BROOKWOOD MEDICAL CENTER OF GULFPORT INC
Form 424B3
May 05, 2010

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PROSPECTUS

HCA Inc.

Offers to Exchange

$310,000,000 aggregate principal amount of its 97/8% Senior Secured Notes due 2017, $1,500,000,000 aggregate principal amount of its 81/2% Senior Secured Notes due 2019, $1,250,000,000 aggregate principal amount of its 77/8% Senior Secured Notes due 2020 and $1,400,000,000 aggregate principal amount of its 71/4% Senior Secured Notes due 2020 (collectively, the exchange notes), each of which have been registered under the Securities Act of 1933, as amended (the Securities Act), for any and all of its outstanding 97/8% Senior Secured Notes due 2017, 81/2% Senior Secured Notes due 2019, 77/8% Senior Secured Notes due 2020 and 71/4% Senior Secured Notes due 2020 (collectively, the outstanding notes), respectively (such transactions, collectively, the exchange offers).

We are conducting the exchange offers in order to provide you with an opportunity to exchange your unregistered notes for freely tradable notes that have been registered under the Securities Act.

The Exchange Offers

We will exchange all outstanding notes that are validly tendered and not validly withdrawn for an equal principal amount of exchange notes that are freely tradable.

You may withdraw tenders of outstanding notes at any time prior to the expiration date of the exchange offers.

The exchange offers expire at 11:59 p.m., New York City time, on June 2, 2010, unless extended. We do not currently intend to extend the expiration date.

The exchange of outstanding notes for exchange notes in the exchange offers will not be a taxable event for U.S. federal income tax purposes.

The terms of the exchange notes to be issued in the exchange offers are substantially identical to the outstanding notes, except that the exchange notes will be freely tradable.

Results of the Exchange Offers

The exchange notes may be sold in the over-the-counter market, in negotiated transactions or through a combination of such methods. We do not plan to list the notes on a national market.

All untendered outstanding notes will continue to be subject to the restrictions on transfer set forth in the outstanding notes and in the indenture. In general, the outstanding notes may not be offered or sold, unless registered under the Securities Act, except pursuant to an exemption from, or in a transaction not subject to, the Securities Act and applicable state securities laws. Other than in connection with the exchange offers, we do not currently anticipate that we will register the outstanding notes under the Securities Act.

See Risk Factors beginning on page 21 for a discussion of certain risks that you should consider before participating in the exchange offers.

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

The date of this prospectus is May 4, 2010.

You should rely only on the information contained in this prospectus. We have not authorized anyone to provide you with different information. The prospectus may be used only for the purposes for which it has been published, and no person has been authorized to give any information not contained herein. If you receive any other information, you should not rely on it. We are not making an offer of these securities in any state where the offer is not permitted.

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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 HCA Inc. (HCA) management s knowledge and experience in the markets in which HCA operates. These estimates have been based on information obtained from our trade and business organizations and other contacts in the markets in which we operate. HCA believes 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 HCA 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. HCA cannot guarantee the accuracy or completeness of any such information contained in this prospectus.

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PROSPECTUS SUMMARY

This summary highlights information appearing elsewhere in this prospectus. This summary is not complete and does not contain all of the information that you should consider to make your decisions regarding the exchange offers. You should carefully read the entire prospectus, including the financial data and related notes and the section entitled Risk Factors.

Unless the context otherwise requires or as otherwise indicated, references in this prospectus to HCA, the Issuer, we, our, us and the Company refer to HCA Inc. and its consolidated subsidiaries.

Our Company

We are one of the leading health care services companies in the United States. At December 31, 2009, we operated 163 hospitals, comprised of 157 general, acute care hospitals; five psychiatric hospitals; and one rehabilitation hospital. The 163 hospital total includes eight hospitals (seven general, acute care hospitals and one rehabilitation hospital) owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. In addition, we operated 105 freestanding surgery centers, eight of which are owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. Our facilities are located in 20 states and England. 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.

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

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.

On November 17, 2006, we completed our merger (the Merger) with Hercules Acquisition Corporation, pursuant to which we were acquired by Hercules Holding II, LLC (Hercules Holding), a Delaware limited liability company owned by a private investor group comprised of affiliates of Bain Capital Partners (Bain Capital), Kohlberg Kravis Roberts & Co. (KKR), Merrill Lynch Global Private Equity (MLGPE) (each a Sponsor), affiliates of Citigroup Inc. (Citigroup) and Bank of America Corporation (the Sponsor Assignees) and affiliates of HCA founder, Dr. Thomas F. Frist Jr., (the Frist Entities, and together with the Sponsors and the Sponsor Assignees, the Investors) and by members of management and certain other investors (the Management Participants). The Merger, the financing transactions related to the Merger and other related transactions are collectively referred to in this prospectus as the Recapitalization. See Ownership and Corporate Structure and Certain Relationships and Related Party Transactions for additional information regarding the Recapitalization and its impact on our corporate and governance structure.

Our Strengths

Largest Provider with a Diversified Revenue Base. We are the largest investor-owned health care services provider in the United States. We maintain a diverse portfolio of assets with no single facility contributing more than 2.4% of revenues and no single metropolitan statistical area contributing more than 7.8% of revenues for the year ended December 31, 2009. In addition, we maintain a diversified payer base,

including approximately 3,000 managed care contracts, with no one commercial payer representing more than approximately 8% of revenues for the year ended December 31, 2009. We believe our broad geographic footprint and diverse revenue base limit exposure to any single local market. We also provide a diverse array of medical and surgical services across different settings ranging from large hospitals to ambulatory surgery centers (ASCs), which, we believe, limits our exposure to changes in reimbursement policies targeting specific services or care settings.

Leading Market Positions. We maintain the number one or two inpatient position in nearly all of our markets, with our share of local inpatient admissions typically ranging from 20% to 40%. Additionally, we believe we have the leading position in one or more clinical areas, such as cardiology or orthopedics, in many of our markets. As a result, our hospitals are in demand by patients and large employers, which enables us to negotiate for favorable rates and terms from a wide range of commercial payers.

Strong Presence in Growth Markets. We have a strong market presence in a number of the fastest growing markets in the United States. We believe the majority of the large markets in which we have a presence will experience more rapid growth among the population aged 65 or older than the national average, based on the most recently available census data. We believe we will benefit from our presence in these key markets due to an expected increase in hospital spending.

Well-Capitalized Portfolio of High-Quality Assets. We have invested over $7.8 billion in our facilities over the five-year period ended December 31, 2009 to expand the range, and improve the quality, of services provided at our facilities. As a result of our disciplined and strategic deployment of capital, we believe our hospitals are competitive and will continue to attract high-quality physicians, maximize cost efficiencies and address the health care needs of our local communities.

Leading Provider of Outpatient Services. We are one of the largest providers of outpatient services in the United States, and these outpatient services accounted for approximately 38% of our revenues in 2009. The scope of our outpatient services reflects a recent trend toward the provision of an increasing number of services on an outpatient basis. An important component of our strategy is to achieve a fully integrated delivery model through the development of market-leading outpatient services, both to address outpatient migration and to provide higher growth, higher margin services.

Reputation for Quality. Since our founding, we have maintained an unwavering focus on patients and clinical outcomes. We have invested extensively in quality over the past 10 years, with an emphasis on implementing information technology and adopting industry-wide best practices and clinical protocols. As a result of these efforts, settled professional liability claims, based on actuarial projections per 1,000 beds, have dropped from 18.3 in 1999 to 12.6 in 2008. We also previously participated in the Centers for Medicare & Medicaid Services (CMS) National Voluntary Hospital Reporting Initiative and now participate in its successor, the Reporting Hospital Quality Data for Annual Payment Update program, which currently requires hospitals to report on their compliance with 46 quality measures in order to receive a full Medicare market basket payment increase. The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (Health Reform Legislation) further ties payment to quality measures by establishing a value based purchasing system and adjusting hospital payment rates based on hospital-acquired conditions (HACs) and hospital readmissions. We believe quality of care increasingly will influence physician and patient choices about health care delivery and impact our reimbursement as payers put more emphasis on performance. Our reputation and focus on providing high-quality patient care continue to make us the provider of choice for thousands of individual health care consumers, physicians and payers.

Proven Ability to Innovate. We strive to be at the forefront of industry best practices and expect to continue to increase our operational efficiency through a variety of strategic initiatives. Our previous operating improvement initiatives include:

Leveraging Our Purchasing Power. We have established a captive group purchasing organization (GPO) to partner with other health care services providers to take advantage of our combined purchasing power. Our GPO generated $107 million, $93 million and $89 million of administrative fees

from suppliers in 2009, 2008 and 2007, respectively, for performing GPO services and significantly lowered our supply costs. Because of our scale, our GPO has a per-unit cost advantage over competitors that we believe ranges from 5% to 21%.

Centralizing Our Billing and Accounts Receivable Collection Efforts. We have built regional service centers to create efficiencies in billing and collection processes, particularly with respect to payment disputes with managed care companies. This effort has resulted in increased, incremental cash collections.

Demonstrated Strong Cash Flows. Our leading market positions, diversified revenues, focus on operational efficiency and high-quality portfolio of assets have enabled us to generate strong operating cash flows over the past several years. We generated cash flows from operating activities of $2.747 billion in 2009, $1.990 billion in 2008 and $1.564 billion in 2007. We believe expected demand for hospital and outpatient services, together with our diversified payer base, geographic locations and service offerings, will allow us to continue to generate strong cash flows.

Experienced Management Team. Members of our management team are widely considered leaders in the hospital industry and have made significant equity investments in our company. Richard M. Bracken was appointed our CEO and President, effective January 1, 2009, and Chairman of the Board of Directors, effective December 15, 2009. Mr. Bracken began his career with us approximately 30 years ago and has held various executive positions with the Company, including, most recently, as our President and Chief Operating Officer since January 2002. Our Executive Vice President and Chief Financial Officer, R. Milton Johnson, joined us over 27 years ago, has held various positions in financial operations at the Company and has served as a director since December 15, 2009. In addition, we benefit from our team of world-class operators who have the experience and talent necessary to run a complex health care business.

Strategy

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

Maintain Our Dedication to the Care and Improvement of Human Life. Our business is built on putting patients first and providing high quality health care services in the communities we serve. Our dedicated professionals oversee our Quality Review System, which measures clinical outcomes, satisfaction and regulatory compliance to improve hospital quality and performance. We are implementing hospitalist programs in some facilities, evidence-based medicine programs and infection reduction initiatives. In addition, we continue to implement health information technology to improve the quality and convenience of services to our communities. We are using our electronic medication administration record, which uses bar coding technology to ensure that each patient receives the right medication, to build toward a fully electronic health record that will provide convenient access, electronic order entry and decision support for physicians. These technologies improve patient safety, quality and efficiency.

Maintain Our Commitment to Ethics and Compliance. We are committed to a corporate culture highlighted by the following values compassion, honesty, integrity, fairness, loyalty, respect and kindness. Our comprehensive ethics and compliance program reinforces our dedication to these values.

Leverage Our Leading Local Market Positions. We strive to maintain and enhance the leading positions we enjoy in the majority of our markets. We believe the broad geographic presence of our facilities across a range of markets, in combination with the breadth and quality of services provided by our facilities, increases our attractiveness to patients and large employers and positions us to negotiate more favorable terms from commercial payers and increase the number of payers with whom we contract. We also intend to strategically enhance our outpatient presence in our

communities to attract more patients to our facilities.

Expand Our Presence in Key Markets. We seek to grow our business in key markets, focusing on large, high growth urban and suburban communities, primarily in the southern and western regions of the United States. We seek to strategically invest in new and expanded services at our existing hospitals and surgery centers to increase our revenues at those facilities and provide the benefits of medical technology advances to our communities. We intend to continue to expand high volume and high margin specialty services, such as cardiology and orthopedic services, and increase the capacity, scope and convenience of our outpatient facilities. To complement this intrinsic growth, we intend to continue to opportunistically develop and acquire new hospitals and outpatient facilities.

Continue to Leverage Our Scale. We will continue to obtain price efficiencies through our group purchasing organization and build on the cost savings and efficiencies in billing, collection and other processes we have achieved through our regional service centers. We are increasingly taking advantage of our national scale by contracting for services on a multistate basis. We are expanding our successful shared services model for additional clinical and support functions, such as physician credentialing, medical transcription, electronic medical recordkeeping and health information management, across multiple markets.

Continue to Develop Physician Relationships. We depend on the quality and dedication of the physicians who practice at our facilities, and we encourage, consistent with applicable laws, both primary care physicians and specialists to join our medical staffs. We sometimes assist physicians who are recruited under applicable regulatory provisions with establishing and building a practice or joining an existing practice. As part of our comprehensive approach to physician integration in our markets, we will continue to:

- expand the number of high quality specialty services, such as cardiology, orthopedics, oncology and neonatology;
- use joint ventures with physicians to further develop our outpatient business, particularly through ASCs;
- develop medical office buildings to provide convenient facilities for physicians to locate their practices and serve their patients;
- focus on improving the quality, advanced technology, infrastructure and performance of our facilities; and
- employ physicians as appropriate.

Become the Health Care Employer of Choice. We will continue to use a number of industry-leading practices to help ensure our hospitals are a health care employer of choice in their respective communities. Our staffing initiatives for both care providers and hospital management provide strategies for recruitment, compensation and productivity to increase employee retention and operating efficiency at our hospitals. For example, we maintain an internal contract nursing agency to supply our hospitals with high quality staffing at a lower cost than external agencies. In addition, we have developed several proprietary training and career development programs for our physicians and hospital administrators, including an executive development program designed to train the next generation of hospital leadership. We believe our continued investment in the training and retention of employees improves the quality of care, enhances operational efficiency and fosters our reputation as an employer of choice.

Recent Developments

On January 27, 2010, our Board of Directors declared a distribution to the Company s stockholders and holders of vested stock options. The distribution was $17.50 per share and vested stock option, or approximately $1.750 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. Pursuant to the terms of our stock

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option plans, the holders of nonvested stock options received a $17.50 per share reduction to the exercise price of their share-based awards. We refer to this distribution as the February 2010 distribution.

On March 10, 2010, we issued $1,400,000,000 aggregate principal amount of 71/4% senior secured notes, which mature on September 15, 2020. These 71/4% senior secured notes are among the notes subject to the exchange offers. The terms of these notes are described in Description of the March 2010 Notes.

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

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Ownership and Corporate Structure

At December 31, 2009, approximately 97.1% of our outstanding shares of capital stock was held indirectly by the Investors, and the remaining approximately 2.9% was held directly by the Management Participants and employees. Our corporate structure was achieved through a series of equity contributions which occurred in connection with the Merger. The indebtedness figures in the diagram below are as of December 31, 2009, except that we also set forth the indebtedness incurred under our existing senior secured credit facilities in connection with the February 2010 distribution, the March 2010 offering of the 71/4% senior secured notes due 2020 and the use of proceeds therefrom.

(1) In connection with the Recapitalization, approximately $3.776 billion of cash equity was invested by investment funds associated with or designated by the Sponsors and their respective assignees and approximately $950 million was invested by the Frist Entities and their respective assignees, of which $885 million was in the form of a rollover of the Frist Entities equity interests in HCA and $65 million was a cash equity investment. As of December 31, 2009, investment funds associated with each of the Sponsors indirectly owned 24.7% of our company, affiliates of Citigroup and Bank of America Corporation (who are the Sponsor Assignees) indirectly owned 3.2% and 1.0% of our company, respectively, and the Frist Entities and their assignees indirectly owned 18.8% of our company. Because it indirectly owns MLGPE, one of the Sponsors, Bank of America Corporation, through its affiliates, is an indirect beneficial owner of a total of approximately 25.7% of our common stock.

(2) Represents $125 million invested by the Management Participants in the form of a rollover of their previously existing equity interests in HCA to equity interests in HCA following the Merger and through cash investments. Additionally, on January 30, 2007, we completed an offering of 781,960 shares of our common stock to approximately 570 of our employees for an aggregate purchase price of $40 million. The original investment amounts have been reduced by $18 million for stock option exercise settlements and shares repurchased through December 31, 2009. Our common stock is registered pursuant to Section 12(g) of the Exchange Act, and as of December 31, 2009, there were 629 holders of record.

(3) In connection with the Recapitalization, we entered into (i) a $2.000 billion asset-based revolving credit facility with an original six-year maturity (the asset-based revolving credit facility) ($715 million outstanding at December 31, 2009, and an additional approximately $1.050 billion drawn in connection with the February 2010 distribution); (ii) a $2.000 billion senior secured revolving credit facility with an original six-year maturity (the senior secured revolving credit facility) (none outstanding at December 31, 2009, without giving effect to outstanding letters of credit, but approximately $600 million of which was

drawn in connection with the February 2010 distribution); (iii) a $2.750 billion senior secured term loan A facility with an original six-year maturity ($1.908 billion outstanding at December 31, 2009, and approximately $1.618 billion outstanding after giving effect to the use of the estimated net proceeds of the outstanding September 2020 notes); (iv) an $8.800 billion senior secured term loan B facility with an original seven-year maturity ($6.515 billion outstanding at December 31, 2009, and approximately $5.528 billion outstanding after giving effect to the use of the estimated net proceeds of the outstanding September 2020 notes); and (v) a 1.000 billion (394 million, or $564 million-equivalent, outstanding at December 31, 2009, and approximately 335 million, or $479 million-equivalent, outstanding after giving effect to the use of the estimated net proceeds of the outstanding September 2020 notes) senior secured European term loan facility with an original seven-year maturity. 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.

(4) Consists of (i) $1.500 billion aggregate principal amount of 81/2% first lien notes due 2019 issued in April 2009 (the outstanding 2019 notes); (ii) $1.250 billion aggregate principal amount of 77/8% first lien notes due 2020 issued in August 2009 (the outstanding February 2020 notes); (iii) $1.400 billion aggregate principal amount of 71/4% first lien notes due 2020 issued in March 2010 (the outstanding September 2020 notes and, together with the outstanding 2019 notes and the outstanding February 2020 notes, the first lien notes) and (iv) $81 million of unamortized debt discounts that reduce the aggregate principal amounts of the indebtedness.

(5) In connection with the Recapitalization, we issued $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 $1.500 billion of 95/8%/103/8% second lien toggle notes (which allow us, at our option, to pay interest in-kind during the first five years at the higher interest rate of 103/8%) due 2016. During 2009, we paid interest of $78 million in-kind increasing the principal balance of the second lien toggle notes to $1.578 billion. In February 2009, we issued $310 million aggregate principal amount of 97/8% notes due 2017 (the 2009 second lien notes). The 2009 second lien notes include a $10 million unamortized debt discount that reduces the existing indebtedness. We refer to the senior secured notes issued in connection with the Recapitalization as the 2006 second lien notes and, collectively with the 2009 second lien notes, as the second lien notes.

(6) Consists of (i) an aggregate principal amount of $367 million medium-term notes with maturities ranging from 2010 to 2025 and a weighted average interest rate of 8.42%; (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 $5.407 billion senior notes with maturities ranging from 2010 to 2033 and a weighted average interest rate of 6.79%; (iv) £121 million ($196 million-equivalent at December 31, 2009) aggregate principal amount of 8.75% senior notes due 2010; (v) $362 million of secured debt, which represents capital leases and other secured debt with a weighted average interest rate of 6.84%; and (vi) $10 million of unamortized debt discounts that reduce the existing indebtedness. For more information regarding our unsecured and other indebtedness, see Description of Other Indebtedness.

(7) The cash flow credit facility and the first lien notes are secured by first-priority liens, and the second lien notes and related guarantees are secured by second-priority liens, on substantially all the capital stock of Healthtrust, Inc. The Hospital Company and the first-tier subsidiaries of the subsidiary guarantors (but limited to 65% of the voting stock of any such first-tier subsidiary that is a foreign subsidiary), subject to certain exceptions.

(8) Includes subsidiaries which are designated as restricted subsidiaries under our indenture dated as of December 16, 1993, certain of their wholly-owned subsidiaries formed in connection with the asset-based revolving credit facility and certain excluded subsidiaries (non-material subsidiaries).

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The Sponsors

Bain Capital Partners

Bain Capital is one of the world s leading private investment firms, with over 20 years of experience in managed buyouts. Headquartered in Boston, Bain Capital has offices in New York, London, Munich, Hong Kong, Shanghai and Tokyo. Bain Capital has a proven track record of enhancing companies financial strength and strategic positions through long-term initiatives and has demonstrated success in the health care sector.

Kohlberg Kravis Roberts & Co.

Founded in 1976 and led by Henry Kravis and George Roberts, KKR is a leading global alternative asset manager with $52.2 billion in assets under management, over 600 people and 13 offices around the world as of December 31, 2009. KKR manages assets through a variety of investment funds and accounts covering multiple asset classes. KKR seeks to create value by bringing operational expertise to its portfolio companies and through active oversight and monitoring of its investments. KKR complements its investment expertise and strengthens interactions with investors through its client relationships and capital markets platforms. KKR is publicly traded through KKR & Co. (Guernsey) L.P. (Euronext Amsterdam: KKR).

Merrill Lynch Global Private Equity

MLGPE is part of Bank of America Corporation s private equity business. MLGPE was previously the private equity arm of Merrill Lynch & Co., Inc., which is a wholly-owned subsidiary of Bank of America Corporation. Bank of America Corporation is one of the world s largest financial institutions, serving individual consumers, small and middle market businesses and large corporations with a full range of banking, investing, asset management and other financial and risk-management products and services.

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The Exchange Offers

On February 19, 2009, April 22, 2009, August 11, 2009 and March 10, 2010, respectively, HCA Inc. issued in private offerings $310,000,000 aggregate principal amount of 97/8% Senior Secured Notes due 2017 (the outstanding 2017 notes), $1,500,000,000 aggregate principal amount of 81/2% Senior Secured Notes due 2019 (the outstanding 2019 notes), $1,250,000,000 aggregate principal amount of 77/8% Senior Secured Notes due 2020 (the outstanding February 2020 notes) and $1,400,000,000 aggregate principal amount of 71/4% Senior Secured Notes due 2020 (the outstanding September 2020 notes and, together with the outstanding 2017 notes, the outstanding 2019 notes and the outstanding February 2020 notes, the outstanding notes). The term exchange 2017 notes refers to the 97/8% Senior Secured Notes due 2017, the term exchange 2019 notes refers to the 81/2% Senior Secured Notes due 2019, the term exchange February 2020 notes refers to the 77/8% Senior Secured Notes due 2020, and the term exchange September 2020 notes refers to the 71/4% Senior Secured Notes due 2020, each as registered under the Securities Act of 1933, as amended (the Securities Act), and all of which collectively are referred to as the exchange notes. The term notes collectively refers to the outstanding notes and the exchange notes.

We also refer to the outstanding 2019 notes, the outstanding February 2020 notes and the outstanding September 2020 notes collectively as the outstanding first lien notes and to the exchange 2019 notes, the exchange February 2020 notes and the exchange September 2020 notes as the exchange first lien notes.

General	In connection with the private offering, HCA Inc. and the guarantors of the outstanding notes entered into a registration rights agreement with the initial purchasers pursuant to which they agreed, among other things, to deliver this prospectus to you and to complete the exchange offers within 450 days after the date of original issuance of the outstanding notes. You are entitled to exchange in the exchange offers your outstanding notes for exchange notes which are identical in all material respects to the outstanding notes except: the exchange notes have been registered under the Securities Act; the exchange notes are not entitled to any registration rights which are applicable to the outstanding notes under the registration rights agreement; and the liquidated damages provisions of the registration rights agreement are not applicable.
The Exchange Offers	HCA Inc. is offering to exchange: $310,000,000 aggregate principal amount of 97/8% Senior Secured Notes due 2017 which have been registered under the Securities Act for any and all of its existing 97/8% Senior Secured Notes due 2017; $1,500,000,000 aggregate principal amount of 81/2% Senior Secured Notes due 2019 which have been registered under the Securities Act for any and all of its existing 81/2% Senior Secured Notes due 2019;

$1,250,000,000 aggregate principal amount of 77/8% Senior Secured Notes due 2020 which have been registered under the Securities Act for any and all of its existing 77/8% Senior Secured Notes due 2020; and

$1,400,000,000 aggregate principal amount of 71/4% Senior Secured Notes due 2020 which have been registered under the

	Securities Act for any and all of its existing 71/4% Senior Secured Notes due 2020. You may only exchange outstanding notes in minimum denominations of $2,000 and integral multiples of $1,000 in excess of $2,000.
Resale	Based on an interpretation by the staff of the Securities and Exchange Commission (the SEC) set forth in no-action letters issued to third parties, we believe that the exchange notes issued pursuant to the exchange offers in exchange for the outstanding notes may be offered for resale, resold and otherwise transferred by you (unless you are our affiliate within the meaning of Rule 405 under the Securities Act) without compliance with the registration and prospectus delivery provisions of the Securities Act, provided that: you are acquiring the exchange notes in the ordinary course of your business; and you have not engaged in, do not intend to engage in, and have no arrangement or understanding with any person to participate in, a distribution of the exchange notes. If you are a broker-dealer and receive exchange notes for your own account in exchange for outstanding notes that you acquired as a result of market-making activities or other trading activities, you must acknowledge that you will deliver this prospectus in connection with any resale of the exchange notes. See Plan of Distribution. Any holder of outstanding notes who: is our affiliate; does not acquire exchange notes in the ordinary course of its business; or tenders its outstanding notes in the exchange offers with the intention to participate, or for the purpose of participating, in a distribution of exchange notes cannot rely on the position of the staff of the SEC enunciated in *Morgan Stanley & Co. Incorporated* (available June 5, 1991) and *Exxon Capital Holdings Corporation* (available May 13, 1988), as interpreted in *Shearman & Sterling* (available July 2, 1993), or similar no-action letters and, in the absence of an exemption therefrom, must comply with the registration and prospectus delivery requirements of the Securities Act in connection with any resale of the exchange notes.
Expiration Date	The exchange offers will expire at 11:59 p.m., New York City time, on June 2, 2010, unless extended by HCA Inc. HCA Inc. currently does not intend to extend the expiration date.

Withdrawal	You may withdraw the tender of your outstanding notes at any time prior to the expiration of the exchange offers. HCA Inc. will return to you any of your outstanding notes that are not accepted for any reason for exchange, without expense to you, promptly after the expiration or termination of the exchange offers.

Conditions to the Exchange Offers	Each exchange offer is subject to customary conditions, which HCA Inc. may waive. See The Exchange Offers Conditions to the Exchange Offers.
Procedures for Tendering Outstanding Notes	If you wish to participate in any of the exchange offers, you must complete, sign and date the applicable accompanying letter of transmittal, or a facsimile of such letter of transmittal, according to the instructions contained in this prospectus and the letter of transmittal. You must then mail or otherwise deliver the letter of transmittal, or a facsimile of such letter of transmittal, together with your outstanding notes and any other required documents, to the exchange agent at the address set forth on the cover page of the letter of transmittal. If you hold outstanding notes through The Depository Trust Company (DTC) and wish to participate in the exchange offers, you must comply with the Automated Tender Offer Program procedures of DTC by which you will agree to be bound by the letter of transmittal. By signing, or agreeing to be bound by, the letter of transmittal, you will represent to us that, among other things: you are not our affiliate within the meaning of Rule 405 under the Securities Act; you do not have an arrangement or understanding with any person or entity to participate in the distribution of the exchange notes; you are acquiring the exchange notes in the ordinary course of your business; and if you are a broker-dealer that will receive exchange notes for your own account in exchange for outstanding notes that were acquired as a result of market-making activities, you will deliver a prospectus, as required by law, in connection with any resale of such exchange notes.
Special Procedures for Beneficial Owners	If you are a beneficial owner of outstanding notes that are registered in the name of a broker, dealer, commercial bank, trust company or other nominee, and you wish to tender those outstanding notes in the exchange offer, you should contact the registered holder promptly and instruct the registered holder to tender those outstanding notes on your behalf. If you wish to tender on your own behalf, you must, prior to completing and executing the letter of transmittal and delivering your outstanding notes, either make appropriate arrangements to register ownership of the outstanding notes in your name or obtain a properly completed bond power from the registered holder. The transfer of registered ownership may take considerable time and may not be able to be completed prior to the expiration date.
Guaranteed Delivery Procedures	If you wish to tender your outstanding notes and your outstanding notes are not immediately available, or you cannot deliver your outstanding

notes, the letter of transmittal or any other required documents, or you cannot comply with the procedures under DTC s

	Automated Tender Offer Program for transfer of book-entry interests prior to the expiration date, you must tender your outstanding notes according to the guaranteed delivery procedures set forth in this prospectus under The Exchange Offers Guaranteed Delivery Procedures.
Effect on Holders of Outstanding Notes	As a result of the making of, and upon acceptance for exchange of all validly tendered outstanding notes pursuant to the terms of the exchange offers, HCA Inc. and the guarantors of the notes will have fulfilled a covenant under the registration rights agreement. Accordingly, there will be no increase in the applicable interest rate on the outstanding notes under the circumstances described in the registration rights agreement. If you do not tender your outstanding notes in the exchange offer, you will continue to be entitled to all the rights and limitations applicable to the outstanding notes as set forth in the indenture, except HCA Inc. and the guarantors of the notes will not have any further obligation to you to provide for the exchange and registration of untendered outstanding notes under the registration rights agreement. To the extent that outstanding notes are tendered and accepted in the exchange offers, the trading market for outstanding notes that are not so tendered and accepted could be adversely affected.
Consequences of Failure to Exchange	All untendered outstanding notes will continue to be subject to the restrictions on transfer set forth in the outstanding notes and in the indenture. In general, the outstanding notes may not be offered or sold, unless registered under the Securities Act, except pursuant to an exemption from, or in a transaction not subject to, the Securities Act and applicable state securities laws. Other than in connection with the exchange offers, HCA Inc. and the guarantors of the notes do not currently anticipate that they will register the outstanding notes under the Securities Act.
Certain United States Federal Income Tax Consequences	The exchange of outstanding notes in the exchange offers will not be a taxable event for United States federal income tax purposes. See Certain United States Federal Tax Consequences.
Regulatory Approvals	Other than compliance with the Securities Act and qualification of the indentures governing the notes under the Trust Indenture Act, there are no federal or state regulatory requirements that must be complied with or approvals that must be obtained in connection with the exchange offers.
Use of Proceeds	We will not receive any cash proceeds from the issuance of the exchange notes in the exchange offers. See Use of Proceeds.
Exchange Agent	The Bank of New York Mellon is the exchange agent for the exchange offers. The addresses and telephone numbers of the exchange agent are set forth in the section captioned The Exchange Offers Exchange Agent.

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The Exchange Notes

The summary below describes the principal terms of the exchange notes. Certain of the terms and conditions described below are subject to important limitations and exceptions. The Description of the February 2009 Notes, Description of the April 2009 Notes, Description of the August 2009 Notes and Description of the March 2010 Notes sections of this prospectus contain more detailed descriptions of the terms and conditions of the outstanding notes and exchange notes. The exchange notes will have terms identical in all material respects to the outstanding notes, except that the exchange notes will not contain terms with respect to transfer restrictions, registration rights and additional interest for failure to observe certain obligations in the registration rights agreement.

Issuer	HCA Inc.
Securities Offered	$310,000,000 aggregate principal amount of 97/8% senior secured notes due 2017. $1,500,000,000 aggregate principal amount of 81/2% senior secured notes due 2019. $1,250,000,000 aggregate principal amount of 77/8% senior secured notes due 2020. $1,400,000,000 aggregate principal amount of 71/4% senior secured notes due 2020.
Maturity Date	The exchange 2017 notes will mature on February 15, 2017. The exchange 2019 notes will mature on April 15, 2019. The exchange February 2020 notes will mature on February 15, 2020. The exchange September 2020 notes will mature on September 15, 2020.
Interest Rate	Interest on the exchange 2017 notes will be payable in cash and will accrue at a rate of 97/8% per annum. Interest on the exchange 2019 notes will be payable in cash and will accrue at a rate of 81/2% per annum. Interest on the exchange February 2020 notes will be payable in cash and will accrue at a rate of 77/8% per annum. Interest on the exchange September 2020 notes will be payable in cash and will accrue at a rate of 71/4% per annum.
Interest Payment Dates	We will pay interest on the exchange 2017 notes and the exchange February 2020 notes on February 15 and August 15. Interest began to accrue from the issue dates of the notes.

	We will pay interest on the exchange 2019 notes on April 15 and October 15. Interest began to accrue from the issue date of the notes.
	We will pay interest on the exchange September 2020 notes on March 15 and September 15. Interest began to accrue from the issue date of the notes.
Ranking of the Exchange First Lien Notes	Each series of exchange first lien notes will be our senior secured obligations and will:

rank senior in right of payment to any future subordinated indebtedness;

rank equally in right of payment with all of our existing and future senior indebtedness;

be effectively senior in right of payment to indebtedness under our existing second lien notes (including the exchange 2017 notes) to the extent of the collateral securing such indebtedness;

be effectively equal in right of payment with indebtedness under our cash flow credit facility and the other exchange first lien notes to the extent of the collateral (other than certain European collateral securing our senior secured European term loan facility) securing such indebtedness;

be effectively subordinated in right of payment to all indebtedness under our asset-based revolving credit facility to the extent of the shared collateral securing such indebtedness; and

be effectively subordinated in right of payment to all existing and future indebtedness and other liabilities of our non-guarantor subsidiaries (other than indebtedness and liabilities owed to us or one of our guarantor subsidiaries).

As of December 31, 2009, on an adjusted basis after giving effect to the February 2010 distribution, the offering of the outstanding September 2020 notes and the use of proceeds therefrom:

the outstanding first lien notes and related guarantees would have been effectively senior in right of payment to $6.088 billion of second lien notes (including the outstanding 2017 notes), effectively equal in right of payment to approximately $7.746 billion of senior secured indebtedness under our cash flow credit facility (other than our senior secured European term loan facility), the other outstanding first lien notes and approximately $170 million of other secured debt, and effectively junior in right in payment to $1.765 billion of indebtedness under our asset-based revolving credit facility, in each case to the extent of the collateral securing such indebtedness;

the outstanding first lien notes and related guarantees would have been effectively subordinated in right of payment to approximately $479 million equivalent outstanding under the senior secured European term loan facility and $192 million of other secured debt of our nonguarantor subsidiaries, which primarily represents capital leases; and

we would have had an additional $1.301 billion of unutilized capacity under our senior secured revolving credit facility and $230 million of unutilized capacity under our asset-based revolving credit facility, subject to borrowing base limitations.

Ranking of the Exchange 2017 Notes	The exchange 2017 notes will be our senior secured obligations and will:
	rank senior in right of payment to any future subordinated indebtedness;

rank equally in right of payment with all of our existing and future senior indebtedness;

be effectively subordinated in right of payment to indebtedness under our asset-based revolving credit facility to the extent of the collateral securing such indebtedness on a first-priority basis, and to indebtedness under our other senior secured credit facilities and to the exchange first lien notes to the extent of the collateral securing such indebtedness on a first- and second-priority basis; and

be effectively subordinated in right of payment to all existing and future indebtedness and other liabilities of our non-guarantor subsidiaries (other than indebtedness and liabilities owed to us or one of our guarantor subsidiaries).

As of December 31, 2009, on an adjusted basis after giving effect to the February 2010 distribution, the outstanding September 2020 notes offering and the use of proceeds therefrom:

the outstanding 2017 notes and related guarantees would have been effectively subordinated in right of payment to approximately $1.765 billion of indebtedness under our asset-based revolving credit facility, approximately $7.746 billion of senior secured indebtedness under our cash flow credit facility (other than our senior secured European term loan facility), approximately $4.150 billion aggregate principal amount of outstanding first lien notes and approximately $170 million of other secured debt, in each case to the extent of the collateral securing such indebtedness;

the outstanding 2017 notes and related guarantees would also have been effectively subordinated in right of payment to approximately $479 million equivalent outstanding under the senior secured European term loan facility and $192 million of other secured debt of our nonguarantor subsidiaries, which primarily represents capital leases;

the outstanding 2017 notes and related guarantees would have ranked equal in right of payment to $5.778 billion of second lien notes issued in 2006 at the time of the Merger; and

we would have had an additional $1.301 billion of unutilized capacity under our senior secured revolving credit facility and $230 million of unutilized capacity under our asset-based revolving credit facility, subject to borrowing base limitations.

Guarantees of the Exchange First Lien Notes

The exchange notes will be fully and unconditionally guaranteed on a senior secured basis by each of our existing and future direct or indirect wholly-owned domestic subsidiaries that guarantees our obligations under our senior secured credit facilities (except for certain special purpose

subsidiaries that have only guaranteed and pledged their assets under our asset-based revolving credit facility). The subsidiary guarantee of each series of exchange first lien notes will:

rank senior in right of payment to all existing and future subordinated indebtedness of the guarantor subsidiary;

rank equally in right of payment with all existing and future senior indebtedness of the guarantor subsidiary;

be effectively senior in right of payment to the guarantees of our second lien notes (including the exchange 2017 notes) to the extent of the guarantor subsidiary s collateral securing such indebtedness;

be effectively equal in right of payment with the guarantees of our cash flow credit facility and the other exchange first lien notes to the extent of the guarantor subsidiary s collateral (other than certain European collateral securing our senior secured European term loan facility) securing such indebtedness;

be effectively subordinated in right of payment to the guarantees of our asset-based revolving credit facility to the extent of the guarantor subsidiary s collateral securing such indebtedness; and

be effectively subordinated in right of payment to all existing and future indebtedness and other liabilities of any subsidiary of a guarantor that is not also a guarantor of the notes.

For the year ended December 31, 2009, our non-guarantor subsidiaries accounted for approximately $12.468 billion, or 41.5%, of our total revenues. As of December 31, 2009, our non-guarantor subsidiaries accounted for approximately $9.672 billion, or 40.1%, of our total assets and approximately $6.750 billion, or 21.1%, of our total liabilities. See Note 16 to our consolidated financial statements included in this prospectus.

Guarantees of the Exchange 2017 Notes

The exchange 2017 notes will be fully and unconditionally guaranteed on a senior secured basis by each of our existing and future direct or indirect wholly-owned domestic subsidiaries that guarantees our obligations under our senior secured credit facilities (except for certain special purpose subsidiaries that have only guaranteed and pledged their assets under our asset-based revolving credit facility). Each subsidiary guarantee will:

rank senior in right of payment to all existing and future subordinated indebtedness of the guarantor subsidiary;

rank equally in right of payment with all existing and future senior indebtedness of the guarantor subsidiary;

be effectively subordinated in right of payment to indebtedness under our asset-based revolving credit facility to the extent of the collateral securing such indebtedness on a first-priority basis, and to indebtedness under our

other senior secured credit facilities and to the exchange first lien notes to the extent of the collateral securing such indebtedness on a first- and second-priority basis; and

be effectively subordinated in right of payment to all existing and future indebtedness and other liabilities of any subsidiary of a guarantor that is not also a guarantor of the notes.

Security for the Exchange First Lien Notes

Each series of exchange first lien notes and guarantees will be secured by first-priority liens, subject to permitted liens, on certain of the assets of HCA Inc. and the subsidiary guarantors that secure our cash flow credit facility and the other exchange first lien notes on a *pari passu* basis, including:

substantially all the capital stock of any wholly owned first-tier subsidiary of HCA Inc. or of any subsidiary guarantor of the notes (but limited to 65% of the voting stock of any such wholly owned first-tier subsidiary that is a foreign subsidiary); and

substantially all tangible and intangible assets of our company and each subsidiary guarantor, other than (1) other properties that do not secure our senior secured credit facilities, (2) deposit accounts, other bank or securities accounts and cash, (3) leaseholds and motor vehicles, (4) certain European collateral and (5) certain receivables collateral that only secures our asset-based revolving credit facility, in each case subject to exceptions, and except that the lien on properties defined as principal properties under our existing indenture dated as of December 16, 1993, so long as such indenture remains in effect, will be limited to securing a portion of the indebtedness under our cash flow credit facility and the first lien notes that, in the aggregate, does not exceed 10% of our consolidated net tangible assets; provided that, with respect to the portion of the collateral comprised of real property for the exchange September 2020 notes, we have up to 60 days from the issue date of the outstanding September 2020 notes to complete those actions required to perfect the first-priority lien on such collateral.

See Risk Factors Risks Related to the Notes There are circumstances other than repayment or discharge of the notes under which the collateral securing the notes and guarantees will be released automatically, without your consent or the consent of the trustee for an explanation of one of the important exceptions to the obligation to pledge the capital stock of first-tier subsidiaries of any subsidiary guarantors.

The exchange first lien notes and guarantees of the exchange first lien notes also will be secured by second-priority liens, subject to permitted liens, on certain receivables of HCA Inc. and the subsidiary guarantors that secure our asset-based revolving credit facility on a first-priority basis.

See Description of the April 2009 Notes Security, Description of the August 2009 Notes Security and Description of the March 2010 Notes Security.

Security for the Exchange 2017 Notes	The exchange 2017 notes and guarantees of the exchange 2017 notes will be secured by second-priority liens, subject to permitted liens, on certain of the assets of HCA Inc. and the subsidiary guarantors that secure our senior secured credit facilities and our first

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	lien notes on a first-priority basis. The assets that will secure the exchange 2017 notes will include:
	substantially all the capital stock of any wholly owned first-tier subsidiary of HCA Inc. or of any subsidiary guarantor of the notes (but limited to 65% of the voting stock of any such wholly owned first-tier subsidiary that is a foreign subsidiary), subject to certain exceptions; and
	substantially all tangible and intangible assets of our company and each subsidiary guarantor, other than (1) properties defined as principal properties under our indenture dated as of December 16, 1993, so long as any indebtedness secured by those properties on a first-priority basis remains outstanding, (2) other properties that will not secure our senior secured facilities, (3) deposit accounts, other bank or securities accounts and cash, (4) leaseholds and motor vehicles, (5) certain European collateral and (6) certain receivables collateral that only secures our asset-based revolving credit facility, in each case subject to certain exceptions.
	See Risk Factors Risks Related to the Notes There are circumstances other than repayment or discharge of the notes under which the collateral securing the notes and guarantees will be released automatically, without your consent or the consent of the trustee for an explanation of one of the important exceptions to the obligation to pledge the capital stock of first-tier subsidiaries of any subsidiary guarantors.
	The exchange 2017 notes and guarantees of the exchange 2017 notes also will be secured by third-priority liens, subject to permitted liens, on the accounts receivable and certain related assets of HCA Inc. and certain of the subsidiary guarantors, and the proceeds thereof, to the extent permitted by law and contract, which assets will secure our asset-based revolving credit facility on a first-priority basis and our other senior secured credit facilities and our first lien notes on a second-priority basis.
	See Description of the February 2009 Notes Security.
Optional Redemption	We may redeem the exchange notes, in whole or in part, at any time prior to February 15, 2013 with respect to the exchange 2017 notes, April 15, 2014 with respect to the exchange 2019 notes, August 15, 2014 with respect to the exchange February 2020 notes and March 15, 2015 with respect to the exchange September 2020 notes, plus accrued and unpaid interest to the redemption date and a make-whole premium, as described under Description of the February 2009 Notes Optional Redemption, Description of the April 2009 Notes Optional Redemption, Description of the August 2009 Notes Optional Redemption and Description of the March 2010 Notes Optional Redemption.
	We may redeem the exchange notes, in whole or in part, on or after February 15, 2013 with respect to the exchange 2017 notes, April 15,

2014 with respect to the exchange 2019 notes, August 15, 2014 with respect to the exchange February 2020 notes and March 15, 2015 with respect to the exchange September 2020 notes, at the prices set forth under Description of the February

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	2009 Notes Optional Redemption, Description of the April 2009 Notes Optional Redemption, Description of the August 2009 Notes Optional Redemption and Description of the March 2010 Notes Optional Redemption.
	Additionally, from time to time before February 15, 2012 with respect to the exchange 2017 notes, April 15, 2012 with respect to the exchange 2019 notes, August 15, 2012 with respect to the exchange February 2020 notes and March 15, 2013 with respect to the exchange September 2020 notes, we may choose to redeem up to 35% of the principal amount of each of the exchange notes at a redemption price equal to 109.875% of the face amount thereof, with respect to the exchange 2017 notes, 108.500% of the face amount thereof, with respect to the exchange 2019 notes, 107.875% of the face amount thereof, with respect to the exchange February 2020 notes and 107.250% of the face amount thereof, with respect to the exchange September 2020 notes, in each case with the net cash proceeds that we raise in one or more equity offerings, so long as at least 50% of the aggregate principal amount of each of the exchange notes remains outstanding afterwards.
Change of Control Offer	Upon the occurrence of a change of control, you will have the right, as holders of the exchange notes, to require us to repurchase some or all of your exchange notes at 101% of their face amount, plus accrued and unpaid interest to the repurchase date.
	We may not be able to pay you the required price for exchange notes you present to us at the time of a change of control, because:
	we may not have enough funds at that time; or
	the terms of our indebtedness under our senior secured credit facilities may prevent us from making such payment.
	Your right to require us to repurchase the exchange notes upon the occurrence of a change of control will cease to apply to a series of exchange notes at all times after such exchange notes have investment grade ratings from both Moody s Investors Service, Inc. and Standard & Poor s.
Certain Covenants	The indenture governing the exchange notes contains covenants limiting our ability and the ability of our restricted subsidiaries to:
	incur additional debt or issue certain preferred shares;
	pay dividends on or make other distributions in respect of our capital stock or make other restricted payments;
	make certain investments;

- sell certain assets;
- create liens on certain assets to secure debt;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates; and
- designate our subsidiaries as unrestricted subsidiaries.

	These covenants are subject to a number of important limitations and exceptions. See Description of the February 2009 Notes, Description of the April 2009 Notes, Description of the August 2009 Notes and Description of the March 2010 Notes. Many of these covenants will cease to apply to a series of exchange notes at all times after such exchange notes have investment grade ratings from both Moody s Investors Service, Inc. and Standard & Poor s.
No Prior Market	The exchange notes will be freely transferable but will be new securities for which there will not initially be a market. Accordingly, we cannot assure you whether a market for the exchange notes will develop or as to the liquidity of any such market that may develop. The initial purchasers in the private offering of the outstanding notes have informed us that they currently intend to make a market in the exchange notes; however, they are not obligated to do so, and they may discontinue any such market-making activities at any time without notice.

Ratio of Earnings to Fixed Charges

The following table sets forth the ratio of earnings to fixed charges of HCA Inc. for the periods indicated. The ratio of earnings to fixed charges for the years ended December 31, 2009, 2008 and 2007 have been derived from our audited consolidated financial statements appearing elsewhere in this prospectus. The ratio of earnings to fixed charges for the years ended December 31, 2006 and 2005 have been derived from our audited consolidated financial statements that are not included in this prospectus.

	Years Ended December 31,				
	2009	**2008**	**2007**	**2006**	**2005**
	(Dollars in millions)				
Ratio of earnings to fixed charges(a)	1.91x	1.52x	1.57x	2.61x	3.85x

(a) For purposes of calculating the ratio of earnings to fixed charges, earnings consist of net income attributable to noncontrolling interests and income taxes plus fixed charges, exclusive of capitalized interest. Fixed charges include cash and noncash interest expense, whether expensed or capitalized, amortization of debt issuance cost, and the portion of rent expense representative of the interest factor.

Risk Factors

You should consider carefully all of the information set forth in this prospectus prior to exchanging your outstanding notes. In particular, we urge you to consider carefully the factors set forth under the heading Risk Factors.

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RISK FACTORS

You should carefully consider the risk factors set forth below as well as the other information contained in this prospectus before deciding to tender your outstanding notes in the exchange offers. Any of the following risks could materially and adversely affect our business, financial condition or results of operations; however, the following risks are not the only risks facing us. Additional risks and uncertainties not currently known to us or those we currently view to be immaterial also may materially and adversely affect our business, financial condition or results of operations. In such a case, the trading price of the exchange notes could decline or we may not be able to make payments of interest and principal on the exchange notes, and you may lose all or part of your original investment.

Risks Related to the Exchange Offers

There may be adverse consequences if you do not exchange your outstanding notes.

If you do not exchange your outstanding notes for exchange notes in the exchange offer, you will continue to be subject to restrictions on transfer of your outstanding notes as set forth in the offering memorandum distributed in connection with the private offering of the outstanding notes. In general, the outstanding notes may not be offered or sold unless they are registered or exempt from registration under the Securities Act and applicable state securities laws. Except as required by the registration rights agreement, we do not intend to register resales of the outstanding notes under the Securities Act. You should refer to Summary The Exchange Offers and The Exchange Offers for information about how to tender your outstanding notes.

The tender of outstanding notes under the exchange offers will reduce the outstanding amount of each series of the outstanding notes, which may have an adverse effect upon, and increase the volatility of, the market prices of the outstanding notes due to a reduction in liquidity.

Your ability to transfer the exchange notes may be limited by the absence of an active trading market, and there is no assurance that any active trading market will develop for the exchange notes.

We are offering the exchange notes to the holders of the outstanding notes. The outstanding notes were offered and sold in 2009 and 2010 to institutional investors.

We do not intend to apply for a listing of the exchange notes on a securities exchange or on any automated dealer quotation system. There is currently no established market for the exchange notes, and we cannot assure you as to the liquidity of markets that may develop for the exchange notes, your ability to sell the exchange notes or the price at which you would be able to sell the exchange notes. If such markets were to exist, the exchange notes could trade at prices that may be lower than their principal amount or purchase price depending on many factors, including prevailing interest rates, the market for similar notes, our financial and operating performance and other factors. The initial purchasers in the private offering of the outstanding notes have advised us that they currently intend to make a market with respect to the exchange notes. However, these initial purchasers are not obligated to do so, and any market making with respect to the exchange notes may be discontinued at any time without notice. In addition, such market making activity may be limited during the pendency of the exchange offers or the effectiveness of a shelf registration statement in lieu thereof. Therefore, we cannot assure you that an active market for the exchange notes will develop or, if developed, that it will continue. Historically, the market for non-investment grade debt has been subject to disruptions that have caused substantial volatility in the prices of securities similar to the notes. The market, if any, for the exchange notes may experience similar disruptions and any such disruptions may adversely affect the prices at which you may sell your exchange notes.

Certain persons who participate in the exchange offers must deliver a prospectus in connection with resales of the exchange notes.

Based on interpretations of the staff of the SEC contained in *Exxon Capital Holdings Corp.*, SEC no-action letter (April 13, 1988), *Morgan Stanley & Co. Inc.*, SEC no-action letter (June 5, 1991) and *Shearman & Sterling*, SEC no-action letter (July 2, 1983), we believe that you may offer for resale, resell or otherwise transfer the exchange notes without compliance with the registration and prospectus delivery

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requirements of the Securities Act. However, in some instances described in this prospectus under Plan of Distribution, certain holders of exchange notes will remain obligated to comply with the registration and prospectus delivery requirements of the Securities Act to transfer the exchange notes. If such a holder transfers any exchange notes without delivering a prospectus meeting the requirements of the Securities Act or without an applicable exemption from registration under the Securities Act, such a holder may incur liability under the Securities Act. We do not and will not assume, or indemnify such a holder against, this liability.

Risks Related to Our Indebtedness

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

We are highly leveraged. As of December 31, 2009, on an as adjusted basis after giving effect to the February 2010 distribution, the offering of the outstanding September 2020 notes and the use of proceeds therefrom, our total indebtedness would have been approximately $27.345 billion. 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 our senior secured credit facilities and the indentures governing our 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.

As of December 31, 2009, on an as adjusted basis after giving effect to the February 2010 distribution, the offering of the outstanding September 2020 notes and the use of proceeds therefrom, our substantial indebtedness would have included $9.990 billion of indebtedness under our senior secured credit facilities maturing in 2012 and 2013, $4.150 billion aggregate principal amount of first lien notes maturing in 2019 and 2020, $6.088 billion of second lien notes maturing in 2014, 2016 and 2017 and $6.856 billion aggregate principal amount of unsecured senior notes and debentures that mature on various dates from 2010 to 2095 (including $5.454 billion maturing through 2016). Because a significant portion of our indebtedness matures in the next few years, we may find it necessary or prudent to refinance that indebtedness with longer-maturity debt at a higher interest rate. In February, April and August of 2009 and in March of 2010, for example, we

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. We used the net proceeds of those offerings to prepay term loans under our 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 debt agreements contain restrictions that limit our flexibility in operating our business.

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

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

Under our asset-based revolving credit facility, when (and for as long as) the combined availability under our asset-based revolving credit facility and our 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 our depository accounts will be transferred on a daily basis into a blocked account with the administrative agent and applied to prepay loans under the asset-based revolving credit facility and to cash collateralize letters of credit issued thereunder.

Under our senior secured credit facilities, we are required to satisfy and maintain specified financial ratios. Our ability to meet those financial ratios can be affected by events beyond our control, and there can be no assurance we will

continue to meet those ratios. A breach of any of these covenants could result in a default under both our cash flow credit facility and our asset-based revolving credit facility. Upon the occurrence of an event of default under our senior secured credit facilities, our lenders could elect to declare all amounts outstanding under our senior secured credit facilities to be immediately due and payable and terminate all commitments to extend further credit. If we were unable to repay those amounts, the lenders under our senior secured credit facilities could proceed against the collateral granted to them to secure such indebtedness. We have pledged a significant portion of our assets as collateral under our senior secured credit facilities, and that collateral (other than certain European collateral securing our senior secured European term loan facility) is also pledged as collateral under our first lien notes. If any of the lenders under our senior

secured credit facilities accelerate the repayment of borrowings, there can be no assurance we will have sufficient assets to repay our senior secured credit facilities and the first lien notes.

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 a 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. In addition, the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (Health Reform Legislation) 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 writeoffs 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. Due to a number of factors, including the recent economic downturn and increase in unemployment, we believe our facilities may experience growth in bad debts, uninsured discounts and charity care. At December 31, 2009, our allowance for doubtful accounts represented approximately 94% of the $5.176 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. The Health Reform Legislation

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 Legislation due to the law s complexity, lack of implementing regulations or interpretive guidance, gradual implementation and possible amendment, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the law.

Health care reform and changes in governmental programs may reduce our revenues.

In March 2010, President Obama signed the Health Reform Legislation into law. The Health Reform Legislation represents significant change across the health care industry. As a result of the law s complexity, lack of implementing regulations or interpretive guidance, gradual implementation and possible amendment, the impact of the Health Reform Legislation is not yet fully known. The primary goal of the Health Reform Legislation is to decrease the number of uninsured individuals by expanding coverage to approximately 32 million additional individuals through a combination of public program expansion and private sector health insurance reforms. The Health Reform Legislation expands eligibility under existing Medicaid programs, imposes financial penalties on individuals who fail to carry insurance coverage and creates affordability credits for those not enrolled in an employer-sponsored health plan. Further, the Health Reform Legislation requires states to establish a health insurance exchange and permits states to create federally funded, non-Medicaid plans for low-income residents not eligible for Medicaid. The Health Reform Legislation establishes a number of health insurance market reforms, including a ban on lifetime limits and pre-existing condition exclusions, new benefit mandates, and increased dependent coverage. Health insurance market reforms that expand insurance coverage should increase revenues from providing care to previously uninsured individuals; however, many of these provisions of the Health Reform Legislation will not become effective until 2014 or later. It is also possible that implementation of these provisions could be delayed or even blocked due to court challenges. In addition, there may be efforts to repeal or amend the Health Reform Legislation.

Further, the Health Reform Legislation contains a number of provisions designed to significantly reduce Medicare and Medicaid program spending, including reductions in Medicare market basket updates and Medicare and Medicaid disproportionate share funding. 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. Reductions to our reimbursement under the Medicare and Medicaid programs by the Health Reform Legislation could adversely affect our business and results of operations, to the extent such reductions are not offset by the expected increases in revenues from providing care to previously uninsured individuals.

Because of the many variables involved, we are unable to predict the net effect on the Company of the reductions in Medicare and Medicaid spending, the expected increases in revenues from providing care to previously uninsured individuals, and numerous other provisions in the law that may affect the Company. We are further unable to foresee how individuals and businesses will respond to the choices afforded them by the Health Reform Legislation. Thus, we cannot predict the full impact of the Health Reform Legislation on the Company at this time.

In addition to the Health Reform Legislation, 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 and Medicaid programs. For example, effective January 1, 2008, CMS significantly revised the payment system used to reimburse ambulatory surgery centers (ASCs) and expanded the number of procedures that Medicare reimburses if performed in an ASC. More Medicare procedures now performed in hospitals, such as ours, may be moved to ASCs, reducing surgical volume in our hospitals. Also, more Medicare procedures now performed in ASCs, such as ours, may be moved to physicians offices. Commercial third-party payers may adopt similar policies.

Further, CMS has recently 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. Realignments in the MS-DRG system could impact the margins we receive for certain services. For federal fiscal year 2010, CMS has provided a 2.1% market basket update for hospitals that submit certain quality patient care indicators and a 0.1% update for hospitals that do not submit this data.

Medicare payments to hospitals in federal fiscal years 2008 and 2009 were reduced to eliminate what CMS estimated to be the effect of coding or classifications changes as a result of hospitals implementing the MS-DRG system. If CMS retrospectively determines the adjustment levels for federal fiscal years 2008 and 2009 were inadequate, CMS may impose additional adjustments in future years. Although CMS has not imposed an adjustment for federal fiscal year 2010, CMS has announced its intent to impose payment adjustments in federal fiscal years 2011 and 2012 because of what CMS has determined to be an inadequate adjustment in federal fiscal year 2008. It is not clear what impact, if any, the market basket reductions required by the Health Reform Legislation will have on CMS s proposal. Additionally, Medicare payments to hospitals are subject to a number of other adjustments, and the actual impact on payments to specific hospitals may vary. In some cases, commercial third-party payers and other payers such as some state Medicaid programs rely on all or portions of the Medicare MS-DRG system to determine payment rates, and adjustments that negatively impact Medicare payments may also negatively impact payments from those payers.

Since most states must operate with balanced budgets and since the Medicaid program is often the state s largest program, states can be expected to adopt or consider adopting legislation designed to reduce their Medicaid expenditures. The current economic downturn has increased the budgetary pressures on most states, and these budgetary pressures have resulted, and likely will continue to result, in decreased spending for Medicaid programs in many states. Further, many states have also adopted, or are considering, legislation designed to reduce coverage, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems. The Health Reform Legislation provides for significant expansions to the Medicaid program, but these changes are not required until 2014. In addition, the Health Reform Legislation will result in increased state legislative and regulatory changes in 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.

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

Current or future health care reform efforts, changes in laws or regulations regarding government health programs, other changes in the administration of government health programs and changes to commercial third-party payers in response to health care reform and changes to government health programs could have a material, adverse effect on our financial position and results of 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 52% and 53% of our patient revenues for 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. 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

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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 Legislation 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, 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 labor 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 revenue 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;
- relationships with physicians and other referral sources;
- 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; 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.

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 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.

CMS published a proposal to collect information from 400 hospitals regarding their ownership, investment and compensation arrangements with physicians. Called the Disclosure of Financial Relationships Report (or DFRR), CMS intends to use this data to monitor compliance with the Stark Law, and CMS may share this information with

other government agencies. Many of these agencies have not previously analyzed this information and have the authority to bring enforcement actions against hospitals filing such reports. The DFRR and its supporting documentation are currently under review by the Office of Management and Budget, and it is unclear when, or if, it will be finalized.

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 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 fee-for-service Medicare program. The Health Reform Legislation expands the RAC program s scope to include Medicaid claims by requiring all states to enter into contracts 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. Throughout 2010, MIC audits will continue to expand. The Health Reform Legislation increases federal funding for the MIC program for federal fiscal year 2011 and later years. In addition to RACs and MICs, several other contractors, including the state Medicaid agencies, have increased their review activities.

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.

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 Legislation eliminates current statutory restrictions on the use of prepayment review by Medicare contractors. 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 recent economic downturn.

The United States economy has weakened significantly. Depressed consumer spending and higher unemployment rates continue to pressure many industries. During economic downturns, governmental entities

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often experience budget deficits as a result of increased costs and lower than expected tax collections. These budget deficits may force 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 Legislation seeks to decrease over time the number of uninsured individuals, provides for the expansion of the Medicaid program and contains a number of insurance market reforms designed to broaden insurance coverage, such as eliminating the use of pre-existing condition exclusions. However, it is difficult to predict the full impact of the Health Reform Legislation due to the law s complexity, lack of implementing regulations or interpretive guidance, gradual implementation and possible amendment.

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 Legislation contains a number of provisions intended to promote value-based purchasing. Beginning in federal fiscal year 2013, hospitals that satisfy certain performance standards will receive increased payments for discharges during the following fiscal year. These payments will be funded by decreases in payments to all hospitals for inpatient services. For discharges occurring during federal fiscal year 2014 and after, the performance standards must assess hospital efficiency, including Medicare spending per beneficiary. In addition, the Health Reform Legislation provides for reduced payments based on a hospital s HAC rates and readmission rates and requires HAC rates and readmission rates to be made public. Currently, Medicare no longer assigns an inpatient hospital discharge to a higher paying MS-DRG if a selected HAC was not present on admission. Effective July 1, 2011, the Health Reform Legislation will likewise prohibit the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat 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 also receive a 1% reduction in Medicare payment rates. For discharges occurring during a fiscal year beginning on or after October 1, 2012, hospitals with excessive readmissions for certain conditions will receive reduced Medicare payments for all inpatient admissions.

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, or cessations in

the availability of systems, all of which could have a material adverse effect on our financial position and results of operations and harm our business reputation.

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, 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. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. Further, beginning in 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 163 hospitals at December 31, 2009, and 73 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities combined revenues represented approximately 51% of our consolidated revenues for the

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

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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.

At December 31, 2009, we were contesting before the Appeals Division of the Internal Revenue Service (IRS) certain claimed deficiencies and adjustments proposed by the IRS in connection with its examination of the 2003 and 2004 federal income tax returns for HCA and eight affiliates that are treated as partnerships for federal income tax purposes (affiliated partnerships). The disputed items include the timing of recognition of certain patient service revenues and our method for calculating the tax allowance for doubtful accounts.

Six taxable periods of HCA and its predecessors ended in 1997 through 2002 and the 2002 taxable year of four affiliated partnerships, for which the primary remaining issue is the computation of the tax allowance for doubtful accounts, are pending before the IRS Examination Division as of December 31, 2009.

The IRS began an audit of the 2005 and 2006 federal income tax returns for HCA and seven affiliated partnerships during 2008. We anticipate the IRS Examination Division will conclude its audit in 2010. During 2009, the seven affiliated partnership audits were resolved with no material impact on our operations or financial position. We anticipate the IRS will begin an audit of the 2007 and 2008 federal income tax returns for HCA during 2010.

Management believes HCA, 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.

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.

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 $1.309 billion and $7 million, respectively, at December 31, 2009. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At December 31, 2009, we had a net unrealized gain of $20 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 December 31, 2009, our wholly-owned insurance subsidiary had invested $396 million ($401 million par value) in municipal, tax-exempt student loan auction rate securities (ARS) that continued to experience market illiquidity since February 2008 when multiple failed auctions occurred due to a severe credit and liquidity crisis in the capital markets. 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 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 net 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.

Since the Recapitalization, the Investors control us and may have conflicts of interest with us in the future.

As of December 31, 2009, the Investors indirectly owned approximately 97.1% of our capital stock due to the Recapitalization. As a result, the Investors have control over our decisions to enter into any significant corporate transaction and have the ability to prevent any transaction that requires the approval of shareholders. For example, the Investors could cause us to make acquisitions that increase the amount of our indebtedness or sell assets.

Additionally, 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. So long as investment funds associated with or designated by the Sponsors continue to indirectly own a significant amount of the outstanding shares of our common stock, even if such amount is less than 50%, the Sponsors will continue to be able to strongly influence or effectively control our decisions.

Risks Related to the Notes

The following risks apply to the outstanding notes and will apply equally to the exchange notes.

The secured indebtedness under our senior secured asset-based revolving credit facility are effectively senior to the first lien notes to the extent of the value of the receivables collateral securing such facility on a first-priority basis.

Our asset-based revolving credit facility has a first-priority lien in the accounts receivable of our company and our domestic subsidiaries, with certain exceptions. Our other senior secured credit facilities and the first lien notes have a second-priority lien in those receivables (except for those of certain special purpose subsidiaries that only guarantee and pledge their assets under our asset-based revolving credit facility). The indentures governing the first lien notes and the second lien notes permit us to incur additional indebtedness secured on a first-priority basis by such assets in the future. The first-priority liens in the collateral securing indebtedness under our asset-based revolving credit facility and any such future indebtedness are higher in priority as to such collateral than the security interests securing the first lien notes and the guarantees. Holders of the indebtedness under our asset-based revolving credit facility and any other indebtedness secured by higher priority liens on such collateral will be entitled to receive proceeds from the realization of value of such collateral to repay such indebtedness in full before the holders of the first lien notes will be entitled to any recovery from such collateral. As a result, holders of the first lien notes will only be entitled to receive proceeds from the realization of value of assets securing our asset-based revolving credit facility on a higher priority basis after all indebtedness and other obligations under our asset-based revolving credit facility and

any other obligations secured by higher priority liens on such assets are repaid in full. The first lien notes are effectively junior in right of payment to indebtedness under our asset-based revolving credit facility and any other indebtedness secured by higher priority liens on such collateral to the extent of the realizable value of such collateral. Even if there were receivables collateral or proceeds left over to pay the exchange first lien notes and the cash flow credit facility after a foreclosure on that collateral and payment of the outstanding amounts under the asset-based revolving credit facility, that collateral would be subject to the first lien intercreditor agreement, and the representative of the lenders under the cash flow credit facility would initially control actions with respect to that collateral. See

Even though the holders of the first lien notes benefit from a first-priority lien on the collateral that secures our cash flow credit facility, the representative of the lenders under the cash flow credit facility will initially control actions with respect to that collateral.

As of December 31, 2009, the first lien notes would have been effectively junior to $715 million of indebtedness outstanding under our asset-based revolving credit facility to the extent of the value of collateral securing such indebtedness, and we borrowed an additional approximately $1.050 billion under our asset-based revolving credit facility in connection with the February 2010 distribution, with which the first lien notes are also effectively junior.

Other secured indebtedness, including our senior secured credit facilities, is effectively senior to the 2009 second lien notes to the extent of the value of the collateral securing such facility on a first- and second-priority basis.

Certain of our senior secured credit facilities are collateralized by a first-priority lien, subject to permitted liens, in, among other things, the capital stock of our company, the capital stock of any material wholly owned first-tier subsidiary of our company or of any U.S. subsidiary guarantor and substantially all of our and the U.S. subsidiary guarantors other tangible and intangible assets, subject to exceptions. In addition, our asset-based revolving credit facility has a first-priority lien in the accounts receivable of our company and certain of our subsidiaries, and our other senior secured credit facilities, other than the European term loan facility, and our first lien notes have a second-priority lien in those receivables. The indentures governing the first lien notes and the second lien notes permit us to incur additional indebtedness secured on a first-priority basis by such assets in the future. The first- and second-priority liens in the collateral securing indebtedness under our senior secured credit facilities and our first lien notes and any such future indebtedness are higher in priority as to such collateral than the security interests securing the 2009 second lien notes and the other second lien notes and the related guarantees.

The 2009 second lien notes and the other second lien notes and the related guarantees are secured, subject to permitted liens, by a second-priority lien or a third-priority lien, as the case may be, in the assets that secure our senior secured credit facilities and first lien notes on a first-priority or second-priority basis, as the case may be. Holders of the indebtedness under our senior secured credit facilities, our first lien notes and any other indebtedness collateralized by a higher-priority lien in such collateral will be entitled to receive proceeds from the realization of value of such collateral to repay such indebtedness in full before the holders of the 2009 second lien notes and the other second lien notes will be entitled to any recovery from such collateral. As a result, holders of the 2009 second lien notes and the other second lien notes will only be entitled to receive proceeds from the realization of value of assets securing our senior secured credit facilities and our first lien notes on a higher-priority basis after all indebtedness and other obligations under our senior secured credit facilities, our first lien notes and any other obligations secured by higher-priority liens on such assets are repaid in full. The 2009 second lien notes and the other second lien notes are effectively junior in right of payment to indebtedness under our senior secured credit facilities, our first lien notes and any other indebtedness collateralized by a higher-priority lien in our assets, to the extent of the realizable value of such collateral. In addition, the indenture governing the 2009 second lien notes permits us to incur additional indebtedness secured by a lien that ranks equally with the 2009 second lien notes and the other second lien notes. Any such indebtedness may further limit the recovery from the realization of the value of such collateral available to satisfy holders of the 2009 second lien notes.

The value of the collateral securing the notes may not be sufficient to satisfy our obligations under the notes.

The fair market value of the collateral is subject to fluctuations based on factors that include, among others, general economic conditions and similar factors. The amount to be received upon a sale of the collateral would be dependent on numerous factors, including, but not limited to, the actual fair market value of the collateral at such time, the timing and the manner of the sale and the availability of buyers. By its nature, portions of the collateral may be illiquid and may have no readily ascertainable market value. In the event of a foreclosure, liquidation, bankruptcy or similar proceeding, the collateral may not be sold in a timely or orderly manner, and the proceeds from any sale or liquidation of this collateral may not be sufficient to pay our obligations under the notes.

To the extent that liens securing obligations under the senior secured credit facilities and the first lien notes, pre-existing liens, liens permitted under the indenture and other rights, including liens on excluded assets, such as those securing purchase money obligations and capital lease obligations granted to other parties (in addition to the holders of any other obligations secured by higher priority liens), encumber any of the collateral securing the notes and the guarantees, those parties have or may exercise rights and remedies with respect to the collateral that could adversely affect the value of the collateral for the applicable series of notes and the ability of the applicable collateral agent, the trustee under the applicable indenture or the holders of the applicable series of notes to realize or foreclose on the collateral.

The first lien notes and the related guarantees are secured, subject to permitted liens, by a first-priority lien in the collateral that secures our cash flow credit facility on a first-priority basis (other than any European collateral securing our senior secured European term loan facility) and share equally in right of payment to the extent of the value of such collateral securing such cash flow credit facility on a first-priority basis. The first lien notes and the related guarantees are not secured by any of the European collateral described in Description of Other Indebtedness Senior Secured Credit Facilities Guarantee and Security. The indentures governing the first lien notes permit us to incur additional indebtedness secured by a lien that ranks equally with the first lien notes. Any such indebtedness may further limit the recovery from the realization of the value of such collateral available to satisfy holders of the first lien notes.

The 2009 second lien notes and the related guarantees are secured, subject to permitted liens, by a second-priority lien in the collateral that secures our cash flow credit facility and our first lien notes on a first-priority basis (other than any European collateral securing our senior secured European term loan facility) and share equally in right of payment with the other second lien to the extent of the value of such collateral. The 2009 second lien notes and the related guarantees are not secured by any of the European collateral described in Description of Other Indebtedness Senior Secured Credit Facilities Guarantee and Security. The indenture governing the 2009 second lien notes permits us to incur additional indebtedness secured by a lien that ranks either senior to the 2009 second lien note or equally with the 2009 second lien notes. Any such indebtedness may further limit the recovery from the realization of the value of such collateral available to satisfy holders of the 2009 second lien notes.

There may not be sufficient collateral to pay off all amounts we may borrow under our senior secured credit facilities, the notes and additional notes that we may offer that would be secured on the same basis as the first lien notes or the second lien notes. Liquidating the collateral securing the notes may not result in proceeds in an amount sufficient to pay any amounts due under the notes after also satisfying the obligations to pay any creditors with prior liens. If the proceeds of any sale of collateral are not sufficient to repay all amounts due on the notes, the holders of the notes (to the extent not repaid from the proceeds of the sale of the collateral) would have only a senior unsecured, unsubordinated claim against our and the subsidiary guarantors remaining assets.

Claims of noteholders are structurally subordinate to claims of creditors of all of our non-U.S. subsidiaries and some of our U.S. subsidiaries because they do not guarantee the notes.

The notes are not guaranteed by any of our non-U.S. subsidiaries, our less than wholly-owned U.S. subsidiaries or certain other U.S. subsidiaries. Accordingly, claims of holders of the notes are structurally

subordinate to the claims of creditors of these non-guarantor subsidiaries, including trade creditors. All obligations of our non-guarantor subsidiaries will have to be satisfied before any of the assets of such subsidiaries would be available for distribution, upon a liquidation or otherwise, to us or a guarantor of the notes.

For the year ended December 31, 2009, our non-guarantor subsidiaries accounted for approximately $12.468 billion, or 41.5%, of our total revenues. As of December 31, 2009, our non-guarantor subsidiaries accounted for approximately $9.672 billion, or 40.1%, of our total assets and approximately $6.750 billion, or 21.1%, of our total liabilities. See Note 16 to our consolidated financial statements.

If we default on our obligations to pay our indebtedness, we may not be able to make payments on the notes.

Any default under the agreements governing our indebtedness, including a default under our senior secured credit facilities that is not waived by the required lenders or a default under the indentures governing our notes, and the remedies sought by the holders of such indebtedness, could prevent us from paying principal, premium, if any, and interest on the notes and substantially decrease the market value of the notes. If we are unable to generate sufficient cash flow and are otherwise unable to obtain funds necessary to meet required payments of principal, premium, if any, and interest on our indebtedness, or if we otherwise fail to comply with the various covenants, including financial and operating covenants, in the instruments governing our indebtedness (including covenants in our senior secured credit facilities, the indentures governing the first lien notes and the indentures governing the second lien notes), we could be in default under the terms of the agreements governing such indebtedness. In the event of such default, the holders of such indebtedness could elect to declare all the funds borrowed thereunder to be due and payable, together with accrued and unpaid interest, the lenders under our senior secured credit facilities could elect to terminate their commitments thereunder, cease making further loans and institute foreclosure proceedings against our assets, and we could be forced into bankruptcy or liquidation. If our operating performance declines, we may in the future need to obtain waivers from the required lenders under our senior secured credit facilities to avoid being in default. If we breach our covenants under our senior secured credit facilities and seek a waiver, we may not be able to obtain a waiver from the required lenders. If this occurs, we would be in default under the instrument governing that indebtedness, the lenders could exercise their rights, as described above, and we could be forced into bankruptcy or liquidation.

The lien ranking provisions of the indentures and other agreements relating to the collateral securing the first lien notes on a second priority basis will limit the rights of holders of the first lien notes with respect to that collateral, even during an event of default.

The rights of the holders of the first lien notes with respect to the receivables collateral that secures the asset-based revolving credit facility on a first-priority basis and that secures our cash flow credit facility and our first lien notes on a second-priority basis are substantially limited by the terms of the lien ranking agreements set forth in the indentures and the applicable receivables intercreditor agreements, even during an event of default. Under the indentures and the applicable receivables intercreditor agreements, at any time that obligations that have the benefit of the higher priority liens are outstanding, any actions that may be taken with respect to such collateral, including the ability to cause the commencement of enforcement proceedings against such collateral, to control the conduct of such proceedings and to approve amendments to releases of such collateral from the lien of, and waive past defaults under, such documents relating to such collateral, will be at the direction of the holders of the obligations secured by the first-priority liens, and the holders of the first lien notes secured by lower-priority liens may be adversely affected.

In addition, the indentures and the applicable receivables intercreditor agreements contain certain provisions benefiting holders of indebtedness under our asset-based revolving credit facility, including provisions requiring the trustee and the collateral agent for the first lien notes not to object following the filing of a bankruptcy petition to certain important matters regarding the receivables collateral. After such filing, the value of this collateral could

materially deteriorate, and holders of the first lien notes would be unable to raise an objection.

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The receivables collateral that secures the first lien notes and guarantees on a lower-priority basis is also subject to any and all exceptions, defects, encumbrances, liens and other imperfections as may be accepted by the lenders under our asset-based revolving credit facility, whether on or after the date the first lien notes and guarantees are issued. The existence of any such exceptions, defects, encumbrances, liens and other imperfections could adversely affect the value of the collateral securing the first lien notes, as well as the ability of the collateral agent to realize or foreclose on such collateral.

The lien ranking provisions of the indenture and other agreements relating to the collateral securing the 2009 second lien notes limit the rights of holders of the 2009 second lien notes with respect to that collateral, even during an event of default.

The rights of the holders of the 2009 second lien notes with respect to the collateral that secures the 2009 second lien notes and the other second lien on a second-priority or third-priority basis, as the case may be, are substantially limited by the terms of the lien ranking agreements set forth in the indenture and the intercreditor agreement relating to the 2009 second lien notes, even during an event of default. Under the indenture and the intercreditor agreement, at any time that obligations that have the benefit of the higher-priority liens are outstanding, any actions that may be taken with respect to such collateral, including the ability to cause the commencement of enforcement proceedings against such collateral and to control the conduct of such proceedings, and the approval of amendments to, releases of such collateral from the lien of, and waivers of past defaults under, such documents relating to such collateral, will be at the direction of the holders of the obligations secured by the first-priority and second-priority liens, as applicable, and the holders of the notes secured by lower-priority liens may be adversely affected.

In addition, the indenture and the intercreditor agreement relating to the 2009 second lien notes contain certain provisions benefiting holders of indebtedness under our senior secured credit facilities and the first lien notes, including provisions requiring the trustee and the collateral agent not to object following the filing of a bankruptcy petition to a number of important matters regarding the collateral. After such filing, the value of this collateral could materially deteriorate, and holders of the 2009 second lien notes and the other second lien notes would be unable to raise an objection. In addition, the right of holders of obligations secured by first-priority and second-priority liens, as applicable, to foreclose upon and sell such collateral upon the occurrence of an event of default also would be subject to limitations under applicable bankruptcy laws if we or any of our subsidiaries become subject to a bankruptcy proceeding.

The collateral that secures the 2009 second lien notes and the other second lien notes and the related guarantees on a lower-priority basis is also subject to any and all exceptions, defects, encumbrances, liens and other imperfections as may be accepted by the lenders under our senior secured credit facilities, the collateral agent for our first lien notes and other creditors that have the benefit of higher-priority liens on such collateral from time to time, whether on or after the date the 2009 second lien notes and guarantees were issued. The existence of any such exceptions, defects, encumbrances, liens and other imperfections could adversely affect the value of the collateral securing the 2009 second lien notes and the other second lien notes as well as the ability of the collateral agent for the second lien notes to realize or foreclose on such collateral.

Even though the holders of the first lien notes benefit from a first-priority lien on the collateral that secures our cash flow credit facility, the representative of the lenders under the cash flow credit facility will initially control actions with respect to that collateral.

The rights of the holders of the first lien notes with respect to the collateral that secures the first lien notes on a first-priority basis is subject to a first lien intercreditor agreement among all holders of obligations secured by that collateral on a first-priority basis, including the obligations under our cash flow credit facility. Under that intercreditor agreement, any actions that may be taken with respect to such collateral, including the ability to cause the

commencement of enforcement proceedings against such collateral, to control such proceedings and to approve amendments to releases of such collateral from the lien of, and waive past defaults under, such documents relating to such collateral, will be at the direction of the authorized representative of the lenders under the cash flow credit facility until (1) our obligations under the cash flow credit facility are discharged (which discharge does not include certain refinancings of the cash flow credit facility) or (2) 90 days

after the occurrence of an event of default under the indentures governing the first lien notes. Under the circumstances described in clause (2) of the preceding sentence, the authorized representative of the holders of the indebtedness that represents the largest outstanding principal amount of indebtedness secured by a first-priority lien on the collateral (other than the cash flow credit facility) and has complied with the applicable notice provisions gains the right to take actions with respect to the collateral.

Even if the authorized representative of a series of first lien notes gains the right to direct the collateral agent in the circumstances described in clause (2) above, the authorized representative must stop doing so (and those powers with respect to the collateral would revert to the authorized representative of the lenders under the cash flow credit facility) if the lenders authorized representative has commenced and is diligently pursuing enforcement action with respect to the collateral or the grantor of the security interest in that collateral (whether our company or the applicable subsidiary guarantor) is then a debtor under or with respect to (or otherwise subject to) an insolvency or liquidation proceeding.

In addition, the senior secured credit facilities and the indentures governing the first lien notes permit us to issue additional series of notes that also have a first-priority lien on the same collateral. As explained above, any time that the representative of the lenders under the cash flow credit facility does not have the right to take actions with respect to the collateral pursuant to the first lien intercreditor agreement, that right passes to the authorized representative of the holders of the next largest outstanding principal amount of indebtedness secured by a first-priority lien on the collateral. Even though the outstanding 2019 notes are the largest series of outstanding first lien notes, if we issue additional first lien notes in the future in a greater principal amount than the outstanding 2019 notes, then the authorized representative for those additional notes would be earlier in line to exercise rights under the first lien intercreditor agreement than the authorized representative for the outstanding 2019 notes.

Under the first lien intercreditor agreement, the authorized representative of the holders of the first lien notes may not object following the filing of a bankruptcy petition to any debtor-in-possession financing or to the use of the shared collateral to secure that financing, subject to conditions and limited exceptions. After such a filing, the value of this collateral could materially deteriorate, and holders of the first lien notes would be unable to raise an objection.

The collateral that secures the first lien notes and guarantees on a first-priority basis will also be subject to any and all exceptions, defects, encumbrances, liens and other imperfections as may be accepted by the authorized representative of the lenders under our cash flow credit facility or of a series of first lien notes during any period that such authorized representative controls actions with respect to the collateral pursuant to the first lien intercreditor agreement. The existence of any such exceptions, defects, encumbrances, liens and other imperfections could adversely affect the value of the collateral securing the first lien notes as well as the ability of the collateral agent for the first lien notes to realize or foreclose on such collateral for the benefit of the holders of the first lien notes.

We will in most cases have control over the collateral, and the sale of particular assets by us could reduce the pool of assets securing the notes and the guarantees.

The collateral documents allow us to remain in possession of, retain exclusive control over, freely operate, and collect, invest and dispose of any income from, the collateral securing the notes and the guarantees, except, under certain circumstances, cash transferred to accounts controlled by the administrative agent under our asset-based revolving credit facility.

In addition, we will not be required to comply with all or any portion of Section 314(d) of the Trust Indenture Act of 1939 (the Trust Indenture Act) if we determine, in good faith based on advice of counsel, that, under the terms of that Section and/or any interpretation or guidance as to the meaning thereof of the SEC and its staff, including no action letters or exemptive orders, all or such portion of Section 314(d) of the Trust Indenture Act is inapplicable to the released collateral. For example, so long as no default or event of default under the indenture would result therefrom

and such transaction would not violate the Trust Indenture Act, we may, among other things, without any release or consent by the indenture trustee, conduct ordinary course activities with respect to collateral, such as selling, factoring, abandoning or otherwise

disposing of collateral and making ordinary course cash payments (including repayments of indebtedness). See Description of the February 2009 Notes, Description of the April 2009 Notes, Description of the August 2009 Notes and Description of the March 2010 Notes.

There are circumstances other than repayment or discharge of the notes under which the collateral securing the notes and guarantees will be released automatically, without your consent or the consent of the trustee.

Under various circumstances, collateral securing the notes will be released automatically, including:

- a sale, transfer or other disposal of such collateral in a transaction not prohibited under the indenture;
- with respect to collateral held by a guarantor, upon the release of such guarantor from its guarantee;
- with respect to collateral that is capital stock, upon the dissolution of the issuer of such capital stock in accordance with the indenture;
- as to the first lien notes, with respect to any receivables collateral in which the first lien notes have a second-priority lien upon any release by the lenders under our asset-based revolving credit facility of their first-priority security interest in such collateral; *provided* that, if the release occurs in connection with a foreclosure or exercise of remedies by the collateral agent for the lenders under our asset-based revolving credit facility, the lien on that collateral will be automatically released but any proceeds thereof not used to repay the obligations under our asset-based revolving credit facility will be subject to lien in favor of the collateral agent for the holders of the first lien notes and our cash flow credit facility;
- as to the first lien notes, with respect to the collateral upon which the first lien notes have a first-priority lien, upon any release in connection with a foreclosure or exercise of remedies with respect to that collateral directed by the authorized representative of the lenders under our cash flow credit facility during any period that such authorized representative controls actions with respect to the collateral pursuant to the first lien intercreditor agreement. Even though the holders of the first lien notes share ratably with the lenders under our cash flow credit facility, the authorized representative of the lenders under our cash flow credit facility will initially control actions with respect to the collateral, whether or not the holders of the notes agree or disagree with those actions. See Even though the holders of the first lien notes benefit from a first-priority lien on the collateral that secures our cash flow credit facility, the representative of the lenders under the cash flow credit facility will initially control actions with respect to that collateral ; and
- as to the 2009 second lien notes, with respect to any collateral in which the 2009 second lien notes have a second-priority or third-priority lien, upon any release by the lenders under our senior secured credit facilities and the collateral agent for our first lien notes of their first-priority or second-priority security interests in such collateral unless such release occurs in connection with a discharge in full in cash of first lien obligations, which discharge is not in connection with a foreclosure of, or other exercise of remedies with respect to, non-receivables collateral by the first lien secured parties (such discharge not in connection with any such foreclosure or exercise of remedies, a Payment Discharge); *provided* that, in the case of a Payment Discharge, the lien on any non-receivables collateral disposed of in satisfaction in whole or in part of first lien obligations shall be automatically released, but any proceeds thereof not used for purposes of the discharge of first lien obligations in full in cash or otherwise in accordance with the indentures governing the second lien notes shall be subject to lien in favor of the collateral agent for the 2009 second lien notes and the other second lien notes.

In addition, the guarantee of a subsidiary guarantor will be automatically released to the extent it is released under the senior secured credit facilities or in connection with a sale of such subsidiary guarantor in a transaction not prohibited

by the indenture.

The indentures governing the notes also permit us to designate one or more of our restricted subsidiaries that is a guarantor of the notes as an unrestricted subsidiary. If we designate a subsidiary guarantor as an

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unrestricted subsidiary for purposes of the indentures governing the notes, all of the liens on any collateral owned by such subsidiary or any of its subsidiaries and any guarantees of the notes by such subsidiary or any of its subsidiaries will be released under the indentures but not necessarily under our senior secured credit facilities. Designation of an unrestricted subsidiary will reduce the aggregate value of the collateral securing the notes to the extent that liens on the assets of the unrestricted subsidiary and its subsidiaries are released. In addition, the creditors of the unrestricted subsidiary and its subsidiaries will have a senior claim on the assets of such unrestricted subsidiary and its subsidiaries. See Description of the February 2009 Notes, Description of the April 2009 Notes, Description of the August 2009 Notes and Description of the March 2010 Notes.

The imposition of certain permitted liens will cause the assets on which such liens are imposed to be excluded from the collateral securing the notes and the guarantees. There are also certain other categories of property that are excluded from the collateral.

The indentures governing the notes permit liens in favor of third parties to secure additional debt, including purchase money indebtedness and capital lease obligations, and any assets subject to such liens are automatically excluded from the collateral securing the notes and the guarantees. Our ability to incur purchase money indebtedness and capital lease obligations is subject to the limitations as described in Description of the February 2009 Notes, Description of the April 2009 Notes, Description of the August 2009 Notes and Description of the March 2010 Notes. In addition, certain categories of assets are excluded from the collateral securing the notes and the guarantees. Excluded assets include the assets of our non-guarantor subsidiaries and equity investees, certain capital stock and other securities of our subsidiaries and equity investees, certain properties that do not secure our senior secured credit facilities, certain European collateral that secures our senior secured European term loan facility, deposit accounts, other bank or securities accounts, cash, leaseholds and motor vehicles, and the proceeds from any of the foregoing. Also, the lien on properties defined as principal properties under our existing indenture dated as of December 16, 1993, so long as that indenture remains in effect, will be limited to securing a portion of the indebtedness under our cash flow credit facility and the first lien notes that, in the aggregate, does not exceed 10% of our consolidated net tangible assets. These principal properties do not secure the 2009 second lien notes or the other second lien notes. See Description of the February 2009 Notes, Description of the April 2009 Notes, Description of the August 2009 Notes and Description of the March 2010 Notes. If an event of default occurs under any series of notes and those notes are accelerated, the notes and the guarantees will rank equally with the holders of other unsubordinated and unsecured indebtedness of the relevant entity with respect to any excluded property.

As of December 31, 2009, our non-guarantor subsidiaries accounted for approximately $9.672 billion, or 40.1%, of our total assets and approximately $6.750 billion, or 21.1%, of our total liabilities.

The pledge of the capital stock, other securities and similar items of our subsidiaries that secure the notes will automatically be released from the lien on them and no longer constitute collateral for so long as the pledge of such capital stock or such other securities would require the filing of separate financial statements with the SEC for that subsidiary.

The notes and the guarantees are secured by a pledge of the stock of some of our subsidiaries. Under the SEC regulations in effect as of the issue date of the notes, if the par value, book value as carried by us or market value (whichever is greatest) of the capital stock, other securities or similar items of a subsidiary pledged as part of the collateral is greater than or equal to 20% of the aggregate principal amount of any class of notes then outstanding, such subsidiary would be required to provide separate financial statements to the SEC. Therefore, the indentures and the collateral documents relating to each series of notes provide that any capital stock and other securities of any of our subsidiaries will be excluded from the collateral for so long as the pledge of such capital stock or other securities to secure that series of notes would cause such subsidiary to be required to file separate financial statements with the SEC pursuant to Rule 3-16 of Regulation S-X (as in effect from time to time).

As a result, holders of the notes could lose a portion or all of their security interest in the capital stock or other securities of those subsidiaries during such period. It may be more difficult, costly and time-consuming

for holders of the notes to foreclose on the assets of a subsidiary than to foreclose on its capital stock or other securities, so the proceeds realized upon any such foreclosure could be significantly less than those that would have been received upon any sale of the capital stock or other securities of such subsidiary. See Description of the February 2009 Notes Security, Description of the April 2009 Notes Security, Description of the August 2009 Notes Security and Description of the March 2010 Notes Security.

Your rights in the collateral may be adversely affected by the failure to perfect security interests in certain collateral in the future.

Applicable law requires that certain property and rights acquired after the grant of a general security interest, such as real property, equipment subject to a certificate and certain proceeds, can only be perfected at the time such property and rights are acquired and identified. The trustees or the collateral agents for the notes may not monitor, or we may not inform the trustees or the collateral agents of, the future acquisition of property and rights that constitute collateral, and necessary action may not be taken to properly perfect the security interest in such after-acquired collateral. The collateral agents for the notes have no obligation to monitor the acquisition of additional property or rights that constitute collateral or the perfection of any security interest in favor of the notes against third parties. Such failure may result in the loss of the security interest therein or the priority of the security interest in favor of the notes against third parties.

The collateral is subject to casualty risks.

We intend to maintain insurance or otherwise insure against hazards in a manner appropriate and customary for our business. There are, however, certain losses that may be either uninsurable or not economically insurable, in whole or in part. Insurance proceeds may not compensate us fully for our losses. If there is a complete or partial loss of any of the pledged collateral, the insurance proceeds may not be sufficient to satisfy all of the secured obligations, including the notes and the guarantees.

We may not be able to repurchase the notes upon a change of control.

Upon the occurrence of specific kinds of change of control events, we will be required to offer to repurchase all outstanding notes at 101% of their principal amount plus accrued and unpaid interest. The source of funds for any such purchase of the notes will be our available cash or cash generated from our subsidiaries operations or other sources, including borrowings, sales of assets or sales of equity. We may not be able to repurchase the notes upon a change of control because we may not have sufficient financial resources to purchase all of the notes that are tendered upon a change of control. Further, we are contractually restricted under the terms of our senior secured credit facilities from repurchasing all of the notes tendered by holders upon a change of control. Accordingly, we may not be able to satisfy our obligations to purchase the notes unless we are able to refinance or obtain waivers under the instruments governing that indebtedness. Our failure to repurchase any series of notes upon a change of control would cause a default under the indenture governing that series of notes and a cross-default under the instruments governing our senior secured credit facilities and the indentures governing our other first lien notes and second lien notes. The instruments governing our senior secured credit facilities also provide that a change of control will be a default that permits lenders to accelerate the maturity of borrowings thereunder. Any of our future debt agreements may contain similar provisions.

In the event of our bankruptcy, the ability of the holders of the notes to realize upon the collateral will be subject to certain bankruptcy law limitations.

The ability of holders of the notes to realize upon the collateral will be subject to certain bankruptcy law limitations in the event of our bankruptcy. Under applicable U.S. federal bankruptcy laws, secured creditors are prohibited from

repossessing their security from a debtor in a bankruptcy case without bankruptcy court approval and may be prohibited from disposing of security repossessed from such a debtor without bankruptcy court approval. Moreover, applicable federal bankruptcy laws generally permit the debtor to continue to retain collateral, including cash collateral, even though the debtor is in default under the applicable debt instruments, provided that the secured creditor is given adequate protection.

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The meaning of the term adequate protection may vary according to the circumstances, but is intended generally to protect the value of the secured creditor s interest in the collateral at the commencement of the bankruptcy case and may include cash payments or the granting of additional security if and at such times as the court, in its discretion, determines that a diminution in the value of the collateral occurs as a result of the stay of repossession or the disposition of the collateral during the pendency of the bankruptcy case. In view of the lack of a precise definition of the term adequate protection and the broad discretionary powers of a U.S. bankruptcy court, we cannot predict whether or when the collateral agent for the notes could foreclose upon or sell the collateral or whether or to what extent holders of notes would be compensated for any delay in payment or loss of value of the collateral through the requirement of adequate protection.

Moreover, the collateral agents may need to evaluate the impact of the potential liabilities before determining to foreclose on collateral consisting of real property, if any, because secured creditors that hold a security interest in real property may be held liable under environmental laws for the costs of remediating or preventing the release or threatened release of hazardous substances at such real property. Consequently, the collateral agents may decline to foreclose on such collateral or exercise remedies available in respect thereof if they does not receive indemnification to their satisfaction from the holders of the notes.

Federal and state fraudulent transfer laws may permit a court to void the guarantees, and, if that occurs, you may not receive any payments on the notes.

Federal and state fraudulent transfer and conveyance statutes may apply to the issuance of the notes and the incurrence of the guarantees. Under federal bankruptcy law and comparable provisions of state fraudulent transfer or conveyance laws, which may vary from state to state, the notes or guarantees could be voided as a fraudulent transfer or conveyance if (1) we or any of the guarantors, as applicable, issued the notes or incurred the guarantees with the intent of hindering, delaying or defrauding creditors or (2) we or any of the guarantors, as applicable, received less than reasonably equivalent value or fair consideration in return for either issuing the notes or incurring the guarantees and, in the case of (2) only, one of the following is also true at the time thereof:

- we or any of the guarantors, as applicable, were insolvent or rendered insolvent by reason of the issuance of the notes or the incurrence of the guarantees;

- the issuance of the notes or the incurrence of the guarantees left us or any of the guarantors, as applicable, with an unreasonably small amount of capital to carry on the business;

- we or any of the guarantors intended to, or believed that we or such guarantor would, incur debts beyond our or such guarantor s ability to pay as they mature; or

- we were or any of the guarantors was a defendant in an action for money damages, or had a judgment for money damages docketed against us or such guarantor if, in either case, after final judgment, the judgment was unsatisfied.

If a court were to find that the issuance of the notes or the incurrence of the guarantee was a fraudulent transfer or conveyance, the court could void the payment obligations under the notes or such guarantee or further subordinate the notes or such guarantee to presently existing and future indebtedness of ours or of the related guarantor, or require the holders of the notes to repay any amounts received with respect to such guarantee. In the event of a finding that a fraudulent transfer or conveyance occurred, you may not receive any repayment on the notes. Further, the voidance of the notes could result in an event of default with respect to our and our subsidiaries other debt that could result in acceleration of such debt.

As a general matter, value is given for a transfer or an obligation if, in exchange for the transfer or obligation, property is transferred or an antecedent debt is secured or satisfied. A debtor will generally not be considered to have received value in connection with a debt offering if the debtor uses the proceeds of that offering to make a dividend payment or otherwise retire or redeem equity securities issued by the debtor.

We cannot be certain as to the standards a court would use to determine whether or not we or the guarantors were solvent at the relevant time or, regardless of the standard that a court uses, that the issuance

of the guarantees would not be further subordinated to our or any of our guarantors other debt. Generally, however, an entity would be considered insolvent if, at the time it incurred indebtedness:

- the sum of its debts, including contingent liabilities, was greater than the fair saleable value of all its assets;
- the present fair saleable value of its assets was less than the amount that would be required to pay its probable liability on its existing debts, including contingent liabilities, as they become absolute and mature; or
- it could not pay its debts as they become due.

Your ability to transfer the notes may be limited by the absence of an active trading market, and there is no assurance that any active trading market will develop for the notes.

We cannot assure you that an active market for the exchange notes will develop or, if developed, that it will continue. Historically, the market for non investment-grade debt has been subject to disruptions that have caused substantial volatility in the prices of securities similar to the notes. We cannot assure you that the market, if any, for the exchange notes will be free from similar disruptions or that any such disruptions may not adversely affect the prices at which you may sell your notes. In addition, the exchange notes may trade at a discount from the price at which the outstanding notes of the applicable series were initially offered, depending upon prevailing interest rates, the market for similar notes, our performance and other factors.

ML Global Private Equity Fund, L.P., ML HCA Co. Invest, L.P. and Merrill Lynch Ventures L.P. 2001 are affiliates of Banc of America Securities LLC, which was one of the initial purchasers of the outstanding notes. As a result of this affiliate relationship, if Banc of America Securities LLC conducts any market making activities with respect to the exchange notes, Banc of America Securities LLC will be required to deliver a market making prospectus when effecting offers and sales of the exchange notes. For as long as a market making prospectus is required to be delivered, the ability of Banc of America Securities LLC to make a market in the exchange notes may, in part, be dependent on our ability to maintain a current market making prospectus for its use. If we are unable to maintain a current market making prospectus, Banc of America Securities LLC may be required to discontinue its market making activities without notice.

The outstanding 2017 notes and the outstanding 2019 notes were issued with original issue discount for U.S. federal income tax purposes.

The outstanding 2017 notes and the outstanding 2019 notes were issued with original issue discount (OID) for U.S. federal income tax purposes in an amount equal to the difference between their stated principal amount and their issue price. U.S. holders of the outstanding 2017 notes and the outstanding 2019 notes will be required to include such difference in gross income on a constant yield to maturity basis in advance of the receipt of cash payment thereof regardless of such holder s method of accounting for U.S. federal income tax purposes. See Certain United States Federal Tax Consequences.

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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 and financial results or to the impact of existing or proposed laws or regulations described or incorporated by reference 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.

Some of the important factors that could cause actual results to differ materially from our expectations are disclosed under Risk Factors and elsewhere in this prospectus, including, without limitation, in conjunction with the forward-looking statements included 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 will not receive any cash proceeds from the issuance of the exchange notes pursuant to the exchange offers. In consideration for issuing the exchange notes as contemplated in this prospectus, we will receive in exchange a like principal amount of outstanding notes, the terms of which are identical in all material respects to the exchange notes. The outstanding notes surrendered in exchange for the exchange notes will be retired and cancelled and cannot be reissued. Accordingly, the issuance of the exchange notes will not result in any change in our capitalization.

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CAPITALIZATION

The following table sets forth our capitalization as of December 31, 2009:

on a historical basis;

on an as adjusted basis after giving effect to the February 2010 distribution of $1.750 billion to our stockholders on February 5, 2010; and

on a further adjusted basis after giving effect to the offering of the outstanding September 2020 notes and the use of proceeds therefrom.

The information in this table should be read in conjunction with Summary Recent Developments, Selected Financial Data and Management s Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements and related notes included in this prospectus.

	As of December 31, 2009		
	Historical	**As Adjusted for February 2010 Distribution(1) (Unaudited)**	**As Further Adjusted for the Outstanding September 2020 Notes Offering (Unaudited)**
	(Dollars in millions)		
Cash and cash equivalents	$ 312	$ 212	$ 212
Senior secured credit facilities(2)	$ 9,702	$ 11,352	$ 9,990
First lien notes(3)	2,682	2,682	4,069
Other secured indebtedness(4)	362	362	362
Existing second lien notes(5)	6,078	6,078	6,078
Total senior secured indebtedness	18,824	20,474	20,499
Unsecured indebtedness(6)	6,846	6,846	6,846
Total debt	25,670	27,320	27,345
Stockholders deficit attributable to HCA Inc.	(8,986)	(10,736)	(10,736)
Noncontrolling interests	1,008	1,008	1,008
Total stockholders deficit	(7,978)	(9,728)	(9,728)
Total capitalization	$ 17,692	$ 17,592	$ 17,617

(1) On January 27, 2010, our Board of Directors declared a distribution to the Company s stockholders and holders of vested stock options, which was paid on February 5, 2010. The distribution was $17.50 per share and vested stock option, or approximately $1.750 billion in the aggregate. The distribution was funded using borrowings of approximately $1.650 billion under our existing senior secured credit facilities and approximately $100 million of cash on hand.

(2) In connection with the Recapitalization, we entered into (i) a $2.000 billion asset-based revolving credit facility with an original six-year maturity (the asset-based revolving credit facility) ($715 million outstanding at December 31, 2009 and an additional approximately $1.050 billion was drawn in connection with the February 2010 distribution); (ii) a $2.000 billion senior secured revolving credit facility with an original six-year maturity (the senior secured revolving credit facility) (none outstanding at December 31, 2009, without giving effect to outstanding letters of credit, but approximately $600 million of which was drawn in connection with the February 2010 distribution); (iii) a $2.750 billion senior secured term loan A facility with an original six-year maturity ($1.908 billion outstanding at December 31, 2009, and approximately $1.618 billion outstanding after giving effect to the use of the estimated net proceeds of the outstanding September 2020 notes); (iv) an $8.800 billion senior secured term loan B facility with an original seven-year maturity ($6.515 billion outstanding at December 31, 2009, and approximately $5.528 billion

outstanding after giving effect to the use of the estimated net proceeds of the offering of the outstanding September 2020 notes); and (v) a 1.000 billion (394 million, or $564 million-equivalent, outstanding at December 31, 2009, and approximately 335 million, or $479 million-equivalent, outstanding after giving effect to the use of the estimated net proceeds of the offering of the outstanding September 2020 notes), senior secured European term loan facility with an original seven-year maturity. 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.

(3) In April 2009, we 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, we 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, we 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 our 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.

(4) Consists of capital leases and other secured debt with a weighted average interest rate of 6.84%.

(5) 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 us, at our 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 our 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.

(6) Consists of (i) an aggregate principal amount of $367 million medium-term notes with maturities ranging from 2010 to 2025 and a weighted average interest rate of 8.42%; (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 $5.407 billion senior notes with maturities ranging from 2010 to 2033 and a weighted average interest rate of 6.79%; (iv) £121 million ($196 million-equivalent at December 31, 2009) aggregate principal amount of 8.75% senior notes due 2010; and (v) $10 million of unamortized debt discounts that reduce the existing indebtedness. For more information regarding our unsecured and other indebtedness, see Description of Other Indebtedness.

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 in the period ended December 31, 2009 have been derived from our audited consolidated financial statements and related notes appearing elsewhere in this prospectus. The selected financial data as of December 31, 2007, 2006 and 2005 and for the two years in the period ended December 31, 2006 presented in this table have been derived from our audited consolidated financial statements that are not included in this prospectus.

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 and the consolidated financial statements and related notes thereto appearing elsewhere in this prospectus.

	As of and for the Years Ended December 31,				
	2009	**2008**	**2007**	**2006**	**2005**
	(Dollars in millions)				
Summary of Operations:					
Revenues	**$ 30,052**	$ 28,374	$ 26,858	$ 25,477	$ 24,455
Salaries and benefits	**11,958**	11,440	10,714	10,409	9,928
Supplies	**4,868**	4,620	4,395	4,322	4,126
Other operating expenses	**4,724**	4,554	4,233	4,056	4,034
Provision for doubtful accounts	**3,276**	3,409	3,130	2,660	2,358
Equity in earnings of affiliates	**(246)**	(223)	(206)	(197)	(221)
Gains on sales of investments				(243)	(53)
Depreciation and amortization	**1,425**	1,416	1,426	1,391	1,374
Interest expense	**1,987**	2,021	2,215	955	655
Losses (gains) on sales of facilities	**15**	(97)	(471)	(205)	(78)
Impairment of long-lived assets	**43**	64	24	24	
Transaction costs				442	
	28,050	27,204	25,460	23,614	22,123
Income before income taxes	**2,002**	1,170	1,398	1,863	2,332
Provision for income taxes	**627**	268	316	626	730
Net income	**1,375**	902	1,082	1,237	1,602
Net income attributable to noncontrolling interests	**321**	229	208	201	178
Net income attributable to HCA Inc.	**$ 1,054**	$ 673	$ 874	$ 1,036	$ 1,424
Financial Position:					
Assets	**$ 24,131**	$ 24,280	$ 24,025	$ 23,675	$ 22,225

Working capital	**2,264**	2,391	2,356	2,502	1,320
Long-term debt, including amounts due within one year	**25,670**	26,989	27,308	28,408	10,475
Equity securities with contingent redemption rights	**147**	155	164	125	
Noncontrolling interests	**1,008**	995	938	907	828
Stockholders (deficit) equity	**(7,978)**	(9,260)	(9,600)	(10,467)	5,691

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	As of and for the Years Ended December 31,				
	2009	2008	2007	2006	2005
	(Dollars in millions)				
Cash Flow Data:					
Cash provided by operating activities	**$ 2,747**	$ 1,990	$ 1,564	$ 1,988	$ 3,162
Cash used in investing activities	**(1,035)**	(1,467)	(479)	(1,307)	(1,681)
Cash used in financing activities	**(1,865)**	(451)	(1,326)	(383)	(1,403)
Other Financial Data:					
Capital expenditures	**$ 1,317**	$ 1,600	$ 1,444	$ 1,865	$ 1,592
Ratio of earnings to fixed charges(a)	**1.91x**	1.52x	1.57x	2.61x	3.85x
Operating Data:					
Number of hospitals at end of period(b)	**155**	158	161	166	175
Number of freestanding outpatient surgical centers at end of period(c)	**97**	97	99	98	87
Number of licensed beds at end of period(d)	**38,839**	38,504	38,405	39,354	41,265
Weighted average licensed beds(e)	**38,825**	38,422	39,065	40,653	41,902
Admissions(f)	**1,556,500**	1,541,800	1,552,700	1,610,100	1,647,800
Equivalent admissions(g)	**2,439,000**	2,363,600	2,352,400	2,416,700	2,476,600
Average length of stay (days)(h)	**4.8**	4.9	4.9	4.9	4.9
Average daily census(i)	**20,650**	20,795	21,049	21,688	22,225
Occupancy(j)	**53%**	54%	54%	53%	53%
Emergency room visits(k)	**5,593,500**	5,246,400	5,116,100	5,213,500	5,415,200
Outpatient surgeries(l)	**794,600**	797,400	804,900	820,900	836,600
Inpatient surgeries(m)	**494,500**	493,100	516,500	533,100	541,400
Days revenues in accounts receivable(n)	**45**	49	53	53	50
Gross patient revenues(o)	**$ 115,682**	$ 102,843	$ 92,429	$ 84,913	$ 78,662
Outpatient revenues as a % of patient revenues(p)	**38%**	37%	37%	36%	36%

(a) For purposes of calculating the ratio of earnings to fixed charges, earnings consist of net income attributable to noncontrolling interests and income taxes plus fixed charges, exclusive of capitalized interest. Fixed charges include cash and noncash interest expense, whether expensed or capitalized, amortization of debt issuance cost, and the portion of rent expense representative of the interest factor.

(b) 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.

(c) 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.

(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 typically 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.

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 audited 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 one of the leading health care services companies in the United States. At December 31, 2009, we operated 163 hospitals, comprised of 157 general, acute care hospitals; five psychiatric hospitals; and one rehabilitation hospital. The 163 hospital total includes eight hospitals (seven general, acute care hospitals and one rehabilitation hospital) owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. In addition, we operated 105 freestanding surgery centers, eight of which are owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. Our facilities are located in 20 states and England. 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.

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.

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 Legislation 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, the Health Reform Legislation contains provisions that seek to decrease the number of uninsured individuals, including requirements, 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, it is difficult to predict the full impact of the Health Reform Legislation due to the law s complexity, lack of implementing regulations or interpretive guidance, gradual implementation and possible amendment.

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 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 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 ended December 31, follows (dollars in millions):

	2009	2008	2007
Provision for doubtful accounts	**$ 3,276**	$ 3,409	$ 3,130
Uninsured discounts	**2,935**	1,853	1,474
Charity care	**2,151**	1,747	1,530

Totals	**$ 8,362**	$ 7,009	$ 6,134

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 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 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 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 insurance coverage. Provisions for losses related to professional liability risks were $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 $1.322 billion and $1.387 billion at December 31, 2009 and 2008, respectively. The current portion of these reserves, $265 million and $279 million at 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 $53 million and $57 million receivable under reinsurance contracts at December 31, 2009 and 2008, respectively) were $1.269 billion and $1.330 billion at December 31, 2009 and 2008, respectively. The estimated total net reserves for professional liability risks at December 31, 2009 and 2008 are comprised of $680 million and $724 million, respectively, of case reserves for known claims and $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

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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.

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.

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 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.

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 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.

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 are set forth below.

	Years Ended December 31,		
	2009	**2008**	**2007**
Medicare	**34%**	35%	35%
Managed Medicare	**10**	9	7
Medicaid	**9**	8	8
Managed Medicaid	**7**	7	7
Managed care and other insurers	**34**	35	37
Uninsured	**6**	6	6
	100%	100%	100%

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

	Years Ended December 31,		
	2009	**2008**	**2007**
Medicare	**31%**	31%	32%
Managed Medicare	**8**	8	7
Medicaid	**8**	7	7
Managed Medicaid	**4**	4	4
Managed care and other insurers	**44**	44	44
Uninsured	**5**	6	6
	100%	100%	100%

At December 31, 2009, we owned and operated 38 hospitals and 33 surgery centers in the state of Florida. Our Florida facilities revenues totaled $7.343 billion and $7.099 billion for the years ended December 31, 2009 and 2008,

respectively. At December 31, 2009, we owned and operated 35 hospitals and 23 surgery centers in the state of Texas. Our Texas facilities revenues totaled $8.042 billion and $7.351 billion for the years ended December 31, 2009 and 2008, respectively. During 2009 and 2008, 57% and 55%, respectively, of our admissions and 51% of our revenues were generated by our Florida and Texas facilities. Uninsured admissions in Florida and Texas represented 64% and 63% of our uninsured admissions during 2009 and 2008, respectively.

We provided $2.151 billion, $1.747 billion and $1.530 billion of charity care (amounts are based upon our gross charges) 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 $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 $474 million, $262 million and $232 million during 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 (dollars in millions):

	2009		2008		2007	
	Amount	Ratio	Amount	Ratio	Amount	Ratio
Revenues	**$ 30,052**	**100.0**	$ 28,374	100.0	$ 26,858	100.0
Salaries and benefits	**11,958**	**39.8**	11,440	40.3	10,714	39.9
Supplies	**4,868**	**16.2**	4,620	16.3	4,395	16.4
Other operating expenses	**4,724**	**15.7**	4,554	16.1	4,233	15.7
Provision for doubtful accounts	**3,276**	**10.9**	3,409	12.0	3,130	11.7
Equity in earnings of affiliates	**(246)**	**(0.8)**	(223)	(0.8)	(206)	(0.8)
Depreciation and amortization	**1,425**	**4.8**	1,416	5.0	1,426	5.4
Interest expense	**1,987**	**6.6**	2,021	7.1	2,215	8.2
Losses (gains) on sales of facilities	**15**		(97)	(0.3)	(471)	(1.8)
Impairment of long-lived assets	**43**	**0.1**	64	0.2	24	0.1
	28,050	**93.3**	27,204	95.9	25,460	94.8
Income before income taxes	**2,002**	**6.7**	1,170	4.1	1,398	5.2
Provision for income taxes	**627**	**2.1**	268	0.9	316	1.1
Net income	**1,375**	**4.6**	902	3.2	1,082	4.1
Net income attributable to noncontrolling interests	**321**	**1.1**	229	0.8	208	0.8
Net income attributable to HCA Inc.	**$ 1,054**	**3.5**	$ 673	2.4	$ 874	3.3
% changes from prior year:						
Revenues	**5.9%**		5.6%		5.4%	
Income before income taxes	**71.1**		(16.3)		(25.0)	
Net income attributable to HCA Inc.	**56.7**		(23.0)		(15.7)	
Admissions(a)	**1.0**		(0.7)		(3.6)	
Equivalent admissions(b)	**3.2**		0.5		(2.7)	
Revenue per equivalent admission	**2.6**		5.2		8.3	
Same facility % changes from prior year(c):						
Revenues	**6.1**		7.0		7.4	
Admissions(a)	**1.2**		0.9		(1.3)	
Equivalent admissions(b)	**3.4**		1.9		(0.7)	
Revenue per equivalent admission	**2.6**		5.1		8.1	

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

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

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

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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.

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.

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.

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 $2.747 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 $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. Planned capital expenditures are expected to approximate $1.5 billion in 2010. At December 31, 2009, there were projects under construction which had an estimated additional cost to complete and equip over the next five years of $1.2 billion. We expect to finance capital expenditures with internally generated and borrowed funds.

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 $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 our senior secured credit facilities ($3.181 billion as of December 31, 2009 and $3.142 billion as of January 31, 2010) and anticipated access to public and private debt markets.

On January 27, 2010, our Board of Directors declared a distribution to the Company s stockholders and holders of vested stock options. The distribution was $17.50 per share and vested stock option, or approximately $1.750 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.

Investments of our professional liability insurance subsidiary, to maintain statutory equity and pay claims, totaled $1.316 billion and $1.622 billion at December 31, 2009 and 2008, respectively. The insurance subsidiary maintained net reserves for professional liability risks of $590 million and $782 million at 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

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risks retained were $679 million and $548 million at December 31, 2009 and 2008, respectively. Claims payments, net of reinsurance recoveries, during the next 12 months are expected to approximate $240 million. We estimate that approximately $90 million of the expected net claim payments during the next 12 months will relate to claims subject to the self-insured retention.

Financing Activities

Due to the Recapitalization, we are a highly leveraged company with significant debt service requirements. Our debt totaled $25.670 billion and $26.989 billion at December 31, 2009 and 2008, respectively. Our interest expense was $1.987 billion for 2009 and $2.021 billion for 2008.

During February 2009, we 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, we 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, we 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. 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.

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.

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

Other Commercial Commitments Not Recorded on the	**Commitment Expiration by Period**				
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.

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 $1.309 billion and $7 million, respectively, at December 31, 2009. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At December 31, 2009, we had a net unrealized gain of $20 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 December 31, 2009, our wholly-owned insurance subsidiary had invested $396 million ($401 million par value) in municipal, tax-exempt student loan auction rate securities (ARS) that continue to experience market illiquidity since February 2008 when multiple failed auctions occurred due to a severe credit and liquidity crisis in the capital markets. 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 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 are included in other comprehensive income.

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With respect to our interest-bearing liabilities, approximately $1.205 billion of long-term debt at December 31, 2009 is subject to variable rates of interest, while the remaining balance in long-term debt of $24.465 billion at December 31, 2009 is 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, with the exception of term loan B where the margin is static, may be reduced subject to attaining certain leverage ratios. The average rate for our long-term debt increased from 6.9% at December 31, 2008 to 7.6% at December 31, 2009.

On March 2, 2009, we amended our $13.550 billion and 1.000 billion senior secured cash flow credit facility, dated as of November 17, 2006, as amended February 16, 2007 (the cash flow credit facility), 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 any scheduled payment or redemption prior to the scheduled term loan B final maturity date as currently in effect and (2) the proceeds from any such issuance are used within three business days of receipt to prepay term loans under the cash flow credit facility in accordance with the terms of 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 granted to holders of such additional secured notes.

On March 2, 2009, we amended our $2.000 billion senior secured asset-based revolving credit facility, dated as of November 17, 2006, as amended and restated as of June 20, 2007 (the ABL credit facility), 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 the proceeds from any such issuance are used to prepay term loans under the cash flow credit facility within three business days of the receipt thereof. The amendment to the ABL credit facility also altered the excess facility availability requirement to include a separate minimum facility availability requirement applicable to the ABL credit facility, and increased the applicable LIBOR and ABR margins for all borrowings under the ABL credit facility by 0.25% each.

The estimated fair value of our total long-term debt was $25.659 billion at December 31, 2009. 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 $12 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 the European term loan expose us to market risks associated with foreign currencies. In order to mitigate the currency exposure related to debt service obligations through December 31, 2011 under the European term loan, 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.

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 December 31, 2009, we were contesting before the Appeals Division of the Internal Revenue Service (the IRS) certain claimed deficiencies and adjustments proposed by the IRS in connection with its examinations of the 2003 and 2004 federal income returns for HCA and eight affiliates that are treated as partnerships for federal income tax purposes (affiliated partnerships). The disputed items include the timing of recognition of certain patient service revenues and our method for calculating the tax allowance for doubtful accounts.

Six taxable periods of HCA and its predecessors ended in 1997 through 2002 and the 2002 taxable year of four affiliated partnerships, for which the primary remaining issue is the computation of the tax allowance for doubtful accounts, are pending before the IRS Examination Division as of December 31, 2009. The IRS began an audit of the 2005 and 2006 federal income tax returns for HCA and seven affiliated partnerships during 2008. We anticipate the IRS Examination Division will conclude its audit in 2010. During 2009, the seven affiliated partnership audits were resolved with no material impact on our operations or financial position. We anticipate the IRS will begin an audit of the 2007 and 2008 federal income tax returns for HCA during 2010.

Management believes HCA, 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.

BUSINESS

Our Company

We are one of the leading health care services companies in the United States. At December 31, 2009, we operated 163 hospitals, comprised of 157 general, acute care hospitals; five psychiatric hospitals; and one rehabilitation hospital. The 163 hospital total includes eight hospitals (seven general, acute care hospitals and one rehabilitation hospital) owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. In addition, we operated 105 freestanding surgery centers, eight of which are owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. Our facilities are located in 20 states and England. 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.

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

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.

Our Strengths

Largest Provider with a Diversified Revenue Base. We are the largest investor-owned health care services provider in the United States. We maintain a diverse portfolio of assets with no single facility contributing more than 2.4% of revenues and no single metropolitan statistical area contributing more than 7.8% of revenues for the year ended December 31, 2009. In addition, we maintain a diversified payer base, including approximately 3,000 managed care contracts, with no one commercial payer representing more than approximately 8% of revenues for the year ended December 31, 2009. We believe our broad geographic footprint and diverse revenue base limit exposure to any single local market. We also provide a diverse array of medical and surgical services across different settings ranging from large hospitals to ambulatory surgery centers (ASCs), which, we believe, limits our exposure to changes in reimbursement policies targeting specific services or care settings.

Leading Market Positions. We maintain the number one or two inpatient position in nearly all of our markets, with our share of local inpatient admissions typically ranging from 20% to 40%. Additionally, we believe we have the leading position in one or more clinical areas, such as cardiology or orthopedics, in many of our markets. As a result, our hospitals are in demand by patients and large employers, which enables us to negotiate for favorable rates and terms from a wide range of commercial payers.

Strong Presence in Growth Markets. We have a strong market presence in a number of the fastest growing markets in the United States. We believe the majority of the large markets in which we have a presence will experience more

rapid growth among the population aged 65 or older than the national average, based on the most recently available census data. We believe we will benefit from our presence in these key markets due to an expected increase in hospital spending.

Well-Capitalized Portfolio of High-Quality Assets. We have invested over $7.8 billion in our facilities over the five-year period ended December 31, 2009 to expand the range, and improve the quality, of services provided at our facilities. As a result of our disciplined and strategic deployment of capital, we believe our

hospitals are competitive and will continue to attract high-quality physicians, maximize cost efficiencies and address the health care needs of our local communities.

Leading Provider of Outpatient Services. We are one of the largest providers of outpatient services in the United States, and these outpatient services accounted for approximately 38% of our revenues in 2009. The scope of our outpatient services reflects a recent trend toward the provision of an increasing number of services on an outpatient basis. An important component of our strategy is to achieve a fully integrated delivery model through the development of market-leading outpatient services, both to address outpatient migration and to provide higher growth, higher margin services.

Reputation for Quality. Since our founding, we have maintained an unwavering focus on patients and clinical outcomes. We have invested extensively in quality over the past 10 years, with an emphasis on implementing information technology and adopting industry-wide best practices and clinical protocols. As a result of these efforts, settled professional liability claims, based on actuarial projections per 1,000 beds, have dropped from 18.3 in 1999 to 12.6 in 2008. We also previously participated in the Centers for Medicare & Medicaid Services (CMS) National Voluntary Hospital Reporting Initiative and now participate in its successor, the Reporting Hospital Quality Data for Annual Payment Update program, which currently requires hospitals to report on their compliance with 46 quality measures in order to receive a full Medicare market basket payment increase. The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (Health Reform Legislation) further ties payment to quality measures by establishing a value based purchasing system and adjusting hospital payment rates based on hospital-acquired conditions (HACs) and hospital readmissions. We believe quality of care increasingly will influence physician and patient choices about health care delivery and impact our reimbursement as payers put more emphasis on performance. Our reputation and focus on providing high-quality patient care continue to make us the provider of choice for thousands of individual health care consumers, physicians and payers.

Proven Ability to Innovate. We strive to be at the forefront of industry best practices and expect to continue to increase our operational efficiency through a variety of strategic initiatives. Our previous operating improvement initiatives include:

> *Leveraging Our Purchasing Power.* We have established a captive group purchasing organization (GPO) to partner with other health care services providers to take advantage of our combined purchasing power. Our GPO generated $107 million, $93 million and $89 million of administrative fees from suppliers in 2009, 2008 and 2007, respectively, for performing GPO services and significantly lowered our supply costs. Because of our scale, our GPO has a per-unit cost advantage over competitors that we believe ranges from 5% to 21%.
>
> *Centralizing Our Billing and Accounts Receivable Collection Efforts.* We have built regional service centers to create efficiencies in billing and collection processes, particularly with respect to payment disputes with managed care companies. This effort has resulted in increased, incremental cash collections.

Demonstrated Strong Cash Flows. Our leading market positions, diversified revenues, focus on operational efficiency and high-quality portfolio of assets have enabled us to generate strong operating cash flows over the past several years. We generated cash flows from operating activities of $2.747 billion in 2009, $1.990 billion in 2008 and $1.564 billion in 2007. We believe expected demand for hospital and outpatient services, together with our diversified payer base, geographic locations and service offerings, will allow us to continue to generate strong cash flows.

Experienced Management Team. Members of our management team are widely considered leaders in the hospital industry and have made significant equity investments in our company. Richard M. Bracken was appointed our CEO and President, effective January 1, 2009, and Chairman of the Board of Directors, effective December 15, 2009. Mr. Bracken began his career with us approximately 30 years ago and has held various executive positions with the

Company, including, most recently, as our President and Chief Operating Officer since January 2002. Our Executive Vice President and Chief Financial Officer, R. Milton Johnson, joined us over 27 years ago, has held various positions in financial operations at the Company and has served as a

director since December 15, 2009. In addition, we benefit from our team of world-class operators who have the experience and talent necessary to run a complex health care business.

Our Strategy

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

Maintain Our Dedication to the Care and Improvement of Human Life. Our business is built on putting patients first and providing high quality health care services in the communities we serve. Our dedicated professionals oversee our Quality Review System, which measures clinical outcomes, satisfaction and regulatory compliance to improve hospital quality and performance. We are implementing hospitalist programs in some facilities, evidence-based medicine programs and infection reduction initiatives. In addition, we continue to implement health information technology to improve the quality and convenience of services to our communities. We are using our electronic medication administration record, which uses bar coding technology to ensure that each patient receives the right medication, to build toward a fully electronic health record that will provide convenient access, electronic order entry and decision support for physicians. These technologies improve patient safety, quality and efficiency.

Maintain Our Commitment to Ethics and Compliance. We are committed to a corporate culture highlighted by the following values compassion, honesty, integrity, fairness, loyalty, respect and kindness. Our comprehensive ethics and compliance program reinforces our dedication to these values.

Leverage Our Leading Local Market Positions. We strive to maintain and enhance the leading positions we enjoy in the majority of our markets. We believe the broad geographic presence of our facilities across a range of markets, in combination with the breadth and quality of services provided by our facilities, increases our attractiveness to patients and large employers and positions us to negotiate more favorable terms from commercial payers and increase the number of payers with whom we contract. We also intend to strategically enhance our outpatient presence in our communities to attract more patients to our facilities.

Expand Our Presence in Key Markets. We seek to grow our business in key markets, focusing on large, high growth urban and suburban communities, primarily in the southern and western regions of the United States. We seek to strategically invest in new and expanded services at our existing hospitals and surgery centers to increase our revenues at those facilities and provide the benefits of medical technology advances to our communities. We intend to continue to expand high volume and high margin specialty services, such as cardiology and orthopedic services, and increase the capacity, scope and convenience of our outpatient facilities. To complement this intrinsic growth, we intend to continue to opportunistically develop and acquire new hospitals and outpatient facilities.

Continue to Leverage Our Scale. We will continue to obtain price efficiencies through our group purchasing organization and build on the cost savings and efficiencies in billing, collection and other processes we have achieved through our regional service centers. We are increasingly taking advantage of our national scale by contracting for services on a multistate basis. We are expanding our successful shared services model for additional clinical and support functions, such as physician credentialing, medical transcription, electronic medical recordkeeping and health information management, across multiple markets.

Continue to Develop Physician Relationships. We depend on the quality and dedication of the physicians who practice at our facilities, and we encourage, consistent with applicable laws, both primary care physicians and specialists to join our medical staffs. We sometimes assist physicians who are recruited under applicable regulatory provisions with establishing and building a practice or joining an

existing practice. As part of our comprehensive approach to physician integration in our markets, we will continue to:

- expand the number of high quality specialty services, such as cardiology, orthopedics, oncology and neonatology;
- use joint ventures with physicians to further develop our outpatient business, particularly through ASCs;
- develop medical office buildings to provide convenient facilities for physicians to locate their practices and serve their patients;
- focus on improving the quality, advanced technology, infrastructure and performance of our facilities; and
- employ physicians as appropriate.

Become the Health Care Employer of Choice. We will continue to use a number of industry-leading practices to help ensure our hospitals are a health care employer of choice in their respective communities. Our staffing initiatives for both care providers and hospital management provide strategies for recruitment, compensation and productivity to increase employee retention and operating efficiency at our hospitals. For example, we maintain an internal contract nursing agency to supply our hospitals with high quality staffing at a lower cost than external agencies. In addition, we have developed several proprietary training and career development programs for our physicians and hospital administrators, including an executive development program designed to train the next generation of hospital leadership. We believe our continued investment in the training and retention of employees improves the quality of care, enhances operational efficiency and fosters our reputation as an employer of choice.

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 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 and suburban communities, primarily in the southern and western regions of the United States. Our specific policies designed to maintain this focus include:

- use investments in new and expanded services to drive use of our facilities;
- seek rate increases from managed care payers commensurate with increases in our underlying costs to provide high quality services;
- manage operating expenses by, among other methods, leveraging our scale;
- seek cost savings by reducing variations in our patient care and support processes and reducing our discretionary operating expenses; and
- consider 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 $8.5 billion aggregate notional amount of pay-fixed rate swap agreements related to our senior secured credit facilities debt at December 31, 2009; and

endeavor to improve our credit quality over time.

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

manage 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 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 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, Nevada, Oklahoma, Texas and Utah. Samuel Hazen, who has held various positions with HCA for 24 years, is the Western Group s President. As of December 31, 2009, there were 55 consolidating hospitals within the Western Group. The Western Group includes seven of our non-consolidated 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, Kentucky, Louisiana, Mississippi, Missouri, New Hampshire, Tennessee and Virginia. Paul Rutledge, who has held various positions with HCA for 20 years, is the Central Group s President. As of December 31, 2009, 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 20 years, is the Eastern Group s President. As of December 31, 2009, 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 December 31, 2009, which are included in our Corporate and Other Segment. 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 audited 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 December 31, 2009, we owned and operated 150 general, acute care hospitals with 38,349 licensed beds, and an additional seven general, acute care hospitals with 2,269 licensed beds, 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 December 31, 2009, we operated five psychiatric hospitals with 490 licensed beds. Our psychiatric hospitals provide therapeutic programs including child, adolescent and adult psychiatric care, adult and adolescent alcohol and drug abuse treatment and counseling.

We also operate outpatient health care facilities which include freestanding 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. A majority 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 Medicare and Medicaid programs. Amounts

received under Medicare and Medicaid programs are generally significantly less than established hospital gross charges for the services provided.

Our hospitals generally offer discounts from established charges to certain group purchasers of health care services, including private insurance companies, employers, HMOs, PPOs and other managed care plans. These discount programs generally limit our ability to increase revenues in response to increasing costs. See Business Competition. Patients are generally not responsible for the total difference between established hospital gross charges and amounts reimbursed for such services under Medicare, Medicaid, HMOs or PPOs and other managed care plans, but are responsible to the extent of any exclusions, deductibles or coinsurance

features of their coverage. The amount of such exclusions, deductibles and coinsurance continues to increase. Collection of amounts due from individuals is typically more difficult than from governmental or third-party payers. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care under our charity care policy. These discounts are similar to those provided to many local managed care plans. In implementing the discount policy, we attempt to qualify uninsured patients for Medicaid, other federal or state assistance or charity care under our charity care policy. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Medicare

Inpatient Acute Care

Under the Medicare program, we receive reimbursement under a prospective payment system (PPS) for general, acute care hospital inpatient services. Under the hospital inpatient PPS, fixed payment amounts per inpatient discharge are established based on the patient s assigned Medicare severity diagnosis-related group (MS-DRG). The Centers for Medicare & Medicaid Services (CMS) recently completed a two-year transition to full implementation of MS-DRGs to replace the previously used Medicare diagnosis related groups in an effort to better recognize severity of illness in Medicare payment rates. MS-DRGs classify treatments for illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. MS-DRG weights represent the average resources for a given MS-DRG relative to the average resources for all MS-DRGs. MS-DRG payments are adjusted for area wage differentials. Hospitals, other than those defined as new, receive PPS reimbursement for inpatient capital costs based on MS-DRG weights multiplied by a geographically adjusted federal rate. When the cost to treat certain patients falls well outside the normal distribution, providers typically receive additional outlier payments.

MS-DRG rates are updated and MS-DRG weights are recalibrated using cost relative weights each federal fiscal year (which begins October 1). The index used to update the MS-DRG rates (the market basket) gives consideration to the inflation experienced by hospitals and entities outside the health care industry in purchasing goods and services. In federal fiscal year 2009, the MS-DRG rate was increased by the full market basket of 3.6%. For the federal fiscal year 2010, CMS has set the MS-DRG rate increase at the full market basket of 2.1%. However, the Health Reform Legislation includes a 0.25% reduction to the market basket for 2010 for discharges occurring on or after April 1, 2010. The Health Reform Legislation 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 Legislation provides for the annual market basket update to be further reduced by a productivity adjustment tied to an economy-wide productivity average as determined by the Department of Health and Human Services (HHS). In addition, the Health Reform Legislation mandates several pilot programs intended to evaluate alternative payment methodologies, including a national bundled payment program for inpatient hospital services provided to treat eligible medical conditions or episodes of care. A decrease in payments rates or an increase in rates that is below the increase in our costs may adversely affect the results of our operations.

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

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

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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. CMS currently requires hospitals to report 46 quality measures in order to qualify for the full market basket update to the inpatient PPS in federal fiscal year 2011. Failure to submit the required quality indicators will result in a two percentage point reduction to the market basket update. All of our hospitals paid under Medicare inpatient MS-DRG PPS are participating in the quality initiative by submitting the requested quality data. While we will endeavor to comply with all data submission requirements as additional requirements continue to be added, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals.

As part of CMS s goal of transforming Medicare from a passive payer to an active purchaser of quality goods and services, for discharges occurring after October 1, 2008, Medicare no longer assigns an inpatient hospital discharge to a higher paying MS-DRG if a selected 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 (NCDs) that prohibit Medicare reimbursement for erroneous surgical procedures performed on an inpatient or outpatient basis. The Health Reform Legislation provides for reduced payments based on a hospital s HAC rates and readmission rates and requires HAC rates and readmission rates to be made public. Beginning in federal fiscal year 2015, hospitals that fall into the top 25% of risk-adjusted HAC rates for all hospitals in the previous year will receive a 1% reduction in payment rates. For discharges occurring during a fiscal year beginning on or after October 1, 2012, hospitals with excessive readmissions for certain conditions will receive reduced payments for all inpatient admissions.

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

Outpatient

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

Hospital outpatient services paid under PPS are classified into groups called ambulatory payment classifications (APCs). Services for each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit. The APC payment rates were updated for calendar years 2008 and 2009 by market baskets of 3.30% and 3.60%, respectively. On November 20, 2009, CMS published a final rule that updated payment rates for calendar year 2010 by the full market basket of 2.1%. However, the Health Reform Legislation includes a 0.25% reduction to the market basket for 2010. The Health Reform Legislation 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 2012 and each subsequent calendar year, the

Health Reform Legislation provides for an annual market basket update to be further reduced by a productivity adjustment tied to an economy-wide productivity average as determined by HHS. CMS continues to require hospitals to submit quality data relating to outpatient care to receive the full market basket increase under the outpatient PPS in

calendar year 2010. CMS required hospitals to report data on eleven quality measures in calendar year 2009 for the payment determination in calendar year 2010 and will continue to require hospitals to report the existing eleven quality measures in calendar year 2010 for the 2011 payment determination. Hospitals that fail to submit such data will receive the market basket update minus two percentage points for the outpatient PPS.

Rehabilitation

CMS reimburses inpatient rehabilitation facilities (IRFs) on a PPS basis. Under IRF PPS, patients are classified into case mix groups based upon impairment, age, comorbidities (additional diseases or disorders from which the patient suffers) and functional capability. IRFs are paid a predetermined amount per discharge that reflects the patient s case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. CMS provided for a market basket update of 2.5% for federal fiscal year 2010. However, the Health Reform Legislation requires a 0.25% reduction to the market basket for 2010 for discharges occurring on or after April 1, 2010. The Health Reform Legislation 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 Legislation provides for the annual market basket update to be further reduced by a productivity adjustment tied to an economy-wide productivity average as determined by HHS. 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 is 2.1%. However, the Health Reform Legislation includes a 0.25% reduction to the market basket for rate year 2010. The Health Reform Legislation also provides for the following reductions to the market basket update for each of the following rate 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 2012 and each subsequent rate year, the Health Reform Legislation provides for the annual market basket update to be further reduced by a productivity adjustment tied to an economy-wide productivity average as determined by HHS. As of December 31, 2009, we had five psychiatric

hospitals and 32 hospital psychiatric units.

Ambulatory Surgery Centers

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

Other

Under PPS, the payment rates are adjusted for the area differences in wage levels by a factor (wage index) reflecting the relative wage level in the geographic area compared to the national average wage level. Beginning in federal fiscal year 2007, CMS adjusted 100% of the wage index factor for occupational mix. The redistributive impact of wage index changes, while slightly negative in the aggregate, is not anticipated to have a material financial impact for 2010. However, the Health Reform Legislation 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. CMS has awarded contracts to all 15 MAC jurisdictions; as a result of filed protests, CMS is taking corrective action regarding the contracts in several jurisdictions. While chain providers had the option of having all hospitals use one home office MAC, HCA chose to use the MACs assigned to the geographic areas in which our hospitals are located. The individual MAC jurisdictions are in varying phases of transition. For the transition periods and for a potentially unforeseen period thereafter, all of these changes could impact claims processing functions and the resulting cash flow; however, we are unable to predict the impact at this time.

Under the Recovery Audit Contractor (RAC) program, CMS contracts with RACs to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. CMS has awarded contracts to four RACs that are implementing the RAC program on a nationwide basis as required by statute. The Health Reform Legislation expands the RAC program s scope to include Medicaid claims by requiring all states to enter contracts with RACs by December 31, 2010.

Managed Medicare

Managed Medicare plans relate to situations where a private company contracts with CMS to provide members with Medicare Part A, Part B and Part D benefits. Managed Medicare plans can be structured as HMOs, PPOs or private fee-for-service plans. The Medicare program allows beneficiaries to choose enrollment in certain managed Medicare

plans. In 2003, MMA increased reimbursement to managed Medicare plans and expanded Medicare beneficiaries healthcare options. Since 2003, the number of beneficiaries choosing to receive their Medicare benefits through such plans has increased. However, the Medicare Improvements for Patients and Providers Act of 2008 imposed new restrictions and implemented focused cuts to certain managed

Medicare plans. In addition, the Health Reform Legislation reduces payments to managed Medicare plans. In light of the current economic downturn and the recently enacted legislation, 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. Effective July 1, 2011, the Health Reform Legislation will prohibit the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. The Health Reform Legislation also requires states to expand Medicaid coverage to all individuals under age 65 with incomes up to 133% of the federal poverty level by 2014. Expansion of the Medicaid program could adversely affect future levels of reimbursement received by our hospitals.

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

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, 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 several of the states assigned to those regions. Throughout 2010, MIC audits will continue to expand to other states. The Health Reform Legislation increases federal funding for the MIC program for federal fiscal year 2011 and later years. In addition to MICs, several other contractors, including the state Medicaid agencies, have increased their review activities. The Health Reform Legislation expands the RAC program s scope to include Medicaid claims by requiring all states to enter contracts with RACs by December 31, 2010. Future legislation or other changes in the administration or interpretation of government health programs could have a material, adverse effect on our financial position and results of operations.

Managed Medicaid

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

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

TRICARE

TRICARE is the Department of Defense s health care program for members of the armed forces. On May 1, 2009, the Department of Defense implemented a prospective payment system for hospital outpatient services furnished to TRICARE beneficiaries similar to that utilized for services furnished to Medicare beneficiaries. Because the Medicare outpatient prospective payment system APC rates have historically been

below TRICARE rates, the adoption of this payment methodology for TRICARE beneficiaries reduces our reimbursement; however, TRICARE outpatient services do not represent a significant portion of our patient volumes.

Annual Cost Reports

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

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

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 Legislation 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 Legislation 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, the Health Reform Legislation contains provisions that seek to decrease the number of uninsured individuals, including requirements, 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, it is difficult to predict the full impact of the Health Reform Legislation due to the law s complexity, lack of implementing regulations or interpretive guidance, gradual implementation 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.

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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.

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 dat