for our stockholders. To achieve these objectives, we align our efforts around the following growth agenda:

Grow Our Presence in Existing Markets. We believe we are well positioned in a number of large and growing markets that will allow us the opportunity to generate long-term, attractive growth through the expansion of our presence in these markets. We plan to continue recruiting and strategically collaborating with the physician community and adding attractive service lines such as cardiology, emergency services, oncology and women s services. Additional components of our growth strategy include expanding our footprint through developing various outpatient access points, including surgery centers, rural outreach, freestanding emergency departments and walk-in clinics. Since our Recapitalization, we have invested significant capital into these markets and expect to continue to see the benefit of this investment.

Achieve Industry-Leading Performance in Clinical and Satisfaction Measures. Achieving high levels of patient safety, patient satisfaction and clinical quality are central goals of our business model. To achieve these goals, we have implemented a number of initiatives including infection reduction initiatives, hospitalist programs, advanced health information technology and evidence-based medicine programs. We routinely analyze operational practices from our best-performing hospitals to identify ways to implement organization-wide performance improvements and

reduce clinical variation. We believe these initiatives will continue to improve patient care, help us achieve cost efficiencies, grow our revenues and favorably position us in an environment where our constituents are increasingly focused on quality, efficacy and efficiency.

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

Continue to Leverage Our Scale and Market Positions to Enhance Profitability. We believe there is significant opportunity to continue to grow the profitability of our company by fully leveraging the scale and scope of our franchise. We are currently pursuing next generation performance improvement initiatives such as contracting for services on a multistate basis and expanding our support infrastructure for additional clinical and support functions, such as physician credentialing, medical transcription and electronic medical recordkeeping. We believe our centrally managed business processes and ability to leverage cost-saving practices across our extensive network will enable us to continue to manage costs effectively.

Selectively Pursue a Disciplined Development Strategy. We continue to believe there are significant growth opportunities in our markets. We will continue to provide financial and operational resources to successfully execute on our in-market opportunities. To complement our in-market growth agenda, we intend to focus on selectively developing and acquiring new hospitals, outpatient facilities and other health care service providers. We believe the challenges faced by the hospital industry may spur consolidation and we believe our size, scale, national presence and access to capital will position us well to participate in any such consolidation. We have a strong record of successfully acquiring and integrating hospitals and entering into joint ventures and intend to continue leveraging this experience.

Business Drivers and Measures

Our Financial Policies and Objectives

We seek to optimize our financial and operating performance by implementing the business strategy set forth under Our Growth Strategy. Our success in implementing this strategy depends, in turn, on our ability to fulfill our financial policies and objectives, which include the following:

Operations: We plan to focus on our core operations the provision of high quality, cost-effective health care in large, high growth urban communities, primarily in the southern and western regions of the United States. Our specific policies designed to maintain this focus include:

- using investments in new and expanded services to drive use of our facilities;
- seeking rate increases from managed care payers commensurate with increases in our underlying costs to provide high quality services;
- managing operating expenses by, among other methods, leveraging our scale;
- seeking cost savings by reducing variations in our patient care and support processes and reducing our discretionary operating expenses; and
- considering divesting non-core assets, where appropriate.

Leverage: We expect to have significant indebtedness for the foreseeable future. However, we expect to:

manage our floating interest rate exposure through our $7.1 billion aggregate notional amount of pay-fixed rate swap agreements related to our senior secured credit facilities debt at September 30, 2010; and

endeavor to improve our credit quality over time.

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Capital Expenditures: We plan to maintain a disciplined capital expenditure approach by:

- targeting new investments with potentially high returns;
- deploying capital strategically to improve our competitive position and market share and to enhance our operations; and
- managing discretionary capital expenditures based on the strength of our cash flows.

Operational Factors

In pursuing our business and our financial policies and objectives, we pay close attention to a number of performance measures and operational factors.

Our revenues depend upon inpatient occupancy levels, the ancillary services and therapy programs ordered by physicians and provided to patients, the volume of outpatient procedures and the charges and negotiated payment rates for such services. Our expenses depend upon the levels of salaries and benefits paid to our employees, the cost of supplies and the costs of other operating expenses. To monitor these variables, we use a variety of metrics, including those described below.

Volume Measures:

- admissions, which is the total number of patients admitted to our hospitals and which we use as a measure of inpatient volume;
- equivalent admissions, which is a measure of patient volume that takes into account both inpatient and outpatient volume;
- the payer mix of our admissions, i.e., the percentage of our admissions related to Medicare, Medicaid, managed Medicare, managed Medicaid, managed care and other insurers, and uninsured patients;
- emergency room visits;
- inpatient and outpatient surgeries; and
- the average daily census of patients in our hospital beds.

Pricing Measures:

- revenue per equivalent admission; and
- revenue, minus our provision for doubtful accounts, per equivalent admission.

Expense Measures:

- salaries and benefits per equivalent admission;
- supply costs per equivalent admission;

other operating expenses (including contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance and nonincome taxes) per equivalent admission; and

operating expenses, minus our provision for doubtful accounts, per equivalent admission.

We set forth the volume measures described above, except for payer mix, for the years ended December 31, 2009, 2008, 2007, 2006 and 2005 and for the nine months ended September 30, 2010 and 2009 under the heading Operating Data in Selected Financial Data. We give details about the payer mix for the years ended December 31, 2009, 2008 and 2007 and for the nine months ended September 30, 2010 and 2009 in Management s Discussion and Analysis of Financial Condition and Results of Operations Results of Operations Revenue/Volume Trends.

The pricing and expense measures described above can be derived by dividing (1) the amounts from the applicable line items in our income statement (minus our provision for doubtful accounts, where indicated) by

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(2) equivalent admissions, which are set forth under the heading Operating Data in Selected Financial Data.

Business Segments

Our company operations are structured in three geographically organized groups:

Western Group. The Western Group is comprised of the markets in Alaska, California, Colorado, Idaho, Kansas (south central portion), Nevada, Oklahoma, Texas and Utah. Samuel Hazen, who has held various positions with HCA for 27 years, is the Western Group s President. As of September 30, 2010, there were 54 consolidating hospitals within the Western Group. The Western Group includes seven of our non-consolidating hospitals, with respect to which major strategic and operating decisions are shared equally with non-HCA partners. For the year ended December 31, 2009, the Western Group generated revenues of $13.140 billion.

Central Group. The Central Group is comprised of the markets in Indiana, Georgia (northern portion), Kansas (eastern portion), Kentucky, Louisiana, Mississippi, Missouri, New Hampshire, Tennessee and Virginia. Paul Rutledge, who has held various positions with HCA for 27 years, is the Central Group s President. As of September 30, 2010, there were 46 consolidating hospitals within the Central Group. The Central Group includes one of our non-consolidating hospitals, with respect to which major strategic and operating decisions are shared equally with non-HCA partners. For the year ended December 31, 2009, the Central Group generated revenues of $7.225 billion.

Eastern Group. The Eastern Group is comprised of the markets in Florida, Georgia (southern portion) and South Carolina. Charles Hall, who has held various positions with HCA for 23 years, is the Eastern Group s President. As of September 30, 2010, there were 48 consolidating hospitals within the Eastern Group. For the year ended December 31, 2009, the Eastern Group generated revenues of $8.807 billion.

We also owned and operated six hospitals in England as of September 30, 2010, which are included in our Corporate and other group. These international facilities generated revenues of $709 million for the year ended December 31, 2009. Our divisions and market structures are designed to augment our market-based strategy to provide integrated services to their respective community. This structure allows our management to focus on manageable groupings of hospitals and provide them with direct support.

Note 13 to our consolidated financial statements contains information by segment on our revenues, equity in earnings of affiliates, adjusted segment EBITDA and depreciation and amortization for the years ended December 31, 2009, 2008 and 2007.

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 September 30, 2010, we owned and operated 149 general, acute care hospitals with 38,130 licensed beds, and an additional seven general, acute care hospitals with 2,269 licensed beds, which 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.

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At September 30, 2010, we operated five psychiatric hospitals with 506 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 ambulatory surgery centers (ASCs), 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. Most of our ASCs are operated through partnerships or limited liability companies, with majority ownership of each partnership or limited liability company typically held by a general partner or 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.

Sources of Revenue

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or payment rates for such services. Charges and reimbursement rates for inpatient services vary significantly depending on the type of 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 the Medicare and Medicaid programs.

Amounts received under the 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 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

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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 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. The Health Reform Law provides for annual decreases to the market basket, including a 0.25% reduction in 2010 for discharges occurring on or after April 1, 2010. The Health Reform Law also provides for the following reductions to the market basket update for each of the following federal fiscal years: 0.25% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. For federal fiscal year 2012 and each subsequent federal fiscal year, the Health Reform Law provides for the annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the Bureau of Labor Statistics (BLS) 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. Based upon the latest available data, federal fiscal year 2012 market basket reductions resulting from this productivity adjustment are likely to range from 1.0% to 1.4%. CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the inpatient PPS by $112.6 billion from 2010 to 2019. 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.

For federal fiscal year 2010, CMS initially set the MS-DRG rate increase at the full market basket of 2.1%, but on May 21, 2010, CMS proposed to reduce the increase to 1.85% for discharges occurring on or after April 1, 2010, as required by the Health Reform Law. For federal fiscal year 2011, CMS issued a final rule increasing the MS-DRG rate for federal fiscal year 2011 by 2.35%, representing the full market basket of 2.6% minus the 0.25% reduction required by the Health Reform Law. CMS will also apply a documentation and coding adjustment of negative 2.9% in federal fiscal year 2011 to account for increases in aggregate payments during implementation of the MS-DRG system. This reduction represents half of the documentation and coding adjustment that CMS intends to implement. CMS plans to recover the remaining 2.9% and interest in federal fiscal year 2012. The market basket update and the documentation

and coding adjustment together result in an aggregate market basket adjustment for federal fiscal year 2011 of negative 0.55%. CMS has also

announced that an additional prospective negative adjustment of 3.9% will be needed to avoid increased Medicare spending unrelated to patient severity of illness. CMS is not implementing this additional 3.9% reduction in federal fiscal year 2011 but has stated that it will be required in the future.

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 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. In federal fiscal year 2011, CMS requires hospitals to report 55 quality measures in order to qualify for the full market basket update to the inpatient PPS in federal fiscal year 2012. 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 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. In addition, CMS has established three National Coverage Determinations that prohibit Medicare reimbursement for erroneous surgical procedures performed on an inpatient or outpatient basis. The Health Reform Law provides for reduced payments based on a hospital s HAC rates. Beginning in federal fiscal year 2015, hospitals that rank in the top 25% nationally of HACs for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. In addition, effective July 1, 2011, the Health Reform Law prohibits the use of federal funds under the Medicaid program to reimburse providers for medical services provided to treat HACs.

The Health Reform Law also provides for reduced payments to hospitals based on readmission rates. Beginning in federal fiscal year 2013, inpatient payments will be reduced if a hospital experiences excessive readmissions within a 30-day period of discharge for heart attack, heart failure, pneumonia or other conditions designated by HHS. Hospitals with what HHS defines as excessive readmissions for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Each hospital s performance will be publicly reported by HHS. HHS has the discretion to determine what excessive readmissions means, the amount of the payment reduction and other terms and conditions of this program.

The Health Reform Law additionally establishes a value-based purchasing program to further link payments to quality and efficiency. In federal fiscal year 2013, HHS is directed to implement a value-based purchasing program for inpatient hospital services. Beginning in federal fiscal year 2013, CMS will reduce the inpatient PPS payment amount for all discharges by the following: 1% for 2013; 1.25% for 2014; 1.5% for 2015; 1.75% for 2016; and 2% for 2017 and subsequent years. For each federal fiscal year, the total amount collected from these reductions will be pooled and used to fund payments to reward hospitals that meet certain quality performance standards established by HHS. HHS will have the authority to determine the quality performance measures, the standards hospitals must achieve in order to meet the quality performance measures and the methodology for calculating payments to hospitals that meet the required quality threshold. HHS will

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also determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by the reductions related to the value-based purchasing program.

Historically, the Medicare program has set aside 5.10% of Medicare inpatient payments to pay for outlier cases. For federal fiscal year 2010, CMS established an outlier threshold of $23,140, and for federal fiscal year 2011, CMS reduced the outlier threshold to $23,075. We do not anticipate that the decrease to the outlier threshold for federal fiscal year 2011 will have a material impact on our results of operations.

Outpatient

CMS reimburses hospital outpatient services (and certain Medicare Part B services furnished to hospital inpatients who have no Part A coverage) on a PPS basis. CMS uses fee schedules to pay for physical, occupational and speech therapies, durable medical equipment, clinical diagnostic laboratory services 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. CMS updated payment rates for calendar year 2010 by the full market basket of 2.1%. However, the Health Reform Law includes a 0.25% reduction to the market basket for 2010. The Health Reform Law also provides for the following reductions to the market basket update for each of the following calendar years: 0.25% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. For calendar year 2011, CMS has announced a final rule that includes a market basket update of 2.6%. With the 0.25% reduction required by the Health Reform Law, this will result in a market basket increase of 2.35%. For calendar year 2012 and each subsequent calendar year, the Health Reform Law provides for an annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the BLS 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. However, CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the outpatient PPS by $26.3 billion from 2010 to 2019. CMS continues to require hospitals to submit quality data relating to outpatient care to receive the full market basket increase under the outpatient PPS. CMS requires hospitals to report data on eleven quality measures in calendar year 2010 for the payment determination in calendar year 2011. CMS has announced a final rule that will require hospitals to report fifteen total measures in calendar year 2011 to receive the full market basket increase in calendar year 2012. 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. CMS provided for a market basket update of 2.5% for federal fiscal year 2010. However, the Health Reform Law requires a 0.25% reduction to the market basket for 2010 for discharges occurring on or after April 1, 2010. The Health Reform Law also provides for the following reductions to the market basket update for each of the following federal fiscal years: 0.25% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. For rate year 2011, CMS issued a notice that includes a market basket update of 2.4%. With the 0.25% reduction required

by the Health Reform Law, this notice will result in a market basket increase of 2.15% for rate year 2011. For federal fiscal year 2012 and each subsequent federal fiscal year, the Health Reform Law provides for the annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the BLS 10-year moving average of changes in specified economy-wide productivity (the

BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. However, CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the IRF PPS by $5.7 billion from 2010 to 2019. Beginning in federal fiscal year 2014, IRFs will be required to report quality measures to HHS or will receive a two percentage point reduction to the market basket update. 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, with each twelve month period referred to as a rate year. 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 was 2.1%, and the annual RPL market basket update for rate year 2011 is 2.4%. However, the Health Reform Law includes a 0.25% reduction to the market basket for rate year 2010 and again in 2011. The Health Reform Law also provides for the following reductions to the market basket update for each of the following rate years: 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. For rate year 2012 and each subsequent rate year, the Health Reform Law provides for the annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the BLS 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. However, CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the IPF PPS by $4.3 billion from 2010 to 2019. As of December 31, 2009, we had five psychiatric hospitals and 32 hospital psychiatric units.

Ambulatory Surgery Centers

CMS reimburses ASCs using a predetermined fee schedule. Reimbursements for ASC overhead costs are limited to no more than the overhead costs paid to hospital outpatient departments under the Medicare hospital outpatient PPS for the same procedure. 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, for services previously in the nine payment groups, 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. The Health Reform Law requires HHS to issue a plan by January 1, 2011 for developing a value-based purchasing program for ASCs. Such a program may further impact Medicare reimbursement of ASCs or increase our operating costs in order to satisfy the value-based standards. For federal fiscal year 2011 and each subsequent federal fiscal year, the Health Reform Law provides for the annual market basket update to be reduced by a productivity adjustment. The amount of that reduction will be the projected nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the BLS 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old).

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 2011. However, the Health Reform Law requires HHS to report to Congress by December 31, 2011 with recommendations on how to comprehensively reform the Medicare wage index system.

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 and service both Part A and Part B providers within a given jurisdiction. Although CMS has awarded initial contracts to all 15 MAC jurisdictions, full transition to the MAC jurisdictions has been delayed due to CMS resoliciting some bids and implementing other corrective actions in response to filed protests. 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. During 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.

Under the Recovery Audit Contractor (RAC) program, CMS contracts with RACs to conduct post-payment reviews to detect and correct improper payments in the Medicare program. CMS has awarded contracts to four RACs that are implementing the RAC program on a nationwide basis as required by statute.

Physician Services

Physician services are reimbursed under the physician fee schedule (PFS) system, under which CMS has assigned a national relative value unit (RVU) to most medical procedures and services that reflects the various resources required by a physician to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service, practice expense (overhead) attributable to the service and malpractice insurance expense attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs then aggregated. The aggregated amount is multiplied by a conversion factor that accounts for inflation and targeted growth in Medicare expenditures (as calculated by the sustainable growth rate (SGR)) to arrive at the payment amount for each service. While RVUs for various services may change in a given year, any alterations are required by statute to be virtually budget neutral, such that total payments made under the PFS may not differ by more than $20 million from what payments would have been if adjustments were not made.

The PFS rates are adjusted each year, and reductions in both current and future payments are anticipated. The SGR formula, if implemented as mandated by statute, would result in significant reductions to payments under the PFS. Since 2003, the U.S. Congress has passed multiple legislative acts delaying application of the SGR to the PFS. For calendar year 2011, CMS issued a final rule that would have applied the SGR and resulted in an aggregate reduction of 24.9% to all physician payments under the PFS for federal fiscal year 2011. On December 15, 2010, President Obama signed legislation delaying application of the SGR until

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January 1, 2012. We cannot predict whether the U.S. Congress will intervene to prevent this reduction to payments in the future.

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 health care 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, the Health Reform Law reduces, over a three year period, premium payments to managed Medicare plans such that CMS managed care per capita premium payments are, on average, equal to traditional Medicare. In addition, the Health Reform Law implements fee payment adjustments based on service benchmarks and quality ratings. The CBO has estimated that, as a result of these changes, payments to plans will be reduced by $138 billion between 2010 and 2019, while CMS has estimated the reduction to be $145 billion. In addition, the Health Reform Law expands the RAC program to include managed Medicare plans. In light of the current economic downturn and the Health Reform Law, 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 payment levels with individual hospitals. Medicaid reimbursement is often less than a hospital s cost of services. The Health Reform Law also requires states to expand Medicaid coverage to all individuals under age 65 with incomes up to 133% of the federal poverty level (FPL) by 2014. However, the Health Reform Law also requires states to apply a 5% income disregard to the Medicaid eligibility standard, so that Medicaid eligibility will effectively be extended to those with incomes up to 138% of the FPL. In addition, effective July 1, 2011, the Health Reform Law will prohibit the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs.

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. ARRA allocated approximately $87.0 billion to temporarily increase the share of program costs paid by the federal government to fund each state s Medicaid program. Although initially scheduled to expire at the end of 2010, Congress has allocated additional funds to extend this increased federal funding to states through June 2011. These funds have helped avoid more extensive program and reimbursement cuts, but the expiration of the increased federal funding could result in significant reductions to state Medicaid programs.

Further, as permitted by law, certain states in which we operate have adopted broad-based provider taxes to fund the non-federal share of Medicaid programs. Many states have also adopted, or are considering, legislation designed to reduce coverage, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems. Effective March 23, 2010, the Health Reform Law requires states to at least maintain Medicaid eligibility standards established prior to the enactment of the law for adults until January 1, 2014 and for children until October 1, 2019. However, states with budget deficits may seek exemptions from this requirement to address eligibility standards that apply to adults making more than 133% of the FPL.

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,

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the DRA 2005 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 states assigned to those regions. The Health Reform Law increases federal funding for the MIC program for federal fiscal year 2011 and later years. In addition to MICs, several other contractors and state Medicaid agencies have increased their review activities. The Health Reform Law expands the RAC program s scope to include Medicaid claims by requiring all states to establish programs to contract with RACs by December 31, 2010.

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 reimbursement received from these plans.

Accountable Care Organizations and Pilot Projects

The Health Reform Law requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of Accountable Care Organizations (ACOs), beginning no later than January 1, 2012. The program will allow providers (including hospitals), physicians and other designated professionals and suppliers to form ACOs and voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. HHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred, and what portion of such savings will be paid to ACOs. In addition, HHS will determine to what degree hospitals, physicians and other eligible participants will be able to form and operate an ACO without violating certain existing laws, including the Civil Monetary Penalty Law, the Anti-kickback Statute and the Stark Law. The Health Reform Law does not authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in ACOs, such as antitrust laws.

The Health Reform Law requires HHS to establish a five-year, voluntary national bundled payment pilot program for Medicare services beginning no later than January 1, 2013. Under the program, providers would agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. HHS will have the discretion to determine how the program will function. For example, HHS will determine what medical conditions will be included in the program and the amount of the payment for each condition. In addition, the Health Reform Law provides for a five-year bundled payment pilot program for Medicaid services to begin January 1, 2012. HHS will select up to eight states to participate based on the potential to lower costs under the Medicaid program while improving care. State programs may target particular categories of beneficiaries, selected diagnoses or geographic regions of the state. The selected state programs will provide one payment for both hospital and physician services provided to Medicaid patients for certain episodes of inpatient care. For both pilot programs, HHS will determine the relationship between the programs and restrictions in certain existing laws, including the Civil Monetary Penalty Law, the Anti-kickback Statute, the Stark Law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy, security and transaction standard requirements. However, the Health Reform Law does not

authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in the pilot programs, such as antitrust laws.

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Disproportionate Share Hospitals

In addition to making payments for services provided directly to beneficiaries, Medicare makes additional payments to hospitals that treat a disproportionately large number of low-income patients (Medicaid and Medicare patients eligible to receive Supplemental Security Income). Disproportionate share hospital (DSH) payments are determined annually based on certain statistical information required by HHS and are calculated as a percentage addition to MS-DRG payments. The primary method used by a hospital to qualify for Medicare DSH payments is a complex statutory formula that results in a DSH percentage that is applied to payments on MS-DRGs.

Under the Health Reform Law, beginning in federal fiscal year 2014, Medicare DSH payments will be reduced to 25% of the amount they otherwise would have been absent the new law. The remaining 75% of the amount that would otherwise be paid under Medicare DSH will be effectively pooled, and this pool will be reduced further each year by a formula that reflects reductions in the national level of uninsured who are under 65 years of age. Each DSH hospital will then be paid, out of the reduced DSH payment pool, an amount allocated based upon its level of uncompensated care. It is difficult to predict the full impact of the Medicare DSH reductions. The CBO estimates $22 billion in reductions to Medicare DSH payments between 2010 and 2019, while for the same time period, CMS estimates reimbursement reductions totaling $50 billion.

Hospitals that provide care to a disproportionately high number of low-income patients may receive Medicaid DSH payments. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. States have broad discretion to define which hospitals qualify for Medicaid DSH payments and the amount of such payments. The Health Reform Law will reduce funding for the Medicaid DSH hospital program in federal fiscal years 2014 through 2020 by the following amounts: 2014 ($500 million); 2015 ($600 million); 2016 ($600 million); 2017 ($1.8 billion); 2018 ($5 billion); 2019 ($5.6 billion); and 2020 ($4 billion). How such cuts are allocated among the states and how the states allocate these cuts among providers, have yet to be determined.

TRICARE

TRICARE is the Department of Defense s health care program for members of the armed forces. For inpatient services, TRICARE reimburses hospitals based on a DRG system modeled on the Medicare inpatient PPS. The Department of Defense has also 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 has reduced 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. It is not clear what impact, if any, the increased obligations on managed care payers and other health plans imposed by the Health Reform Law will have on our ability to negotiate reimbursement increases.

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. The Health Reform Law requires health plans to reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place. Further, as enacted, the Health Reform Law contains provisions that seek to decrease the number of uninsured individuals, including requirements and incentives, which do not become effective until 2014, for individuals to obtain, and employers to provide, insurance coverage. These mandates may reduce the financial impact of screening for and stabilizing emergency medical conditions. However, many factors are unknown regarding the impact of the Health Reform Law, including how many previously uninsured individuals will obtain coverage as a result of the new law or the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals. In addition, it is difficult to predict the full impact of the Health Reform Law due to the law s complexity, lack of implementing regulations or interpretive guidance, gradual and potentially delayed implementation, pending court challenges and possible amendment.

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 that 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.

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

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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 ASCs and diagnostic centers (including facilities owned by physicians) in the geographic areas in which we operate has increased significantly. As a result, most of our hospitals operate in a highly competitive environment. In some cases, competing hospitals are more established than our hospitals. Some competing 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 specialty hospitals, some of which are physician-owned, and both our own and unaffiliated freestanding ASCs 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. Pursuant to the Health Reform Law, hospitals will be required to publish annually a list of their standard charges for items and services. We have increased our focus on operating outpatient services with improved accessibility and more convenient service for patients, and increased predictability and efficiency for physicians.

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

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. In addition, as various provisions of the Health Reform Law are implemented, including the establishment of Exchanges and limitations on rescissions of coverage and pre-existing condition exclusions, non-government payers may increasingly demand reduced fees or be unwilling to negotiate reimbursement increases. The importance of obtaining contracts with managed care

organizations varies from community to community, depending on the market strength of such organizations.

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State certificate of need (CON) laws, which place limitations on a hospital s ability to expand hospital services and facilities, make capital expenditures and otherwise make changes in operations, may also have the effect of restricting competition. We currently operate health care facilities in a number of states with CON laws. Before issuing a CON, these states consider the need for additional or expanded health care facilities or services. In those states which have no CON laws or which set relatively high levels of expenditures before they become reviewable by state authorities, competition in the form of new services, facilities and capital spending is more prevalent. See Regulation and Other Factors.

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

Admissions, average lengths of stay and reimbursement amounts continue to be negatively affected by payer-required pre-admission authorization, utilization review and payer pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. The Health Reform Law potentially expands the use of prepayment review by Medicare contractors by eliminating statutory restrictions on their use. Increased competition, admission constraints and payer pressures are expected to continue. To meet these challenges, we intend to expand our facilities or acquire or construct new facilities where appropriate, to enhance the provision of a comprehensive array of outpatient services, offer market competitive pricing to private payer groups, upgrade facilities and equipment and offer new or expanded programs and services.

Environmental Matters

We are subject to various federal, state and local statutes and ordinances regulating the discharge of materials into the environment. We do not believe that we will be required to expend any material amounts in order to comply with these laws and regulations.

Insurance

As is typical in the health care industry, we are subject to claims and legal actions by patients in the ordinary course of business. Subject to a $5 million per occurrence self-insured retention, our facilities are insured by our wholly-owned insurance subsidiary for losses up to $50 million per occurrence. The insurance subsidiary has obtained reinsurance for professional liability risks generally above a retention level of $15 million per occurrence. We also maintain professional liability insurance with unrelated commercial carriers for losses in excess of amounts insured by our insurance subsidiary.

We purchase, from unrelated insurance companies, coverage for directors and officers liability and property loss in amounts we believe are adequate. The directors and officers liability coverage includes a $25 million corporate deductible for the period prior to the Recapitalization and a $1 million corporate deductible subsequent to the Recapitalization. In addition, we will continue to purchase coverage for our directors and officers on an ongoing basis. The property coverage includes varying deductibles depending on the cause of the property damage. These deductibles range from $500,000 per claim up to 5% of the affected property values for certain flood and wind and earthquake related incidents.

Employees and Medical Staffs

At September 30, 2010, we had approximately 191,000 employees, including approximately 47,000 part-time employees. References herein to employees refer to employees of our affiliates. We are subject to various state and

federal laws that regulate wages, hours, benefits and other terms and conditions relating to employment. At September 30, 2010, employees at 26 of our hospitals are represented by various labor unions. It is possible additional hospitals may unionize in the future. We consider our employee relations to be good and have not experienced work stoppages that have materially, adversely affected our business or results of operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate. In some markets, nurse and medical support personnel availability has become a significant operating issue to health care providers. To address this challenge, we have implemented several initiatives to improve retention, recruiting, compensation programs and productivity.

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Our hospitals are staffed by licensed physicians, who generally are not employees of our hospitals. However, some physicians provide services in our hospitals under contracts, which generally describe a term of service, provide and establish the duties and obligations of such physicians, require the maintenance of certain performance criteria and fix compensation for such services. Any licensed physician may apply to be accepted to the medical staff of any of our hospitals, but the hospital s medical staff and the appropriate governing board of the hospital, in accordance with established credentialing criteria, must approve acceptance to the staff. Members of the medical staffs of our hospitals often also serve on the medical staffs of other hospitals and may terminate their affiliation with one of our hospitals at any time.

We may be required to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary or contract personnel. As a result, our labor costs could increase. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Certain proposed changes in federal labor laws, including the Employee Free Choice Act, could increase the likelihood of employee unionization attempts. To the extent a significant portion of our employee base unionizes, our costs could increase materially. In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse-staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs, and have an adverse impact on revenues if we are required to limit patient admissions in order to meet the required ratios.

Properties

The following table lists, by state, the number of hospitals (general, acute care, psychiatric and rehabilitation) directly or indirectly owned and operated by us as of September 30, 2010:

State	Hospitals	Beds
Alaska	1	250
California	5	1,637
Colorado	7	2,259
Florida	38	9,808
Georgia	11	1,946
Idaho	2	481
Indiana	1	278
Kansas	4	1,286
Kentucky	2	384
Louisiana	6	1,251
Mississippi	1	130
Missouri	6	1,055
Nevada	3	1,074
New Hampshire	2	295
Oklahoma	2	793
South Carolina	3	740
Tennessee	12	2,345
Texas	34	10,232
Utah	6	968
Virginia	10	3,089
International		
England	6	704

	162	41,005

In addition to the hospitals listed in the above table, we directly or indirectly operate 104 freestanding surgery centers. We also operate medical office buildings in conjunction with some of our hospitals. These office buildings are primarily occupied by physicians who practice at our hospitals. Fourteen of our general, acute care hospitals and three of our other properties have been mortgaged to support our obligations under our senior secured cash flow credit facility and the first lien secured notes we issued in 2009 and 2010. These

three other properties are also subject to second mortgages to support our obligations under the second lien secured notes we issued in 2006 and 2009.

We maintain our headquarters in approximately 1,200,000 square feet of space in the Nashville, Tennessee area. In addition to the headquarters in Nashville, we maintain regional service centers related to our shared services initiatives. These service centers are located in markets in which we operate hospitals.

We believe our headquarters, hospitals and other facilities are suitable for their respective uses and are, in general, adequate for our present needs. Our properties are subject to various federal, state and local statutes and ordinances regulating their operation. Management does not believe that compliance with such statutes and ordinances will materially affect our financial position or results of operations.

Legal Proceedings

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. The resolution of any such lawsuits, claims or legal and regulatory proceedings could materially and adversely affect our results of operations and financial position in a given period.

Government Investigations, Claims and Litigation

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

In January 2001, we entered into an eight-year Corporate Integrity Agreement (the CIA) with the Office of Inspector General at HHS (OIG), which expired on January 24, 2009. Under the CIA, we had numerous affirmative obligations, including the requirement to report potential violations of applicable federal health care laws and regulations. Pursuant to these obligations, we reported a number of potential violations of the Stark Law, the Anti-kickback Statute, EMTALA and other laws, most of which we consider to be nonviolations or technical violations. We submitted our final report pursuant to the CIA on April 30, 2009. In April 2010, we received notice from the OIG that the final report was accepted, relieving us of future obligations under the CIA. However, the government could still determine that our reporting and/or our resolution of reported issues was inadequate. Violation or breach of the CIA, or violation of federal or state laws relating to Medicare, Medicaid or similar programs, could subject us to substantial monetary fines, civil and criminal penalties and/or exclusion from participation in the Medicare and Medicaid programs. Alleged violations may be pursued by the government or through private *qui tam* actions. Sanctions imposed against us as a result of such actions could have a material, adverse effect on our results of operations or financial position.

The Civil Division of the Department of Justice (DOJ) has contacted us in connection with its nationwide review of whether, in certain cases, hospital charges to the federal government relating to implantable cardio-defibrillators (ICDs) met the CMS criteria. In connection with this nationwide review, the DOJ has indicated that it will be reviewing certain ICD billing and medical records at 95 HCA hospitals; the review covers the period from October 2003 to the present. The review could potentially give rise to claims against us under the federal FCA or other statutes, regulations or laws. At this time, we cannot predict what effect, if any, this review or any resulting claims could have on us.

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New Hampshire Hospital Litigation

In 2006, the Foundation for Seacoast Health (the Foundation) filed suit against HCA in state court in New Hampshire. The Foundation alleged that both the 2006 Recapitalization transaction and a prior 1999 intra-corporate transaction violated a 1983 agreement that placed certain restrictions on transfers of the Portsmouth Regional Hospital. In May 2007, the trial court ruled against the Foundation on all its claims. On appeal, the New Hampshire Supreme Court affirmed the ruling on the Recapitalization, but remanded to the trial court the claims based on the 1999 intra-corporate transaction. The trial court ruled in December 2009 that the 1999 intra-corporate transaction breached the transfer restriction provisions of the 1983 agreement. The court will now conduct additional proceedings to determine whether any harm has flowed from the alleged breach, and if so, what the appropriate remedy should be. The court may consider whether to, among other things, award monetary damages, rescind or undo the 1999 intra-corporate transfer or give the Foundation a right to purchase hospital assets at a price to be determined (which the Foundation asserts should be below the fair market value of the hospital). The trial for the remedies phase is currently set for May 2011.

General Liability and Other Claims

We are a party to certain proceedings relating to claims for income taxes and related interest before the IRS Appeals Division. For a description of those proceedings, see Management s Discussion and Analysis of Financial Condition and Results of Operations IRS Disputes and Note 5 to our consolidated financial statements and Note 2 to our condensed consolidated financial statements.

We are also subject to claims and suits arising in the ordinary course of business, including claims for personal injuries or for wrongful restriction of, or interference with, physicians staff privileges. In certain of these actions the claimants have asked for punitive damages against us, which may not be covered by insurance. In the opinion of management, the ultimate resolution of these pending claims and legal proceedings will not have a material, adverse effect on our results of operations or financial position.

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REGULATION AND OTHER FACTORS

Licensure, Certification and Accreditation

Health care facility construction and operation are subject to numerous federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, fire prevention, rate-setting and compliance with building codes and environmental protection laws. Facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe our health care facilities are properly licensed under applicable state laws. Each of our acute care hospitals are certified for participation in the Medicare and Medicaid programs and are accredited by The Joint Commission. If any facility were to lose its Medicare or Medicaid certification, the facility would be unable to receive reimbursement from federal health care programs. If any facility were to lose accreditation by The Joint Commission, the facility would be subject to state surveys, potentially be subject to increased scrutiny by CMS and likely lose payment from non-government payers. Management believes our facilities are in substantial compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, it may become necessary for us to make changes in our facilities, equipment, personnel and services. The requirements for licensure also may include notification or approval in the event of the transfer or change of ownership. Failure to obtain the necessary state approval in these circumstances can result in the inability to complete an acquisition or change of ownership.

Certificates of Need

In some states where we operate hospitals and other health care facilities, the construction or expansion of health care facilities, the acquisition of existing facilities, the transfer or change of ownership and the addition of new beds or services may be subject to review by and prior approval of state regulatory agencies under a CON program. Such laws generally require the reviewing state agency to determine the public need for additional or expanded health care facilities and services. Failure to obtain necessary state approval can result in the inability to expand facilities, complete an acquisition or change ownership.

State Rate Review

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

Federal Health Care Program Regulations

Participation in any federal health care program, including the Medicare and Medicaid programs, is heavily regulated by statute and regulation. If a hospital fails to substantially comply with the numerous conditions of participation in the Medicare and Medicaid programs or performs certain prohibited acts, the hospital s participation in the federal health care programs may be terminated, or civil and/or criminal penalties may be imposed.

Anti-kickback Statute

A section of the Social Security Act known as the Anti-kickback Statute prohibits providers and others from directly or indirectly soliciting, receiving, offering or paying any remuneration with the intent of generating referrals or orders for services or items covered by a federal health care program. Courts have interpreted this statute broadly and held that there is a violation of the Anti-kickback Statute if just one purpose of the remuneration is to generate referrals, even if there are other lawful purposes. Furthermore, the Health Reform Law provides that knowledge of the law or the intent to violate the law is not required.

Violations of the Anti-kickback Statute may be punished by a criminal fine of up to $25,000 for each violation or imprisonment, civil money penalties of up to $50,000 per violation and damages of up to three times the total amount of the remuneration and/or exclusion from participation in federal health care programs, including Medicare and Medicaid. The Health Reform Law provides that submission of a claim for services or items generated in violation of the Anti-kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal FCA.

The OIG, among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse and waste. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. As one means of providing guidance to health care providers, the OIG issues Special Fraud Alerts. These alerts do not have the force of law, but identify features of arrangements or transactions that the government believes may cause the arrangements or transactions to violate the Anti-kickback Statute or other federal health care laws. The OIG has identified several incentive arrangements that constitute suspect practices, including: (a) payment of any incentive by a hospital each time a physician refers a patient to the hospital, (b) the use of free or significantly discounted office space or equipment in facilities usually located close to the hospital, (c) provision of free or significantly discounted billing, nursing or other staff services, (d) free training for a physician s office staff in areas such as management techniques and laboratory techniques, (e) guarantees which provide, if the physician s income fails to reach a predetermined level, the hospital will pay any portion of the remainder, (f) low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital, (g) payment of the costs of a physician s travel and expenses for conferences, (h) coverage on the hospital s group health insurance plans at an inappropriately low cost to the physician, (i) payment for services (which may include consultations at the hospital) which require few, if any, substantive duties by the physician, (j) purchasing goods or services from physicians at prices in excess of their fair market value, and (k) rental of space in physician offices, at other than fair market value terms, by persons or entities to which physicians refer. The OIG has encouraged persons having information about hospitals who offer the above types of incentives to physicians to report such information to the OIG.

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

In addition to issuing Special Fraud Alerts and Special Advisory Bulletins, the OIG issues compliance program guidance for certain types of health care providers. The OIG guidance identifies a number of risk areas under federal fraud and abuse statutes and regulations. These areas of risk include compensation arrangements with physicians, recruitment arrangements with physicians and joint venture relationships with physicians.

As authorized by Congress, the OIG has published safe harbor regulations that outline categories of activities deemed protected from prosecution under the Anti-kickback Statute. Currently, there are statutory exceptions and safe harbors for various activities, including the following: certain investment interests, space rental, equipment rental, practitioner recruitment, personnel services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, freestanding surgery centers, ambulance replenishing, and referral agreements for specialty services.

The fact that conduct or a business arrangement does not fall within a safe harbor, or it is identified in a Special Fraud Alert or Advisory Bulletin or as a risk area in the Supplemental Compliance Guidelines for Hospitals, does not

necessarily render the conduct or business arrangement illegal under the Anti-kickback Statute. However, such conduct and business arrangements may lead to increased scrutiny by government enforcement authorities.

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

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

Stark Law

The Social Security Act also includes a provision commonly known as the Stark Law. The Stark Law prevents the entity from billing Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires the entity to refund amounts received for items or services provided pursuant to the prohibited referral. The law, thus, effectively prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship, if these entities provide certain designated health services reimbursable by Medicare or Medicaid, including inpatient and outpatient hospital services, clinical laboratory services and radiology services. Sanctions for violating the Stark Law include denial of payment, civil monetary penalties of up to $15,000 per claim submitted and exclusion from the federal health care programs. The statute also provides for a penalty of up to $100,000 for a circumvention scheme. There are exceptions to the self-referral prohibition for many of the customary financial arrangements between physicians and providers, including employment contracts, leases and recruitment agreements. Unlike safe harbors under the Anti-kickback Statute with which compliance is voluntary, an arrangement must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law. Although there is an exception for a physician s ownership interest in an entire hospital, the Health Reform Law prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. As a result, the new law will effectively prevent the formation of physician-owned hospitals after December 31, 2010. While the new law grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand services.

Through a series of rulemakings, CMS has issued final regulations implementing the Stark Law. Additional changes to these regulations, which became effective October 1, 2009, further restrict the types of arrangements facilities and physicians may enter, including additional restrictions on certain leases, percentage compensation arrangements, and agreements under which a hospital purchases services under arrangements. While these regulations were intended to clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. CMS has indicated it is considering additional changes to the Stark Law regulations. Because many of these laws and their implementing regulations are relatively new, we do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot assure that every relationship complies fully with the Stark Law.

Similar State Laws

Many states in which we operate also have laws similar to the Anti-kickback Statute that prohibit payments to physicians for patient referrals and laws similar to the Stark Law that prohibit certain self-referrals. The scope of these state laws is broad, since they can often apply regardless of the source of payment for care, they frequently cover a broad range of health care services, and little precedent exists for

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their interpretation or enforcement. These statutes typically provide for criminal and civil penalties, as well as loss of facility licensure.

Other Fraud and Abuse Provisions

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) broadened the scope of certain fraud and abuse laws by adding several criminal provisions for health care fraud offenses that apply to all health benefit programs. The Social Security Act also imposes criminal and civil penalties for making false claims and statements to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered or for misrepresenting actual services rendered in order to obtain higher reimbursement, billing for unnecessary goods and services and cost report fraud. Federal enforcement officials have the ability to exclude from Medicare and Medicaid any investors, officers and managing employees associated with business entities that have committed health care fraud, even if the officer or managing employee had no knowledge of the fraud. Criminal and civil penalties may be imposed for a number of other prohibited activities, including failure to return known overpayments, certain gainsharing arrangements, billing Medicare amounts that are substantially in excess of a provider s usual charges, offering remuneration to influence a Medicare or Medicaid beneficiary s selection of a health care provider, contracting with an individual or entity known to be excluded from a federal health care program, making or accepting a payment to induce a physician to reduce or limit services, and soliciting or receiving any remuneration in return for referring an individual for an item or service payable by a federal health care program. Like the Anti-kickback Statute, these provisions are very broad. Under the Health Reform Law, civil penalties may be imposed for the failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments and accurately prepare cost reports.

Some of these provisions, including the federal Civil Monetary Penalty Law, require a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute. Civil monetary penalties that may be imposed under the federal Civil Monetary Penalty Law range from $10,000 to $50,000 per act, and in some cases may result in penalties of up to three times the remuneration offered, paid, solicited or received. In addition, a violator may be subject to exclusion from federal and state health care programs. Federal and state governments increasingly use the federal Civil Monetary Penalty Law, especially where they believe they cannot meet the higher burden of proof requirements under the Anti-kickback Statute. Further, individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds under the Medicare Integrity Program.

The Federal False Claims Act and Similar State Laws

The *qui tam*, or whistleblower, provisions of the FCA allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. Further, the government may use the FCA to prosecute Medicare and other government program fraud in areas such as coding errors, billing for services not provided and submitting false cost reports. When a private party brings a *qui tam* action under the FCA, the defendant is not made aware of the lawsuit until the government commences its own investigation or makes a determination whether it will intervene. When a defendant is determined by a court of law to be liable under the FCA, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. There are many potential bases for liability under the FCA. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA defines the term knowingly broadly. Though simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity constitutes a knowing submission under the FCA and, therefore, will qualify for liability. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding

repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Health Reform Law, the FCA is implicated by the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later. Further,

the Health Reform Law expands the scope of the FCA to cover payments in connection with the new health insurance exchanges to be created by the Health Reform Law, if those payments include any federal funds.

In some cases, whistleblowers and the federal government have taken the position, and some courts have held, that providers who allegedly have violated other statutes, such as the Anti-kickback Statute and the Stark Law, have thereby submitted false claims under the FCA. The Health Reform Law clarifies this issue with respect to the Anti-kickback Statute by providing that submission of claims for services or items generated in violation of the Anti-kickback Statute constitutes a false or fraudulent claim under the FCA. Every entity that receives at least $5 million annually in Medicaid payments must have written policies for all employees, contractors or agents, providing detailed information about false claims, false statements and whistleblower protections under certain federal laws, including the FCA, and similar state laws. In addition, federal law provides an incentive to states to enact false claims laws comparable to the FCA. A number of states in which we operate have adopted their own false claims provisions as well as their own whistleblower provisions under which a private party may file a civil lawsuit in state court. We have adopted and distributed policies pertaining to the FCA and relevant state laws.

HIPAA Administrative Simplification and Privacy and Security Requirements

The Administrative Simplification Provisions of HIPAA require the use of uniform electronic data transmission standards for certain health care claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the health care industry. HHS has issued regulations implementing the HIPAA Administrative Simplification Provisions and compliance with these regulations is mandatory for our facilities. In addition, HIPAA requires that each provider use a National Provider Identifier. In January 2009, CMS published a final rule making changes to the formats used for certain electronic transactions and requiring the use of updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets. While use of the ICD-10 code sets is not mandatory until October 1, 2013, we will be modifying our payment systems and processes to prepare for the implementation. Implementing the ICD-10 code sets will require significant administrative changes, but we believe that the cost of compliance with these regulations has not had and is not expected to have a material, adverse effect on our business, financial position or results of operations. The Health Reform Law requires HHS to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

The privacy and security regulations promulgated pursuant to HIPAA extensively regulate the use and disclosure of individually identifiable health information and require covered entities, including health plans and most health care providers, to implement administrative, physical and technical safeguards to protect the security of such information. The American Recovery and Reinvestment Act of 2009 (ARRA) broadened the scope of the HIPAA privacy and security regulations. In addition, ARRA extends the application of certain provisions of the security and privacy regulations to business associates (entities that handle identifiable health information on behalf of covered entities) and subjects business associates to civil and criminal penalties for violation of the regulations. On July 14, 2010, HHS issued a proposed rule that would implement many of these ARRA provisions. If finalized, these changes would likely require amendments to existing agreements with business associates and would subject business associates and their subcontractors to direct liability under the HIPAA privacy and security regulations. We currently enforce a HIPAA compliance plan, which we believe complies with HIPAA privacy and security requirements and under which a HIPAA compliance group monitors our compliance. The privacy regulations and security regulations have and will continue to impose significant costs on our facilities in order to comply with these standards.

As required by ARRA, HHS published an interim final rule on August 24, 2009, that requires covered entities to report breaches of unsecured protected health information to affected individuals without unreasonable delay but not to exceed 60 days of discovery of the breach by a covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all

covered entities that report a breach involving more than 500 individuals. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information.

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Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties, and ARRA has strengthened the enforcement provisions of HIPAA, which may result in increased enforcement activity. Under ARRA, HHS is required to conduct periodic compliance audits of covered entities and their business associates. ARRA broadens the applicability of the criminal penalty provisions to employees of covered entities and requires HHS to impose penalties for violations resulting from willful neglect. ARRA also significantly increases the amount of the civil penalties, with penalties of up to $50,000 per violation for a maximum civil penalty of $1,500,000 in a calendar year for violations of the same requirement. In addition, ARRA authorizes state attorneys general to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. Our facilities also remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties.

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. For example, the Federal Trade Commission issued a final rule in October 2007 requiring financial institutions and creditors, which arguably included health providers and health plans, to implement written identity theft prevention programs to detect, prevent and mitigate identity theft in connection with certain accounts. The Federal Trade Commission has delayed enforcement of this rule until December 31, 2010. In addition, Congress recently has passed legislation that would restrict the definition of a creditor and may exempt many hospitals from complying with the rule.

EMTALA

All of our hospitals in the United States are subject to EMTALA. This federal law requires any hospital participating in the Medicare program to conduct an appropriate medical screening examination of every individual who presents to the hospital s emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize the condition or make an appropriate transfer of the individual to a facility able to handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual s ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer an individual or if the hospital delays appropriate treatment in order to first inquire about the individual s ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program. In addition, an injured individual, the individual s family or a medical facility that suffers a financial loss as a direct result of a hospital s violation of the law can bring a civil suit against the hospital.

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

Corporate Practice of Medicine/Fee Splitting

Some of the states in which we operate have laws prohibiting corporations and other entities from employing physicians, practicing medicine for a profit and making certain direct and indirect payments or fee-splitting arrangements between health care providers designed to induce or encourage the referral of patients to, or the recommendation of, particular providers for medical products and services. Possible sanctions for violation of these

restrictions include loss of license and civil and criminal penalties. In addition, agreements between the corporation and the physician may be considered void and unenforceable. These statutes vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies.

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Health Care Industry Investigations

Significant media and public attention has focused in recent years on the hospital industry. This media and public attention, changes in government personnel or other factors may lead to increased scrutiny of the health care industry. While we are currently not aware of any material investigations of the Company under federal or state health care laws or regulations, it is possible that governmental entities could initiate investigations or litigation in the future at facilities we operate and that such matters could result in significant penalties, as well as adverse publicity. It is also possible that our executives and managers could be included in governmental investigations or litigation or named as defendants in private litigation.

Our substantial Medicare, Medicaid and other governmental billings result in heightened scrutiny of our operations. We continue to monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Because the law in this area is complex and constantly evolving, governmental investigations or litigation may result in interpretations that are inconsistent with our or industry practices.

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

Both federal and state government agencies have increased their focus on and coordination of civil and criminal enforcement efforts in the health care area. The OIG and the Department of Justice have, from time to time, established national enforcement initiatives, targeting all hospital providers that focus on specific billing practices or other suspected areas of abuse. The Health Reform Law includes additional federal funding of $350 million over the next 10 years to fight health care fraud, waste and abuse, including $105 million for federal fiscal year 2011 and $65 million in federal fiscal year 2012. In addition, governmental agencies and their agents, such as the MACs, fiscal intermediaries and carriers, may conduct audits of our health care operations. Private payers may conduct similar post-payment audits, and we also perform internal audits and monitoring.

In addition to national enforcement initiatives, federal and state investigations have addressed a wide variety of routine health care operations such as: cost reporting and billing practices, including for Medicare outliers; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. We engage in many of these routine health care operations and other activities that could be the subject of governmental investigations or inquiries. For example, we have significant Medicare and Medicaid billings, numerous financial arrangements with physicians who are referral sources to our hospitals and joint venture arrangements involving physician investors. Certain of our individual facilities have received, and other facilities may receive, government inquiries from federal and state agencies. Any additional investigations of the Company, our executives or managers could result in significant liabilities or penalties to us, as well as adverse publicity.

Commencing in 1997, we became aware we were the subject of governmental investigations and litigation relating to our business practices. As part of the investigations, the United States intervened in a number of *qui tam* actions brought by private parties. The investigations related to, among other things, DRG coding, outpatient laboratory billing, home health issues, physician relations, cost report and wound care issues. The investigations were concluded through a series of agreements executed in 2000 and 2003 with the Criminal Division of the Department of Justice, the Civil Division of the Department of Justice, various U.S. Attorneys offices, CMS, a negotiating team representing states with claims against us, and others. In January 2001, we entered into an eight-year CIA with the OIG, which

expired January 24, 2009. We submitted our final report pursuant to the CIA on April 30, 2009, and in April 2010, we received notice from the OIG that our final report was accepted, relieving us of future obligations under the CIA. If the government were to determine that we violated or breached the CIA or other federal or state laws relating to Medicare, Medicaid or similar programs, we could be subject to substantial monetary fines, civil and criminal penalties and/or exclusion from participation in the Medicare and Medicaid programs and other federal and state health care programs. Alleged violations may be pursued by the government

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or through private *qui tam* actions. Sanctions imposed against us as a result of such actions could have a material, adverse effect on our results of operations and financial position.

Health Care Reform

As enacted, the Health Reform Law will change how health care services are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced growth in Medicare program spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs where reimbursement is tied to quality and integration. In addition, the new law reforms certain aspects of health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality, and contains provisions intended to strengthen fraud and abuse enforcement. More than twenty challenges to the Health Reform Law have been filed in federal courts. Although some federal district courts have upheld the constitutionality of the Health Reform Law or dismissed cases on procedural grounds, on December 13, 2010, a Virginia federal district court held the requirement that individuals maintain health insurance or pay a penalty to be unconstitutional, while leaving the remainder of the Health Reform Law intact. These lawsuits are subject to appeal, and it is unclear how they will be resolved.

Expanded Coverage

Based on the Congressional Budget Office (CBO) and CMS estimates, by 2019, the Health Reform Law will expand coverage to 32 to 34 million additional individuals (resulting in coverage of an estimated 94% of the legal U.S. population). This increased coverage will occur through a combination of public program expansion and private sector health insurance and other reforms.

Medicaid Expansion

The primary public program coverage expansion will occur through changes in Medicaid, and to a lesser extent, expansion of the Children s Health Insurance Program (CHIP). The most significant changes will expand the categories of individuals eligible for Medicaid coverage and permit individuals with relatively higher incomes to qualify. The federal government reimburses the majority of a state s Medicaid expenses, and it conditions its payment on the state meeting certain requirements. The federal government currently requires that states provide coverage for only limited categories of low-income adults under 65 years old (e.g., women who are pregnant, and the blind or disabled). In addition, the income level required for individuals and families to qualify for Medicaid varies widely from state to state.

The Health Reform Law materially changes the requirements for Medicaid eligibility. Commencing January 1, 2014, all state Medicaid programs are required to provide, and the federal government will subsidize, Medicaid coverage to virtually all adults under 65 years old with incomes at or under 133% of the FPL. This expansion will create a minimum Medicaid eligibility threshold that is uniform across states. Further, the Health Reform Law also requires states to apply a 5% income disregard to the Medicaid eligibility standard, so that Medicaid eligibility will effectively be extended to those with incomes up to 138% of the FPL. These new eligibility requirements will expand Medicaid and CHIP coverage by an estimated 16 to 18 million persons nationwide. A disproportionately large percentage of the new Medicaid coverage is likely to be in states that currently have relatively low income eligibility requirements.

As Medicaid is a joint federal and state program, the federal government provides states with matching funds in a defined percentage, known as the federal medical assistance percentage (FMAP). Beginning in 2014, states will receive an enhanced FMAP for the individuals enrolled in Medicaid pursuant to the Health Reform Law. The FMAP percentage is as follows: 100% for calendar years 2014 through 2016; 95% for 2017; 94% in 2018; 93% in 2019; and 90% in 2020 and thereafter.

The Health Reform Law also provides that the federal government will subsidize states that create non-Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL. Approved state plans will be eligible to receive federal funding. The amount of that funding per individual will be equal to 95% of subsidies that would have been provided for that individual had he or she enrolled in a health plan offered through one of the Exchanges, as discussed below.

Historically, states often have attempted to reduce Medicaid spending by limiting benefits and tightening Medicaid eligibility requirements. Effective March 23, 2010, the Health Reform Law requires states to at least maintain Medicaid eligibility standards established prior to the enactment of the law for adults until January 1, 2014 and for children until October 1, 2019. States with budget deficits may, however, seek exemptions from this requirement, but only to address eligibility standards that apply to adults making more than 133% of the FPL.

Private Sector Expansion

The expansion of health coverage through the private sector as a result of the Health Reform Law will occur through new requirements on health insurers, employers and individuals. Commencing January 1, 2014, health insurance companies will be prohibited from imposing annual coverage limits, dropping coverage, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. Effective January 1, 2011, each health plan must keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. In addition, effective September 23, 2010, health insurers will not be permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old.

Larger employers will be subject to new requirements and incentives to provide health insurance benefits to their full time employees. Effective January 1, 2014, employers with 50 or more employees that do not offer health insurance will be held subject to a penalty if an employee obtains coverage through an Exchange if the coverage is subsidized by the government. The employer penalties will range from $2,000 to $3,000 per employee, subject to certain thresholds and conditions.

As enacted, the Health Reform Law uses various means to induce individuals who do not have health insurance to obtain coverage. By January 1, 2014, individuals will be required to maintain health insurance for a minimum defined set of benefits or pay a tax penalty. The penalty in most cases is $95 in 2014, $325 in 2015, $695 in 2016, and indexed to a cost of living adjustment in subsequent years. The IRS, in consultation with HHS, is responsible for enforcing the tax penalty, although the Health Reform Law limits the availability of certain IRS enforcement mechanisms. In addition, for individuals and families below 400% of the FPL, the cost of obtaining health insurance will be subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. It is anticipated that those at the lowest income levels will have the majority of their premiums subsidized by the federal government, in some cases in excess of 95% of the premium amount.

To facilitate the purchase of health insurance by individuals and small employers, each state must establish an Exchange by January 1, 2014. Based on CBO and CMS estimates, between 29 and 31 million individuals will obtain their health insurance coverage through an Exchange by 2019. Of that amount, an estimated 16 million will be individuals who were previously uninsured, and 13 to 15 million will be individuals who switched from their prior insurance coverage to a plan obtained through the Exchange. The Health Reform Law requires that the Exchanges be designed to make the process of evaluating, comparing and acquiring coverage simple for consumers. For example, each state s Exchange must maintain an internet website through which consumers may access health plan ratings that are assigned by the state based on quality and price, view governmental health program eligibility requirements and calculate the actual cost of health coverage. Health insurers participating in the Exchange must offer a set of minimum benefits to be defined by HHS and may offer more benefits. Health insurers must offer at least two, and up to five, levels of plans that vary by the percentage of medical expenses that must be paid by the enrollee. These levels are referred to as platinum, gold, silver, bronze and catastrophic plans, with gold and silver being the two mandatory levels of plans. Each level of plan must require the enrollee to share the following percentages of medical expenses up to the deductible/co-payment limit: platinum, 10%; gold, 20%; silver, 30%; bronze, 40%; and catastrophic, 100%. Health insurers may establish varying deductible/co-payment levels, up to the statutory maximum (estimated to be

between $6,000 and $7,000 for an individual). The health insurers must cover 100% of the amount of medical expenses in excess of the deductible/co-payment limit. For example, an

individual making 100% to 200% of the FPL will have co-payments and deductibles reduced to about one-third of the amount payable by those with the same plan with incomes at or above 400% of the FPL.

Public Program Spending

The Health Reform Law provides for Medicare, Medicaid and other federal health care program spending reductions between 2010 and 2019. The CBO estimates that these will include $156 billion in Medicare fee-for-service market basket and productivity reimbursement reductions for all providers, the majority of which will come from hospitals; CMS sets this estimate at $233 billion. The CBO estimates also include an additional $36 billion in reductions of Medicare and Medicaid disproportionate share funding ($22 billion for Medicare and $14 billion for Medicaid). CMS estimates include an additional $64 billion in reductions of Medicare and Medicaid disproportionate share funding, with $50 billion of the reductions coming from Medicare.

Payments for Hospitals and ASCs

Inpatient Market Basket and Productivity Adjustment. Under the Medicare program, hospitals receive reimbursement under a PPS for general, acute care hospital inpatient services. CMS establishes fixed PPS payment amounts per inpatient discharge based on the patient s assigned MS-DRG. These MS-DRG rates are updated each federal fiscal year, which begins October 1, using the market basket, which takes into account inflation experienced by hospitals and other entities outside the health care industry in purchasing goods and services.

The Health Reform Law provides for three types of annual reductions in the market basket. The first is a general reduction of a specified percentage each federal fiscal year starting in 2010 and extending through 2019. These reductions are as follows: federal fiscal year 2010, 0.25% for discharges occurring on or after April 1, 2010; 2011 (0.25%); 2012 (0.1%); 2013 (0.1%); 2014 (0.3%); 2015 (0.2%); 2016 (0.2%); 2017 (0.75%); 2018 (0.75%); and 2019 (0.75%).

The second type of reduction to the market basket is a productivity adjustment that will be implemented by HHS beginning in federal fiscal year 2012. The amount of that reduction will be the projected nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the Bureau of Labor Statistics (BLS) 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for HHS to use in projecting the productivity figure. Based upon the latest available data, federal fiscal year 2012 market basket reductions resulting from this productivity adjustment are likely to range from 1% to 1.4%.

The third type of reduction is in connection with the value-based purchasing program discussed in more detail below. Beginning in federal fiscal year 2013, CMS will reduce the inpatient PPS payment amount for all discharges by the following: 1% for 2013; 1.25% for 2014; 1.5% for 2015; 1.75% for 2016; and 2% for 2017 and subsequent years. For each federal fiscal year, the total amount collected from these reductions will be pooled and used to fund payments to hospitals that satisfy certain quality metrics. While some or all of these reductions may be recovered if a hospital satisfies these quality metrics, the recovery amounts may be delayed.

If the aggregate of the three market basket reductions described above is more than the annual market basket adjustments made to account for inflation, there will be a reduction in the MS-DRG rates paid to hospitals. For example, for the federal fiscal year 2011 hospital inpatient PPS, the market basket increase to account for inflation is 2.6% and the aggregate reduction due to the Health Reform Law and the documentation and coding adjustment is 3.15%. Thus, the rates paid to a hospital for inpatient services in federal fiscal year 2011 will be 0.55% less than rates paid for the same services in the prior year.

Quality-Based Payment Adjustments and Reductions for Inpatient Services. The Health Reform Law establishes or expands three provisions to promote value-based purchasing and to link payments to quality and efficiency. First, in federal fiscal year 2013, HHS is directed to implement a value-based purchasing program for inpatient hospital services. This program will reward hospitals that meet certain quality performance

standards established by HHS. The Health Reform Law provides HHS considerable discretion over the value-based purchasing program. For example, HHS will have the authority to determine the quality performance measures, the standards hospitals must achieve in order to meet the quality performance measures, and the methodology for calculating payments to hospitals that meet the required quality threshold. HHS will also determine how much money each hospital will receive from the pool of dollars created by the reductions related to the value-based purchasing program as described above. Because the Health Reform Law provides that the pool will be fully distributed, hospitals that meet or exceed the quality performance standards set by HHS will receive greater reimbursement under the value-based purchasing program than they would have otherwise. On the other hand, hospitals that do not achieve the necessary quality performance will receive reduced Medicare inpatient hospital payments.

Second, beginning in federal fiscal year 2013, inpatient payments will be reduced if a hospital experiences excessive readmissions within a 30-day period of discharge for heart attack, heart failure, pneumonia or other conditions designated by HHS. Hospitals with what HHS defines as excessive readmissions for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Each hospital s performance will be publicly reported by HHS. HHS has the discretion to determine what excessive readmissions means, the amount of the payment reduction and other terms and conditions of this program.

Third, reimbursement will be reduced based on a facility s hospital acquired condition, or HAC, rates. An HAC is a condition that is acquired by a patient while admitted as an inpatient in a hospital, such as a surgical site infection. Beginning in federal fiscal year 2015, hospitals that rank in the top 25% nationally of HACs for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. In addition, effective July 1, 2011, the Health Reform Law prohibits the use of federal funds under the Medicaid program to reimburse providers for medical services provided to treat HACs.

Outpatient Market Basket and Productivity Adjustment. Hospital outpatient services paid under PPS are classified into APCs. The APC payment rates are updated each calendar year based on the market basket. The first two market basket changes outlined above the general reduction and the productivity adjustment apply to outpatient services as well as inpatient services, although these are applied on a calendar year basis. The percentage changes specified in the Health Reform Law summarized above as the general reduction for inpatients e.g., 0.2% in 2015 are the same for outpatients.

Medicare and Medicaid Disproportionate Share Hospital (DSH) Payments. The Medicare DSH program provides for additional payments to hospitals that treat a disproportionate share of low-income patients. Under the Health Reform Law, beginning in federal fiscal year 2014, Medicare DSH payments will be reduced to 25% of the amount they otherwise would have been absent the new law. The remaining 75% of the amount that would otherwise be paid under Medicare DSH will be effectively pooled, and this pool will be reduced further each year by a formula that reflects reductions in the national level of uninsured who are under 65 years of age. In other words, the greater the level of coverage for the uninsured nationally, the more the Medicare DSH payment pool will be reduced. Each hospital will then be paid, out of the reduced DSH payment pool, an amount allocated based upon its level of uncompensated care.

It is difficult to predict the full impact of the Medicare DSH reductions, and CBO and CMS estimates differ by $38 billion. The Health Reform Law does not mandate what data source HHS must use to determine the reduction, if any, in the uninsured population nationally. In addition, the Health Reform Law does not contain a definition of uncompensated care. As a result, it is unclear how a hospital s share of the Medicare DSH payment pool will be calculated. CMS could use the definition of uncompensated care used in connection with hospital cost reports. However, in July 2009, CMS proposed material revisions to the definition of uncompensated care used for cost report purposes. Those revisions would exclude certain significant costs that had historically been covered, such as unreimbursed costs of Medicaid services. CMS has not issued a final rule, and the Health Reform Law does not

require HHS to use this definition, even if finalized, for DSH purposes. How CMS ultimately defines uncompensated care for purposes of these DSH funding provisions could have a material effect on a hospital s Medicare DSH reimbursements.

In addition to Medicare DSH funding, hospitals that provide care to a disproportionately high number of low-income patients may receive Medicaid DSH payments. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. Although Federal Medicaid law defines some level of hospitals that must receive Medicaid DSH funding, states have broad discretion to define additional hospitals that also may qualify for Medicaid DSH payments and the amount of such payments. The Health Reform Law will reduce funding for the Medicaid DSH hospital program in federal fiscal years 2014 through 2020 by the following amounts: 2014 ($500 million); 2015 ($600 million); 2016 ($600 million); 2017 ($1.8 billion); 2018 ($5 billion); 2019 ($5.6 billion); and 2020 ($4 billion). How such cuts are allocated among the states, and how the states allocate these cuts among providers, have yet to be determined.

Accountable Care Organizations. The Health Reform Law requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of ACOs. Beginning no later than January 1, 2012, the program will allow providers (including hospitals), physicians and other designated professionals and suppliers to form ACOs and voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. HHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred, and what portion of such savings will be paid to ACOs. In addition, HHS will determine to what degree hospitals, physicians and other eligible participants will be able to form and operate an ACO without violating certain existing laws, including the Civil Monetary Penalty Law, the Anti-kickback Statute and the Stark Law. However, the Health Reform Law does not authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in ACOs, such as antitrust laws.

Bundled Payment Pilot Programs. The Health Reform Law requires HHS to establish a five-year, voluntary national bundled payment pilot program for Medicare services beginning no later than January 1, 2013. Under the program, providers would agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. HHS will have the discretion to determine how the program will function. For example, HHS will determine what medical conditions will be included in the program and the amount of the payment for each condition. In addition, the Health Reform Law provides for a five-year bundled payment pilot program for Medicaid services to begin January 1, 2012. HHS will select up to eight states to participate based on the potential to lower costs under the Medicaid program while improving care. State programs may target particular categories of beneficiaries, selected diagnoses or geographic regions of the state. The selected state programs will provide one payment for both hospital and physician services provided to Medicaid patients for certain episodes of inpatient care. For both pilot programs, HHS will determine the relationship between the programs and restrictions in certain existing laws, including the Civil Monetary Penalty Law, the Anti-kickback Statute, the Stark Law and the HIPAA privacy, security and transaction standard requirements. However, the Health Reform Law does not authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in the pilot programs, such as antitrust laws.

Ambulatory Surgery Centers. The Health Reform Law reduces reimbursement for ASCs through a productivity adjustment to the market basket similar to the productivity adjustment for inpatient and outpatient hospital services, beginning in federal fiscal year 2011.

Medicare Managed Care (Medicare Advantage or MA). Under the MA program, the federal government contracts with private health plans to provide inpatient and outpatient benefits to beneficiaries who enroll in such plans. Nationally, approximately 22% of Medicare beneficiaries have elected to enroll in MA plans. Effective in 2014, the Health Reform Law requires MA plans to keep annual administrative costs lower than 15% of annual premium

revenue. The Health Reform Law reduces, over a three year period, premium payments to the MA Plans such that CMS managed care per capita premium payments are, on average, equal to traditional Medicare. In addition, the Health Reform Law implements fee payment adjustments based on

service benchmarks and quality ratings. As a result of these changes, payments to MA plans will be reduced by $138 to $145 billion between 2010 and 2019. These reductions to MA plan premium payments may cause some plans to raise premiums or limit benefits, which in turn might cause some Medicare beneficiaries to terminate their MA coverage and enroll in traditional Medicare.

Specialty Hospital Limitations

Over the last decade, we have faced significant competition from hospitals that have physician ownership. The Health Reform Law prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. As a result, the new law will effectively prevent the formation of physician-owned hospitals after December 31, 2010. While the new law grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand services.

Program Integrity and Fraud and Abuse

The Health Reform Law makes several significant changes to health care fraud and abuse laws, provides additional enforcement tools to the government, increases cooperation between agencies by establishing mechanisms for the sharing of information and enhances criminal and administrative penalties for non-compliance. For example, the Health Reform Law: (1) provides $350 million in increased federal funding over the next 10 years to fight health care fraud, waste and abuse; (2) expands the scope of the RAC program to include MA plans and Medicaid; (3) authorizes HHS, in consultation with the OIG, to suspend Medicare and Medicaid payments to a provider of services or a supplier pending an investigation of a credible allegation of fraud; (4) provides Medicare contractors with additional flexibility to conduct random prepayment reviews; and (5) tightens up the rules for returning overpayments made by governmental health programs and expands False Claims Act liability to include failure to timely repay identified overpayments.

Impact of Health Reform Law on the Company

The expansion of health insurance coverage under the Health Reform Law may result in a material increase in the number of patients using our facilities who have either private or public program coverage. In addition, a disproportionately large percentage of the new Medicaid coverage is likely to be in states that currently have relatively low income eligibility requirements. Two such states are Texas and Florida, where about one-half of our licensed beds are located. We also have a significant presence in other relatively low income eligibility states, including Georgia, Kansas, Louisiana, Missouri, Oklahoma and Virginia. Further, the Health Reform Law provides for a value-based purchasing program, the establishment of ACOs and bundled payment pilot programs, which will create possible sources of additional revenue.

However, it is difficult to predict the size of the potential revenue gains to the Company as a result of these elements of the Health Reform Law, because of uncertainty surrounding a number of material factors, including the following:

- how many previously uninsured individuals will obtain coverage as a result of the Health Reform Law (while the CBO estimates 32 million, CMS estimates almost 34 million; both agencies made a number of assumptions to derive that figure, including how many individuals will ignore substantial subsidies and decide to pay the penalty rather than obtain health insurance and what percentage of people in the future will meet the new Medicaid income eligibility requirements);

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

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

the pace at which insurance coverage expands, including the pace of different types of coverage expansion;

- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the rate paid by state governments under the Medicaid program for newly covered individuals;
- how the value-based purchasing and other quality programs will be implemented;
- the percentage of individuals in the Exchanges who select the high deductible plans, since health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- whether the net effect of the Health Reform Law, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and
- the possibility that implementation of provisions expanding health insurance coverage will be delayed or even blocked due to court challenges or revised or eliminated as a result of court challenges and efforts to repeal or amend the new law.

On the other hand, the Health Reform Law provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. Since approximately 40% of our revenues in 2009 were from Medicare and Medicaid, reductions to these programs may significantly impact us and could offset any positive effects of the Health Reform Law. It is difficult to predict the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from Medicare and Medicaid business when the reductions are implemented;
- whether reductions required by the Health Reform Law will be changed by statute prior to becoming effective;
- the size of the Health Reform Law s annual productivity adjustment to the market basket beginning in 2012 payment years;
- the amount of the Medicare DSH reductions that will be made, commencing in federal fiscal year 2014;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in federal fiscal year 2014;
- what the losses in revenues will be, if any, from the Health Reform Law s quality initiatives;
- how successful ACOs, in which we participate, will be at coordinating care and reducing costs;

the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs;

whether our revenues from UPL programs will be adversely affected, because there may be fewer indigent, non-Medicaid patients for whom we provide services pursuant to UPL programs; and

reductions to Medicare payments CMS may impose for excessive readmissions.

Because of the many variables involved, we are unable to predict the net effect on the Company of the expected increases in insured individuals using our facilities, the reductions in Medicare spending and reductions in Medicare and Medicaid DSH Funding, and numerous other provisions in the Health Reform Law

that may affect us. Further, it is unclear how federal lawsuits challenging the constitutionality of the Health Reform Law will be resolved or what the impact will be of any resulting changes to the law. For example, should the requirement that individuals maintain health insurance ultimately be deemed unconstitutional but the prohibition on health insurers excluding coverage due to pre-existing conditions be maintained, significant disruption to the health insurance industry could result, which could impact our revenues and operations.

General Economic and Demographic Factors

The United States economy has weakened significantly in recent years. Depressed consumer spending and higher unemployment rates continue to pressure many industries. During economic downturns, governmental entities often experience budget deficits as a result of increased costs and lower than expected tax collections. These budget deficits have forced federal, state and local government entities to decrease spending for health and human service programs, including Medicare, Medicaid and similar programs, which represent significant payer sources for our hospitals. Other risks we face from general economic weakness include potential declines in the population covered under managed care agreements, patient decisions to postpone or cancel elective and non-emergency health care procedures, potential increases in the uninsured and underinsured populations and further difficulties in our collecting patient co-payment and deductible receivables. The Health Reform Law seeks to decrease over time the number of uninsured individuals, by among other things requiring employers to offer, and individuals to carry, health insurance or be subject to penalties. However, it is difficult to predict the full impact of the Health Reform Law due to the law s complexity, lack of implementing regulations or interpretive guidance, gradual and potentially delayed implementation, pending court challenges, and possible amendment.

The health care industry is impacted by the overall United States financial pressures. The federal deficit, the growing magnitude of Medicare expenditures and the aging of the United States population will continue to place pressure on federal health care programs.

Compliance Program and Corporate Integrity Agreement

We maintain a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. The program is intended to monitor and raise awareness of various regulatory issues among employees and to emphasize the importance of complying with governmental laws and regulations. As part of the ethics and compliance program, we provide annual ethics and compliance training to our employees and encourage all employees to report any violations to their supervisor, an ethics and compliance officer or a toll-free telephone ethics line. The Health Reform Law requires providers to implement core elements of a compliance program criteria to be established by HHS, on a timeline to be established by HHS, as a condition of enrollment in the Medicare or Medicaid programs, and we may have to modify our compliance programs to comply with these new criteria.

Until January 24, 2009, we operated under a CIA, which was structured to assure the federal government of our overall federal health care program compliance and specifically covered DRG coding, outpatient PPS billing and physician relations. We underwent major training efforts to ensure that our employees learned and applied the policies and procedures implemented under the CIA and our ethics and compliance program. The CIA had the effect of increasing the amount of information we provided to the federal government regarding our health care practices and our compliance with federal regulations. Under the CIA, we had numerous affirmative obligations, including the requirement to report potential violations of applicable federal health care laws and regulations. Pursuant to this obligation, we reported a number of potential violations of the Stark Law, the Anti-kickback Statute, EMTALA, HIPAA and other laws, most of which we consider to be nonviolations or technical violations. We submitted our final report pursuant to the CIA on April 30, 2009, and in April 2010, we received notice from the OIG that our final report was accepted, relieving us of future obligations under the CIA. These reports could result in greater scrutiny by

regulatory authorities. The government could determine that our reporting and/or our resolution of reported issues was inadequate. A determination that we breached the CIA and/or a finding of violations of applicable health care laws or regulations could subject us to repayment requirements, substantial monetary penalties, civil penalties, exclusion from participation in the Medicare and Medicaid and other federal and state health care programs and, for violations of certain laws and regulations, criminal penalties. Although the CIA expired on January 24, 2009, we maintain our ethics and compliance program in substantially the same form. However, the

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audit plans in the CIA have been modified, and the reportable events process has been converted to an internal reporting process.

Antitrust Laws

The federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties. Antitrust enforcement in the health care industry is currently a priority of the Federal Trade Commission. We believe we are in compliance with such federal and state laws, but courts or regulatory authorities may reach a determination in the future that could adversely affect our operations.

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MANAGEMENT

Directors

The following is a brief description of the background and business experience of each member of our Board of Directors:

Name	Age(1)	Director Since	Position(s)
Richard M. Bracken	58	2002	Chairman of the Board and Chief Executive Officer
R. Milton Johnson	53	2009	Executive Vice President, Chief Financial Officer and Director
Christopher J. Birosak	56	2006	Director
John P. Connaughton	45	2006	Director
James D. Forbes	51	2009	Director
Kenneth W. Freeman	60	2009	Director
Thomas F. Frist III	42	2006	Director
William R. Frist	40	2009	Director
Christopher R. Gordon	37	2006	Director
Michael W. Michelson	59	2006	Director
James C. Momtazee	38	2006	Director
Stephen G. Pagliuca	55	2006	Director
Nathan C. Thorne	56	2006	Director

(1) As of December 1, 2010.

Richard M. Bracken has served as Chief Executive Officer of the Company since January 2009 and was appointed as Chairman of the Board in December 2009. Mr. Bracken served as President and Chief Executive Officer from January 2009 to December 2009. Mr. Bracken was appointed Chief Operating Officer in July 2001 and served as President and Chief Operating Officer from January 2002 to January 2009. Mr. Bracken served as President Western Group of the Company from August 1997 until July 2001. From January 1995 to August 1997, Mr. Bracken served as President of the Pacific Division of the Company. Prior to 1995, Mr. Bracken served in various hospital Chief Executive Officer and Administrator positions with HCA-Hospital Corporation of America.

R. Milton Johnson has served as Executive Vice President and Chief Financial Officer of the Company since July 2004 and was appointed as a director in December 2009. Mr. Johnson served as Senior Vice President and Controller of the Company from July 1999 until July 2004. Mr. Johnson served as Vice President and Controller of the Company from November 1998 to July 1999. Prior to that time, Mr. Johnson served as Vice President Tax of the Company from April 1995 to October 1998. Prior to that time, Mr. Johnson served as Director of Tax for Healthtrust, Inc. The Hospital Company from September 1987 to April 1995.

Christopher J. Birosak is a Managing Director of BAML Capital Partners, the private equity division of Bank of America Corporation. BAML Capital Partners is the successor organization to Merrill Lynch Global Private Equity.

Prior to joining the Global Private Equity Division of Merrill Lynch in 2004, Mr. Birosak worked in various capacities in the Merrill Lynch Leveraged Finance Group with particular emphasis on leveraged buyouts and mergers and acquisitions related financings. Mr. Birosak served as a director of Atrium Companies, Inc. from 2004 to 2009 and currently serves on the board of directors of NPC International. Mr. Birosak joined Merrill Lynch in 1994.

John P. Connaughton has been a Managing Director of Bain Capital Partners, LLC since 1997 and a member of the firm since 1989. Prior to joining Bain Capital, Mr. Connaughton was a consultant at Bain &

Company, Inc., where he worked in the health care, consumer products and business services industries. Mr. Connaughton served as a director of Stericycle, Inc. from 1999 to 2005, M/C Communications (PriMed) from 2004 to 2009 and AMC Theatres from 2007 to 2009 and currently serves as a director of Air Medical Group Holdings, Inc., Clear Channel Communications, Inc., CRC Health Corporation, Warner Chilcott, Ltd., Sungard Data Systems, Warner Music Group, Quintiles Transnational Corp. and The Boston Celtics.

James D. Forbes has been Head of Bank of America s Global Principal Investments Division since March 2009. From November 2008 to March 2009, Mr. Forbes served as Head of Asia Pacific Corporate and Investment Banking based in Hong Kong. Mr. Forbes chairs the Investment Committee at BAML Capital Partners, the private equity division of the Bank of America Corporation. From August 2002 to November 2008, he served as Global Head of Healthcare Investment Banking at Merrill Lynch. Before joining Merrill Lynch in 1995, Mr. Forbes worked at CS First Boston where he was part of its Debt Capital Markets Group. Mr. Forbes also serves on the Board of Conversus Capital, L.P. and Sterling Stamos Capital Management, L.P.

Kenneth W. Freeman has been a senior advisor of Kohlberg Kravis Roberts & Co. since August 2010 and, in August 2010, was appointed Dean of Boston University School of Management. From October 2009 to August 2010, Mr. Freeman was a member of KKR Management LLC, the general partner of KKR & Co. L.P. Before that, he was a member of the limited liability company which served as the general partner of Kohlberg Kravis Roberts & Co. L.P. since 2007 and joined the firm as Managing Director in May 2005. From May 2004 to December 2004, Mr. Freeman was Chairman of Quest Diagnostics Incorporated, and from January 1996 to May 2004, he served as Chairman and Chief Executive Officer of Quest Diagnostics Incorporated. From May 1995 to December 1996, Mr. Freeman was President and Chief Executive Officer of Corning Clinical Laboratories, the predecessor company to Quest Diagnostics. Prior to that, he served in various general management and financial roles with Corning Incorporated. Mr. Freeman currently serves as a director of Accellent, Inc. and Masonite, Inc., and is chairman of the board of trustees of Bucknell University.

Thomas F. Frist III is a principal of Frist Capital LLC, a private investment vehicle for Mr. Frist and certain related persons and has held such position since 1998. Mr. Frist is also a general partner at Frisco Partners, another Frist family investment vehicle. Mr. Frist served as a director of Triad Hospitals, Inc. from 1998 to October 2006 and currently serves as a director of SAIC, Inc. Mr. Frist is the brother of William R. Frist, who also serves as a director of the Company.

William R. Frist is a principal of Frist Capital LLC, a private investment vehicle for Mr. Frist and certain related persons and has held such position since 2003. Mr. Frist is also a general partner at Frisco Partners, another Frist family investment vehicle. Mr. Frist is the brother of Thomas F. Frist III, who also serves as a director of the Company.

Christopher R. Gordon is a Managing Director of Bain Capital Partners, LLC and joined the firm in 1997. Prior to joining Bain Capital, Mr. Gordon was a consultant at Bain & Company. Mr. Gordon currently serves as a director of Accellent, Inc., Air Medical Group Holdings, Inc., CRC Health Corporation and Quintiles Transnational Corp.

Michael W. Michelson has been a member of KKR Management, LLC, the general partner of KKR & Co. L.P., since October 1, 2009. Before that, he was a member of the limited liability company which served as the general partner of Kohlberg Kravis Roberts & Co. L.P. since 1996. Prior to that, he was a general partner of Kohlberg Kravis Roberts & Co. L.P. Mr. Michelson served as a director of Accellent Inc. from 2005 to 2009 and Alliance Imaging from 1999 to 2007. Mr. Michelson is currently a director of Biomet, Inc. and Jazz Pharmaceuticals, Inc.

James C. Momtazee has been a member of KKR Management LLC, the general partner of KKR & Co. L.P. since October 1, 2009. Before that, he was a member of the limited liability company which served as the general partner of

Kohlberg Kravis Roberts & Co. L.P. since 2009. From 1996 to 2009, he was an executive of Kohlberg Kravis Roberts & Co. L.P. From 1994 to 1996, Mr. Momtazee was with Donaldson, Lufkin & Jenrette in its investment banking department. Mr. Momtazee served as a director of Alliance Imaging from 2002 to 2007 and Accuride from March 2005 to December 2005 and currently serves as a director of Accellent, Inc. and Jazz Pharmaceuticals, Inc.

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Stephen G. Pagliuca is a Managing Director of Bain Capital Partners, LLC. Mr. Pagliuca is also a Managing Partner and an owner of the Boston Celtics basketball franchise. Mr. Pagliuca joined Bain & Company in 1982 and founded the Information Partners private equity fund for Bain Capital in 1989. He also worked as a senior accountant and international tax specialist for Peat Marwick Mitchell & Company in the Netherlands. Mr. Pagliuca served as a director of Warner Chilcott, Ltd. from 2005 to 2009, HCA Inc. from November 2006 to September 2009, Quintiles Transnational Corp. from 2008 to 2009, M/C Communications from 2004 to 2009, FCI, S.A. from 2005 to 2009 and Burger King Holdings Inc. from 2002 to 2010 and currently serves as a director of Gartner, Inc.

Nathan C. Thorne was a Senior Vice President of Merrill Lynch & Co., Inc., a subsidiary of Bank of America Corporation, from February 2006 to July 2009, and President of Merrill Lynch Global Private Equity from 2002 to 2009. Mr. Thorne joined Merrill Lynch in 1984. Mr. Thorne currently serves as a director of Nuveen Investments, Inc.

Executive Officers

As of December 1, 2010, our executive officers (other than Messrs. Bracken and Johnson who are listed above) were as follows:

Name	Age	Position(s)
David G. Anderson	63	Senior Vice President Finance and Treasurer
Victor L. Campbell	63	Senior Vice President
Charles J. Hall	57	President Eastern Group
Samuel N. Hazen	50	President Western Group
A. Bruce Moore, Jr.	50	President Outpatient Services Group
Jonathan B. Perlin, M.D.	49	President Clinical Services Group and Chief Medical Officer
W. Paul Rutledge	55	President Central Group
Joseph A. Sowell, III	54	Senior Vice President and Chief Development Officer
Joseph N. Steakley	56	Senior Vice President Internal Audit Services
John M. Steele	55	Senior Vice President Human Resources
Donald W. Stinnett	54	Senior Vice President and Controller
Beverly B. Wallace	59	President Shared Services Group
Robert A. Waterman	56	Senior Vice President, General Counsel and Chief Labor Relations Officer
Noel Brown Williams	55	Senior Vice President and Chief Information Officer
Alan R. Yuspeh	61	Senior Vice President and Chief Ethics and Compliance Officer

David G. Anderson has served as Senior Vice President Finance and Treasurer of the Company since July 1999. Mr. Anderson served as Vice President Finance of the Company from September 1993 to July 1999 and was appointed to the additional position of Treasurer in November 1996. From March 1993 until September 1993, Mr. Anderson served as Vice President Finance and Treasurer of Galen Health Care, Inc. From July 1988 to March 1993, Mr. Anderson served as Vice President Finance and Treasurer of Humana Inc.

Victor L. Campbell has served as Senior Vice President of the Company since February 1994. Prior to that time, Mr. Campbell served as HCA-Hospital Corporation of America s Vice President for Investor, Corporate and Government Relations. Mr. Campbell joined HCA-Hospital Corporation of America in 1972. Mr. Campbell serves on the board of the Nashville Health Care Council, as a member of the American Hospital Association s President s

Forum, and on the board and Executive Committee of the Federation of American Hospitals.

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

Samuel N. Hazen was appointed President Western Group of the Company in July 2001. Mr. Hazen served as Chief Financial Officer Western Group of the Company from August 1995 to July 2001. Mr. Hazen served as Chief Financial Officer North Texas Division of the Company from February 1994 to July 1995. Prior to that time, Mr. Hazen served in various hospital and regional Chief Financial Officer positions with Humana Inc. and Galen Health Care, Inc.

Bruce Moore, Jr. was appointed President Outpatient Services Group in January 2006. Mr. Moore had served as Senior Vice President and as Chief Operating Officer Outpatient Services Group since July 2004 and as Senior Vice President Operations Administration from July 1999 until July 2004. Mr. Moore served as Vice President Operations Administration of the Company from September 1997 to July 1999, as Vice President Benefits from October 1996 to September 1997, and as Vice President Compensation from March 1995 until October 1996.

Dr. Jonathan B. Perlin was appointed President Clinical Services Group and Chief Medical Officer in November 2007. Dr. Perlin had served as Chief Medical Officer and Senior Vice President Quality of the Company from August 2006 to November 2007. Prior to joining the Company, Dr. Perlin served as Under Secretary for Health in the U.S. Department of Veterans Affairs since April 2004. Dr. Perlin joined the Veterans Health Administration in November 1999 where he served in various capacities, including as Deputy Under Secretary for Health from July 2002 to April 2004, and as Chief Quality and Performance Officer from November 1999 to September 2002.

W. Paul Rutledge was appointed as President Central Group in October 2005. Mr. Rutledge had served as President of the MidAmerica Division since January 2001. He served as President of TriStar Health System from June 1996 to January 2001 and served as President of Centennial Medical Center from May 1993 to June 1996. He has served in leadership capacities with HCA for more than 27 years, working with hospitals in the United States and London, England.

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

Joseph N. Steakley has served as Senior Vice President Internal Audit Services of the Company since July 1999. Mr. Steakley served as Vice President Internal Audit Services from November 1997 to July 1999. From October 1989 until October 1997, Mr. Steakley was a partner with Ernst & Young LLP. Mr. Steakley is a member of the board of directors of J. Alexander s Corporation, where he serves on the compensation committee and as chairman of the audit committee.

John M. Steele has served as Senior Vice President Human Resources of the Company since November 2003. Mr. Steele served as Vice President Compensation and Recruitment of the Company from November 1997 to October 2003. From March 1995 to November 1997, Mr. Steele served as Assistant Vice President Recruitment.

Donald W. Stinnett has served as Senior Vice President and Controller since December 2008. Mr. Stinnett served as Chief Financial Officer Eastern Group from October 2005 to December 2008 and Chief Financial Officer of the Far West Division from July 1999 to October 2005. Mr. Stinnett served as Chief Financial Officer and Vice President of Finance of Franciscan Health System of the Ohio Valley from 1995 until 1999,

and served in various capacities with Franciscan Health System of Cincinnati and Providence Hospital in Cincinnati prior to that time.

Beverly B. Wallace was appointed President Shared Services Group in March 2006. From January 2003 until March 2006, Ms. Wallace served as President Financial Services Group. Ms. Wallace served as Senior Vice President Revenue Cycle Operations Management of the Company from July 1999 to January 2003. Ms. Wallace served as Vice President Managed Care of the Company from July 1998 to July 1999. From 1997 to 1998, Ms. Wallace served as President Homecare Division of the Company. From 1996 to 1997, Ms. Wallace served as Chief Financial Officer Nashville Division of the Company. From 1994 to 1996, Ms. Wallace served as Chief Financial Officer Mid-America Division of the Company.

Robert A. Waterman has served as Senior Vice President and General Counsel of the Company since November 1997 and Chief Labor Relations Officer since March 2009. Mr. Waterman served as a partner in the law firm of Latham & Watkins from September 1993 to October 1997; he was Chair of the firm s health care group during 1997.

Noel Brown Williams has served as Senior Vice President and Chief Information Officer of the Company since October 1997. From October 1996 to September 1997, Ms. Williams served as Chief Information Officer for American Service Group/Prison Health Services, Inc. From September 1995 to September 1996, Ms. Williams worked as an independent consultant. From June 1993 to June 1995, Ms. Williams served as Vice President, Information Services for HCA Information Services. From February 1979 to June 1993, she held various positions with HCA-Hospital Corporation of America Information Services.

Alan R. Yuspeh has served as Senior Vice President and Chief Ethics and Compliance Officer of the Company since May 2007. From October 1997 to May 2007, Mr. Yuspeh served as Senior Vice President Ethics, Compliance and Corporate Responsibility of the Company. From September 1991 until October 1997, Mr. Yuspeh was a partner with the law firm of Howrey & Simon. As a part of his law practice, Mr. Yuspeh served from 1987 to 1997 as Coordinator of the Defense Industry Initiative on Business Ethics and Conduct.

Board of Directors

Our Board of Directors consists of thirteen directors, who are each managers of Hercules Holding. The Amended and Restated Limited Liability Company Agreement of Hercules Holding requires that the members of Hercules Holding take all necessary action to ensure that the persons who serve as managers of Hercules Holding also serve on our Board of Directors. See Certain Relationships and Related Party Transactions. In addition, Mr. Bracken s employment agreement provides that he will continue to serve as a member of our Board of Directors so long as he remains an officer of HCA. Because of these requirements, together with Hercules Holding s ownership of more than 95% of our outstanding common stock prior to this offering, we do not currently have a policy or procedures with respect to stockholder recommendations for nominees to the Board of Directors, nor do we have a nominating and corporate governance committee, or a committee that serves a similar purpose. We intend to establish a nominating and corporate governance committee and stockholder nomination recommendation procedures following this offering. Effective December 31, 2008, Jack O. Bovender, Jr. retired as Chief Executive Officer but retained the role of executive Chairman of the Board until December 15, 2009, and effective January 1, 2009, Mr. Bracken was appointed to serve as Chief Executive Officer of the Company. Effective December 15, 2009, Mr. Bracken was appointed Chairman of the Board, and Mr. Johnson was appointed as a member of the Board of Directors.

Upon the consummation of this offering, we intend to appoint , and as new members of our Board of Directors. Our Board has affirmatively determined that each of such nominees meets the definition of independent director for purposes of the New York Stock Exchange rules.

Controlled Company Exception

After completion of this offering, the Investors will continue to control a majority of our outstanding common stock. As a result, we will be a controlled company within the meaning of the New York Stock Exchange corporate governance standards. Under the New York Stock Exchange rules, a company of which more than 50% of the voting power is held by an individual, group or another company is a controlled

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company and may elect not to comply with certain New York Stock Exchange corporate governance requirements, including:

- the requirement that a majority of the Board of Directors consist of independent directors;
- the requirement that we have a nominating and corporate governance committee that is composed entirely of independent directors with a written charter addressing the committee s purpose and responsibilities;
- the requirement that we have a compensation committee that is composed entirely of independent directors with a written charter addressing the committee s purpose and responsibilities; and
- the requirement for an annual performance evaluation of the nominating and corporate governance and compensation committees.

Following this offering, we intend to rely on these exemptions. As a result, we will not have a majority of independent directors nor will our compensation committee or nominating and corporate governance committee consist entirely of independent directors and such committees will not be subject to annual performance evaluations. Accordingly, you will not have the same protections afforded to stockholders of companies that are subject to all of the New York Stock Exchange corporate governance requirements.

Committees of the Board of Directors

Our Board of Directors currently has four standing committees: the Audit and Compliance Committee, the Compensation Committee, the Executive Committee and the Patient Safety and Quality of Care Committee. Each of the Investors (other than the Sponsor Assignees) has the right to have at least one director serve on all standing committees. The chart below reflects the current composition of the standing committees, which will change upon consummation of this offering.

Name of Director	Audit and Compliance	Compensation	Executive	Patient Safety and Quality of Care
Christopher J. Birosak	**X**			
Richard M. Bracken*			**Chair**	
John P. Connaughton		**Chair**	**X**	
James D. Forbes		**X**	**X**	
Kenneth W. Freeman				**X**
Thomas F. Frist III	**X**		**X**	
William R. Frist				**X**
Christopher R. Gordon	**X**			
R. Milton Johnson*				
Michael W. Michelson		**X**	**X**	
James C. Momtazee	**Chair**			
Stephen G. Pagliuca				**X**
Nathan C. Thorne				**Chair**

* Indicates management director.

Audit and Compliance Committee. Our Audit and Compliance Committee is composed of James C. Momtazee, Chairman, Christopher J. Birosak, Thomas F. Frist III, and Christopher R. Gordon. This committee reviews the programs of our internal auditors, the results of their audits, and the adequacy of our system of internal controls and accounting practices. This committee also reviews the scope of the annual audit by our independent registered public accounting firm before its commencement, reviews the results of the audit and reviews the types of services for which we retain our independent registered public accounting firm. The Audit and Compliance Committee has adopted a charter which can be obtained on the Corporate Governance page of our website at www.hcahealthcare.com. In 2009, the Audit and Compliance Committee met five times. Upon completion of this offering, the current Audit and Compliance Committee members will resign and we

intend to appoint , and to our Audit and Compliance Committee. Our Board has affirmatively determined that each of such nominees meets the definition of independent director for purposes of the New York Stock Exchange rules and the independence requirements of Rule 10A-3 of the Exchange Act. Our Board intends to name as the member of our Audit and Compliance Committee who qualifies as an audit committee financial expert under SEC rules and regulations.

Our Audit and Compliance Committee will be responsible for, among other things:

- selecting the independent auditors,
- pre-approving all audit engagement fees and terms, as well as audit and permitted non-audit services to be provided by the independent auditors,
- at least annually, obtaining and reviewing a report of the independent auditors describing the audit firm s internal quality-control procedures and any material issues raised by its most recent review of internal quality controls,
- annually evaluating the qualifications, performance and independence of the independent auditors,
- discussing the scope of the audit and any problems or difficulties,
- setting policies regarding the hiring of current and former employees of the independent auditors,
- reviewing and discussing the annual audited and quarterly unaudited financial statements with management and the independent auditor,
- discussing types of information to be disclosed in earnings press releases and provided to analysts and rating agencies,
- discussing policies governing the process by which risk assessment and risk management is to be undertaken,
- reviewing disclosures made by the CEO and CFO regarding any significant deficiencies or material weaknesses in our internal control over financial reporting,
- reviewing the internal audit activities, projects and budget,
- establishing procedures for receipt, retention and treatment of complaints we receive regarding accounting, auditing or internal controls and the submission of anonymous employee concerns regarding accounting and auditing,
- discussing with our general counsel legal matters that could reasonably be expected to have a material impact on business or financial statements,
- periodically reviewing and reassessing the Audit and Compliance Committee charter,
- providing information to our Board that may be relevant to the annual evaluation of performance and effectiveness of the Board and its committees, and

preparing the report required by the SEC to be included in our annual report on Form 10-K or our proxy or information statement.

Our Board of Directors will update its written charter for the Audit and Compliance Committee in connection with this offering which will be available on our website as soon as practical upon the consummation of this offering.

Compensation Committee. Our Compensation Committee is currently composed of John P. Connaughton, Chairman, James D. Forbes and Michael W. Michelson. Responsibilities of the Compensation Committee include the review and approval of the following items:

Executive compensation strategy and philosophy;

Compensation arrangements for executive management;

Design and administration of the annual cash-based Senior Officer Performance Excellence Program;

Design and administration of our equity incentive plans;

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Executive benefits and perquisites (including the HCA Restoration Plan and the Supplemental Executive Retirement Plan); and

Any other executive compensation or benefits related items deemed noteworthy by the Compensation Committee.

In addition, the Compensation Committee considers the proper alignment of executive pay policies with our values and strategy by overseeing employee compensation policies, corporate performance measurement and assessment and Chief Executive Officer performance assessment. The Compensation Committee may retain the services of independent outside consultants, as it deems appropriate, to assist in the strategic review of programs and arrangements relating to executive compensation and performance. In 2009 the Compensation Committee hired Semler Brossy Consulting Group, LLC to assist in conducting an assessment of competitive executive compensation. The Compensation Committee may consider recommendations from our Chief Executive Officer and compensation consultants, among other factors, in making its compensation determinations. The Compensation Committee has the authority to delegate any of its responsibilities to one or more subcommittees as the committee may deem appropriate. For a discussion of the processes and procedures for determining executive and director compensation and the role of executive officers and compensation consultants in determining or recommending the amount or form of compensation, see Executive Compensation Compensation Discussion and Analysis. The Compensation Committee will adopt an updated charter which will be available on our website as soon as practical after the consummation of this offering. In 2009, the Compensation Committee met eight times.

Upon completion of this offering, we intend to appoint and as additional members of our Compensation Committee. Our Board of Directors has affirmatively determined that each of such newly-appointed nominees meets the definition of independent director for purposes of the New York Stock Exchange rules, the definition of outside director for purposes of Section 162(m) of the Internal Revenue Code of 1986, as amended, and the definition of non-employee director for purposes of Section 16 of the Securities Exchange Act of 1934, as amended. In addition, we intend to establish a sub-committee of our Compensation Committee consisting of and for purposes of approving any compensation that may otherwise be subject to Section 162(m) of the Internal Revenue Code of 1986, as amended.

Nominating and Corporate Governance Committee. Immediately prior to the closing of this offering, we will form a Nominating and Corporate Governance Committee that will consist of , and . The Nominating and Corporate Governance Committee will be responsible for (1) identifying, recruiting and recommending to the Board of Directors individuals qualified to become members of our Board of Directors, (2) reviewing the qualifications of incumbent directors to determine whether to recommend them for reelection, (3) reviewing and recommending corporate governance policies, principles and procedures applicable to the Company and (4) handling such other matters that are specifically delegated to the Nominating and Corporate Governance Committee by the Board of Directors from time to time.

Our Board of Directors will adopt a written charter for the Nominating and Corporate Governance Committee which will be available on our website as soon as practical after the consummation of this offering.

Patient Safety and Quality of Care Committee. Our Patient Safety and Quality of Care Committee is composed of Nathan C. Thorne, Chairman, Kenneth W. Freeman, William R. Frist and Stephen G. Pagliuca. This committee reviews our policies and procedures relating to the delivery of quality medical care to patients as well as matters concerning or relating to the efforts to advance the quality of health care provided and patient safety. In 2009, the Patient Safety and Quality of Care Committee met three times.

The Board of Directors seeks to ensure the Board is composed of members whose particular experience, qualifications, attributes and skills, when taken together, will allow the Board to satisfy its oversight responsibilities effectively. In identifying candidates for membership on the Board, the Board takes into account (1) minimum individual qualifications, such as high ethical standards, integrity, mature and careful judgment, industry knowledge or experience and an ability to work collegially with the other members of the Board and (2) all other factors it considers appropriate, including alignment with our stockholders, especially investment funds affiliated with the Sponsors. While we do not have any specific diversity policies for considering Board candidates, we believe each director contributes to the Board of Directors overall

diversity diversity being broadly construed to mean a variety of opinions, perspectives, personal and professional experiences and backgrounds.

In 2010, Messrs. Birosak, Bracken, Connaughton, Forbes, Freeman, Frist III, Frist, Gordon, Johnson, Michelson, Momtazee, Pagliuca and Thorne were elected to the Company s Board. Messrs. Birosak, Connaughton, Forbes, Freeman, Frist III, Frist, Gordon, Michelson, Momtazee, Pagliuca and Thorne were appointed to the Board as a consequence of their respective relationships with investment funds affiliated with the Sponsors and the Frist Entities. They are collectively referred to as the Sponsor Directors. Messrs. Bracken and Johnson are collectively referred to as the Management Directors.

When considering whether the Board s directors and nominees have the experience, qualifications, attributes and skills, taken as a whole, to enable the Board to satisfy its oversight responsibilities effectively in light of our business and structure, the Board focused primarily on the information discussed in each of the Board members and nominees biographical information set forth above.

Each of our directors and director nominees possesses high ethical standards, acts with integrity, and exercises careful, mature judgment. Each is committed to employing their skills and abilities to aid the long-term interests of the stakeholders of the Company. In addition, our directors and director nominees are knowledgeable and experienced in one or more business, governmental or civic endeavors, which further qualifies them for service as members of the Board. Alignment with our stockholders is important in building value at the Company over time.

Each of the Sponsor Directors was elected to the Board pursuant to the Amended and Restated Limited Liability Company Agreement of Hercules Holding. Pursuant to such agreement, Messrs. Freeman, Michelson and Momtazee were appointed to the Board as a consequence of their respective relationships with KKR, Messrs. Birosak, Forbes and Thorne were appointed to the Board as a consequence of their respective relationships with MLGPE (an affiliate of Bank of America Corporation), Messrs. Connaughton, Gordon and Pagliuca were appointed to the Board as a consequence of their respective relationships with Bain Capital Partners, LLC and Messrs. Frist III and Frist were appointed to the Board as a consequence of their respective relationships with the Frist Entities.

As a group, the Sponsor Directors possess experience in owning and managing enterprises like the Company and are familiar with corporate finance, strategic business planning activities and issues involving stakeholders more generally.

The Management Directors bring leadership, extensive business, operating, legal and policy experience, and tremendous knowledge of the Company and the Company s industry, to the Board. In addition, the Management Directors bring their broad strategic vision for our Company to the Board. Mr. Bracken s service as the Chairman and Chief Executive Officer of the Company and Mr. Johnson s service as Executive Vice President, Chief Financial Officer and Director creates a critical link between management and the Board, enabling the Board to perform its oversight function with the benefits of management s perspectives on the business. In addition, having the Chief Executive Officer and Executive Vice President and Chief Financial Officer, and Messrs. Bracken and Johnson in particular, on our Board provides the Company with ethical, decisive and effective leadership.

The Amended and Restated Limited Liability Company Agreement of Hercules Holding provides that each Sponsor has the right to designate three directors, that the Frist Entities have the right to designate two directors and that the Board will include two representatives of management of our Company. Any directors nominated to fill the directorships selected by the Sponsors and the Frist Entities are chosen by the applicable Sponsor or the Frist Entities, as the case may be. The Sponsors, the Frist Entities and the other members of the Board participate in the consideration of nominees to the Board as representatives of the Company s management.

Board Leadership Structure

The Board appointed the Company s Chief Executive Officer as Chairman because he is the director most familiar with the Company s business and industry, and as a result is best suited to effectively identify strategic priorities and lead the discussion and execution of strategy. The Board believes the combined position of

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Chairman and CEO promotes a unified direction and leadership for the Board and gives a single, clear focus for the chain of command for our organization, strategy and business plans.

Board s Role in Risk Oversight

Risk is inherent with every business. Management is responsible for the day-to-day management of risks the Company faces, while the Board of Directors, as a whole and through its committees, has responsibility for the oversight of risk management. In its risk oversight role, the Board of Directors has the responsibility to satisfy itself that the risk management processes designed and implemented by management are adequate and functioning as designed. Our Board of Directors oversees an enterprise-wide approach to risk management, designed to support the achievement of organizational objectives, including strategic objectives, to improve long-term organizational performance and enhance stockholder value. A fundamental aspect of risk management is not only understanding the risks a company faces and what steps management is taking to manage those risks, but also understanding what level of risk is appropriate for the company. The involvement of the full Board of Directors in setting our business strategy is a key part of its assessment of management s appetite for risk and also a determination of what constitutes an appropriate level of risk for the Company.

We conduct an annual enterprise risk management assessment, which is facilitated by our enterprise risk management team in collaboration with our internal auditors. The senior internal audit executive officer reports to the Chief Executive Officer and Chairman and to the Audit and Compliance Committee in this capacity. In this process, we assess risk throughout the Company by conducting surveys and interviews of our employees and directors soliciting information regarding business risks that could significantly adversely affect the Company, including the achievement of its strategic plan. We then identify any controls or initiatives in place to mitigate any material risk and the effectiveness of any such controls or initiatives. The enterprise risk management team annually prepares a report for senior management and, ultimately, the Board of Directors regarding the key identified risks and how we manage these risks to review and analyze both on an annual and ongoing basis. Senior management attends the quarterly Board meetings and is available to address any questions or concerns raised by the Board regarding risk management and any other matters. Additionally, each quarter, the Board of Directors receives presentations from senior management on strategic matters involving our operations.

While the Board of Directors has the ultimate oversight responsibility for the risk management process, various committees of the Board assist the Board in fulfilling its oversight responsibilities in certain areas of risk. In particular, the Audit and Compliance Committee focuses on financial and enterprise risk exposures, including internal controls, and discusses with management, the senior internal audit executive officer, the senior chief ethics and compliance officer and the independent auditor our policies with respect to risk assessment and risk management. The Audit and Compliance Committee also assists the Board in fulfilling its duties and oversight responsibilities relating to the Company s compliance with applicable laws and regulations, the Company Code of Conduct and related Company policies and procedures, including the Corporate Ethics and Compliance Program. The Compensation Committee assists the Board in fulfilling its oversight responsibilities with respect to the management of risks arising from our compensation policies and programs. The Patient Safety and Quality of Care Committee assists the Board in fulfilling its risk oversight responsibility with respect to our policies and procedures relating to patient safety and the delivery of quality medical care to patients.

Board Meetings

During 2009, our Board of Directors held nine meetings. All directors attended at least 75% of the Board meetings and meetings of the committees of the Board on which the director served. The Company did not have an annual meeting of stockholders in 2009 or 2010, and our directors were re-elected through stockholder actions taken on written consent effective September 21, 2009 and April 28, 2010.

Policy Regarding Communications with the Board of Directors

Stockholders, employees and other interested parties may communicate with any of our directors by writing to such director(s) c/o Board of Directors, HCA Holdings, Inc., One Park Plaza, Nashville, TN 37203, Attention: Corporate Secretary. All communications from stockholders, employees and other interested parties

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addressed in that manner will be forwarded to the appropriate director. If the volume of communication becomes such that the Board adopts a process for determining which communications will be relayed to Board members, that process will appear on the Corporate Governance page of our website at www.hcahealthcare.com.

Code of Ethics

We have a Code of Conduct, which is applicable to all our directors, officers and employees (the Code of Conduct). The Code of Conduct is available on the Ethics and Compliance and Corporate Governance pages of our website at www.hcahealthcare.com. To the extent required pursuant to applicable SEC regulations, we intend to post amendments to or waivers from our Code of Conduct (to the extent applicable to our chief executive officer, principal financial officer or principal accounting officer) at these locations on our website or report the same on a Current Report on Form 8-K. Our Code of Conduct is available free of charge upon request to our Corporate Secretary, HCA Holdings, Inc., One Park Plaza, Nashville, TN 37203.

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EXECUTIVE COMPENSATION

Compensation Risk Assessment

In consultation with the Compensation Committee, members of Human Resources, Legal, Enterprise Risk Management and Internal Audit, management conducted an assessment of whether our compensation policies and practices encourage excessive or inappropriate risk taking by our employees, including employees other than our named executive officers. This assessment included a review of the risk characteristics of our business and the design of our incentive plans and policies. Although a significant portion of our executive compensation program is performance-based, the Compensation Committee has focused on aligning our compensation policies with the long-term interests of the Company and avoiding rewards or incentive structures that could create unnecessary risks to the Company.

Management reported its findings to the Compensation Committee, which agreed with management s assessment that our plans and policies do not encourage excessive or inappropriate risk taking and determined such policies or practices are not reasonably likely to have a material, adverse effect on the Company.

Compensation Discussion and Analysis

The Compensation Committee (the Committee) of the Board of Directors is generally charged with the oversight of our executive compensation and rewards programs. The Committee is currently composed of John P. Connaughton, James D. Forbes and Michael W. Michelson. In early 2009, the Committee also included George A. Bitar, and determinations with respect to 2009 compensation were made by such Committee. Responsibilities of the Committee include the review and approval of the following items:

- Executive compensation strategy and philosophy;
- Compensation arrangements for executive management;
- Design and administration of the annual cash-based Senior Officer Performance Excellence Program (PEP);
- Design and administration of our equity incentive plans;
- Executive benefits and perquisites (including the HCA Restoration Plan and the Supplemental Executive Retirement Plan); and
- Any other executive compensation or benefits related items deemed appropriate by the Committee.

In addition, the Committee considers the proper alignment of executive pay policies with Company values and strategy by overseeing executive compensation policies, corporate performance measurement and assessment, and Chief Executive Officer performance assessment. The Committee may retain the services of independent outside consultants, as it deems appropriate, to assist in the strategic review of programs and arrangements relating to executive compensation and performance.

The following executive compensation discussion and analysis describes the principles underlying our executive compensation policies and decisions as well as the material elements of compensation for our named executive officers. Our named executive officers for 2009 were:

Richard M. Bracken, Chairman and Chief Executive Officer;

R. Milton Johnson, Executive Vice President and Chief Financial Officer;

Beverly B. Wallace, President Shared Services Group;

Samuel N. Hazen, President Western Group;

W. Paul Rutledge, President Central Group; and

Jack O. Bovender, Jr., Executive Chairman of the Board (Retired).

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Effective December 31, 2008, Mr. Bovender retired as Chief Executive Officer but retained the role of executive Chairman of the Board, and effective January 1, 2009, Mr. Bracken was appointed to serve as Chief Executive Officer and President of the Company. Mr. Bovender retired as executive Chairman of the Board on December 15, 2009, and Mr. Bracken assumed the additional responsibilities as Chairman of the Board at such time.

As discussed in more detail below, the material elements and structure of the named executive officers compensation program were negotiated and determined in connection with the Recapitalization, subject to annual adjustments in the Committee s discretion.

Compensation Philosophy and Objectives

The core philosophy of our executive compensation program is to support our primary objective of providing the highest quality health care to our patients while enhancing the long term value of the Company to our stockholders. Specifically, the Committee believes the most effective executive compensation program (for all executives, including named executive officers):

Reinforces HCA s strategic initiatives;

Aligns the economic interests of our executives with those of our stockholders; and

Encourages attraction and long term retention of key contributors.

The Committee is committed to a strong, positive link between our objectives and our compensation and benefits practices.

Our compensation philosophy also allows for flexibility in establishing executive compensation based on an evaluation of information prepared by management or other advisors and other subjective and objective considerations deemed appropriate by the Committee, subject to any contractual agreements with our executives. The Committee will also consider the recommendations of our Chief Executive Officer. This flexibility is important to ensure our compensation programs are competitive and that our compensation decisions appropriately reflect the unique contributions and characteristics of our executives.

Compensation Structure and Benchmarking

Our compensation program is heavily weighted towards performance-based compensation, reflecting our philosophy of increasing the long-term value of the Company and supporting strategic imperatives. Total direct compensation and other benefits consist of the following elements:

Total Direct Compensation	Base Salary Annual Cash-Based Incentives (offered through our PEP) Long-Term Equity Incentives (in the form of Stock Options)
Other Benefits	Retirement Plans Limited Perquisites and Other Personal Benefits Severance Benefits

The Committee does not support rigid adherence to benchmarks or compensatory formulas and strives to make compensation decisions which effectively support our compensation objectives and reflect the unique attributes of the Company and each executive. Our general practice, however, with respect to pay positioning, is that executive base salaries and annual incentive (PEP) target values should generally position total annual cash compensation between the median and 75th percentile of similarly-sized general industry companies. We utilize the general industry as our primary source for competitive pay levels because HCA is significantly larger than its industry peers. See the discussion of benchmarking below for further information. The named executive officers pay fell within the range noted above for jobs with equivalent market comparisons.

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The cash compensation mix between salary and PEP has historically been more weighted towards salary than competitive practice among our general industry peers would suggest. Over time, we have made steps towards a mix of cash compensation that will place a greater emphasis on annual performance-based compensation.

Although we look at competitive long-term equity incentive award values in similarly-sized general industry companies when assessing the competitiveness of our compensation programs, we do not make annual executive option grants (and we did not base our initial post-Recapitalization 2007 stock option grants on these levels) since equity is structured differently in closely held companies than in publicly-traded companies. As is typical in similar situations, the Investors wanted to share a certain percentage of the equity with executives shortly after the consummation of the Recapitalization and establish performance objectives and incentives up front in lieu of annual grants to ensure our executives long-term economic interests would be aligned with those of the Investors. This pool of equity was then further allocated based on the executives responsibilities and anticipated impact on, and potential for, driving Company strategy and performance. The resulting total direct pay mix on a cumulative basis, is heavily weighted towards performance-based pay (PEP plus stock options) rather than fixed pay, which the Committee believes reflects the compensation philosophy and objectives discussed above.

In accordance with agreements entered into at the time of the Recapitalization, our named executive officers received the 2x Time Options (as defined below) in 2009 with an exercise price equal to two times the share price at the Recapitalization (or $102.00). The Committee allocated those options in consultation with our Chief Executive Officer based on past executive contributions and future anticipated impact on Company objectives. For additional information regarding the 2x Time Options, see Elements of Compensation Long-Term Equity Incentive Awards: Options below.

Compensation Process

The Committee ensures executives pay levels are materially consistent with the compensation strategy described above, in part, by conducting annual assessments of competitive executive compensation. Management (but no named executive officer), in collaboration with the Committee s independent consultant, Semler Brossy Consulting Group, LLC, collects and presents compensation data from similarly-sized general industry companies, based to the extent possible on comparable position matches and compensation components. The following nationally recognized survey sources were utilized in anticipation of establishing 2009 executive compensation:

Survey	**Revenue Scope**
Towers Perrin Executive Compensation Database	Greater than $20B
Hewitt Total Compensation Measurement	$10B - $25B
Hewitt Total Compensation Measurement	Greater than $25B

These particular revenue scopes were selected because they were the closest approximations to HCA s revenue size. Each survey that provided an appropriate position match and sufficient sample size to be used in the compensation review was weighted equally. For this purpose, the two Hewitt survey cuts were considered as one survey, and we used a weighted average of the two surveys (65% for the $10B $25B cut and 35% for the Greater than $25B).

Data was also collected from health care providers within our industry including Community Health Systems, Inc., Health Management Associates, Inc., Kindred Healthcare, Inc., LifePoint Hospitals, Inc., Tenet Healthcare Corporation and Universal Health Services, Inc. These health care providers are used only to obtain a general understanding of current industry compensation practices since we are significantly larger than these companies. CEO and CFO compensation data was also collected and reviewed for large public health care companies which included,

in addition to health care providers, companies in the health insurance, pharmaceutical, medical supplies and related industries. This peer group s 2008 revenues ranged from $7.2 billion to $81.2 billion with median revenues of $21.3 billion. The companies in this analysis included Abbott Laboratories, Aetna Inc., Amgen Inc., Baxter International Inc., Boston Scientific Corporation, Bristol-Myers Squibb Company, CIGNA Corporation, Coventry Health Care, Inc., Express Scripts, Inc., Humana Inc.,

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Johnson & Johnson, Eli Lilly and Company, Medco Health Solutions Inc., Merck & Co., Inc., Pfizer Inc., Quest Diagnostics Incorporated, Schering-Plough Corporation, Tenet Healthcare Corporation, Thermo Fisher Scientific Inc., UnitedHealth Group Incorporated, WellPoint, Inc. and Wyeth.

Consistent with our flexible compensation philosophy, the Committee is not required to approve compensation precisely reflecting the results of these surveys, and may also consider, among other factors (typically not reflected in these surveys): the requirements of the applicable employment agreements, the executive s individual performance during the year, his or her projected role and responsibilities for the coming year, his or her actual and potential impact on the successful execution of Company strategy, recommendations from our Chief Executive Officer and compensation consultants, an officer s prior compensation, experience, and professional status, internal pay equity considerations, and employment market conditions and compensation practices within our peer group. The weighting of these and other relevant factors is determined on a case-by-case basis for each executive upon consideration of the relevant facts and circumstances.

Employment Agreements

In connection with the Recapitalization, we entered into employment agreements with each of our named executive officers and certain other members of senior management to help ensure the retention of those executives critical to the future success of the Company. Among other things, these agreements set the executives compensation terms, their rights upon a termination of employment, and restrictive covenants around non-competition, non-solicitation, and confidentiality. These terms and conditions are further explained in the remaining portion of this Compensation Discussion and Analysis and under Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table Employment Agreements.

In light of Mr. Bovender s retirement from the position of Chief Executive Officer, effective December 31, 2008, and continuing service to the Company as executive Chairman until December 15, 2009, the Company entered into an Amended and Restated Employment Agreement with Mr. Bovender, effective December 31, 2008. The material amendments to Mr. Bovender s prior employment agreement as set forth in the Amended and Restated Employment Agreement are described below under Severance and Change in Control Benefits Mr. Bovender s Continuing Severance Benefits and under Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table Employment Agreements.

The Company also amended Mr. Bracken s employment agreement, effective January 1, 2009, to reflect his appointment to the position of Chief Executive Officer.

Elements of Compensation

Base Salary

Base salaries are intended to provide reasonable and competitive fixed compensation for regular job duties. The threshold base salaries for our executives are set forth in their employment agreements. We did not increase named executive officer base salaries in 2009, other than an increase in Mr. Johnson s base salary, as detailed below, in order to better align his salary with market for his position as Chief Financial Officer based on general industry surveys. In light of Mr. Bovender s retirement from the position of Chief Executive Officer and continuing role as executive Chairman and Mr. Bracken s assumption of the responsibilities of Chief Executive Officer, Mr. Bovender s base salary for 2009 was reduced to $1.144 million (as described further in Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table Employment Agreements Mr. Bovender s Employment Agreements), and Mr. Bracken s 2009 base salary was increased to $1.325 million. Similarly, taking into consideration the additional responsibilities being assumed by the position of Executive Vice President and Chief Financial Officer

and relevant market comparables from the survey data, Mr. Johnson s 2009 salary was set at $850,000, reflecting an increase of approximately 7.6% from his 2008 salary. In light of actual total cash compensation realized for 2009 and current target cash compensation opportunities levels, no merit base salary increases are planned for 2010 at this time. Mr. Rutledge s salary will be increased by 3.7% effective April 1, 2010 as an internal equity adjustment to internal peer roles.

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Annual Incentive Compensation: PEP

The PEP is intended to reward named executive officers for annual financial performance, with the goals of providing high quality health care for our patients and increasing stockholder value. Accordingly, in 2008, our 2008-2009 Senior Officer Performance Excellence Program, as amended (the 2008-2009 PEP), was approved by the Committee to cover annual cash incentive awards for both 2008 and 2009. Each named executive officer in the 2008-2009 PEP was initially assigned a maximum 2009 annual award target expressed as a percentage of salary ranging from 72% to 132%, which under the terms of the 2008-2009 PEP applies to the lesser of (a) the named executive officer s 2009 base salary, or (b) 125% of the named executive officer s 2008 base salary. The Committee had the discretion to reduce, but not increase, the 2009 Threshold, Target and Maximum percentages as set forth in the 2008-2009 PEP. Mr. Bovender s 2009 PEP target and an additional one-time $250,000 bonus opportunity based on his contributions to certain legislative initiatives as determined by the Committee were set forth in his Amended Employment Agreement, as described in Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table Employment Agreements Mr. Bovender s Employment Agreement. The Committee set Mr. Bracken s 2009 target percentage at 130% of his 2009 base salary in connection with his appointment as Chief Executive Officer and amended the 2008-2009 PEP to set Mr. Johnson s 2009 target percentage at 80% of his 2009 base salary in light of the additional responsibilities assumed by the position of Executive Vice President and Chief Financial Officer. The 2009 target percentage for each of Ms. Wallace and Messrs. Hazen and Rutledge was set at 66% of their respective 2009 base salaries (see individual targets in the table below). These targets were intended to provide a meaningful incentive for executives to achieve or exceed performance goals.

The 2008-2009 PEP was designed to provide 100% of the target award for target performance, 50% of the target award for a minimum acceptable (threshold) level of performance, and a maximum of 200% of the target award for maximum performance, while no payments were to be made for performance below threshold levels. The Committee believes this payout curve is consistent with competitive practice. More importantly, it promotes and rewards continuous growth as performance goals have consistently been set at increasingly higher levels each year. Actual awards under the PEP are generally determined using the following two steps:

1. The executive s conduct must reflect our mission and values by upholding our Code of Conduct and following our compliance policies and procedures. This step is critical to reinforcing our commitment to integrity and the delivery of high quality health care. In the event the Committee determines the participant s conduct during the fiscal year is not in compliance with the first step, he or she will not be eligible for an incentive award.

2. The actual award amount is determined based upon Company performance. In 2009, the PEP for all named executive officers, other than Mr. Hazen and Mr. Rutledge, incorporated one Company financial performance measure, EBITDA, defined in the 2008-2009 PEP as earnings before interest, taxes, depreciation, amortization, minority interest expense (now, net income attributable to noncontrolling interests), gains or losses on sales of facilities, gains or losses on extinguishment of debt, asset or investment impairment charges, restructuring charges, and any other significant nonrecurring non-cash gains or charges (but excluding any expenses for share-based compensation under ASC 718, *Compensation-Stock Compensation* (ASC 718)) (EBITDA). The Company EBITDA target for 2009, as adjusted, was $4.768 billion for the named executive officers. Mr. Hazen s 2009 PEP, as the Western Group President, was based 50% on Company EBITDA and 50% on Western Group EBITDA (with a Western Group EBITDA target for 2009 of $2.352 billion, as adjusted) to ensure his accountability for his group s results. Similarly, Mr. Rutledge s 2009 PEP, as the Central Group President, was based 50% on Company EBITDA and 50% on Central Group EBITDA (with a Central Group EBITDA target for 2009 of $1.137 billion, as adjusted). The Committee chose to base annual incentives on EBITDA for a number of reasons:

- It effectively measures overall Company performance;

It can be considered an important surrogate for cash flow, a critical metric related to paying down the Company s significant debt obligation;

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It is the key metric driving the valuation in the internal Company model, consistent with the valuation approach used by industry analysts; and

It is consistent with the metric used for the vesting of the financial performance portion of our option grants.

These EBITDA targets should not be understood as management s predictions of future performance or other guidance and investors should not apply these in any other context. Our 2009 threshold and maximum goals were set at approximately +/- 3.6% of the target goal to reflect likely performance volatility. EBITDA targets were linked to our short-term and long-term business objectives to ensure incentives are provided for appropriate annual growth.

Upon review of the Company s 2009 financial performance, the Committee determined that Company EBITDA performance for the fiscal year ended December 31, 2009 was above the maximum performance levels as set by the Compensation Committee, as adjusted; likewise, the EBITDA performance of the Western Group and Central Group also exceeded the maximum performance targets, as adjusted.

	2009 Adjusted EBITDA Target	2009 Actual Adjusted EBITDA
Company	$ 4.768 billion	$ 5.512 billion
Western Group	$ 2.352 billion	$ 2.841 billion
Central Group	$ 1.137 billion	$ 1.325 billion

Accordingly, the 2009 PEP was paid out as follows to the named executive officers (the actual 2009 PEP payout amounts are included in the Non-Equity Incentive Plan Compensation column of the Summary Compensation Table):

Named Executive Officer	2009 Target PEP (% of Salary)	2009 Actual PEP Award (% of Salary)
Richard M. Bracken (Chairman and CEO)	130%	260%
R. Milton Johnson (Executive Vice President and CFO)	80%	160%
Beverly B. Wallace (President, Shared Services Group)	66%	132%
Samuel N. Hazen (President, Western Group)	66%	132%
W. Paul Rutledge (President, Central Group)	66%	132%
Jack O. Bovender, Jr. (Retired Chairman)	50%	100%

Mr. Bovender also received the additional bonus of $250,000 based upon his contributions to certain of our legislative initiatives as described above.

On March 31, 2010, the Committee adopted the 2010 Senior Officer Performance Excellence Program (the 2010 PEP). Under the 2010 PEP, the named executive officers of the Company shall be eligible to earn performance awards based upon the achievement of certain specified performance targets. The specified performance criteria for the Company s named executive officers and other participants is EBITDA (as defined in the 2010 PEP), and with respect to the Western and Central Group Presidents, 50% of their respective award opportunities are based on EBITDA for the Company s Western and Central Groups, respectively. Target awards for the named executive officers are the same

as for 2009 and are as follows:

130% of base salary for Richard M. Bracken, our Chairman and CEO;

80% of base salary for R. Milton Johnson, our Executive Vice President and CFO;

66% of base salary for Beverly B. Wallace, our President Shared Services Group;

66% of base salary for Samuel N. Hazen, our President Western Group; and

66% of base salary for W. Paul Rutledge, our President Central Group.

Participants will receive 100% of the target award for target performance, 25% of the target award for a minimum acceptable (threshold) level of performance, and a maximum of 200% of the target award for

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maximum performance. No payments will be made for performance below specified threshold amounts. Payouts between threshold and maximum will be calculated by the Committee in its sole discretion using straight-line interpolation. The Committee may make adjustments to the terms and conditions of, and the criteria included in, awards under the 2010 PEP in recognition of unusual or nonrecurring events affecting a participant or the Company, or the financial statements of the Company, or in certain other instances specified in the 2010 PEP.

The Committee set the named executive officers 2010 target performance goals under the PEP based on realistic expectations of Company performance, ensuring successful execution of our plans in order to realize the most value from these awards. While we do not intend to disclose our 2010 PEP EBITDA target, as an understanding of that target is not necessary for a fair understanding of the named executive officers compensation for 2009 and could result in competitive harm and market confusion, we consistently set targets that require an increase in EBITDA year over year to promote continuous growth consistent with our business plan. For 2010, the Committee has the ability to apply negative discretion based on performance of company-wide quality metrics against industry benchmarks, and for Ms. Wallace, negative discretion can be applied based on performance of individual goals related to the operations of the Shared Services Group.

Awards pursuant to the 2010 PEP that are attributable to the performance goals being met at target level or below will be paid solely in cash, and, in the event performance goals are achieved above the target level, the amount of an award attributable to performance results in excess of target levels shall be payable 50% in cash and 50% in restricted stock units.

We can recover (or clawback) incentive compensation pursuant to our 2010 PEP that was based on (i) achievement of financial results that are subsequently the subject of a restatement due to material noncompliance with any financial reporting requirement under either GAAP or federal securities laws, other than as a result of changes to accounting rules and regulations, or (ii) a subsequent finding that the financial information or performance metrics used by the Committee to determine the amount of the incentive compensations are materially inaccurate, in each case regardless of individual fault. In addition, we may recover any incentive compensation awarded or paid pursuant to this policy based on the participant s conduct which is not in good faith and which materially disrupts, damages, impairs or interferes with the business of the Company and its affiliates. The Committee may also provide for incremental additional payments to then-current executives in the event any restatement or error indicates that such executives should have received higher performance-based payments. This policy is administered by the Committee in the exercise of its discretion and business judgment based on the relevant facts and circumstances.

Long-Term Equity Incentive Awards: Options

In connection with the Recapitalization, the Board of Directors approved and adopted the 2006 Stock Incentive Plan for Key Employees of HCA Inc. and its Affiliates (the 2006 Plan). The purpose of the 2006 Plan is to:

- Promote our long term financial interests and growth by attracting and retaining management and other personnel and key service providers with the training, experience and abilities to enable them to make substantial contributions to the success of our business;
- Motivate management personnel by means of growth-related incentives to achieve long range goals; and
- Further the alignment of interests of participants with those of our stockholders through opportunities for increased stock or stock-based ownership in the Company.

In January 2007, pursuant to the terms of the named executive officers respective employment agreements, the Committee approved long-term stock option grants to our named executive officers under the 2006 Plan consisting

solely of a one-time, multi-year stock option grant in lieu of annual long-term equity incentive award grants (New Options). In addition to the New Options granted in 2007, the Company committed to grant the named executive officers 2x Time Options (as defined below) in their respective employment agreements, as described in more detail below under Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table Employment Agreements. The

Committee believes stock options are the most effective long-term vehicle to directly align the interests of executives with those of our stockholders by motivating performance that results in the long-term appreciation of the Company s value, since they only provide value to the executive if the value of the Company increases. As is typical in leveraged buyout situations, the Committee determined that granting all of the stock options (except the 2x Time Options) up front rather than annually was appropriate to aid in retaining key leaders critical to our success over the next several years and, coupled with the executives significant personal investments in connection with the Recapitalization, provide an equity incentive and stake in the Company that directly aligns the long-term economic interests of the executives with those of the Investors.

The New Options have a ten year term and are divided so that 1/3 are time vested options, 1/3 are EBITDA-based performance vested options and 1/3 are performance options that vest based on investment return to the Sponsors, each as described below. The combination of time, performance and investor return based vesting of these awards is designed to compensate executives for long term commitment to the Company, while motivating sustained increases in our financial performance and helping ensure the Sponsors have received an appropriate return on their invested capital before executives receive significant value from these grants.

The time vested options are granted to aid in retention. Consistent with this goal, the time vested options granted in 2007 vest and become exercisable in equal increments of 20% on each of the first five anniversaries of the grant date. The time vested options have an exercise price equivalent to fair market value on the date of grant. Since our common stock is not currently traded on a national securities exchange, fair market value was determined reasonably and in good faith by the Board of Directors after consultation with the Chief Executive Officer and other advisors.

The EBITDA-based performance vested options are intended to motivate sustained improvement in long-term performance. Consistent with this goal, the EBITDA-based performance vested options granted in 2007 are eligible to vest and become exercisable in equal increments of 20% at the end of fiscal years 2007, 2008, 2009, 2010 and 2011 if certain annual EBITDA performance targets are achieved. These EBITDA performance targets were established at the time of the Recapitalization and can be adjusted by the Board of Directors in consultation with the Chief Executive Officer as described below. We chose EBITDA (defined in the award agreements as earnings before interest, taxes, depreciation, amortization, minority interest expense (now, net income attributable to noncontrolling interests), gains or losses on sales of facilities, gains or losses on extinguishment of debt, asset or investment impairment charges, restructuring charges, and any other significant nonrecurring non-cash gains or charges (but excluding any expenses for share-based compensation under ASC 718 with respect to any awards granted under the 2006 Plan)) as the performance metric since it is a key driver of our valuation and for other reasons as described above in the Elements of Compensation Annual Incentive Compensation: PEP section of this Compensation Discussion and Analysis. Due to the number of events that can occur within our industry in any given year that are beyond the control of management but may significantly impact our financial performance (e.g., health care regulations, industry-wide significant fluctuations in volume, etc.), we have incorporated vesting provisions. The EBITDA-based performance vested options may vest and become exercisable on a catch up basis, such that options that were eligible to vest but failed to vest due to our failure to achieve prior EBITDA targets will vest if at the end of any subsequent year or at the end of fiscal year 2012, the cumulative total EBITDA earned in all prior years exceeds the cumulative EBITDA target at the end of such fiscal year.

As discussed above, we do not intend to disclose the 2010-2011 EBITDA performance targets as they reflect competitive, sensitive information regarding our budget. However, we deliberately set our targets at increasingly higher levels. Thus, while designed to be attainable, target performance levels for these years require strong, improving performance and execution, which in our view, provides an incentive firmly aligned with stockholder interests.

As with the EBITDA targets under our PEP, pursuant to the terms of the 2006 Plan and the Stock Option Agreements governing the 2007 grants, the Board of Directors, in consultation with our Chief Executive Officer, has the ability to adjust the established EBITDA targets for significant events, changes in accounting rules and other customary adjustment events. We believe these adjustments may be necessary in order to effectuate the intents and purposes of our compensation plans and to avoid unintended consequences that are

inconsistent with these intents and purposes. For example, the Board of Directors exercised its ability to make adjustments to the Company s 2009-2011 EBITDA performance targets (including cumulative EBITDA targets) for facility dispositions and accounting changes occurring during the 2009 fiscal year.

The options that vest based on investment return to the Sponsors are intended to align the interests of executives with those of our principal stockholders to ensure stockholders receive their expected return on their investment before the executives can receive their gains on this portion of the option grant. These options vest and become exercisable with respect to 10% of the common stock subject to such options at the end of fiscal years 2007, 2008, 2009, 2010 and 2011 if the Investor Return (as defined below) is at least equal to two times the price paid to stockholders in the Recapitalization (or $102.00), and with respect to an additional 10% at the end of fiscal years 2007, 2008, 2009, 2010 and 2011 if the Investor Return is at least equal to two-and-a-half times the price paid to stockholders in the Recapitalization (or $127.50). Investor Return means, on any of the first five anniversaries of the closing date of the Recapitalization, or any date thereafter, all cash proceeds actually received by affiliates of the Sponsors after the closing date in respect of their common stock, including the receipt of any cash dividends or other cash distributions (including the fair market value of any distribution of common stock by the Sponsors to their limited partners), determined on a fully diluted, per share basis. The Sponsor investment return options also may become vested and exercisable on a catch up basis if the relevant Investor Return is achieved at any time occurring prior to the expiration of such options.

Upon review of the Company s 2009 financial performance, the Committee determined the Company achieved the 2009 EBITDA performance target of $4.821 billion, as adjusted, under the New Option awards; therefore, pursuant to the terms of the 2007 Stock Option Agreements, 20% of each named executive officer s EBITDA-based performance vested options vested as of December 31, 2009. Further, 20% of each named executive officer s time vested options vested on the second anniversary of their grant date, January 30, 2009. As of the end of the 2009 fiscal year, no portion of the options that vest based on Investor Return have vested; however, such options remain subject to the catch up vesting provisions described above.

In each of the employment agreements with the named executive officers, we also committed to grant, among the named executive officers and certain other executives, 10% of the options initially authorized for grant under the 2006 Plan at some time before November 17, 2011 (but with a good faith commitment to do so before a change in control (as defined in the 2006 Plan) or a public offering (as defined in the 2006 Plan) and before the time when our Board of Directors reasonably believes that the fair market value of our common stock is likely to exceed the equivalent of $102.00 per share) at an exercise price per share that is the equivalent of $102.00 per share (2x Time Options). On October 6, 2009, the 2x Time Options were granted. The Committee allocated those options in consultation with our Chief Executive Officer based on past executive contributions and future anticipated impact on Company objectives. Forty percent of the 2x Time Options were vested upon grant to reflect employment served since the Recapitalization, an additional twenty percent of the options vested on November 17, 2009, and twenty percent of the options granted to each recipient will vest on November 17, 2010 and November 17, 2011, respectively. The terms of the 2x Time Options are otherwise consistent with other time vesting options granted under the 2006 Plan.

For additional information concerning the options awarded in 2007 and 2009, see the 2009 Grants of Plan-Based Awards and Outstanding Equity Awards at 2009 Fiscal Year-End Tables.

Effective upon the consummation of this offering, the Company s Board of Directors and its stockholders will have adopted the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (the Amended and Restated Plan). The Amended and Restated Plan provides for the granting of stock options, stock appreciation rights, restricted shares, restricted share units and other stock-based awards or dividend equivalent rights to key employees, directors, consultants or other persons having a service relationship with the Company, its subsidiaries and certain of its affiliates. As of the effectiveness of the Amended and Restated Plan, there

will be approximately shares authorized for issuance pursuant to such plan.

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Ownership Guidelines

While we have maintained stock ownership guidelines in the past, as a non-listed company, we no longer have a policy regarding stock ownership guidelines. However, we do believe equity ownership aligns our executive officers interests with those of the Investors. Accordingly, all of our named executive officers were required to rollover at least half their pre-Recapitalization equity and, therefore, maintain significant stock ownership in the Company.

Retirement Plans

We currently maintain one qualified retirement plan for which the named executive officers are eligible, the HCA 401(k) Plan, to aid in retention and to assist employees in providing for their retirement. We also used to maintain the HCA Retirement Plan, which as of April 1, 2008, merged into the HCA 401(k) Plan resulting in one qualified retirement plan. Generally all employees who have completed the required service are eligible to participate in the HCA 401(k) Plan. Each of our named executive officers participates in the plan. For additional information on these plans, including amounts contributed by HCA in 2009 to the named executive officers, see the Summary Compensation Table and related footnotes and narratives and 2009 Pension Benefits.

Our key executives, including the named executive officers, also participate in two supplemental retirement programs. The Committee and the Board initially approved these supplemental programs to:

Recognize significant long-term contributions and commitments by executives to the Company and to performance over an extended period of time;

Induce our executives to continue in our employ through a specified normal retirement age (initially 62 through 65, but reduced to 60 upon the change in control at the time of the Recapitalization in 2006); and

Provide a competitive benefit to aid in attracting and retaining key executive talent.

The Restoration Plan provides a benefit to replace a portion of the contributions lost in the HCA 401(k) Plan due to certain IRS limitations. Effective January 1, 2008, participants in the SERP (described below) are no longer eligible for Restoration Plan contributions; however, the hypothetical accounts maintained for each named executive officer as of January 1, 2008 will continue to be maintained and will be increased or decreased with hypothetical investment returns based on the actual investment return of the Mix B fund within the HCA 401(k) Plan through the end of 2010. For additional information concerning the Restoration Plan, see 2009 Nonqualified Deferred Compensation.

Key executives also participate in the Supplemental Executive Retirement Plan (the SERP), adopted in 2001. The SERP benefit brings the total value of annual retirement income to a specific income replacement level. For named executive officers with 25 years or more of service, this income replacement level is 60% of final average pay (base salary and PEP payouts) at normal retirement, a competitive level of benefit at the time the plan was implemented. Due to the Recapitalization, all participants are fully vested in their SERP benefits and the plan is now frozen to new entrants. For additional information concerning the SERP, see 2009 Pension Benefits.

In the event a participant renders service to another health care organization within five years following retirement or termination of employment, he or she forfeits the rights to any further payment, and must repay any payments already made. This non-competition provision is subject to waiver by the Committee with respect to the named executive officers.

Personal Benefits

Our executive officers receive limited, if any, benefits outside of those offered to our other employees. Generally, we provide these benefits to increase travel and work efficiencies and allow for more productive use of the executive s time. Mr. Bracken is permitted to use the Company aircraft for personal trips, subject to the aircraft s availability. Prior to his retirement, Mr. Bovender was also permitted to use the Company aircraft

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for personal trips, subject to the aircraft s availability. The named executive officers may have their spouses accompany them on business trips taken on the Company aircraft, subject to seat availability. In addition, there are times when it is appropriate for an executive s spouse to attend events related to our business. On those occasions, we will pay for the travel expenses of the executive s spouse. We will, on an as needed basis, provide mobile telephones and personal digital assistants to our employees and certain of our executive officers have obtained such devices through us. The value of these personal benefits, if any, is included in the executive officer s income for tax purposes and, in certain limited circumstances, the additional income attributed to an executive officer as a result of one or more of these benefits will be grossed up to cover the taxes due on that income. Except as otherwise discussed herein, other welfare and employee-benefit programs are the same for all of our eligible employees, including our executive officers. For additional information, see footnote (4) to the Summary Compensation Table.

Severance and Change in Control Benefits

As noted above, all of our named executive officers have entered into employment agreements, which provide, among other things, each executive s rights upon a termination of employment in exchange for non-competition, non-solicitation, and confidentiality covenants. We believe that reasonable severance benefits are appropriate in order to be competitive in our executive retention efforts. These benefits should reflect the fact that it may be difficult for such executives to find comparable employment within a short period of time. We also believe that these types of agreements are appropriate and customary in situations such as the Recapitalization wherein the executives have made significant personal investments in the Company and that investment is generally illiquid for a significant period of time. Finally, we believe formalized severance arrangements are common benefits offered by employers competing for similar senior executive talent.

Severance Benefits for Named Executive Officers (other than Mr. Bovender)

If employment is terminated by the Company without cause or by the executive for good reason (whether or not the termination was in connection with a change-in-control), the executive would be entitled to accrued rights (cause, good reason and accrued rights are as defined in Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table Employment Agreements) plus:

Subject to restrictive covenants and the signing of a general release of claims, an amount equal to two times for Ms. Wallace and Messrs. Hazen and Rutledge and three times in the case of Messrs. Bracken and Johnson the sum of base salary plus PEP paid or payable in respect of the fiscal year immediately preceding the fiscal year in which termination occurs, payable over a two year period;

Pro-rata bonus; and

Continued coverage under our group health plans during the period over which the cash severance is paid.

Additionally, unvested options will be forfeited; however, vested New Options (including 2x Time Options) will remain exercisable until the first anniversary of the termination of the executive s employment.

Because we believe a termination by the executive for good reason (a constructive termination) is conceptually the same as an actual termination by the Company without cause, we believe it is appropriate to provide severance benefits following such a constructive termination of the named executive officer s employment. All of our severance provisions are believed to be within the realm of competitive practice and are intended to provide fair and reasonable compensation to the executive upon a termination event.

Mr. Bovender s Continuing Severance Benefits

In light of his long-term service to the Company and his retirement from the position of Chief Executive Officer, the Company entered into an Amended and Restated Employment Agreement with Mr. Bovender, effective December 31, 2008 (the Amended Employment Agreement). Mr. Bovender s Amended Employment Agreement provides that, effective as of the expiration of the Employment Term (as defined in

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Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table Employment Agreements), Mr. Bovender was entitled to receive the accrued rights as described above for the other named executive officers. Mr. Bovender was also entitled to receive a pro rata portion of his bonus under the 2008-2009 PEP based on the Company s actual results for 2009 (Mr. Bovender s Prorated Bonus). Mr. Bovender is also entitled to continued coverage under the Company s group health plans for Mr. Bovender and his wife until age 65, reimbursement of any unreimbursed business expenses properly incurred and such employee benefits, if any, as to which Mr. Bovender would be entitled under the Company s employee benefit plans.

The Amended Employment Agreement also provides that, effective as of the expiration of the Employment Term (December 15, 2009), (i) neither Mr. Bovender nor the Company have any put or call rights with respect to Mr. Bovender s New Options or stock acquired upon the exercise of any such options; (ii) Mr. Bovender s rollover stock options will remain exercisable as if Mr. Bovender s employment terminated by reason of retirement in accordance with the terms of the applicable equity plans and award agreements; (iii) the unvested New Options (including the 2x Time Options) held by Mr. Bovender that vest solely based on the passage of time will vest as if Mr. Bovender s employment had continued through the next three anniversaries of their date of grant; (iv) the unvested New Options held by Mr. Bovender that are EBITDA performance options will remain outstanding and will vest, if at all, on the next four dates that they would have otherwise vested had Mr. Bovender s employment continued, based upon the extent to which performance goals are met; (v) the unvested New Options held by Mr. Bovender that are Investor Return performance options will remain outstanding and will vest, if at all, on the dates that they would have otherwise vested had Mr. Bovender s employment continued through the expiration of such options, based upon the extent to which performance goals are met; and (vi) Mr. Bovender s New Options will remain exercisable until the second anniversary of the last date on which his EBITDA performance options are eligible to vest (which is December 31, 2014), except that (a) Mr. Bovender s 2x Time Options will remain exercisable until the fifth anniversary of the last date on which his EBITDA performance options are eligible to vest (which is December 31, 2017), and (b) Mr. Bovender s Investor Return performance options will remain exercisable until the expiration of such options.

Change in Control Benefits

Pursuant to the Stock Option Agreements governing the New Options granted in 2007 and the 2x Time Options granted in 2009, both under the 2006 Plan, upon a Change in Control of the Company (as defined below), all unvested time vesting New Options and 2x Time Options (that have not otherwise terminated or become exercisable) shall become immediately exercisable. Performance options that vest subject to the achievement of EBITDA targets will become exercisable upon a Change in Control of the Company if: (i) prior to the date of the occurrence of such event, all EBITDA targets have been achieved for years ending prior to such date; (ii) on the date of the occurrence of such event, the Company s actual cumulative total EBITDA earned in all years occurring after the performance option grant date, and ending on the date of the Change in Control, exceeds the cumulative total of all EBITDA targets in effect for those same years; or (iii) the Investor Return is at least two-and-a-half times the price paid to the stockholders in the Recapitalization (or $127.50). For purposes of the vesting provision set forth in clause (ii) above, the EBITDA target for the year in which the Change in Control occurs shall be equitably adjusted by the Board of Directors in good faith in consultation with the chief executive officer (which adjustment shall take into account the time during such year at which the Change in Control occurs). Performance vesting options that vest based on the investment return to the Sponsors will only vest upon the occurrence of a Change in Control if, as a result of such event, the applicable Investor Return (i.e., at least two times the price paid to the stockholders in the Recapitalization for half of these options and at least two-and-one-half times the price paid to the stockholders in the Recapitalization for the other half of these options) is also achieved in such transaction (if not previously achieved). Change in Control means in one or more of a series of transactions (i) the transfer or sale of all or substantially all of the assets of the Company (or any direct or indirect parent of the Company) to an Unaffiliated Person (as defined below); (ii) a merger, consolidation, recapitalization or reorganization of the Company (or any direct or indirect parent of the Company) with or into

another Unaffiliated Person, or a transfer or sale of the voting stock of the Company (or any direct or indirect parent of the Company), an

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Investor, or any affiliate of any of the Investors to an Unaffiliated Person, in any such event that results in more than 50% of the common stock of the Company (or any direct or indirect parent of the Company) or the resulting company being held by an Unaffiliated Person; or (iii) a merger, consolidation, recapitalization or reorganization of the Company (or any direct or indirect parent of the Company) with or into another Unaffiliated Person, or a transfer or sale by the Company (or any direct or indirect parent of the Company), an Investor or any affiliate of any of the Investors, in any such event after which the Investors and their affiliates (x) collectively own less than 15% of the common stock of and (y) collectively have the ability to appoint less than 50% of the directors to the Board (or any resulting company after a merger). For purposes of this definition, the term Unaffiliated Person means a person or group who is not an Investor, an affiliate of any of the Investors or an entity in which any Investor holds, directly or indirectly, a majority of the economic interest in such entity.

Additional information regarding applicable payments under such agreements for the named executive officers is provided under Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table Employment Agreements and Potential Payments Upon Termination or Change in Control.

Recoupment of Compensation

Information regarding our policy with respect to recovery of incentive compensation is provided under Elements of Compensation Annual Incentive Compensation: PEP above.

Tax and Accounting Implications

On April 29, 2008, we registered our common stock pursuant to Section 12(g) of the Securities Exchange Act of 1934, as amended; and we became subject to Section 162(m) of the Internal Revenue Code, as amended (the Code) for fiscal year 2008 and beyond, so long as our stock remains registered with the SEC. The Committee considers the impact of Section 162(m) in the design of its compensation strategies. Under Section 162(m), compensation paid to executive officers in excess of $1,000,000 cannot be taken by us as a tax deduction unless the compensation qualifies as performance-based compensation. We have determined, however, that we will not necessarily seek to limit executive compensation to amounts deductible under Section 162(m) if such limitation is not in the best interests of our stockholders. While considering the tax implications of its compensation decisions, the Committee believes its primary focus should be to attract, retain and motivate executives and to align the executives interests with those of our stakeholders.

The Committee operates its compensation programs with the good faith intention of complying with Section 409A of the Internal Revenue Code. We account for stock based payments with respect to our long term equity incentive award programs in accordance with the requirements of ASC 718.

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2009 Summary Compensation Table

The following table sets forth information regarding the compensation earned by the Chief Executive Officer, the Chief Financial Officer and our other three most highly compensated executive officers during 2009 and Mr. Bovender, who would have been one of our most highly compensated executive officers had he not retired as an executive officer on December 15, 2009.

ame and Principal Positions	Year	Salary ($)	Option Awards ($)(1)	Non-Equity Incentive Plan Compensation ($)(2)	Changes in Pension Value and Nonqualified Deferred Compensation Earnings ($)(3)	All Other Compensation ($)(4)	Total ($)
ichard M. Bracken	2009	$ 1,324,975	$ 3,361,016	$ 3,445,000	$ 4,096,368	$ 25,532	$ 12,252,891
hairman and Chief	2008	$ 1,060,872		$ 694,370	$ 1,740,620	$ 31,781	$ 3,527,643
xecutive Officer	2007	$ 1,060,872	$ 5,560,666	$ 1,909,570	$ 590,370	$ 142,932	$ 9,264,410
. Milton Johnson	2009	$ 849,984	$ 2,520,714	$ 1,360,000	$ 2,032,089	$ 17,674	$ 6,780,461
xecutive Vice President,	2008	$ 786,698		$ 355,491	$ 1,871,790	$ 38,769	$ 3,052,748
hief Financial Officer	2007	$ 750,379	$ 3,971,905	$ 900,455	$ 509,442	$ 82,462	$ 6,214,643
nd Director							
everly B. Wallace	2009	$ 700,000	$ 997,771	$ 924,018	$ 2,047,036	$ 16,500	$ 4,685,325
resident Shared	2008	$ 700,000		$ 314,992	$ 2,080,836	$ 15,651	$ 3,111,479
ervices Group	2007	$ 700,000	$ 2,224,258	$ 840,000	$ 676,111	$ 75,013	$ 4,515,382
amuel N. Hazen	2009	$ 788,672	$ 997,771	$ 1,041,067	$ 1,725,405	$ 16,499	$ 4,569,414
resident Western Group	2008	$ 788,672		$ 350,807	$ 810,462	$ 15,651	$ 1,965,592
	2007	$ 788,672	$ 2,542,007	$ 830,779	$ 258,787	$ 84,767	$ 4,505,012
V. Paul Rutledge	2009	$ 675,000	$ 997,771	$ 891,017	$ 1,510,040	$ 16,500	$ 4,090,328
resident Central Group							
ack O. Bovender, Jr.	2009	$ 1,288,676	$ 1,470,443	$ 1,250,000	$ 4,127,725	$ 76,399	$ 8,213,243
xecutive Chairman*	2008	$ 1,620,228		$ 1,391,886	$ 3,926,217	$ 45,321	$ 6,983,652
	2007	$ 1,620,228	$ 6,355,038	$ 3,888,547		$ 197,092	$ 12,060,905

* Mr. Bovender retired as executive Chairman of the Company effective December 15, 2009.

(1) Option Awards for 2007 and 2009 include the aggregate grant date fair value of the stock option awards granted during fiscal years 2007 and 2009, respectively, in accordance with ASC 718 with respect to New Options (including the 2x Time Options) to purchase shares of our common stock awarded to the named executive officers in fiscal years 2007 and 2009, respectively, under the 2006 Plan. See Note 2 to our consolidated financial statements included in this prospectus.

(2) Non-Equity Incentive Plan Compensation for 2009 reflects amounts earned for the year ended December 31, 2009 under the 2008-2009 PEP, which amounts were paid in the first quarter of 2010 pursuant to the terms of the 2008-2009 PEP. For 2009, the Company exceeded its maximum performance level, as adjusted, with respect to the Company s EBITDA and the Central and Western Group EBITDA; therefore, pursuant to the terms of the

2008-2009 PEP, awards under the 2008-2009 PEP were paid out to the named executive officers, at the maximum level of 200% of their respective target amounts. Mr. Bovender was also awarded, pursuant to his Amended Employment Agreement, an additional one-time bonus of $250,000 based upon his contributions to certain legislative initiatives as determined by the Committee.

Non-Equity Incentive Plan Compensation for 2008 reflects amounts earned for the year ended December 31, 2008 under the 2008-2009 PEP, which amounts were paid in the first quarter of 2009 pursuant to the terms of the 2008-2009 PEP. For 2008, the Company did not achieve its target performance level, but exceeded its threshold performance level, as adjusted, with respect to the Company s EBITDA; therefore, pursuant to the terms of the 2008-2009 PEP, 2008 awards under the 2008-2009 PEP were paid out to the named executive officers at approximately 68.2% of each such officer s respective target amount, with the exception of Mr. Hazen, whose award was paid out at approximately 67.4% of his target amount, due to the 50% of his PEP based on the Western Group EBITDA, which also exceeded the threshold performance level but did not reach the target performance level.

Non-Equity Incentive Plan Compensation for 2007 reflects amounts earned for the year ended December 31, 2007 under the 2007 PEP, which amounts were paid in the first quarter of 2008 pursuant to

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the terms of the 2007 PEP. For 2007, the Company exceeded its maximum performance level, as adjusted, with respect to the Company s EBITDA; therefore, pursuant to the terms of the 2007 PEP, awards under the 2007 PEP were paid out to the named executive officers, at the maximum level of 200% of their respective target amounts, with the exception of Mr. Hazen, whose award was paid out at 175.6% of the target amount, due to the 50% of his PEP based on the Western Group EBITDA, which exceeded the target but did not reach the maximum performance level.

(3) All amounts for 2009 are attributable to changes in value of the SERP benefits. Assumptions used to calculate these figures are provided under the table titled 2009 Pension Benefits. The changes in the SERP benefit value during 2009 were impacted mainly by: (i) the passage of time which reflects another year of pay and service plus actual investment return, (ii) the discount rate changing from 6.25% to 5.00%, which resulted in an increase in the value and (iii) the use of the actual 2009 interest rate of 4.24% for Mr. Bovender who retired in 2009. The impact of these events on the SERP benefit values was:

	Bracken	Johnson	Wallace	Hazen	Rutledge	Bovender
Passage of Time	$ 1,655,097	$ 618,320	$ 788,376	$ 343,653	$ 420,979	$ 2,053,402
Discount Rate Change	$ 2,441,271	$ 1,413,769	$ 1,258,660	$ 1,381,752	$ 1,089,061	
Actual Retirement						$ 2,074,323

All amounts for 2008 are attributable to changes in value of the SERP benefits. Assumptions used to calculate these figures are provided under the table titled 2009 Pension Benefits. The changes in the SERP benefit value during 2008 were impacted mainly by: (i) the passage of time which reflects another year of pay and service plus actual investment return, (ii) the discount rate changing from 6.00% to 6.25%, which resulted in a decrease in the value and (iii) the opportunity for participants to change their benefit election before 2009 for terminations and retirements occurring after 2008. Mr. Bovender elected to change his benefit payment from an annuity to a lump sum. The impact of these events on the SERP benefit values was:

	Bracken	Johnson	Wallace	Hazen	Bovender
Passage of Time	$ 2,142,217	$ 2,100,290	$ 2,301,107	$ 1,037,631	$ 1,432,831
Discount Rate Change	$ (401,597)	$ (228,500)	$ (220,271)	$ (227,169)	$ (467,374)
Change in Election					$ 2,960,760

All amounts for 2007 are attributable to changes in value of the SERP benefits. Assumptions used to calculate these figures are provided under the table titled 2009 Pension Benefits. The changes in the SERP benefit value during 2007 were impacted mainly by: (i) the passage of time which reflects another year of pay and service, (ii) the discount rate changing from 5.75% to 6.00%, which resulted in a decrease in the value and (iii) the use of the named executive officers actual elections compared to 2006 when benefits were valued assuming a 50% probability of electing a lump sum and a 50% probability of electing an annuity. All named executive officers elected a lump sum payment at retirement, with the exception of Mr. Bovender, who elected an annuity. The impact of these events on the SERP benefit values was:

	Bracken	Johnson	Wallace	Hazen	Bovender

Passage of Time	$ 399,630	$ 510,118	$ 549,404	$ 266,066	$ (966,974)
Discount Rate Change	$ (351,603)	$ (145,992)	$ (165,945)	$ (186,325)	$ (542,195)
Actual Election	$ 542,343	$ 145,315	$ 292,652	$ 179,046	$ (1,322,788)

(4) 2009 amounts generally consist of:

Matching Company contributions to our 401(k) Plan as set forth below.

	Bracken	**Johnson**	**Wallace**	**Hazen**	**Rutledge**	**Bovender**
HCA 401(k) matching contribution	$ 16,500	$ 16,500	$ 16,500	$ 16,499	$ 16,500	$ 16,500

Personal use of corporate aircraft. In 2009, Messrs. Bracken, Johnson and Bovender were allowed personal use of Company aircraft with an estimated incremental cost of $5,025, $1,129 and $13,141, respectively, to the Company. Ms. Wallace and Messrs. Hazen and Rutledge did not have any personal

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travel on Company aircraft in 2009. We calculate the aggregate incremental cost of the personal use of Company aircraft based on a methodology that includes the average aggregate cost, on a per nautical mile basis, of variable expenses incurred in connection with personal plane usage, including trip-related maintenance, landing fees, fuel, crew hotels and meals, on-board catering, trip-related hangar and parking costs and other variable costs. Because our aircraft are used primarily for business travel, our incremental cost methodology does not include fixed costs of owning and operating aircraft that do not change based on usage. We grossed up the income attributed to Mr. Bracken with respect to certain trips on Company aircraft. The additional income attributed to him as a result of gross ups was $594. In addition, we will pay the expenses of our executives spouses associated with travel to and/or attendance at business related events at which spouse attendance is appropriate. We paid approximately $2,477 and $13,327 for travel and/or other expenses incurred by Messrs. Bracken s and Bovender s wives, respectively, for such business related events, and additional income of $891 and $4,793 was attributed to Messrs. Bracken and Bovender, respectively, as a result of the gross up on such amounts.

Additional income of $28,638 was attributed to Mr. Bovender for gifts received from the Company in connection with his retirement.

2008 amounts consist of:

Company contributions to our former Retirement Plan and matching Company contributions to our 401(k) Plan as set forth below.

	Bracken	Johnson	Wallace	Hazen	Bovender
HCA Retirement Plan	$ 3,163	$ 3,163	$ 3,163	$ 3,163	$ 3,163
HCA 401(k) matching contribution	$ 12,488	$ 12,488	$ 12,488	$ 12,488	$ 12,488
HCA Restoration Plan					

Effective January 1, 2008, participants in the SERP are no longer eligible for Restoration Plan contributions.

Personal use of corporate aircraft. In 2008, Messrs. Bovender, Bracken and Johnson were allowed personal use of Company aircraft with an estimated incremental cost of $28,913, $15,233 and $4,546, respectively, to the Company. Ms. Wallace and Mr. Hazen did not have any personal travel on Company aircraft in 2008. We calculate the aggregate incremental cost of the personal use of Company aircraft based on a methodology that includes the average aggregate cost, on a per nautical mile basis, of variable expenses incurred in connection with personal plane usage, including trip-related maintenance, landing fees, fuel, crew hotels and meals, on-board catering, trip-related hangar and parking costs and other variable costs. Because our aircraft are used primarily for business travel, our incremental cost methodology does not include fixed costs of owning and operating aircraft that do not change based on usage. We grossed up the income attributed to Messrs. Bovender and Bracken with respect to certain trips on Company aircraft. The additional income attributed to them as a result of gross ups was $588 and $599, respectively. In addition, we will pay the expenses of our executives spouses associated with travel to and/or attendance at business related events at which spouse attendance is appropriate. We paid approximately $107, $189 and $13,660 for travel and/or other expenses incurred by Messrs. Bovender s, Bracken s and Johnson s wives, respectively, for such business related events, and additional income of $62, $109 and $4,912 was attributed to Messrs. Bovender, Bracken and Johnson, respectively, as a result of the gross up on such amounts.

2007 amounts consist of:

Company contributions to our former Retirement Plan, matching Company contributions to our 401(k) Plan and Company accruals for our Restoration Plan as set forth below.

	Bracken	Johnson	Wallace	Hazen	Bovender
HCA Retirement Plan	$ 19,388	$ 19,388	$ 19,388	$ 19,388	$ 19,388
HCA 401(k) matching contribution	$ 3,375	$ 3,375	$ 3,375	$ 3,375	$ 2,250
HCA Restoration Plan	$ 91,946	$ 57,792	$ 52,250	$ 62,004	$ 153,475

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Personal use of corporate aircraft. In 2007, Messrs. Bovender and Bracken were allowed personal use of Company aircraft with an estimated incremental cost of $21,350 and $26,895, respectively, to the Company, calculated as described above. Ms. Wallace and Mr. Hazen did not have any personal travel on Company aircraft in 2007. We grossed up the income attributed to Messrs. Bovender and Bracken with respect to certain trips on Company aircraft. The additional income attributed to them as a result of gross ups was $629 and $863, respectively. In addition, we will pay the travel expenses of our executives spouses associated with travel to business related events at which spouse attendance is appropriate. We paid approximately $342 for travel by Mr. Bracken s wife on a commercial airline and related expenses for such an event, and additional income of $123 was attributed to Mr. Bracken as a result of the gross up on such amount.

2009 Grants of Plan-Based Awards

The following table provides information with respect to awards made under our 2006 Plan and 2008-2009 PEP during the 2009 fiscal year.

		Estimated Possible Payouts Under Non-Equity Incentive Plan Awards ($)(1)			Estimated Possible Payouts Under Equity Incentive Plan Awards (#)			All Other Option Awards: Number of Securities Underlying Options(2)	Exercise or Base Price of Option Awards ($/sh)	Grant Date Fair Value of Option Awards
Name	Grant Date	Threshold ($)	Target ($)	Maximum ($)	Threshold (#)	Target (#)	Maximum (#)			
Richard M. Bracken	10/6/2009							315,742	$ 102.00	$ 3,361,016
Richard M. Bracken	N/A	$ 861,250	$ 1,722,500	$ 3,445,000						
R. Milton Johnson	10/6/2009							236,802	$ 102.00	$ 2,520,714
R. Milton Johnson	N/A	$ 340,000	$ 680,000	$ 1,360,000						
Beverly B. Wallace	10/6/2009							93,733	$ 102.00	$ 997,771
Beverly B. Wallace	N/A	$ 231,004	$ 462,009	$ 924,018						
Samuel N. Hazen	10/6/2009							93,733	$ 102.00	$ 997,771
Samuel N. Hazen	N/A	$ 260,267	$ 520,534	$ 1,041,067						
W. Paul Rutledge	10/6/2009							93,733	$ 102.00	$ 997,771

W. Paul Rutledge	N/A	$ 222,754	$ 445,509	$ 891,017				
Jack O. Bovender, Jr.	10/6/2009				138,137	$ 102.00	$ 1,470,443	
Jack O. Bovender, Jr.	N/A	$ 250,000	$ 500,000	$ 1,000,000				

(1) Non-equity incentive awards granted to each of the named executive officers pursuant to our 2008-2009 PEP for the 2009 fiscal year, as described in more detail under Compensation Discussion and Analysis Elements of Compensation Annual Incentive Compensation: PEP. The amounts shown in the Threshold column reflect the threshold payment, which is 50% of the amount shown in the Target column. The amount shown in the Maximum column is 200% of the target amount. Mr. Bovender s Amended Employment Agreement set forth his PEP target for the 2009 fiscal year. Pursuant to the terms of the 2008-2009 PEP, the Company exceeded its maximum performance level, as adjusted, for 2009 with respect to the Company s EBITDA and the Central and Western Group EBITDA; therefore, pursuant to the terms of the 2008-2009 PEP, awards were paid out to the named executive officers, at the maximum level of 200% of their respective target amounts for 2009. Messrs. Bracken, Johnson, Hazen, Rutledge and Bovender and Ms. Wallace received $3,445,000, $1,360,000, $1,041,067, $891,017, $1,000,000 and $924,018, respectively, under the 2008-2009 Senior Officer PEP for the 2009 fiscal year. Such amounts are reflected in the Non-Equity Incentive Plan Compensation column of the Summary Compensation Table.

(2) Stock options awarded under the 2006 Plan, pursuant to the named executive officers respective employment agreements, by the Compensation Committee as a part of the named executive officers long term equity incentive award. The 2x Time Options granted in 2009 are structured, pursuant to the named executive officer s respective employment agreements, so that 40% were vested on the grant date to reflect employment served since the Recapitalization, an additional 20% vested on November 17, 2009 and an additional 20% will vest on each of November 17, 2010 and November 17, 2011, respectively. The terms of these option awards are described in more detail under Compensation Discussion and Analysis Elements of Compensation Long Term Equity Incentive Awards: Options. The aggregate grant date fair value of these option grants in accordance with ASC 718 is reflected in the Option Awards column of the Summary Compensation Table.

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Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table

Total Compensation

In 2009, 2008 and 2007, total direct compensation, as described in the Summary Compensation Table, consisted primarily of base salary, annual PEP awards payable in cash, and, in 2007, long term stock option grants designed to be one-time grants to cover at least five years of service and, in 2009, 2x Time Option grants as set forth in each named executive officer s employment agreement to be fully vested on the fifth anniversary of the Recapitalization. This mix was intended to reflect our philosophy that a significant portion of an executive s compensation should be equity-linked and/or tied to our operating performance. In addition, we provided an opportunity for executives to participate in two supplemental retirement plans; however, effective January 1, 2008, participants in the SERP are no longer eligible for Restoration Plan contributions, although Restoration Plan accounts will continue to be maintained for such participants (for additional information concerning the Restoration Plan, see 2009 Nonqualified Deferred Compensation).

Options

In January 2007, New Options to purchase common stock of the Company were granted under the 2006 Plan to members of management and key employees, including the named executive officers. The New Options were designed to be long term equity incentive awards, constituting a one-time stock option grant in lieu of annual equity grants. The New Options granted in 2007 have a ten year term and are structured so that 1/3 are time vested options (vesting in five equal installments on the first five anniversaries of the grant date), 1/3 are EBITDA-based performance vested options and 1/3 are performance options that vest based on investment return to the Sponsors. The terms of the New Options granted in 2007 are described in greater detail under Compensation Discussion and Analysis Elements of Compensation Long Term Equity Incentive Awards: Options. The aggregate grant date fair value of the New Options granted in 2007 in accordance with ASC 718 is included under the Option Awards column of the Summary Compensation Table.

In accordance with their employment agreements entered into at the time of the Recapitalization, as each may have been or may be subsequently amended, our named executive officers received the 2x Time Options in October 2009 with an exercise price equal to two times the share price at the Recapitalization (or $102.00). The Committee allocated the 2x Time Options in consultation with our Chief Executive Officer based on past executive contributions and future anticipated impact on Company objectives. The 2x Time Options have a ten year term and are structured so that forty percent were vested upon grant, an additional twenty percent of the options vested on November 17, 2009, and twenty percent of the options granted to each recipient will vest on November 17, 2010 and November 17, 2011, respectively. Thereby, a portion of the grant was vested on the date of the grant based on employment served since the Recapitalization. The terms of the 2x Time Options are otherwise consistent with other time vesting options granted under the 2006 Plan. The terms of the 2x Time Options granted in 2009 are described in greater detail under Compensation Discussion and Analysis Elements of Compensation Long Term Equity Incentive Awards: Options. The aggregate grant date fair value of the 2x Time Options granted in 2009 in accordance with ASC 718 is included under the Option Awards column of the Summary Compensation Table.

As a result of the Recapitalization, all unvested awards under the HCA 2005 Equity Incentive Plan (the 2005 Plan) (and all predecessor equity incentive plans) vested in November 2006. Generally, all outstanding options under the 2005 Plan (and any predecessor plans) were cancelled and converted into the right to receive a cash payment equal to the number of shares of common stock underlying the option multiplied by the amount by which the Recapitalization consideration of $51.00 per share exceeded the exercise price for the options (without interest and less any applicable withholding taxes). However, certain members of management, including the named executive officers, were given

the opportunity to convert options held by them prior to consummation of the Recapitalization into options to purchase shares of common stock of the surviving corporation (Rollover Options). Immediately after the consummation of the Recapitalization, all Rollover Options (other than those with an exercise price below $12.75) were adjusted so that they retained the same spread value (as defined below) as immediately prior to the Recapitalization, but the new per share exercise price for all Rollover Options would be $12.75. The term spread value means the difference between (x) the

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aggregate fair market value of the common stock (determined using the Recapitalization consideration of $51.00 per share) subject to the outstanding options held by the participant immediately prior to the Recapitalization that became Rollover Options, and (y) the aggregate exercise price of those options.

New Options, 2x Time Options and Rollover Options held by the named executive officers are described in the Outstanding Equity Awards at 2009 Fiscal Year-End Table.

Employment Agreements

In connection with the Recapitalization, on November 16, 2006, Hercules Holding entered into substantially similar employment agreements with each of the named executive officers and certain other executives, which agreements were shortly thereafter assumed by the Company and which agreements govern the terms of each executive s employment. However, in light of Mr. Bovender s retirement from the positions of Chief Executive Officer and Chairman, effective December 31, 2008 and December 15, 2009, respectively, the Company entered into an Amended and Restated Employment Agreement with Mr. Bovender, effective December 31, 2008, the terms of which are described below. The Company also entered into an amendment to Mr. Bracken s employment agreement, effective January 1, 2009, to reflect his appointment to the position of Chief Executive Officer.

Executive Employment Agreements (Other than Mr. Bovender s)

The term of employment under each of these agreements is indefinite, and they are terminable by either party at any time; provided that an executive must give no less than 90 days notice prior to a resignation.

Each employment agreement sets forth the executive s annual base salary, which will be subject to discretionary annual increases upon review by the Board of Directors, and states that the executive will be eligible to earn an annual bonus as a percentage of salary with respect to each fiscal year, based upon the extent to which annual performance targets established by the Board of Directors are achieved. The employment agreements committed us to provide each executive with annual bonus opportunities in 2008 that were consistent with those applicable to the 2007 fiscal year, unless doing so would be adverse to our interests or the interests of our stockholders, and for later fiscal years, the agreements provide that the Board of Directors will set bonus opportunities in consultation with our Chief Executive Officer. With respect to the 2009 and 2008 fiscal years and the 2007 fiscal year, each executive was eligible to earn under the 2008-2009 PEP and the 2007-2008 PEP, respectively, (i) a target bonus, if performance targets were met; (ii) a specified percentage of the target bonus, if threshold levels of performance were achieved but performance targets were not met; or (iii) a multiple of the target bonus if maximum performance goals were achieved, with the annual bonus amount being interpolated, in the sole discretion of the Board of Directors, for performance results that exceeded threshold levels but do not meet or exceed maximum levels. The annual bonus opportunities for 2009 were set forth in the 2008-2009 PEP, as described in more detail under Compensation Discussion and Analysis Annual Incentive Compensation: PEP. As described above, the Company exceeded its maximum performance level, as adjusted, for 2009 with respect to the Company s EBITDA and the Central and Western Group EBITDA; therefore, pursuant to the terms of the 2008-2009 PEP, awards were paid out to the named executive officers, at the maximum level of 200% of their respective target amounts for 2009. As described above, awards under the 2008 PEP were paid out to the named executive officers at approximately 68.2% of each such officer s respective target amount, with the exception of Mr. Hazen, whose award was paid out at approximately 67.4% of the target amount. Awards under the 2007 PEP were paid out to the named executive officers, at the maximum level of 200% of their respective target amounts, with the exception of Mr. Hazen, whose award was paid out at 175.6% of his target amount. Each employment agreement also sets forth the number of options that the executive received pursuant to the 2006 Plan as a percentage of the total equity initially made available for grants pursuant to the 2006 Plan. Such option awards, the New Options, were made January 30, 2007 and are described above under Options.

In each of the employment agreements with the named executive officers, we also committed to grant, among the named executive officers and certain other executives, the 2x Time Options, which were granted, as described above, on October 6, 2009. Additionally, pursuant to the employment agreements, we agree to

indemnify each executive against any adverse tax consequences (including, without limitation, under Section 409A and 4999 of the Internal Revenue Code), if any, that result from the adjustment by us of stock options held by the executive in connection with Recapitalization or the future payment of any extraordinary cash dividends.

Pursuant to each employment agreement, if an executive s employment terminates due to death or disability, the executive would be entitled to receive (i) any base salary and any bonus that is earned and unpaid through the date of termination; (ii) reimbursement of any unreimbursed business expenses properly incurred by the executive; (iii) such employee benefits, if any, as to which the executive may be entitled under our employee benefit plans (the payments and benefits described in (i) through (iii) being accrued rights); and (iv) a pro rata portion of any annual bonus that the executive would have been entitled to receive pursuant to the employment agreement based upon our actual results for the year of termination (with such proration based on the percentage of the fiscal year that shall have elapsed through the date of termination of employment, payable to the executive when the annual bonus would have been otherwise payable (the pro rata bonus)).

If an executive s employment is terminated by us without cause (as defined below) or by the executive for good reason (as defined below) (each a qualifying termination), the executive would be (i) entitled to the accrued rights; (ii) subject to compliance with certain confidentiality, non-competition and non-solicitation covenants contained in his or her employment agreement and execution of a general release of claims on behalf of the Company, an amount equal to the product of (x) two (three in the case of Richard M. Bracken and R. Milton Johnson) and (y) the sum of (A) the executive s base salary and (B) annual bonus paid or payable in respect of the fiscal year immediately preceding the fiscal year in which termination occurs, payable over a two-year period; (iii) entitled to the pro rata bonus; and (iv) entitled to continued coverage under our group health plans during the period over which the cash severance described in clause (ii) is paid. The executive s vested New Options and 2x Time Options would also remain exercisable until the first anniversary of the termination of the executive s employment. However, in lieu of receiving the payments and benefits described in (ii), (iii) and (iv) immediately above, the executive may instead elect to have his or her covenants not to compete waived by us. The same severance applies regardless of whether the termination was in connection with a change in control of the Company.

Cause is defined as an executive s (i) willful and continued failure to perform his material duties to the Company which continues beyond 10 business days after a written demand for substantial performance is delivered; (ii) willful or intentional engagement in material misconduct that causes material and demonstrable injury, monetarily or otherwise, to the Company or the Sponsors; (iii) conviction of, or a plea of *nolo contendere* to, a crime constituting a felony, or a misdemeanor for which a sentence of more than six months imprisonment is imposed; or (iv) willful and material breach of his covenants under the employment agreement which continues beyond the designated cure period or of the agreements relating to the new equity. Good Reason is defined as (i) a reduction in the executive s base salary (other than a general reduction that affects all similarly situated employees in substantially the same proportions which is implemented by the Board in good faith after consultation with the chief executive officer and chief operating officer), a reduction in the executive s annual incentive compensation opportunity, or the reduction of benefits payable to the executive under the SERP; (ii) a substantial diminution in the executive s title, duties and responsibilities; or (iii) a transfer of the executive s primary workplace to a location that is more than 20 miles from his or her current workplace (other than, in the case of (i) and (ii), any isolated, insubstantial and inadvertent failure that is not in bad faith and is cured within 10 business days after the executive s written notice to the Company).

In the event of an executive s termination of employment that is not a qualifying termination or a termination due to death or disability, he or she will only be entitled to the accrued rights (as defined above).

Additional information with respect to potential payments to the named executive officers pursuant to their employment agreements and the 2006 Plan is contained in Potential Payments Upon Termination or Change in Control.

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Mr. Bovender s Employment Agreement

The Company entered into the Amended Employment Agreement with Jack O. Bovender, Jr. on October 27, 2008, which became effective on December 31, 2008. Pursuant to the terms of the Amended Employment Agreement, Mr. Bovender was employed by HCA Management Services, L.P., an affiliate of the Company, and served as executive Chairman of the Company for a period commencing December 31, 2008 and ending December 15, 2009 (the Employment Term).

The Amended Employment Agreement provided that Mr. Bovender receive a base salary (i) at the monthly rate of $135,000 for the first three months of the Employment Term and (ii) at the monthly rate of $86,957 for the next eight and one-half months of the Employment Term (Mr. Bovender s Base Salary). Mr. Bovender was also entitled to the full amount of any annual bonus earned, but unpaid, as of the effective date of the Amended Employment Agreement for the year ended December 31, 2008 under the Company s 2008-2009 PEP. For calendar year 2009, Mr. Bovender was eligible to earn a bonus under the 2008-2009 PEP with a target bonus of $500,000. Mr. Bovender had an additional 2009 bonus opportunity of up to $250,000 based upon his contributions to certain legislative initiatives as determined by the Committee (Mr. Bovender s Additional Bonus). Pursuant to the terms of the 2008-2009 PEP, the Company exceeded its maximum performance level, as adjusted, for 2009 with respect to the Company s EBITDA; therefore, pursuant to the terms of the 2008-2009 PEP, Mr. Bovender s award for the 2009 fiscal year was paid out at the maximum level of 200% of his target amount. Mr. Bovender was also awarded, pursuant to his Amended Employment Agreement, an additional one-time bonus of $250,000 based upon his contributions to certain legislative initiatives as determined by the Committee. The Amended Employment Agreement generally provides for the provision of or reimbursement of expenses associated with office space, shared clerical support and office equipment until Mr. Bovender reaches age 70.

The terms of Mr. Bovender s employment agreement with respect to termination of his employment are described in detail under Compensation Discussion and Analysis Severance and Change in Control Agreements Mr. Bovender s Continuing Severance Benefits.

Additional information with respect to payments to Mr. Bovender pursuant to his Amended Employment Agreement and the 2006 Plan is contained in Potential Payments Upon Termination or Change in Control.

Outstanding Equity Awards at 2009 Fiscal Year-End

The following table includes certain information with respect to options held by the named executive officers as of December 31, 2009.

Name	Number of Securities Underlying Unexercised Options Exercisable (#)(1)(2)(3)	Number of Securities Underlying Unexercised Options Unexercisable (#)(2)(3)	Equity Incentive Plan Awards: Number of Securities Underlying Unexercised Unearned Options (#)(2)	Option Exercise Price ($)(4)(5)(6)	Option Expiration Date
Richard M. Bracken	8,052			$ 12.75	3/22/2011
Richard M. Bracken	26,248			$ 12.75	7/26/2011

Richard M. Bracken	29,934			$ 12.75	1/24/2012
Richard M. Bracken	40,490			$ 12.75	1/29/2013
Richard M. Bracken	30,235			$ 12.75	1/29/2014
Richard M. Bracken	10,739			$ 12.75	1/27/2015
Richard M. Bracken	7,095			$ 12.75	1/26/2016
Richard M. Bracken	116,550	69,932	163,172	$ 51.00	1/30/2017
Richard M. Bracken	189,444	126,298		$ 102.00	10/6/2019
R. Milton Johnson	6,039			$ 12.75	3/22/2011
R. Milton Johnson	9,579			$ 12.75	1/24/2012

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Name	Number of Securities Underlying Unexercised Options Exercisable (#)(1)(2)(3)	Number of Securities Underlying Unexercised Options Unexercisable (#)(2)(3)	Equity Incentive Plan Awards: Number of Securities Underlying Unexercised Unearned Options (#)(2)	Option Exercise Price ($)(4)(5)(6)	Option Expiration Date
R. Milton Johnson	9,254			$ 12.75	1/29/2013
R. Milton Johnson	8,062			$ 12.75	1/29/2014
R. Milton Johnson	26,013			$ 12.75	7/22/2014
R. Milton Johnson	6,441			$ 12.75	1/27/2015
R. Milton Johnson	4,301			$ 12.75	1/26/2016
R. Milton Johnson	83,250	49,951	116,552	$ 51.00	1/30/2017
R. Milton Johnson	142,080	94,722		$ 102.00	10/6/2019
Beverly B. Wallace	6,039			$ 12.75	3/22/2011
Beverly B. Wallace	9,579			$ 12.75	1/24/2012
Beverly B. Wallace	13,882			$ 12.75	1/29/2013
Beverly B. Wallace	11,422			$ 12.75	1/29/2014
Beverly B. Wallace	4,601			$ 12.75	1/27/2015
Beverly B. Wallace	3,559			$ 12.75	1/26/2016
Beverly B. Wallace	46,620	27,973	65,268	$ 51.00	1/30/2017
Beverly B. Wallace	56,238	37,495		$ 102.00	10/6/2019
Samuel N. Hazen	6,039			$ 12.75	3/22/2011
Samuel N. Hazen	13,124			$ 12.75	7/26/2011
Samuel N. Hazen	19,158			$ 12.75	1/24/2012
Samuel N. Hazen	23,137			$ 12.75	1/29/2013
Samuel N. Hazen	16,797			$ 12.75	1/29/2014
Samuel N. Hazen	6,441			$ 12.75	1/27/2015
Samuel N. Hazen	4,301			$ 12.75	1/26/2016
Samuel N. Hazen	53,280	31,969	74,592	$ 51.00	1/30/2017
Samuel N. Hazen	56,238	37,495		$ 102.00	10/6/2019
W. Paul Rutledge	8,381			$ 12.75	1/24/2012
W. Paul Rutledge	9,254			$ 12.75	1/29/2013
W. Paul Rutledge	5,375			$ 12.75	1/29/2014
W. Paul Rutledge	2,297			$ 12.75	1/27/2015
W. Paul Rutledge	5,395			$ 12.75	10/1/2015
W. Paul Rutledge	4,301			$ 12.75	1/26/2016
W. Paul Rutledge	46,620	27,973	65,268	$ 51.00	1/30/2017
W. Paul Rutledge	56,238	37,495		$ 102.00	10/6/2019
Jack O. Bovender, Jr.	133,200	79,922	186,482	$ 51.00	1/30/2017
Jack O. Bovender, Jr.	82,881	55,256		$ 102.00	10/6/2019

(1) Reflects Rollover Options, as further described under Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table Options, the 40% of the named executive officer s time vested

New Options, comprised of the 20% that vested as of January 30, 2008 and January 30, 2009, respectively, the 60% of the named executive officer s EBITDA-based performance vested New Options, comprised of the 20% that vested as of December 31, 2007, December 31, 2008 and December 31, 2009, respectively (upon the Committee s determination that the Company achieved the 2007, 2008 and 2009

EBITDA performance targets under the option awards, as adjusted, as described in more detail under Compensation Discussion and Analysis Elements of Compensation Long Term Equity Incentive Awards: Options) and the 60% of the named executive officer s vested 2x Time Options, comprised of the 40% that were vested on the grant date and the 20% that vested on November 17, 2009.

(2) Reflects New Options awarded in January 2007 under the 2006 Plan by the Compensation Committee as part of the named executive officer s long term equity incentive award. The New Options granted in 2007 are structured so that 1/3 are time vested options (vesting in five equal installments on the first five anniversaries of the January 30, 2007 grant date), 1/3 are EBITDA-based performance vested options (vesting in equal increments of 20% at the end of fiscal years 2007, 2008, 2009, 2010 and 2011 if certain annual EBITDA performance targets are achieved, subject to catch up vesting, such that, options that were eligible to vest but failed to vest due to our failure to achieve prior EBITDA targets will vest if at the end of any subsequent year or at the end of fiscal year 2012, the cumulative total EBITDA earned in all prior years exceeds the cumulative EBITDA target at the end of such fiscal year) and 1/3 are performance options that vest based on investment return to the Sponsors (vesting with respect to 10% of the common stock subject to such options at the end of fiscal years 2007, 2008, 2009, 2010 and 2011 if the Investor Return is at least $102.00 and with respect to an additional 10% at the end of fiscal years 2007, 2008, 2009, 2010 and 2011 if the Investor Return is at least $127.50, subject to catch up vesting if the relevant Investor Return is achieved at any time occurring prior to January 30, 2017, so long as the named executive officer remains employed by the Company). The time vested options are reflected in the Number of Securities Underlying Unexercised Options Unexercisable column (with the exception of the 40% of the time vested options that were vested as of December 31, 2009, which are reflected in the Number of Securities Underlying Unexercised Options Exercisable column), and the EBITDA-based performance vested options and investment return performance vested options are both reflected in the Equity Incentive Plan Awards: Number of Securities Underlying Unexercised Unearned Options column (with the exception of the 60% of the EBITDA-based performance vested options that were vested as of December 31, 2009, which are reflected in the Number of Securities Underlying Unexercised Options Exercisable column). The terms of these option awards are described in more detail under Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table Options.

(3) Reflects 2x Time Options awarded in October 2009 under the 2006 Plan by the Compensation Committee, pursuant to the named executive officer s employment agreement, as part of the named executive officer s long term equity incentive award. The 2x Time Options are structured, pursuant to the named executive officer s respective employment agreements, so that 40% were vested on the grant date, an additional 20% vested on November 17, 2009 and an additional 20% will vest on November 17, 2010 and November 17, 2011, respectively. The 60% of the 2x Time Options that were vested as of December 31, 2009 are reflected in the Number of Securities Underlying Unexercised Options Exercisable column, and the 40% of the 2x Time Options that were not vested as of December 31, 2009 are reflected in the Number of Securities Underlying Unexercised Options Unexercisable column. The terms of these option awards are described in more detail under Narrative Disclosure to Summary Compensation Table and 2009 Grants of Plan-Based Awards Table Options.

(4) Immediately after the consummation of the Recapitalization, all Rollover Options (other than those with an exercise price below $12.75) were adjusted such that they retained the same spread value (as defined below) as immediately prior to the Recapitalization, but the new per share exercise price for all Rollover Options would be $12.75. The term spread value means the difference between (x) the aggregate fair market value of the common stock (determined using the Recapitalization consideration of $51.00 per share) subject to the outstanding options held by the participant immediately prior to the Recapitalization that became Rollover Options, and (y) the aggregate exercise price of those options.

(5)

The exercise price for the New Options granted under the 2006 Plan to the named executive officers on January 30, 2007 was equal to the fair value of our common stock on the date of the grant, as determined by our Board of Directors in consultation with our Chief Executive Officer and other advisors, pursuant to the terms of the 2006 Plan.

(6) The exercise price for the 2x Time Options granted under the 2006 Plan to the named executive officers on October 6, 2009 was $102.00, pursuant to the named executive officers employment agreements.

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Option Exercises and Stock Vested in 2009

The following table includes certain information with respect to options exercised by the named executive officers during the fiscal year ended December 31, 2009.

	Option Awards	
Name	**Number of Shares Acquired on Exercise(1)**	**Value Realized on Exercise ($)(2)**
Jack O. Bovender, Jr.	188,340	$ 21,243,911

(1) Mr. Bovender elected a cashless exercise of 360,494 stock options resulting in net shares realized of 188,340.

(2) Represents the difference between the exercise price of the options and the fair market value of the common stock on the date of exercise, as determined by our Board of Directors in consultation with our Chief Executive Officer and other advisors.

2009 Pension Benefits

Our SERP is intended to qualify as a top-hat plan designed to benefit a select group of management or highly compensated employees. There are no other defined benefit plans that provide for payments or benefits to any of the named executive officers. Information about benefits provided by the SERP is as follows:

Name	**Plan Name**	**Number of Years Credited Service**	**Present Value of Accumulated Benefit**	**Payments During Last Fiscal Year**
Richard M. Bracken	SERP	28	$ 14,303,696	
R. Milton Johnson	SERP	27	$ 6,353,324	
Beverly B. Wallace	SERP	26	$ 8,696,543	
Samuel N. Hazen	SERP	27	$ 5,330,983	
W. Paul Rutledge	SERP	28	$ 5,504,026	
Jack O. Bovender, Jr.	SERP	29		$ 26,300,528

Mr. Bovender retired in 2009, and he received a SERP payment in April 2009. Mr. Bracken and Ms. Wallace are eligible for early retirement. The remaining named executive officers have not satisfied the eligibility requirements for normal or early retirement. All of the named executive officers are 100% vested in their accrued SERP benefit.

Plan Provisions

In the event the employee s accrued benefits under the Company s Plans (computed using actuarial factors) are insufficient to provide the life annuity amount, the SERP will provide a benefit equal to the amount of the shortfall. Benefits can be paid in the form of an annuity or a lump sum. The lump sum is calculated by converting the annuity

benefit using the actuarial factors. All benefits with a present value not exceeding one million dollars are paid as a lump sum regardless of the election made.

Normal retirement eligibility requires attainment of age 60 for employees who were participants at the time of the change in control which occurred as a result of the Recapitalization, including all of the named executive officers. Early retirement eligibility requires age 55 with 20 or more years of service. The service requirement for early retirement is waived for employees participating in the SERP at the time of its inception in 2001, including all of the named executive officers. The life annuity amount payable to a participant who takes early retirement is reduced by three percent for each full year or portion thereof that the participant retires prior to normal retirement age.

The life annuity amount is the annual benefit payable as a life annuity to a participant upon normal retirement. It is equal to the participant s accrual rate multiplied by the product of the participant s years of service times the participant s pay average. The SERP benefit for each year equals the life annuity amount less the annual life annuity amount produced by the employee s accrued benefit under the Company s Plans.

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The accrual rate is a percentage assigned to each participant, and is either 2.2% or 2.4%. All of the named executive officers are assigned a percentage of 2.4%.

A participant is credited with a year of service for each calendar year that the participant performs 1,000 hours of service for HCA or one of our subsidiaries, or for each year the participant is otherwise credited by us, subject to a maximum credit of 25 years of service.

A participant s pay average is an amount equal to one-fifth of the sum of the compensation during the period of 60 consecutive months for which total compensation is greatest within the 120 consecutive month period immediately preceding the participant s retirement. For purposes of this calculation, the participant s compensation includes base compensation, payments under the PEP, and bonuses paid prior to the establishment of the PEP.

The accrued benefits under the Company s Plans for an employee equals the sum of the employer-funded benefits accrued under the former HCA Retirement Plan, the HCA 401(k) Plan and any other tax-qualified plan maintained by us or one of our subsidiaries, the income/loss adjusted amount distributed to the participant under any of these plans, the account credit and the income/loss adjusted amount distributed to the participant under the Restoration Plan and any other nonqualified retirement plans sponsored by us or one of our subsidiaries.

The actuarial factors include (a) interest at the long term Applicable Federal Rate under Section 1274(d) of the Code or any successor thereto as of the first day of November preceding the plan year in or for which a benefit amount is calculated, and (b) mortality being the applicable Section 417(e)(3) of the Code mortality table, as specified and changed by the U.S. Treasury Department.

Credited service does not include any amount other than service with us or one of our subsidiaries.

Assumptions

The Present Value of Accumulated Benefit is based on a measurement date of December 31, 2009.

The assumption is made that there is no probability of pre-retirement death or termination. Retirement age is assumed to be the Normal Retirement Age as defined in the SERP for all named executive officers, as adjusted by the provisions relating to change in control, or age 60. Age 60 also represents the earliest date the named executive officers are eligible to receive an unreduced benefit.

All other assumptions used in the calculations are the same as those used for the valuation of the plan liabilities in this prospectus.

Supplemental Information

In the event a participant renders service to another health care organization within five years following retirement or termination of employment, he or she forfeits his rights to any further payment, and must repay any benefits already paid. This non-competition provision is subject to waiver by the Committee with respect to the named executive officers.

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2009 Nonqualified Deferred Compensation

Amounts shown in the table are attributable to the HCA Restoration Plan, an unfunded, nonqualified defined contribution plan designed to restore benefits under the HCA 401(k) Plan based on compensation in excess of the Code Section 401(a)(17) compensation limit ($245,000 in 2009).

Name	Executive Contributions in Last Fiscal Year	Registrant Contributions in Last Fiscal Year	Aggregate Earnings in Last Fiscal Year	Aggregate Withdrawals/ Distributions	Aggregate Balance at Last Fiscal Year End
Richard M. Bracken			$ 267,148		$ 1,418,398
R. Milton Johnson			$ 109,549		$ 581,639
Beverly B. Wallace			$ 90,252		$ 479,186
Samuel N. Hazen			$ 146,239		$ 776,440
W. Paul Rutledge			$ 80,356		$ 426,642
Jack O. Bovender, Jr.			$ 498,306		$ 2,692,051

The following amounts from the column titled Aggregate Balance at Last Fiscal Year have been reported in the Summary Compensation Tables in prior years:

	Restoration Contribution						
Name	2001	2002	2003	2004	2005	2006	2007
Richard M. Bracken	$ 87,924	$ 146,549	$ 162,344	$ 192,858	$ 172,571	$ 409,933	$ 91,946
R. Milton Johnson					$ 71,441	$ 212,109	$ 57,792
Beverly B. Wallace							$ 52,250
Samuel N. Hazen			$ 79,510	$ 101,488	$ 97,331	$ 247,060	$ 62,004
Jack O. Bovender, Jr.	$ 187,193	$ 268,523	$ 289,899	$ 363,481	$ 295,062	$ 856,424	$ 153,475

Plan Provisions

Until 2008, hypothetical accounts for each participant were credited each year with a contribution designed to restore the HCA Retirement Plan based on compensation in excess of the Code Section 401(a)(17) compensation limit ($245,000 in 2009), based on years of service. Effective January 1, 2008, participants in the SERP are no longer eligible for Restoration Plan contributions. However, the hypothetical accounts as of January 1, 2008 will continue to be maintained and will be increased or decreased with hypothetical investment returns based on the actual investment return of the Mix B fund of the HCA 401(k) Plan through the end of 2010.

No employee deferrals are allowed under this or any other nonqualified deferred compensation plan.