BROOKWOOD MEDICAL CENTER OF GULFPORT INC
Form 424B3
March 01, 2010

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Filed Pursuant to Rule 424(b)(3)
Registration Nos. 333-159511 and 333-159511-01 to 333-159511-184

HCA INC.
SUPPLEMENT NO. 10 TO
MARKET MAKING PROSPECTUS DATED
JULY 10, 2009
THE DATE OF THIS SUPPLEMENT IS MARCH 1, 2010
On March 1, 2010, HCA Inc. filed the attached Annual Report on Form 10-K
for the fiscal year ended December 31, 2009

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

Form 10-K

(Mark One)

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

Commission File Number 1-11239

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

Delaware (State or Other Jurisdiction of Incorporation or Organization)	**75-2497104** (I.R.S. Employer Identification No.)
One Park Plaza **Nashville, Tennessee** (Address of Principal Executive Offices)	**37203** (Zip Code)

Registrant s telephone number, including area code: **(615) 344-9551**

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

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

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

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

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

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

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

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

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

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes o No þ

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

DOCUMENTS INCORPORATED BY REFERENCE

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

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PART I

Item 1. *Business*

General

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

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

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

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

Available Information

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

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

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

Business Strategy

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

- maintain our dedication to the care and improvement of human life;
- maintain our commitment to ethics and compliance;
- leverage our leading local market positions;
- expand our presence in key markets;
- continue to leverage our scale;
- continue to develop physician relationships; and
- become the health care employer of choice.

Health Care Facilities

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

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

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

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

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

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

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

Medicare

Inpatient Acute Care

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

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

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

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

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

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

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

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Outpatient

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

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

Rehabilitation

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

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

Psychiatric

Inpatient hospital services furnished in psychiatric hospitals and psychiatric units of general, acute care hospitals and critical access hospitals are reimbursed under a prospective payment system (IPF PPS), a per diem payment, with adjustments to account for certain patient and facility characteristics. IPF PPS contains an outlier policy for extraordinarily costly cases and an adjustment to a facility s base payment if it maintains a full-service emergency department. CMS has established the IPF PPS payment rate in a manner intended to be budget neutral and has adopted a July 1 update cycle. The rehabilitation, psychiatric and long-term care (RPL) market basket update is used to update the IPF PPS. The annual RPL market basket update for rate year 2010 is 2.1%. As of December 31, 2009, we had five psychiatric hospitals and 32 hospital psychiatric units.

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Ambulatory Surgery Centers

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

Other

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

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

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

Managed Medicare

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

Medicaid

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

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

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

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

Managed Medicaid

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

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

TRICARE

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

Annual Cost Reports

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

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

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Managed Care and Other Discounted Plans

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

Uninsured and Self-Pay Patients

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

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

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

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

Hospital Utilization

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

The following table sets forth certain operating statistics for our health care facilities. Health care facility operations are subject to certain seasonal fluctuations, including decreases in patient utilization during holiday periods and increases in the cold weather months. The data set forth in this table includes only those facilities that are consolidated for financial reporting purposes.

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

(a) Excludes eight facilities in 2009, 2008 and 2007 and seven facilities in 2006 and 2005 that are not consolidated (accounted for using the equity method) for financial reporting purposes.

(b) Excludes eight facilities in 2009 and 2008, nine facilities in 2007 and 2006 and seven facilities in 2005 that are not consolidated (accounted for using the equity method) for financial reporting purposes.

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

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

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

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

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

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

(i) Represents the percentage of hospital licensed beds occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.

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

(k) Represents the number of surgeries performed on patients who were not admitted to our hospitals. Pain management and endoscopy procedures are not included in outpatient surgeries.

(l) Represents the number of surgeries performed on patients who have been admitted to our hospitals. Pain management and endoscopy procedures are not included in inpatient surgeries.

Competition

Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. Additionally, in recent years the number of freestanding surgery centers and diagnostic centers (including facilities owned by physicians) in the geographic areas in which we operate has increased significantly. As a result, most of our hospitals operate in a highly competitive environment. In some cases, competing hospitals are more established than our hospitals. Some competing hospitals are owned by tax-supported government agencies and many others are owned by not-for-profit entities that may be supported by endowments, charitable contributions and/or tax revenues and are exempt from sales, property and income taxes. Such exemptions and support are not available to our hospitals. In certain localities there are large teaching hospitals that provide highly specialized facilities, equipment and services which may not be available at most of our hospitals. We are facing increasing competition from physician-owned specialty hospitals and both our own and unaffiliated freestanding surgery centers for market share in high margin services.

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

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

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

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

State certificate of need (CON) laws, which place limitations on a hospital s ability to expand hospital services and facilities, make capital expenditures and otherwise make changes in operations, may also have the effect of restricting competition. We currently operate health care facilities in a number of states with CON laws. Before issuing a CON, these states consider the need for additional or expanded health care facilities or services. In those states which have no CON laws or which set relatively high levels of expenditures before they become reviewable by state authorities, competition in the form of new services, facilities and capital spending is more prevalent. See Item 1, Business Regulation and Other Factors.

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

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Admissions and average lengths of stay continue to be negatively affected by payer-required pre-admission authorization, utilization review and payer pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Increased competition, admission constraints and payer pressures are expected to continue. To meet these challenges, we intend to expand our facilities or acquire or construct new facilities where appropriate, to better enable the provision of a comprehensive array of outpatient services, offer market competitive pricing to private payer groups, upgrade facilities and equipment, and offer new or expanded programs and services.

Regulation and Other Factors

Licensure, Certification and Accreditation

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

Certificates of Need

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

State Rate Review

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

Federal Health Care Program Regulations

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

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Anti-kickback Statute

A section of the Social Security Act known as the Anti-kickback Statute prohibits providers and others from directly or indirectly soliciting, receiving, offering or paying any remuneration with the intent of generating referrals or orders for services or items covered by a federal health care program. Courts have interpreted this statute broadly and held that there is a violation of the Anti-kickback Statute if just one purpose of the remuneration is to generate referrals, even if there are other lawful purposes. Violations of the Anti-kickback Statute may be punished by a criminal fine of up to $25,000 for each violation or imprisonment, civil money penalties of up to $50,000 per violation and damages of up to three times the total amount of the remuneration and/or exclusion from participation in federal health care programs, including Medicare and Medicaid.

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

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

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

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

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

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not necessarily render the conduct or business arrangement illegal under the Anti-kickback Statute. However, such conduct and business arrangements may lead to increased scrutiny by government enforcement authorities.

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

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

Stark Law

The Social Security Act also includes a provision commonly known as the Stark Law. The Stark Law prevents the entity from billing Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires the entity to refund amounts received for items or services provided pursuant to the prohibited referral. The law, thus, effectively prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship, if these entities provide certain designated health services reimbursable by Medicare, including inpatient and outpatient hospital services, clinical laboratory services and radiology services. Sanctions for violating the Stark Law include denial of payment, civil monetary penalties of up to $15,000 per claim submitted and exclusion from the federal health care programs. The statute also provides for a penalty of up to $100,000 for a circumvention scheme. There are exceptions to the self-referral prohibition for many of the customary financial arrangements between physicians and providers, including employment contracts, leases and recruitment agreements. There is also an exception for a physician s ownership interest in an entire hospital, as opposed to an ownership interest in a hospital department. Unlike safe harbors under the Anti-kickback Statute with which compliance is voluntary, an arrangement must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law.

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

On September 14, 2007, CMS published an information collection request called the Disclosure of Financial Relations Report (DFRR). 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. CMS has indicated that responding hospitals will have a limited amount of time to compile a significant amount of information relating to their financial relationships with physicians. A hospital may be subject to substantial penalties if it is unable to assemble and report this information within the required time frame or if any applicable government agency determines that

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the submission is inaccurate or incomplete. Depending on the final format of the DFRR, responding hospitals may be subject to substantial penalties as a result of enforcement actions brought by government agencies and whistleblowers acting pursuant to the federal False Claims Act (FCA) and similar state laws, based on such allegations as failure to respond within required deadlines, that the response is inaccurate or contains incomplete information, or that the response indicates a potential violation of the Stark Law or other requirements.

Similar State Laws

Many states in which we operate also have laws similar to the Anti-kickback Statute that prohibit payments to physicians for patient referrals and laws similar to the Stark Law that prohibit certain self-referrals. The scope of these state laws is broad, since they can often apply regardless of the source of payment for care, and little precedent exists for their interpretation or enforcement. These statutes typically provide for criminal and civil penalties, as well as loss of facility licensure.

Other Fraud and Abuse Provisions

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

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

The Federal False Claims Act and Similar State Laws

The *qui tam*, or whistleblower, provisions of the FCA allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. Further, the government may use the FCA to prosecute Medicare and other government program fraud in areas such as coding errors, billing for services not provided and submitting false cost reports. When a private party brings a *qui tam* action under the FCA, the defendant is not made aware of the lawsuit until the government commences its own investigation or makes a determination whether it will intervene. When a defendant is determined by a court of law to be liable under the FCA, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. There are many potential bases for liability under the FCA. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA defines the term knowingly broadly. Though simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity constitutes a knowing submission under the FCA and, therefore, will qualify for liability. On May 20, 2009, the Fraud Enforcement and Recovery Act of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers.

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

HIPAA Administrative Simplification and Privacy and Security Requirements

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

The privacy and security regulations promulgated pursuant to HIPAA extensively regulate the use and disclosure of individually identifiable health information and require covered entities, including health plans and most health care providers, to implement administrative, physical and technical safeguards to protect the security of such information. The American Recovery and Reinvestment Act of 2009 (ARRA), which was signed into law on February 17, 2009, broadened the scope of the HIPAA privacy and security regulations. In addition, ARRA extends the application of certain provisions of the security and privacy regulations to business associates (entities that handle identifiable health information on behalf of covered entities) and subjects business associates to civil and criminal penalties for violation of the regulations. We enforce a HIPAA compliance plan, which we believe complies with HIPAA privacy and security requirements and under which a HIPAA compliance group monitors our compliance. The privacy regulations and security regulations have and will continue to impose significant costs on our facilities in order to comply with these standards.

As required by ARRA, HHS published an interim final rule on August 24, 2009, that requires covered entities to report breaches of unsecured protected health information to affected individuals without unreasonable delay but not to exceed 60 days of discovery of the breach by a covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information.

Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties, and ARRA has strengthened the enforcement provisions of HIPAA, which may result in increased enforcement activity. Under ARRA, HHS is required to conduct periodic compliance audits of covered entities and their business associates. ARRA broadens the applicability of the criminal penalty provisions to employees of covered entities and requires HHS to impose penalties for violations resulting from willful neglect. ARRA also significantly increases the amount of the civil penalties, with penalties of up to $50,000 per violation for a maximum civil penalty of

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$1,500,000 in a calendar year for violations of the same requirement. In addition, ARRA authorizes state attorneys general to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. Our facilities also remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties.

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. For example, the Federal Trade Commission issued a final rule in October 2007 requiring financial institutions and creditors, which may include health providers and health plans, to implement written identity theft prevention programs to detect, prevent, and mitigate identity theft in connection with certain accounts. The Federal Trade Commission has delayed enforcement of this rule until June 1, 2010.

EMTALA

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

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

Corporate Practice of Medicine/Fee Splitting

Some of the states in which we operate have laws prohibiting corporations and other entities from employing physicians, practicing medicine for a profit and making certain direct and indirect payments or fee-splitting arrangements between health care providers designed to induce or encourage the referral of patients to, or the recommendation of, particular providers for medical products and services. Possible sanctions for violation of these restrictions include loss of license and civil and criminal penalties. In addition, agreements between the corporation and the physician may be considered void and unenforceable. These statutes vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies.

Health Care Industry Investigations

Significant media and public attention has focused in recent years on the hospital industry. This media and public attention, changes in government personnel or other factors may lead to increased scrutiny of the health care industry.

While we are currently not aware of any material investigations of the Company under federal or state health care laws or regulations, it is possible that governmental entities could initiate investigations or litigation in the future at facilities we operate and that such matters could result in significant penalties, as well as adverse

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publicity. It is also possible that our executives and managers could be included in governmental investigations or litigation or named as defendants in private litigation.

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

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

Both federal and state government agencies have increased their focus on and coordination of civil and criminal enforcement efforts in the health care area. The OIG and the Department of Justice have, from time to time, established national enforcement initiatives, targeting all hospital providers that focus on specific billing practices or other suspected areas of abuse. In addition, governmental agencies and their agents, such as the Medicare Administrative Contractors, fiscal intermediaries and carriers, may conduct audits of our health care operations. Private payers may conduct similar post-payment audits, and we also perform internal audits and monitoring.

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

Commencing in 1997, we became aware we were the subject of governmental investigations and litigation relating to our business practices. As part of the investigations, the United States intervened in a number of *qui tam* actions brought by private parties. The investigations related to, among other things, DRG coding, outpatient laboratory billing, home health issues, physician relations, cost report and wound care issues. The investigations were concluded through a series of agreements executed in 2000 and 2003 with the Criminal Division of the Department of Justice, the Civil Division of the Department of Justice, various U.S. Attorneys offices, CMS, a negotiating team representing states with claims against us, and others. In January 2001, we entered into an eight-year Corporate Integrity Act (CIA) with the Office of Inspector General of the Department of Health and Human Services, which expired January 24, 2009. If the government were to determine that we violated or breached the CIA or other federal or state laws relating to Medicare, Medicaid or similar programs, we could be subject to substantial monetary fines, civil and criminal penalties and/or exclusion from participation in the Medicare and Medicaid programs and other federal and state health care programs. Alleged violations may be pursued by the government or through private *qui tam* actions. Sanctions imposed against us as a result of such actions could have a material, adverse effect on our results of operations and financial position.

Health Care Reform

Health care is one of the largest industries in the United States and continues to attract much legislative interest and public attention. National health care reform is a focus at the federal level. In the final months of 2009, both houses of the U.S. Congress passed separate bills intended to reform the health care system through, among other things, decreasing the number of uninsured individuals and reducing health care costs. While neither of these bills has yet become law, such laws or similar proposals have been, and we anticipate will continue to be, a focus at the federal level. Several states are also considering health care reform measures. This focus on health care reform may increase the likelihood of significant changes affecting the health care industry. In addition, possible future changes in the Medicare, Medicaid, and other state programs, including Medicaid supplemental payments pursuant to upper payment limit programs, may impact reimbursements to health care providers and insurers. Many states have enacted, or are considering enacting, measures designed to reduce their Medicaid expenditures and change private health care insurance. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand states Medicaid systems. Some states, including the states in which we operate, have applied for and have been granted federal waivers from current Medicaid regulations to allow them to serve some or all of their Medicaid participants through managed care providers. Hospital operating margins have been, and may continue to be, under significant pressure because of deterioration in pricing flexibility and payer mix, and growth in operating expenses in excess of the increase in PPS payments under the Medicare program.

General Economic and Demographic Factors

The United States economy has weakened significantly. Depressed consumer spending and higher unemployment rates continue to pressure many industries. During economic downturns, governmental entities often experience budget deficits as a result of increased costs and lower than expected tax collections. These budget deficits 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 care industry is impacted by the overall United States financial pressures. The federal deficit, the growing magnitude of Medicare expenditures and the aging of the United States population will continue to place pressure on federal health care programs.

Compliance Program and Corporate Integrity Agreement

We maintain a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. The program is intended to monitor and raise awareness of various regulatory issues among employees and to emphasize the importance of complying with governmental laws and regulations. As part of the ethics and compliance program, we provide annual ethics and compliance training to our employees and encourage all employees to report any violations to their supervisor, an ethics and compliance officer or a toll-free telephone ethics line.

Until January 24, 2009, we operated under a Corporate Integrity Agreement (CIA), which was structured to assure the federal government of our overall federal health care program compliance and specifically covered DRG coding, outpatient PPS billing and physician relations. We underwent major training efforts to ensure that our employees learned and applied the policies and procedures implemented under the CIA and our ethics and compliance program. The CIA had the effect of increasing the amount of information we provided to the federal government regarding our health care practices and our compliance with federal regulations. Under the CIA, we had numerous affirmative obligations, including the requirement to report potential violations of applicable federal health care laws and regulations. Pursuant to this obligation, we reported a number of potential violations of the Stark Law, the Anti-kickback Statute, EMTALA, HIPAA and other laws, most of which we consider to be nonviolations or technical violations. We submitted our final report pursuant to the CIA on April 30, 2009. These reports could result in greater scrutiny by regulatory authorities. The government could determine that our reporting and/or our resolution of reported issues was inadequate. A determination that we breached the CIA and/or a finding of violations of applicable health care laws or regulations could subject us to repayment requirements, substantial monetary penalties, civil penalties, exclusion from participation in the Medicare and Medicaid and other federal and state health care programs and, for violations of certain laws and regulations, criminal penalties. Although the CIA expired on January 24, 2009, we maintain our ethics and compliance program in substantially the same form. However, the audit plans in the CIA have been modified and the reportable events process has been converted to an internal reporting process.

Antitrust Laws

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

Environmental Matters

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

Insurance

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

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

Employees and Medical Staffs

At December 31, 2009, we had approximately 190,000 employees, including approximately 49,000 part-time employees. References herein to employees refer to employees of our affiliates. We are subject to various state and federal laws that regulate wages, hours, benefits and other terms and conditions relating to employment. At December 31, 2009, employees at 20 of our hospitals are represented by various labor unions. It is possible additional hospitals may unionize in the future. We consider our employee relations to be good and have not experienced work stoppages that have materially, adversely affected our business or results of operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate. In some markets, nurse and medical support personnel availability has become a significant operating issue to health care providers. To address this challenge, we have implemented several initiatives to improve retention, recruiting, compensation programs and productivity.

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

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

Executive Officers of the Registrant

As of February 28, 2010, our executive officers were as follows:

Name	Age	Position(s)
Richard M. Bracken	57	Chairman of the Board and Chief Executive Officer
R. Milton Johnson	53	Executive Vice President, Chief Financial Officer and Director
David G. Anderson	62	Senior Vice President Finance and Treasurer
Victor L. Campbell	63	Senior Vice President
Charles J. Hall	56	President Eastern Group
Samuel N. Hazen	49	President Western Group
A. Bruce Moore, Jr.	50	President Outpatient Services Group
Jonathan B. Perlin, M.D.	49	President Clinical Services Group and Chief Medical Officer
W. Paul Rutledge	55	President Central Group
Joseph A. Sowell, III	53	Senior Vice President Development
Joseph N. Steakley	55	Senior Vice President Internal Audit Services
John M. Steele	54	Senior Vice President Human Resources
Donald W. Stinnett	53	Senior Vice President and Controller
Beverly B. Wallace	59	President Shared Services Group
Robert A. Waterman	56	Senior Vice President, General Counsel and Chief Labor Relations Officer
Noel Brown Williams	54	Senior Vice President and Chief Information Officer
Alan R. Yuspeh	60	Senior Vice President and Chief Ethics and Compliance Officer

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

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

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

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

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

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

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

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

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

Joseph A. Sowell, III was appointed as Senior Vice President and Chief Development Officer of the Company in December 2009. From 1987 to 1996 and again from 1999 to 2009, Mr. Sowell was a partner at the law firm of Waller Lansden Dortch & Davis. From 1996 to 1999, Mr. Sowell served as the head of development, and later as the Chief Operating Officer of Arcon Healthcare.

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

John M. Steele has served as Senior Vice President Human Resources of the Company since November 2003. Mr. Steele served as Vice President Compensation and Recruitment of the Company from November 1997

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to October 2003. From March 1995 to November 1997, Mr. Steele served as Assistant Vice President Recruitment.

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

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

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

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

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

Item 1A. *Risk Factors*

If any of the events discussed in the following risk factors were to occur, our business, financial position, results of operations, cash flows or prospects could be materially, adversely affected. Additional risks and uncertainties not presently known, or currently deemed immaterial, may also constrain our business and operations.

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, our total indebtedness was $25.670 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 is 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, our substantial indebtedness included $9.702 billion of indebtedness under our senior secured credit facilities maturing in 2012 and 2013, $2.750 billion aggregate principal amount of first lien notes maturing in 2019 and 2020, $6.088 billion aggregate principal amount 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, 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 and $1.250 billion in aggregate principal amount of 77/8% 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 outstanding 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 or our outstanding notes.

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. 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, 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 physician-owned specialty hospitals 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 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.

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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 Item 1, 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.

Health Care Reform And Changes In Governmental Programs May Reduce Our Revenues.

National health care reform remains a focus at the federal level. In the final months of 2009, both houses of the U.S. Congress passed separate bills intended to reform the health care system through, among other things, decreasing the number of uninsured individuals and reducing health care costs. While neither of these bills has yet become law, such laws or similar proposals have been, and we anticipate will continue to be, a focus at the federal level. Several states are also considering health care reform measures. Federal or state health care reform could adversely affect our business and results of operations.

The focus on health care reform may also increase the likelihood of significant changes affecting existing government health care programs. A significant portion of our patient volumes is derived from government health care programs, principally Medicare and Medicaid, which are highly regulated and subject to frequent and substantial changes. We derived approximately 60% of our admissions from the Medicare and Medicaid programs in 2009. 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 these government programs. Possible future changes in the Medicare, Medicaid, and other state programs may reduce reimbursements to health care providers and insurers and may also increase our operating costs, which could reduce our profitability.

Effective January 1, 2008, CMS increased ASC payment groups 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. CMS established a four-year transition period for implementing the revised payment rates and significantly expanded the number of procedures that Medicare reimburses if performed in an ASC. CMS also limited ASC reimbursement for procedures commonly performed in physicians offices. 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.

CMS has recently completed a two-year transition to full implementation of the MS-DRGs system, which represents a refinement to the existing MS-DRG system. Realignments in the 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

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submit this data. While we will endeavor to comply with all quality data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals. 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. 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 and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems.

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.

Changes in laws or regulations regarding government health programs or other changes in the administration of 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 exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. 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

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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 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 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.

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 Be The Subject Of Governmental Investigations, Claims And Litigation.

Health care companies are subject to numerous investigations by various governmental agencies. Further, under the federal FCA, private parties have the right to bring *qui tam*, or whistleblower, suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions. Certain of our individual facilities have received, and 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.

The MMA established the RAC three-year demonstration program to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The Tax Relief and Health Care Act of 2006 made the RAC program permanent and mandated its nationwide expansion by 2010. CMS has awarded contracts to four RACs that are implementing the permanent RAC program on a nationwide basis. In addition, CMS employs MICs to perform post-payment audits of Medicaid claims and identify overpayments. Throughout 2010, MIC audits will continue to expand. In addition to 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. 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 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 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 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. 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.

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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 ARRA, 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 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 Item 3, 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.

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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 Item 7, 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.

Item 1B. *Unresolved Staff Comments*

None.

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Item 2. *Properties*

The following table lists, by state, the number of hospitals (general, acute care, psychiatric and rehabilitation) directly or indirectly owned and operated by us as of December 31, 2009:

State	Hospitals	Beds
Alaska	1	250
California	5	1,587
Colorado	7	2,259
Florida	38	9,780
Georgia	11	1,946
Idaho	2	481
Indiana	1	278
Kansas	4	1,286
Kentucky	2	384
Louisiana	7	1,428
Mississippi	1	130
Missouri	6	1,055
Nevada	3	1,075
New Hampshire	2	295
Oklahoma	2	793
South Carolina	3	740
Tennessee	12	2,313
Texas	35	10,493
Utah	6	968
Virginia	9	2,963
International		
England	6	704
	163	41,208

In addition to the hospitals listed in the above table, we directly or indirectly operate 105 freestanding surgery centers. We also operate medical office buildings in conjunction with some of our hospitals. These office buildings are primarily occupied by physicians who practice at our hospitals. Fourteen of our general, acute care hospitals and three of our other properties have been mortgaged to support our obligations under our senior secured cash flow credit facility and the first lien secured notes we issued in 2009. These three other properties are also subject to second mortgages to support our obligations under the second lien secured notes we issued in 2006 and 2009.

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

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

Item 3. ***Legal Proceedings***

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

Government Investigations, Claims and Litigation

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

Merger Litigation in State Court

In 2006, the Foundation for Seacoast Health filed suit against HCA in state court in New Hampshire. The Foundation alleged that both the 2006 Recapitalization transaction and a prior 1999 intra-corporate transaction violated a 1983 agreement that placed certain restrictions on transfers of the Portsmouth Regional Hospital. In May 2007, the trial court ruled against the Foundation on all its claims. On appeal, the New Hampshire Supreme Court affirmed the ruling on the Recapitalization, but remanded to the trial court the claims based on the 1999 intra-corporate transaction. The trial court ruled in December 2009 that the 1999 intra-corporate transaction breached the transfer restriction provisions of the 1983 agreement. The trial court will now conduct further proceedings to determine whether any harm has flowed from the alleged breach, and if so, what the appropriate remedy should be, including determining whether, pursuant to the Foundation s assertion, that it should have the right to purchase the hospital.

General Liability and Other Claims

We are a party to certain proceedings relating to claims for income taxes and related interest before the IRS Appeals Division. For a description of those proceedings, see Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations Pending IRS Disputes and Note 5 to our consolidated financial statements.

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

Item 4. *Submission of Matters to a Vote of Security Holders*

No matters were submitted to a vote of security holders during the fourth quarter of 2009.

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PART II

Item 5. ***Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Our outstanding common stock is privately held, and there is no established public trading market for our common stock. As of February 28, 2010, there were 625 holders of our common stock. See Item 7, Management s Discussion and Analysis of Financial condition and Results of Operations Liquidity and Capital Resources Financing Activities for a description of the restrictions on our ability to pay dividends. We did not pay any dividends in 2007, 2008 or 2009.

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 option plans, the holders of nonvested stock options received a $17.50 per share reduction to the exercise price of their share-based awards.

During the quarter ended December 31, 2009, HCA issued and sold 4,284 shares of common stock in connection with the cashless exercise of stock options for aggregate consideration of $54,621 resulting in 2,691 net settled shares. HCA also issued and sold 19,641 shares of common stock in connection with the cash exercise of stock options for aggregate consideration of $250,423. The shares were issued without registration in reliance on the exemptions afforded by Section 4(2) of the Securities Act of 1933, as amended, and Rule 701 promulgated thereunder.

On April 29, 2008, we registered our common stock pursuant to Section 12(g) of the Securities Exchange Act of 1934, as amended.

The following table provides certain information with respect to our repurchase of common stock from October 1, 2009 through December 31, 2009.

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares That May Yet Be Purchased Under Publicly Announced Plans or Programs

October 1, 2009 through October 31, 2009	206	$	71.68	$
November 1, 2009 through November 30, 2009				
December 1, 2009 through December 31, 2009	5,521		87.99	
Total for Fourth Quarter 2009	5,727	$	87.40	$

During the fourth quarter of 2009, we purchased 5,727 shares pursuant to the terms of the Management Stockholders Agreement and/or separation agreements and stock purchase agreements between former employees and the Company.

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Item 6. ***Selected Financial Data***

HCA INC.
SELECTED FINANCIAL DATA
AS OF AND FOR THE YEARS ENDED DECEMBER 31
(Dollars in millions)

	2009	2008	2007	2006	2005
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
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)

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	2009	2008	2007	2006	2005
Operating Data:					
Number of hospitals at end of period(a)	**155**	158	161	166	175
Number of freestanding outpatient surgical centers at end of period(b)	**97**	97	99	98	87
Number of licensed beds at end of period(c)	**38,839**	38,504	38,405	39,354	41,265
Weighted average licensed beds(d)	**38,825**	38,422	39,065	40,653	41,902
Admissions(e)	**1,556,500**	1,541,800	1,552,700	1,610,100	1,647,800
Equivalent admissions(f)	**2,439,000**	2,363,600	2,352,400	2,416,700	2,476,600
Average length of stay (days)(g)	**4.8**	4.9	4.9	4.9	4.9
Average daily census(h)	**20,650**	20,795	21,049	21,688	22,225
Occupancy(i)	**53%**	54%	54%	53%	53%
Emergency room visits(j)	**5,593,500**	5,246,400	5,116,100	5,213,500	5,415,200
Outpatient surgeries(k)	**794,600**	797,400	804,900	820,900	836,600
Inpatient surgeries(l)	**494,500**	493,100	516,500	533,100	541,400
Days revenues in accounts receivable(m)	**45**	49	53	53	50
Gross patient revenues(n)	**$ 115,682**	$ 102,843	$ 92,429	$ 84,913	$ 78,662
Outpatient revenues as a % of patient revenues(o)	**38%**	37%	37%	36%	36%

(a) Excludes eight facilities in 2009, 2008 and 2007 and seven facilities in 2006 and 2005 that are not consolidated (accounted for using the equity method) for financial reporting purposes.

(b) Excludes eight facilities in 2009 and 2008, nine facilities in 2007 and 2006 and seven facilities in 2005 that are not consolidated (accounted for using the equity method) for financial reporting purposes.

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

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

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

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

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

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

(i) Represents the percentage of hospital licensed beds occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.

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

(k) Represents the number of surgeries performed on patients who were not admitted to our hospitals. Pain management and endoscopy procedures are not included in outpatient surgeries.

(l) Represents the number of surgeries performed on patients who have been admitted to our hospitals. Pain management and endoscopy procedures are not included in inpatient surgeries.

(m) 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.

(n) 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.

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

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HCA INC.

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

Item 7. ***Management s Discussion and Analysis of Financial Condition and Results of Operations***

The selected financial data and the accompanying consolidated financial statements present certain information with respect to the financial position, results of operations and cash flows of HCA Inc. which should be read in conjunction with the following discussion and analysis. The terms HCA, Company, we, our, or us, as used herein, refer to H Inc. and our affiliates unless otherwise stated or indicated by context. The term affiliates means direct and indirect subsidiaries of HCA Inc. and partnerships and joint ventures in which such subsidiaries are partners.

Forward-Looking Statements

This annual report on Form 10-K includes certain disclosures which contain forward-looking statements. Forward-looking statements include all statements that do not relate solely to historical or current facts, and can be identified by the use of words like may, believe, will, expect, project, estimate, anticipate, plan, initiat These forward-looking statements are based on our current plans and expectations and are subject to a number of known and unknown uncertainties and risks, many of which are beyond our control, that could significantly affect current plans and expectations and our future financial position and results of operations. These factors include, but are not limited to, (1) the ability to recognize the benefits of the Recapitalization, (2) the impact of the substantial indebtedness incurred to finance the Recapitalization and the ability to refinance such indebtedness on acceptable terms, (3) the possible enactment of federal or state health care reform and changes in federal, state or local laws or regulations affecting the health care industry, (4) increases, particularly in the current economic downturn, in the amount and risk of collectibility of uninsured accounts, and deductibles and copayment amounts for insured accounts, (5) the ability to achieve operating and financial targets, attain expected levels of patient volumes and control the costs of providing services, (6) possible changes in the Medicare, Medicaid and other state programs, including Medicaid supplemental payments pursuant to upper payment limit (UPL) programs, that may impact reimbursements to health care providers and insurers, (7) the highly competitive nature of the health care business, (8) changes in revenue mix, including potential declines in the population covered under managed care agreements due to the current economic downturn, and the ability to enter into and renew managed care provider agreements on acceptable terms, (9) the efforts of insurers, health care providers and others to contain health care costs, (10) the outcome of our continuing efforts to monitor, maintain and comply with appropriate laws, regulations, policies and procedures, (11) increases in wages and the ability to attract and retain qualified management and personnel, including affiliated physicians, nurses and medical and technical support personnel, (12) the availability and terms of capital to fund the expansion of our business and improvements to our existing facilities, (13) changes in accounting practices, (14) changes in general economic conditions nationally and regionally in our markets, (15) future divestitures which may result in charges, (16) changes in business strategy or development plans, (17) delays in receiving payments for services provided, (18) the outcome of pending and any future tax audits, appeals and litigation associated with our tax positions, (19) potential liabilities and other claims that may be asserted against us, and (20) other risk factors described in this annual report on Form 10-K. As a consequence, current plans, anticipated actions and future financial position and results of operations may differ from those expressed in any forward-looking statements made by or on behalf of HCA. You are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented in this report.

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.

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

2009 Operations Summary (Continued)

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.

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.

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Business Strategy (Continued)

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 seek 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 ambulatory surgery centers;
- 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.

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.

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HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Critical Accounting Policies and Estimates (Continued)

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.

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)

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Critical Accounting Policies and Estimates (Continued)

Provision for Doubtful Accounts and the Allowance for Doubtful Accounts (Continued)

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

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HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Critical Accounting Policies and Estimates (Continued)

Provision for Doubtful Accounts and the Allowance for Doubtful Accounts (Continued)

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

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Critical Accounting Policies and Estimates (Continued)

Professional Liability Claims (Continued)

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.

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Critical Accounting Policies and Estimates (Continued)

Professional Liability Claims (Continued)

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

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

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

Income Taxes

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

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

Results of Operations

Revenue/Volume Trends

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

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HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Results of Operations (Continued)

Revenue/Volume Trends (Continued)

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%

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Results of Operations (Continued)

Revenue/Volume Trends (Continued)

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.

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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HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Results of Operations (Continued)

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 Amount	2009 Ratio	2008 Amount	2008 Ratio	2007 Amount	2007 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.

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Results of Operations (Continued)

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.

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Results of Operations (Continued)

Years Ended December 31, 2009 and 2008 (Continued)

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.

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Results of Operations (Continued)

Years Ended December 31, 2008 and 2007 (Continued)

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

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Results of Operations (Continued)

Years Ended December 31, 2008 and 2007 (Continued)

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

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Liquidity and Capital Resources (Continued)

$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 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.

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HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

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.

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

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.

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.

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Market Risk (Continued)

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 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

HCA INC.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Effects of Inflation and Changing Prices (Continued)

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.

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Item 7A. ***Quantitative and Qualitative Disclosures about Market Risk***

Information with respect to this Item is provided under the caption Market Risk under Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations.

Item 8. ***Financial Statements and Supplementary Data***

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

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None.

Item 9A. ***Controls and Procedures***

1. Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of our disclosure controls and procedures, as such term is defined under Rule 13a-15(e) promulgated under the Securities Exchange Act of 1934, as amended (the Exchange Act). Based on this evaluation, our principal executive officer and our principal financial officer concluded that our disclosure controls and procedures were effective as of the end of the period covered by this annual report.

2. Internal Control Over Financial Reporting

(a) Management s Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining effective internal control over financial reporting, as such term is defined in Exchange Act Rule 13a-15(f). Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an assessment of the effectiveness of our internal control over financial reporting based on the framework in Internal Control Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our assessment under the framework in Internal Control Integrated Framework, our management concluded that our internal control over financial reporting was effective as of December 31, 2009.

Ernst & Young, LLP, the independent registered public accounting firm that audited our consolidated financial statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which is included herein.

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(b) Attestation Report of the Independent Registered Public Accounting Firm

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
HCA Inc.

We have audited HCA Inc. s internal control over financial reporting as of December 31, 2009, based on criteria established in Internal Control Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). HCA Inc. s management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management s Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company s internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company s internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company s assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, HCA Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2009, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of HCA Inc. as of December 31, 2009 and 2008, and the related consolidated statements of income, stockholders deficit, and cash flows for each of the three years in the period ended December 31, 2009 and our report dated March 1, 2010 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee

March 1, 2010

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(c) Changes in Internal Control Over Financial Reporting

During the fourth quarter of 2009, there have been no changes in our internal control over financial reporting that have materially affected or are reasonably likely to materially affect our internal control over financial reporting.

Item 9B. ***Other Information***

See the information incorporated by reference in Item 13, Certain Relationships and Related Transactions, and Director Independence for a description of certain relationships between the Administrative Agent under the cash flow credit facility and the ABL credit facility, and our company.

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PART III

Item 10. *Directors, Executive Officers and Corporate Governance*

The information required by this Item regarding the identity and business experience of our directors and executive officers is set forth under the heading Action 1 Election of Directors in the definitive information statement to be filed in connection with our written consent of stockholders in lieu of an annual meeting with respect to our directors and is set forth in Item 1 of Part I of this annual report on Form 10-K with respect to our executive officers. The information required by this Item contained in the definitive information statement is incorporated herein by reference.

Information on the beneficial ownership reporting for our directors and executive officers required by this Item is contained under the caption Section 16(a) Beneficial Ownership Reporting Compliance in the definitive information statement to be filed in connection with our written consent of stockholders in lieu of an annual meeting and is incorporated herein by reference.

Information on our Audit and Compliance Committee and Audit Committee Financial Experts required by this Item is contained under the caption Corporate Governance in the definitive information statement to be filed in connection with our written consent of stockholders in lieu of an annual meeting and is incorporated herein by reference.

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

Item 11. *Executive Compensation*

The information required by this Item is set forth under the headings Executive Compensation and Compensation Committee Interlocks and Insider Participation in the definitive information statement to be filed in connection with our written consent of stockholders in lieu of an annual meeting, which information is incorporated herein by reference.

Item 12. *Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters*

Information about security ownership of certain beneficial owners required by this Item is set forth under the heading Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters in the definitive information statement to be filed in connection with our written consent of stockholders in lieu of an annual meeting, which information is incorporated herein by reference.

Information about our equity compensation plans required by this Item is set forth under the heading Equity Compensation Plan Information in the definitive information statement to be filed in connection with our written consent of stockholders in lieu of an annual meeting, which information is incorporated herein by reference.

Item 13. *Certain Relationships and Related Transactions, and Director Independence*

The information required by this Item is set forth under the headings Certain Relationships and Related Transactions and Corporate Governance in the definitive information statement to be filed in connection with our written consent of stockholders in lieu of an annual meeting, which information is incorporated herein by reference.

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Item 14. ***Principal Accountant Fees and Services***

The information required by this Item is set forth under the heading Principal Accountant Fees and Services in the definitive information statement to be filed in connection with our written consent of stockholders in lieu of an annual meeting, which information is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) *Documents filed as part of the report:*

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

2. *List of Financial Statement Schedules.* All schedules are omitted because the required information is either not present, not present in material amounts or presented within the consolidated financial statements.

3. *List of Exhibits*

2.1	Agreement and Plan of Merger, dated July 24, 2006, by and among HCA Inc., Hercules Holding II, LLC and Hercules Acquisition Corporation (filed as Exhibit 2.1 to the Company s Current Report on Form 8-K filed July 25, 2006, and incorporated herein by reference).
3.1	Amended and Restated Certificate of Incorporation of the Company (filed as Exhibit 3.1 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2007, and incorporated herein by reference).
3.2	Amended and Restated Bylaws of the Company (filed as Exhibit 3.2 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2007, and incorporated herein by reference).
4.1	Specimen Certificate for shares of Common Stock, par value $0.01 per share, of the Company (filed as Exhibit 3 to the Company s Form 8-A/A, Amendment No. 2, filed March 11, 2004 (File No. 001-11239), and incorporated herein by reference).
4.2	Indenture, dated November 17, 2006, among HCA Inc., the guarantors party thereto and The Bank of New York, as trustee (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed November 24, 2006, and incorporated herein by reference).
4.3	Security Agreement, dated as of November 17, 2006, among HCA Inc., the subsidiary grantors party thereto and The Bank of New York, as collateral agent (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed November 24, 2006, and incorporated herein by reference).
4.4	Pledge Agreement, dated as of November 17, 2006, among HCA Inc., the subsidiary pledgors party thereto and The Bank of New York, as collateral agent (filed as Exhibit 4.3 to the Company s Current Report of Form 8-K filed November 24, 2006, and incorporated herein by reference).
4.5(a)	Form of 91/8% Senior Secured Notes due 2014 (included in Exhibit 4.2).
4.5(b)	Form of 91/4% Senior Secured Notes due 2016 (included in Exhibit 4.2).
4.5(c)	Form of 95/8%/103/8% Senior Secured Toggle Notes due 1016 (included in Exhibit 4.2).
4.6	Indenture, dated February 19, 2009, among HCA Inc, the guarantors party thereto, The Bank of New York Mellon, as collateral agent and The Bank of New York Mellon Trust Company, N.A., as trustee. (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed February 25, 2009, and incorporated herein by reference).
4.7	Form of 97/8% Senior Secured Notes due 2017 (included in Exhibit 4.6).

4.8	Indenture, dated as of April 22, 2009, among HCA Inc., the guarantors party thereto, Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent, and Law Debenture Trust Company of New York, as trustee (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed April 28, 2009, and incorporated herein by reference).
4.9	Form of 81/2% Senior Secured Notes due 2019 (included in Exhibit 4.8).

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4.10	Indenture, dated as of August 11, 2009, among HCA Inc., the guarantors party thereto, Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent, and Law Debenture Trust Company of New York, as trustee (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed August 17, 2009, and incorporated herein by reference).
4.11	Form of 77/8% Senior Secured Notes due 2020 (included in Exhibit 4.10).
4.12(a)	$13,550,000,000 1,000,000,000 Credit Agreement, dated as of November 17, 2006, among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Banc of America Securities LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and joint bookrunners, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A. and Citicorp North America, Inc., as co-syndication agents and Merrill Lynch Capital Corporation, as documentation agent (filed as Exhibit 4.8 to the Company s Current Report on Form 8-K filed November 24, 2006, and incorporated herein by reference).
4.12(b)	Amendment No. 1 to the Credit Agreement, dated as of February 16, 2007, among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and Citicorp North America, Inc., as Co-Syndication Agents, Banc of America Securities, LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche Bank Securities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill Lynch Capital Corporation, as documentation agent (filed as Exhibit 4.7(b) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).
4.12(c)	Amendment No. 2 to the Credit Agreement, dated as of March 2, 2009, among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and Citicorp North America, Inc., as Co-Syndication Agents, Banc of America Securities, LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche Bank Securities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill Lynch Capital Corporation, as documentation agent. (filed as Exhibit 4.8(c) to the Company s Annual Report on Form 10-K filed for the fiscal year ended December 31, 2008 and incorporated herein by reference).
4.12(d)	Amendment No. 3 to the Credit Agreement, dated as of June 18, 2009, among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and Citicorp North America, Inc., as Co-Syndication Agents, Banc of America Securities, LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche Bank Securities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill Lynch Capital Corporation, as documentation agent (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed June 22, 2009, and incorporated herein by reference).
4.13	U.S. Guarantee, dated November 17, 2006, among HCA Inc., the subsidiary guarantors party thereto and Bank of America, N.A., as administrative agent (filed as Exhibit 4.9 to the Company s Current Report on Form 8-K filed November 24, 2006, and incorporated herein by reference).
4.14	Security Agreement, dated as of November 17, 2006, and amended and restated as of March 2, 2009, among the Company, the Subsidiary Grantors named therein and Bank of America, N.A., as Collateral Agent (filed as exhibit 4.10 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).
4.15	

Pledge Agreement, dated as of November 17, 2006, and amended and restated as of March 2, 2009, among the Company, the Subsidiary Pledgors named therein and Bank of America, N.A., as Collateral Agent (filed as exhibit 4.11 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).

4.16(a)	$2,000,000,000 Amended and Restated Credit Agreement, dated as of June 20, 2007, among HCA Inc., the subsidiary borrowers parties thereto, the lending institutions from time to time parties thereto, Banc of America Securities LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and joint bookrunners, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A. and Citicorp North America, Inc., as co-syndication agents, and Merrill Lynch Capital Corporation, as documentation agent (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed June 26, 2007, and incorporated herein by reference).
4.16(b)	Amendment No. 1 to the $2,000,000,000 Amended and Restated Credit Agreement, dated as of March 2, 2009, among HCA Inc., the subsidiary borrowers parties thereto, the lending institutions from time to time parties thereto, Banc of America Securities LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and joint bookrunners, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A. and Citicorp North America, Inc., as co-syndication agents, and Merrill Lynch Capital Corporation, as documentation agent (filed as exhibit 4.12(b) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).
4.17	Security Agreement, dated as of November 17, 2006, among HCA Inc., the subsidiary borrowers party thereto and Bank of America, N.A., as collateral agent (filed as Exhibit 4.13 to the Company s Current Report on Form 8-K filed November 24, 2006, and incorporated herein by reference).
4.18(a)	General Intercreditor Agreement, dated as of November 17, 2006, between Bank of America, N.A., as First Lien Collateral Agent, and The Bank of New York, as Junior Lien Collateral Agent (filed as Exhibit 4.13(a) to the Company s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
4.18(b)	Additional General Intercreditor Agreement, dated as of April 22, 2009, by and among Bank of America, N.A., in its capacity as First Lien Collateral Agent, The Bank of New York Mellon, in its capacity as Junior Lien Collateral Agent and in its capacity as 2006 Second Lien Trustee and The Bank of New York Mellon Trust Company, N.A., in its capacity as 2009 Second Lien Trustee (filed as Exhibit 4.6 to the Company s Current Report on Form 8-K filed April 28, 2009, and incorporated herein by reference).
4.18(c)	Additional General Intercreditor Agreement, dated as of August 11, 2009, by and among Bank of America, N.A., in its capacity as First Lien Collateral Agent, The Bank of New York Mellon, in its capacity as Junior Lien Collateral Agent and in its capacity as trustee for the Second Lien Notes issued on November 17, 2006, and The Bank of New York Mellon Trust Company, N.A., in its capacity as trustee for the Second Lien Notes issued on February 19, 2009 (filed as Exhibit 4.6 to the Company s Current Report on Form 8-K filed August 17, 2009, and incorporated herein by reference).
4.18(d)	Receivables Intercreditor Agreement, dated as of November 17, 2006, among Bank of America, N.A., as ABL Collateral Agent, Bank of America, N.A., as CF Collateral Agent and The Bank of New York, as Bonds Collateral Agent (filed as Exhibit 4.13(b) to the Company s Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
4.18(e)	Additional Receivables Intercreditor Agreement, dated as of April 22, 2009, by and between Bank of America, N.A. as ABL Collateral Agent, and Bank of America, N.A. as New First Lien Collateral Agent (filed as Exhibit 4.7 to the Company s Current Report on Form 8-K filed April 28, 2009, and incorporated herein by reference).
4.18(f)	Additional Receivables Intercreditor Agreement, dated as of August 11, 2009, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent (filed as Exhibit 4.7 to the Company s Current Report on Form 8-K filed August 17, 2009, and incorporated herein by reference).

4.18(g)	First Lien Intercreditor Agreement, dated as of April 22, 2009, among Bank of America, N.A. as Collateral Agent, Bank of America, N.A. as Authorized Representative under the Credit Agreement and Law Debenture Trust Company of New York as the Initial Additional Authorized Representative (filed as Exhibit 4.5 to the Company s Current Report on Form 8-K filed April 28, 2009, and incorporated herein by reference).
4.19	Registration Rights Agreement, dated as of November 17, 2006, among HCA Inc., Hercules Holding II, LLC and certain other parties thereto (filed as Exhibit 4.4 to the Company s Current Report on Form 8-K filed November 24, 2006, and incorporated herein by reference).

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4.20	Registration Rights Agreement, dated as of March 16, 1989, by and among HCA-Hospital Corporation of America and the persons listed on the signature pages thereto (filed as Exhibit(g)(24) to Amendment No. 3 to the Schedule 13E-3 filed by HCA-Hospital Corporation of America, Hospital Corporation of America and The HCA Profit Sharing Plan on March 22, 1989, and incorporated herein by reference).
4.21	Assignment and Assumption Agreement, dated as of February 10, 1994, between HCA-Hospital Corporation of America and the Company relating to the Registration Rights Agreement, as amended (filed as Exhibit 4.7 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 1993 (File No. 001-11239), and incorporated herein by reference).
4.22(a)	Indenture, dated as of December 16, 1993 between the Company and The First National Bank of Chicago, as Trustee (filed as Exhibit 4.11 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 1993 (File No. 001-11239), and incorporated herein by reference).
4.22(b)	First Supplemental Indenture, dated as of May 25, 2000 between the Company and Bank One Trust Company, N.A., as Trustee (filed as Exhibit 4.4 to the Company s Quarterly Report on Form 10-Q for the quarter ended June 30, 2000 (File No. 001-11239), and incorporated herein by reference).
4.22(c)	Second Supplemental Indenture, dated as of July 1, 2001 between the Company and Bank One Trust Company, N.A., as Trustee (filed as Exhibit 4.1 to the Company s Quarterly Report on Form 10-Q for the quarter ended June 30, 2001 (File No. 001-11239), and incorporated herein by reference).
4.22(d)	Third Supplemental Indenture, dated as of December 5, 2001 between the Company and The Bank of New York, as Trustee (filed as Exhibit 4.5(d) to the Company s Annual Report of Form 10-K for the fiscal year ended December 31, 2001(File No. 001-11239), and incorporated herein by reference).
4.22(e)	Fourth Supplemental Indenture, dated as of November 14, 2006, between the Company and The Bank of New York, as Trustee (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed November 16, 2006, and incorporated herein by reference).
4.23	Form of 7.5% Debentures due 2023 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K dated December 15, 1993, and incorporated herein by reference).
4.24	Form of 8.36% Debenture due 2024 (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed April 25, 1994 (File No. 001-11239), and incorporated herein by reference).
4.25	Form of Fixed Rate Global Medium Term Note (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed July 11, 1994 (File No. 001-11239), and incorporated herein by reference).
4.26	Form of Floating Rate Global Medium Term Note (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed July 11, 1994 (File No. 001-11239), and incorporated herein by reference).
4.27	Form of 7.69% Note due 2025 (filed as Exhibit 4.10 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2004 (File No. 001-11239), and incorporated herein by reference).
4.28	Form of 7.19% Debenture due 2015 (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed November 24, 1995 (File No. 033-58919), and incorporated herein by reference).
4.29	Form of 7.50% Debenture due 2095 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed November 24, 1995 (File No. 033-58919), and incorporated herein by reference).
4.30	Form of 7.05% Debenture due 2027 (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed December 8, 1995 (File No. 033-58919), and incorporated herein by reference).
4.31(a)	8.750% Note in the principal amount of $400,000,000 due 2010 (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed August 24, 2000 (File No. 001-11239), and

	incorporated herein by reference).
4.31(b)	8.750% Note in the principal amount of $350,000,000 due 2010 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed August 24, 2000 (File No. 001-11239), and incorporated herein by reference).
4.32	8.75% Note due 2010 in the principal amount of £150,000,000 (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed November 11, 2000 (File No. 001-11239), and incorporated herein by reference).
4.33(a)	71/8% Note in the principal amount of $100,000,000 due 2011 (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed January 31, 2001 (File No. 001-11239), and incorporated herein by reference).

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4.33(b)	71/8% Note in the principal amount of $400,000,000 due 2011 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed January 31, 2001 (File No. 001-11239), and incorporated herein by reference).
4.34(a)	6.95% Note due 2012 in the principal amount of $400,000,000. (filed as Exhibit 4.5 to the Company s Current Report on Form 8-K filed April 30, 2002 (File No. 001-11239), and incorporated herein by reference).
4.34(b)	6.95% Note due 2012 in the principal amount of $100,000,000. (filed as Exhibit 4.6 to the Company s Current Report on Form 8-K filed April 30, 2002 (File No. 001-11239), and incorporated herein by reference).
4.35(a)	6.30% Note due 2012 in the principal amount of $400,000,000. (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed September 25, 2002 (File No. 001-11239), and incorporated herein by reference).
4.35(b)	6.30% Note due 2012 in the principal amount of $100,000,000. (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed September 25, 2002 (File No. 001-11239), and incorporated herein by reference).
4.36(a)	6.25% Note due 2013 in the principal amount of $400,000,000 (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed February 5, 2003 (File No. 001-11239), and incorporated herein by reference).
4.36(b)	6.25% Note due 2013 in the principal amount of $100,000,000 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed February 5, 2003 (File No. 001-11239), and incorporated herein by reference).
4.37(a)	63/4% Note due 2013 in the principal amount of $400,000,000 (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed July 29, 2003 (File No. 001-11239), and incorporated herein by reference).
4.37(b)	63/4% Note due 2013 in the principal amount of $100,000,000 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed July 29, 2003 (File No. 001-11239), and incorporated herein by reference).
4.38	7.50% Note due 2033 in the principal amount of $250,000,000 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed November 6, 2003 (File No. 001-11239), and incorporated herein by reference).
4.39	5.75% Note due 2014 in the principal amount of $500,000,000 (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed March 11, 2004 (File No. 001-11239), and incorporated herein by reference).
4.40(a)	6.375% Note due 2015 in the principal amount of $500,000,000 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed November 19, 2004 (File No. 001-11239), and incorporated herein by reference).
4.40(b)	6.375% Note due 2015 in the principal amount of $250,000,000 (filed as Exhibit 4.3 to the Company s Current Report on Form 8-K filed November 19, 2004 (File No. 001-11239), and incorporated herein by reference).
4.41(a)	6.500% Note due 2016 in the principal amount of $500,000,000 (filed as Exhibit 4.1 to the Company s Current Report on Form 8-K filed on February 8, 2006, and incorporated herein by reference).
4.41(b)	6.500% Note due 2016 in the principal amount of $500,000,000 (filed as Exhibit 4.2 to the Company s Current Report on Form 8-K filed on February 8, 2006, and incorporated herein by reference).
10.1(a)	Amended and Restated Columbia/HCA Healthcare Corporation 1992 Stock and Incentive Plan (filed as Exhibit 10.7(b) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 1998 (File No. 001-11239), and incorporated herein by reference).*

10.1(b)	First Amendment to Amended and Restated Columbia/HCA Healthcare Corporation 1992 Stock and Incentive Plan (filed as Exhibit 10.2 to the Company s Quarterly Report on Form 10-Q for the quarter ended September 30, 1999 (File No. 001-11239), and incorporated herein by reference).*
10.2	HCA-Hospital Corporation of America Nonqualified Initial Option Plan (filed as Exhibit 4.6 to the Company s Registration Statement on Form S-3 (File No. 33-52379), and incorporated herein by reference).*

10.3	Form of Indemnity Agreement with certain officers and directors (filed as Exhibit 10(kk) to Galen Health Care, Inc. s Registration Statement on Form 10, as amended, and incorporated herein by reference) (filed as Exhibit 10.3 to the Company s Registration Statement on Form S-4 (File No. 333-145054) and incorporated herein by reference).
10.4	Form of Galen Health Care, Inc. 1993 Adjustment Plan (filed as Exhibit 4.15 to the Company s Registration Statement on Form S-8 (File No. 33-50147), and incorporated herein by reference).*
10.5	HCA-Hospital Corporation of America 1992 Stock Compensation Plan (filed as Exhibit 10(t) to HCA-Hospital Corporation of America s Registration Statement on Form S-1 (File No. 33-44906), and incorporated herein by reference).*
10.6	Columbia/HCA Healthcare Corporation 2000 Equity Incentive Plan (filed as Exhibit A to the Company s Proxy Statement for the Annual Meeting of Stockholders on May 25, 2000 (File No. 001-11239), and incorporated herein by reference).*
10.7	Form of Non-Qualified Stock Option Award Agreement (Officers) (filed as Exhibit 99.2 to the Company s Current Report on Form 8-K filed February 2, 2005 (File No. 001-11239), and incorporated herein by reference).*
10.8	HCA 2005 Equity Incentive Plan (filed as Exhibit B to the Company s Proxy Statement for the Annual Meeting of Shareholders on May 26, 2005, and incorporated herein by reference).*
10.9	Form of 2005 Non-Qualified Stock Option Agreement (Officers) (filed as Exhibit 99.2 to the Company s Current Report on Form 8-K dated October 6, 2005, and incorporated herein by reference).*
10.10	Form of 2006 Non-Qualified Stock Option Award Agreement (Officers) (filed as Exhibit 10.2 to the Company s Current Report on Form 8-K dated February 1, 2006, and incorporated herein by reference).*
10.11	2006 Stock Incentive Plan for Key Employees of HCA Inc. and its Affiliates (filed as Exhibit 10.11 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).*
10.12	Management Stockholder s Agreement dated November 17, 2006 (filed as Exhibit 10.12 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).
10.13	Sale Participation Agreement dated November 17, 2006 (filed as Exhibit 10.13 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).
10.14	Form of Option Rollover Agreement (filed as Exhibit 10.14 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).*
10.15	Form of Option Agreement (2007) (filed as Exhibit 10.15 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).*
10.16	Form of Option Agreement (2008) (filed as Exhibit 10.16 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2007, and incorporated herein by reference).*
10.17	Form of Option Agreement (2009) (filed as Exhibit 10.17 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).*
10.18	Form of Option Agreement (filed as Exhibit 10.1 to the Company s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2009, and incorporated herein by reference).*
10.19	Form of 2x Time Option Agreement (filed as Exhibit 10.1 to the Company s Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2009, and incorporated herein by reference).*
10.20	Form of Option Agreement (2010).*
10.21	Exchange and Purchase Agreement (filed as Exhibit 10.16 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).

10.22	Civil and Administrative Settlement Agreement, dated December 14, 2000 between the Company, the United States Department of Justice and others (filed as Exhibit 99.2 to the Company s Current Report on Form 8-K filed December 20, 2000 (File No. 001-11239), and incorporated herein by reference).

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10.23	Plea Agreement, dated December 14, 2000 between the Company, Columbia Homecare Group, Inc., Columbia Management Companies, Inc. and the United States Department of Justice (filed as Exhibit 99.3 to the Company s Current Report on Form 8-K filed December 20, 2000 (File No. 001-11239), and incorporated herein by reference).
10.24	Corporate Integrity Agreement, dated December 14, 2000 between the Company and the Office of Inspector General of the United States Department of Health and Human Services (filed as Exhibit 99.4 to the Company s Current Report on Form 8-K filed December 20, 2000 (File No. 001-11239), and incorporated herein by reference).
10.25	Management Agreement, dated November 17, 2006, among HCA Inc., Bain Capital Partners, LLC, Kohlberg Kravis Roberts & Co. L.P., Dr. Thomas F. Frist Jr., Patricia F. Elcan, William R. Frist and Thomas F. Frist, III, and Merrill Lynch Global Partners, Inc. (filed as Exhibit 10.20 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).
10.26	Retirement Agreement between the Company and Thomas F. Frist, Jr., M.D. dated as of January 1, 2002 (filed as Exhibit 10.30 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2001 (File No. 001-11239), and incorporated herein by reference).*
10.27	Amended and Restated HCA Supplemental Executive Retirement Plan, effective January 1, 2007, except as provided therein (filed as Exhibit 10.24 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).*
10.28(a)	Amended and Restated HCA Restoration Plan, effective January 1, 2008 (filed as Exhibit 10.25 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).*
10.28(b)	First Amendment to the January 1, 2008 Restatement of the HCA Restoration Plan, dated December 17, 2008.*
10.28(c)	Second Amendment to the January 1, 2008 Restatement of the HCA Restoration Plan, dated December 23, 2009.*
10.29	HCA Inc. 2007 Senior Officer Performance Excellence Program (filed as Exhibit 10.26 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).*
10.30(a)	HCA Inc. 2008-2009 Senior Officer Performance Excellence Program (filed as Exhibit 10.27 to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2007, and incorporated herein by reference).*
10.30(b)	HCA Inc. Amendment No. 1 to the 2008-2009 Senior Officer Performance Excellence Program (filed as Exhibit 10.28(b) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).*
10.31(a)	Amended and Restated Employment Agreement dated October 27, 2008 (Jack O. Bovender, Jr.) (filed as Exhibit 10.29(f) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).*
10.31(b)	Employment Agreement dated November 16, 2006 (Richard M. Bracken) (filed as Exhibit 10.27(b) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).*
10.31(c)	Amendment to Employment Agreement effective January 1, 2009 (Richard M. Bracken) (filed as Exhibit 10.29(g) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).*
10.31(d)	Employment Agreement dated November 16, 2006 (R. Milton Johnson) (filed as Exhibit 10.27(c) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).*
10.31(e)	

	Employment Agreement dated November 16, 2006 (Samuel N. Hazen) (filed as Exhibit 10.27(d) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).*
10.31(f)	Employment Agreement dated November 16, 2006 (Beverly B. Wallace) (filed as Exhibit 10.28(e) to the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2007, and incorporated herein by reference).*

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10.32	Administrative Settlement Agreement dated June 25, 2003 by and between the United States Department of Health and Human Services, acting through the Centers for Medicare and Medicaid Services, and the Company (filed as Exhibit 10.1 to the Company s Quarterly Report of Form 10-Q for the quarter ended June 30, 2003 (File No. 001-11239), and incorporated herein by reference).
10.33	Civil Settlement Agreement by and among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General of the Department of Health and Human Services, the TRICARE Management Activity (filed as Exhibit 10.2 to the Company s Quarterly Report of Form 10-Q for the quarter ended June 30, 2003 (File No. 001-11239), and incorporated herein by reference).
10.34	Form of Amended and Restated Limited Liability Company Agreement of Hercules Holding II, LLC dated as of November 17, 2006, among Hercules Holding II, LLC and certain other parties thereto (filed as Exhibit 10.3 to the Company s Registration Statement on Form 8-A (File No. 000-18406) and incorporated herein by reference).
10.35	Indemnification Priority and Information Sharing Agreement, dated as of November 1, 2009, between HCA Inc. and certain other parties thereto.
21	List of Subsidiaries.
23	Consent of Ernst & Young LLP.
31.1	Certification of Chief Executive Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Chief Financial Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32	Certification Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

* Management compensatory plan or arrangement.

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SIGNATURES

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

HCA INC.

By: /s/ Richard M. Bracken
Richard M. Bracken
Chairman of the Board and
Chief Executive Officer

Dated: March 1, 2010

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Richard M. Bracken Richard M. Bracken	Chairman of the Board and Chief Executive Officer (Principal Executive Officer)	March 1, 2010
/s/ R. Milton Johnson R. Milton Johnson	Executive Vice President, Chief Financial Officer and Director (Principal Financial Officer and Principal Accounting Officer)	March 1, 2010
/s/ Christopher J. Birosak Christopher J. Birosak	Director	March 1, 2010
/s/ John P. Connaughton John P. Connaughton	Director	March 1, 2010
/s/ James D. Forbes James D. Forbes	Director	March 1, 2010
/s/ Kenneth W. Freeman Kenneth W. Freeman	Director	March 1, 2010
/s/ Thomas F. Frist, III	Director	March 1, 2010

Thomas F. Frist, III		
/s/ William R. Frist	Director	March 1, 2010
William R. Frist		
/s/ Christopher R. Gordon	Director	March 1, 2010
Christopher R. Gordon		
/s/ Michael W. Michelson	Director	March 1, 2010
Michael W. Michelson		
/s/ James C. Momtazee	Director	March 1, 2010
James C. Momtazee		
/s/ Stephen G. Pagliuca	Director	March 1, 2010
Stephen G. Pagliuca		
/s/ Nathan C. Thorne	Director	March 1, 2010
Nathan C. Thorne		

HCA INC.

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
HCA Inc.

We have audited the accompanying consolidated balance sheets of HCA Inc. as of December 31, 2009 and 2008, and the related consolidated statements of income, stockholders deficit, and cash flows for each of the three years in the period ended December 31, 2009. These financial statements are the responsibility of the Company s management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of HCA Inc. at December 31, 2009 and 2008, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2009, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), HCA Inc. s internal control over financial reporting as of December 31, 2009, based on criteria established in Internal Control Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 1, 2010 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee
March 1, 2010

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HCA INC.
CONSOLIDATED INCOME STATEMENTS
FOR THE YEARS ENDED DECEMBER 31, 2009, 2008 AND 2007
(Dollars in millions)

	2009	2008	2007
Revenues	**$ 30,052**	$ 28,374	$ 26,858
Salaries and benefits	**11,958**	11,440	10,714
Supplies	**4,868**	4,620	4,395
Other operating expenses	**4,724**	4,554	4,233
Provision for doubtful accounts	**3,276**	3,409	3,130
Equity in earnings of affiliates	**(246)**	(223)	(206)
Depreciation and amortization	**1,425**	1,416	1,426
Interest expense	**1,987**	2,021	2,215
Losses (gains) on sales of facilities	**15**	(97)	(471)
Impairment of long-lived assets	**43**	64	24
	28,050	27,204	25,460
Income before income taxes	**2,002**	1,170	1,398
Provision for income taxes	**627**	268	316
Net income	**1,375**	902	1,082
Net income attributable to noncontrolling interests	**321**	229	208
Net income attributable to HCA Inc.	**$ 1,054**	$ 673	$ 874

The accompanying notes are an integral part of the consolidated financial statements.

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HCA INC.
CONSOLIDATED BALANCE SHEETS
DECEMBER 31, 2009 AND 2008
(Dollars in millions)

	2009	2008
ASSETS		
Current assets:		
Cash and cash equivalents	$ 312	$ 465
Accounts receivable, less allowance for doubtful accounts of $4,860 and $4,741	3,692	3,780
Inventories	802	737
Deferred income taxes	1,192	914
Other	579	405
	6,577	6,301
Property and equipment, at cost:		
Land	1,202	1,189
Buildings	9,108	8,670
Equipment	13,575	12,833
Construction in progress	784	1,022
	24,669	23,714
Accumulated depreciation	(13,242)	(12,185)
	11,427	11,529
Investments of insurance subsidiary	1,166	1,422
Investments in and advances to affiliates	853	842
Goodwill	2,577	2,580
Deferred loan costs	418	458
Other	1,113	1,148
	$ 24,131	$ 24,280
LIABILITIES AND STOCKHOLDERS DEFICIT		
Current liabilities:		
Accounts payable	$ 1,460	$ 1,370
Accrued salaries	849	854
Other accrued expenses	1,158	1,282
Long-term debt due within one year	846	404
	4,313	3,910
Long-term debt	24,824	26,585
Professional liability risks	1,057	1,108

Income taxes and other liabilities	**1,768**	1,782
Equity securities with contingent redemption rights	**147**	155
Stockholders deficit:		
Common stock $0.01 par; authorized 125,000,000 shares 2009 and 2008; outstanding 94,637,400 shares 2009 and 94,367,500 shares 2008	**1**	1
Capital in excess of par value	**226**	165
Accumulated other comprehensive loss	**(450)**	(604)
Retained deficit	**(8,763)**	(9,817)
Stockholders deficit attributable to HCA Inc.	**(8,986)**	(10,255)
Noncontrolling interests	**1,008**	995
	(7,978)	(9,260)
	$ 24,131	$ 24,280

The accompanying notes are an integral part of the consolidated financial statements.

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HCA INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS DEFICIT
FOR THE YEARS ENDED DECEMBER 31, 2009, 2008 AND 2007
(Dollars in millions)

	Equity (Deficit) Attributable to HCA Inc.						
	Common Stock		Capital in Excess of Par Value	Accumulated Other Comprehensive Income (Loss)	Retained Deficit	Equity Attributable to Noncontrolling Interests	Total
	Shares (000)	Par Value					
Balances, December 31, 2006	92,218	$ 1	$	$ 16	$ (11,391)	$ 907	$ (10,467)
Comprehensive income:							
Net income					874	208	1,082
Other comprehensive income:							
Change in fair value of investment securities				(2)			(2)
Foreign currency translation adjustments				(15)			(15)
Defined benefit plans				23			23
Change in fair value of derivative instruments				(194)			(194)
Total comprehensive income				(188)	874	208	894
Equity contributions	1,961		60				60
Share-based benefit plans			24				24
Distributions						(152)	(152)
Other	3		28		38	(25)	41
Balances, December 31, 2007	94,182	1	112	(172)	(10,479)	938	(9,600)
Comprehensive income:							
Net income					673	229	902
Other comprehensive income:							
Change in fair value of investment securities				(44)			(44)
Foreign currency translation adjustments				(62)			(62)
Defined benefit plans				(62)			(62)
Change in fair value of derivative instruments				(264)			(264)
Total comprehensive income				(432)	673	229	470
Share-based benefit plans	185		40				40
Distributions						(178)	(178)
Other			13		(11)	6	8

Balances, December 31, 2008	94,367		1		165		(604)		(9,817)		995		(9,260)
Comprehensive income:													
Net income									1,054		321		1,375
Other comprehensive income:													
Change in fair value of investment securities							44						44
Foreign currency translation adjustments							25						25
Change in fair value of derivative instruments							85						85
Total comprehensive income							154		1,054		321		1,529
Share-based benefit plans	270				47								47
Distributions											(330)		(330)
Other					14						22		36
Balances, December 31, 2009	94,637	$	1	$	226	$	(450)	$	(8,763)	$	1,008	$	(7,978)

The accompanying notes are an integral part of the consolidated financial statements.

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HCA INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2009, 2008 AND 2007
(Dollars in millions)

	2009	2008	2007
Cash flows from operating activities:			
Net income	**$ 1,375**	$ 902	$ 1,082
Adjustments to reconcile net income to net cash provided by operating activities:			
Increase (decrease) in cash from operating assets and liabilities:			
Accounts receivable	**(3,180)**	(3,328)	(3,345)
Inventories and other assets	**(191)**	159	(241)
Accounts payable and accrued expenses	**280**	(198)	(29)
Provision for doubtful accounts	**3,276**	3,409	3,130
Depreciation and amortization	**1,425**	1,416	1,426
Income taxes	**(520)**	(448)	(105)
Losses (gains) on sales of facilities	**15**	(97)	(471)
Impairment of long-lived assets	**43**	64	24
Amortization of deferred loan costs	**80**	79	78
Share-based compensation	**40**	32	24
Pay-in-kind interest	**58**		
Other	**46**		(9)
Net cash provided by operating activities	**2,747**	1,990	1,564
Cash flows from investing activities:			
Purchase of property and equipment	**(1,317)**	(1,600)	(1,444)
Acquisition of hospitals and health care entities	**(61)**	(85)	(32)
Disposal of hospitals and health care entities	**41**	193	767
Change in investments	**303**	21	207
Other	**(1)**	4	23
Net cash used in investing activities	**(1,035)**	(1,467)	(479)
Cash flows from financing activities:			
Issuances of long-term debt	**2,979**		
Net change in revolving bank credit facilities	**(1,335)**	700	(520)
Repayment of long-term debt	**(3,103)**	(960)	(750)
Distributions to noncontrolling interests	**(330)**	(178)	(152)
Payment of debt issuance costs	**(70)**		
Issuances of common stock			100
Other	**(6)**	(13)	(4)
Net cash used in financing activities	**(1,865)**	(451)	(1,326)

Change in cash and cash equivalents	**(153)**	72	(241)
Cash and cash equivalents at beginning of period	**465**	393	634
Cash and cash equivalents at end of period	**$ 312**	$ 465	$ 393
Interest payments	**$ 1,751**	$ 1,979	$ 2,163
Income tax payments, net of refunds	**$ 1,147**	$ 716	$ 421

The accompanying notes are an integral part of the consolidated financial statements.

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 ACCOUNTING POLICIES

Merger, Recapitalization and Reporting Entity

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

HCA Inc. is a holding company whose affiliates own and operate hospitals and related health care entities. The term affiliates includes direct and indirect subsidiaries of HCA Inc. and partnerships and joint ventures in which such subsidiaries are partners. At December 31, 2009, these affiliates owned and operated 155 hospitals, 97 freestanding surgery centers and provided extensive outpatient and ancillary services. Affiliates of HCA are also partners in joint ventures that own and operate eight hospitals and eight freestanding surgery centers, which are accounted for using the equity method. The Company s facilities are located in 20 states and England. The terms HCA, Company, we, our us, as used in this annual report on Form 10-K, refer to HCA Inc. and its affiliates unless otherwise stated or indicated by context.

Basis of Presentation

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

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

We have completed various acquisitions and joint venture transactions. The accounts of these entities have been included in our consolidated financial statements for periods subsequent to our acquisition of controlling interests. The majority of our expenses are cost of revenue items. Costs that could be classified as general and administrative include our corporate office costs, which were $164 million, $174 million and $169 million for the years ended December 31, 2009, 2008 and 2007, respectively.

Revenues

Revenues consist primarily of net patient service revenues that are recorded based upon established billing rates less allowances for contractual adjustments. Revenues are recorded during the period the health care services are provided, based upon the estimated amounts due from the patients and third-party payers. Third-party payers

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (Continued)

Revenues (Continued)

include federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies and employers. Estimates of contractual allowances under managed care health plans are based upon the payment terms specified in the related contractual agreements. Contractual payment terms in managed care agreements are generally based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility recorded estimates will change by a material amount. Estimated reimbursement amounts are adjusted in subsequent periods as cost reports are prepared and filed and as final settlements are determined (in relation to certain government programs, primarily Medicare, this is generally referred to as the cost report filing and settlement process). The 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.

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, us to provide services to patients who are financially unable to pay for the health care services they receive. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in revenues. Patients treated at hospitals for nonelective care, who have income at or below 200% of the federal poverty level, are eligible for charity care. Charity care (amounts are based on our gross charges) totaled $2.151 billion, $1.747 billion and $1.530 billion in 2009, 2008 and 2007, respectively. The federal poverty level is established by the federal government and is based on income and family size. 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 in 2009, 2008 and 2007, respectively. In implementing the discount policy, we first attempt to qualify uninsured patients for Medicaid, other federal or state assistance or charity care. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with a maturity of three months or less when purchased. Our insurance subsidiary s cash equivalent investments in excess of the amounts required to pay estimated professional liability claims during the next twelve months are not included in cash and cash equivalents as these funds are not available for general corporate purposes. Carrying values of cash and cash equivalents approximate fair value due to the short-term nature of these instruments.

Our cash management system provides for daily investment of available balances and the funding of outstanding checks when presented for payment. Outstanding, but unpresented, checks totaling $392 million and $382 million at December 31, 2009 and 2008, respectively, have been included in accounts payable in the consolidated balance sheets. Upon presentation for payment, these checks are funded through available cash balances or our credit facility.

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (Continued)

Accounts Receivable

We receive payments for services rendered from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, employers and patients. During the years ended December 31, 2009, 2008 and 2007, 23%, 23% and 24%, respectively, of our revenues related to patients participating in the fee-for-service Medicare program and 7%, 6% and 5%, respectively, of our revenues related to patients participating in managed Medicare programs. We recognize that revenues and receivables from government agencies are significant to our operations, but do not believe there are significant credit risks associated with these government agencies. We do not believe there are any other significant concentrations of revenues from any particular payer that would subject us to any significant credit risks in the collection of our accounts receivable.

Additions to the allowance for doubtful accounts are made by means of the provision for doubtful accounts. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts and subsequent recoveries are added. The amount of the provision for doubtful accounts is based upon management s assessment of historical and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts (including copayment and deductible amounts from patients who have health care coverage) due directly from patients. Accounts are written off when all reasonable internal and external collection efforts have been performed. We consider the return of an account from the secondary external collection agency to be the culmination of our reasonable collection efforts and the timing basis for writing off the account balance. Writeoffs are based upon specific identification and the writeoff process requires a writeoff adjustment entry to the patient accounting system. 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 to utilize in estimating the collectibility of our accounts receivable. We perform the hindsight analysis quarterly, utilizing rolling twelve-months accounts receivable collection and writeoff data. 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. Days revenues in accounts receivable were 45 days, 49 days and 53 days at December 31, 2009, 2008 and 2007, respectively. Adverse changes in general economic conditions, patient accounting service center operations, payer mix or trends in federal or state governmental health care coverage could affect our collection of accounts receivable, cash flows and results of operations.

Inventories

Inventories are stated at the lower of cost (first-in, first-out) or market.

Property and Equipment and Amortizable Intangibles

Depreciation expense, computed using the straight-line method, was $1.419 billion in 2009, $1.412 billion in 2008 and $1.421 billion in 2007. Buildings and improvements are depreciated over estimated useful lives ranging generally from 10 to 40 years. Estimated useful lives of equipment vary generally from four to 10 years.

Debt issuance costs are amortized based upon the terms of the respective debt obligations. The gross carrying amount of deferred loan costs at December 31, 2009 and 2008 was $689 million and $650 million, respectively, and accumulated amortization was $271 million and $192 million, respectively. Amortization of deferred loan costs is included in interest expense and was $80 million, $79 million and $78 million for 2009, 2008 and 2007, respectively.

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (Continued)

Property and Equipment and Amortizable Intangibles (Continued)

When events, circumstances or operating results indicate the carrying values of certain long-lived assets and related identifiable intangible assets (excluding goodwill) expected to be held and used, might be impaired, we prepare projections of the undiscounted future cash flows expected to result from the use of the assets and their eventual disposition. If the projections indicate the recorded amounts are not expected to be recoverable, such amounts are reduced to estimated fair value. Fair value may be estimated based upon internal evaluations that include quantitative analyses of revenues and cash flows, reviews of recent sales of similar facilities and independent appraisals.

Long-lived assets to be disposed of are reported at the lower of their carrying amounts or fair value less costs to sell or close. The estimates of fair value are usually based upon recent sales of similar assets and market responses based upon discussions with and offers received from potential buyers.

Investments of Insurance Subsidiary

At December 31, 2009 and 2008, the investments of our wholly-owned insurance subsidiary were classified as available-for-sale as defined in Accounting Standards Codification No. 320, *Investments Debt and Equity Securities* and are recorded at fair value. The investment securities are held for the purpose of providing the funding source to pay professional liability claims covered by the insurance subsidiary. We perform a quarterly assessment of individual investment securities to determine whether declines in market value are temporary or other-than-temporary. Our investment securities evaluation process involves multiple subjective judgments, often involves estimating the outcome of future events, and requires a significant level of professional judgment in determining whether an impairment has occurred. We evaluate, among other things, the financial position and near term prospects of the issuer, conditions in the issuer s industry, liquidity of the investment, changes in the amount or timing of expected future cash flows from the investment, and recent downgrades of the issuer by a rating agency, to determine if, and when, a decline in the fair value of an investment below amortized cost is considered other-than-temporary. The length of time and extent to which the fair value of the investment is less than amortized cost and our ability and intent to retain the investment, to allow for any anticipated recovery of the investment s fair value, are important components of our investment securities evaluation process.

Goodwill

Goodwill is not amortized, but is subject to annual impairment tests. In addition to the annual impairment review, impairment reviews are performed whenever circumstances indicate a possible impairment may exist. Impairment testing for goodwill is done at the reporting unit level. Reporting units are one level below the business segment level, and our impairment testing is performed at the operating division or market level. We compare the fair value of the reporting unit assets to the carrying amount, on at least an annual basis, to determine if there is potential impairment. If the fair value of the reporting unit assets is less than their carrying value, we compare the fair value of the goodwill to its carrying value. If the fair value of the goodwill is less than its carrying value, an impairment loss is recognized. Fair value of goodwill is estimated based upon internal evaluations of the related long-lived assets for each reporting unit that include quantitative analyses of revenues and cash flows and reviews of recent sales of similar facilities. We recognized goodwill impairments of $19 million and $48 million during 2009 and 2008, respectively. No goodwill impairments were recognized during 2007.

During 2009, goodwill increased by $5 million related to acquisitions, decreased by $19 million related to impairments and increased by $11 million related to foreign currency translation and other adjustments. During 2008, goodwill increased by $43 million related to acquisitions, decreased by $14 million related to facility sales, decreased by $48 million related to impairments and decreased by $30 million related to foreign currency translation and other adjustments.

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (Continued)

Goodwill (Continued)

Since January 1, 2000, we have recognized total goodwill impairments of $88 million in the aggregate. None of the goodwill impairments related to evaluations of goodwill at the reporting unit level, as all recognized goodwill impairments during this period related to goodwill allocated to asset disposal groups.

Physician Recruiting Agreements

In order to recruit physicians to meet the needs of our hospitals and the communities they serve, we enter into minimum revenue guarantee arrangements to assist the recruited physicians during the period they are relocating and establishing their practices. A guarantor is required to recognize, at the inception of a guarantee, a liability for the fair value of the stand-ready obligation undertaken in issuing the guarantee. We expense the total estimated guarantee liability amount at the time the physician recruiting agreement becomes effective as we are not able to justify recording a contract-based asset based upon our analysis of the related control, regulatory and legal considerations.

The physician recruiting liability amounts of $24 million and $27 million at December 31, 2009 and 2008, respectively, represent the amount of expense recognized in excess of payments made through December 31, 2009 and 2008, respectively. At December 31, 2009 the maximum amount we could have to pay under all effective minimum revenue guarantees was $64 million.

Professional Liability Claims

Reserves for professional liability risks were $1.322 billion and $1.387 billion at December 31, 2009 and 2008, respectively. The current portion of the reserves, $265 million and $279 million at December 31, 2009 and 2008, respectively, is included in other accrued expenses in the consolidated balance sheets. Provisions for losses related to professional liability risks were $211 million, $175 million and $163 million for 2009, 2008 and 2007, respectively, and are included in other operating expenses in our consolidated income statements. Provisions for losses related to professional liability risks are based upon actuarially determined estimates. Loss and loss expense reserves represent the estimated ultimate net cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves for unpaid losses and loss expenses are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. Adjustments to the estimated reserve amounts are included in current operating results. 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. During 2009 and 2008, $272 million and $314 million, respectively, of net payments were made for professional and general liability claims. The estimation of the timing of payments beyond a year can vary significantly. Although considerable variability is inherent in professional liability reserve estimates, we believe the reserves for losses and loss expenses are adequate; however, there can be no assurance the ultimate liability will not exceed our estimates.

A portion of our professional liability risks is insured through a wholly-owned insurance subsidiary. Subject to a $5 million per occurrence self-insured retention, our facilities are insured by our wholly-owned insurance subsidiary for losses up to $50 million per occurrence. The insurance subsidiary has obtained reinsurance for professional liability risks generally above a retention level of $15 million per occurrence. We also maintain professional liability insurance with unrelated commercial carriers for losses in excess of amounts insured by our insurance subsidiary.

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (Continued)

Professional Liability Claims (Continued)

The obligations covered by reinsurance contracts are included in the reserves for professional liability risks, as the insurance subsidiary remains liable to the extent the reinsurers do not meet their obligations under the reinsurance contracts. The amounts receivable under the reinsurance contracts include $28 million at December 31, 2009 and 2008 recorded in other assets and $25 million and $29 million at December 31, 2009 and 2008, respectively, recorded in other current assets .

Financial Instruments

Derivative financial instruments are employed to manage risks, including interest rate and foreign currency 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 (loss), 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. Generally, changes in fair values of derivatives accounted for as fair value hedges are recorded in earnings, along with the changes in the fair value of the hedged items related to the hedged risk. Gains and losses on derivatives designated as cash flow hedges, to the extent they are effective, are recorded in other comprehensive income (loss), and subsequently reclassified to earnings to offset the impact of the forecasted transactions when they occur. In the event the forecasted transaction to which a cash flow hedge relates is no longer likely, the amount in other comprehensive income (loss) is recognized in earnings and generally the derivative is terminated. 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 interest expense over the remaining term of the debt originally covered by the terminated swap.

Noncontrolling Interests in Consolidated Entities

The consolidated financial statements include all assets, liabilities, revenues and expenses of less than 100% owned entities that we control. Accordingly, we have recorded noncontrolling interests in the earnings and equity of such entities.

Related Party Transactions Management Agreement

Affiliates of the Investors entered into a management agreement with us pursuant to which such affiliates will provide us with management services. Under the management agreement, the affiliates of the Investors are entitled to receive an aggregate annual management fee of $15 million, which amount increases annually, beginning in 2008, at a rate equal to the percentage increase in Adjusted EBITDA (as defined in the Management Agreement) in the applicable year compared to the preceding year, and reimbursement of out-of-pocket expenses incurred in connection with the provision of services pursuant to the agreement. The annual management fee was $15 million for each of 2009, 2008 and 2007. The management agreement has an initial term expiring on December 31, 2016, provided that the term will be extended annually for one additional year unless we or the Investors provide notice to the other of their desire not to automatically extend the term. In addition, the management agreement provides that the affiliates of the Investors are entitled to receive a fee equal to 1% of the gross transaction value in connection with certain financing, acquisition, disposition, and change of control transactions, as well as a termination fee based on the net present value of future payment obligations under the management agreement in the event of an initial public offering or under certain other circumstances. The agreement also contains customary exculpation and indemnification provisions in favor of the Investors and their affiliates.

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 ACCOUNTING POLICIES (Continued)

Reclassifications

Certain prior year amounts have been reclassified to conform to the 2009 presentation.

NOTE 2 SHARE-BASED COMPENSATION

Certain management holders of outstanding HCA stock options retained certain of their stock options (the Rollover Options) in lieu of receiving the Merger consideration. The Rollover Options remain outstanding in accordance with the terms of the governing stock incentive plans and grant agreements pursuant to which the holder originally received the stock option grants, except the exercise price and number of shares subject to the rollover option agreement were adjusted so that the aggregate intrinsic value for each applicable option holder was maintained and the exercise price for substantially all the options was adjusted to $12.75 per option. Pursuant to the rollover option agreement, 10,967,500 prerecapitalization HCA stock options were converted into 2,285,200 Rollover Options, of which 1,349,800 are outstanding and exercisable at December 31, 2009.

2006 Stock Incentive Plan

The 2006 Stock Incentive Plan for Key Employees of HCA Inc. and its Affiliates (the 2006 Plan) is designed to promote the long term financial interests and growth of the Company and its subsidiaries by attracting and retaining management and other personnel and key service providers and to motivate management personnel by means of incentives to achieve long range goals and further the alignment of interests of participants with those of our stockholders through opportunities for increased stock, or stock-based, ownership in the Company. A portion of the options under the 2006 Plan vests solely based upon continued employment over a specific period of time, and a portion of the options vests based both upon continued employment over a specific period of time and upon the achievement of predetermined financial and Investor return targets over time. We granted 1,785,900 and 357,500 options under the 2006 Plan during 2009 and 2008, respectively. As of December 31, 2009, 3,010,000 options granted under the 2006 Plan have vested, and there were 392,400 shares available for future grants under the 2006 Plan.

Stock Option Activity

The fair value of each stock option award is estimated on the grant date, using option valuation models and the weighted average assumptions indicated in the following table. Awards under the 2006 Plan generally vest based on continued employment and based upon achievement of certain financial and Investor return targets. Each grant is valued as a single award with an expected term equal to the average expected term of the component vesting tranches. We use historical option exercise behavior data and other factors to estimate the expected term of the options. The expected term of the option is limited by the contractual term, and employee post-vesting termination behavior is incorporated in the historical option exercise behavior data. Compensation cost is recognized on the straight-line attribution method. The straight-line attribution method requires that total compensation expense recognized must at least equal the vested portion of the grant-date fair value. The expected volatility is derived using historical stock price information of certain peer group companies for a period of time equal to the expected option term. The risk-free interest rate is the approximate yield on United States Treasury Strips having a life equal to the expected option life on the date of grant. The expected life is an estimate of the number of years an option will be held before it is exercised.

	2009	2008	2007
Risk-free interest rate	**1.45%**	2.50%	4.86%
Expected volatility	**35%**	30%	30%
Expected life, in years	**5**	4	5
Expected dividend yield			

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 2 SHARE-BASED COMPENSATION (Continued)

Stock Option Activity (Continued)

Information regarding stock option activity during 2009, 2008 and 2007 is summarized below (share amounts in thousands):

	Stock Options	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value (dollars in millions)
Options outstanding, December 31, 2006	2,285	$ 12.50		
Granted	9,328	51.34		
Exercised	(36)	12.75		
Cancelled	(405)	51.00		
Options outstanding, December 31, 2007	11,172	43.54		
Granted	357	58.21		
Exercised	(480)	15.01		
Cancelled	(412)	51.14		
Options outstanding, December 31, 2008	10,637	45.02		
Granted	1,786	88.74		
Exercised	(506)	17.16		
Cancelled	(390)	52.08		
Options outstanding, December 31, 2009	11,527	52.78	7.1 years	$ 406
Options exercisable, December 31, 2009	4,208	$ 46.63	6.3 years	$ 174

The weighted average fair values of stock options granted during 2009, 2008 and 2007 were $15.96, $14.01 and $16.01 per share, respectively. The total intrinsic value of stock options exercised in the year ended December 31, 2009 was $26 million.

NOTE 3 ACQUISITIONS AND DISPOSITIONS

During 2009, we paid $61 million to acquire nonhospital health care entities. During 2008, we paid $18 million to acquire one hospital and $67 million to acquire other health care entities. During 2007, we paid $32 million to acquire nonhospital health care entities. Purchase price amounts have been allocated to the related assets acquired and liabilities assumed based upon their respective fair values. The purchase price paid in excess of the fair value of identifiable net assets of acquired entities aggregated $5 million, $43 million and $44 million in 2009, 2008 and 2007, respectively. The consolidated financial statements include the accounts and operations of the acquired entities subsequent to the respective acquisition dates. The pro forma effects of the acquired entities on our results of operations for periods prior to the respective acquisition dates were not significant.

During 2009, we received proceeds of $3 million and recognized a net pretax loss of $8 million ($5 million after tax) on the sales of three hospitals. We also received proceeds of $38 million and recognized a net pretax loss of $7 million ($4 million after tax) from sales of other health care entities and real estate investments. During 2008, we received proceeds of $143 million and recognized a net pretax gain of $81 million ($48 million after tax) from the sales of two hospitals. We also received proceeds of $50 million and recognized a net pretax gain of $16 million ($10 million after tax) from sales of other health care entities and real estate investments. During 2007, we received proceeds of $661 million and recognized a net pretax gain of $443 million ($272 million after tax) from sales of three hospitals. We also received proceeds of $106 million and recognized a net pretax gain of $28 million ($18 million after tax) from sales of real estate investments.

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 IMPAIRMENTS OF LONG-LIVED ASSETS

During 2009, we recorded pretax charges of $43 million to reduce the carrying value of identified assets to estimated fair value. The $43 million asset impairment includes $15 million related to certain hospital facilities and other health care entity investments in our Central Group, $14 million related to other health care entity investments in our Eastern Group and $14 million related to certain hospital facilities in our Western Group. During 2008, we recorded pretax charges of $64 million to reduce the carrying value of identified assets to estimated fair value. The $64 million asset impairment includes $55 million related to other health care entity investments in our Eastern Group and $9 million related to certain hospital facilities in our Central Group. During 2007, we recorded a pretax charge of $24 million to adjust the value of a building in our Central Group to estimated fair value.

The asset impairment charges did not have a significant impact on our operations or cash flows and are not expected to significantly impact cash flows for future periods. The impairment charges affected our property and equipment asset category by $24 million, $16 million and $24 million in 2009, 2008 and 2007, respectively.

NOTE 5 INCOME TAXES

The provision for income taxes consists of the following (dollars in millions):

	2009	2008	2007
Current:			
Federal	**$ 809**	$ 699	$ 566
State	**75**	56	37
Foreign	**21**	25	32
Deferred:			
Federal	**(274)**	(505)	(391)
State	**(37)**	(29)	(62)
Foreign	**33**	22	134
	$ 627	$ 268	$ 316

The provision for income taxes reflects $18 million and $20 million ($12 million net of tax for each) reductions in interest related to taxing authority examinations for the years ended December 31, 2009 and 2008, respectively, and interest expense of $17 million ($11 million net of tax) for the year ended December 31, 2007.

A reconciliation of the federal statutory rate to the effective income tax rate follows:

	2009	2008	2007

Federal statutory rate	**35.0%**	35.0%	35.0%
State income taxes, net of federal tax benefit	**3.2**	3.7	0.2
Change in liability for uncertain tax positions	**(0.2)**	(7.4)	(7.2)
Nondeductible intangible assets	**0.4**	0.4	
Tax exempt interest income	**(0.8)**	(2.5)	(2.1)
Income attributable to noncontrolling interests from consolidated partnerships	**(6.0)**	(5.6)	(4.0)
Other items, net	**(0.3)**	(0.7)	0.7
Effective income tax rate	**31.3%**	22.9%	22.6%

As a result of a settlement reached with the Appeals Division of the Internal Revenue Service (the IRS) and the revision of a proposed IRS adjustment related to prior taxable years, we reduced our provision for income taxes

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 5 INCOME TAXES (Continued)

by $69 million in 2008. Our 2007 provision for income taxes was reduced by $85 million, principally based on new information received 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.

A summary of the items comprising the deferred tax assets and liabilities at December 31 follows (dollars in millions):

	2009		2008	
	Assets	**Liabilities**	**Assets**	**Liabilities**
Depreciation and fixed asset basis differences	**$**	**$ 258**	$	$ 324
Allowances for professional liability and other risks	**288**		244	
Accounts receivable	**1,453**		1,263	
Compensation	**190**		201	
Other	**740**	**336**	786	287
	$ 2,671	**$ 594**	$ 2,494	$ 611

At December 31, 2009, state net operating loss carryforwards (expiring in years 2010 through 2029) available to offset future taxable income approximated $116 million. Utilization of net operating loss carryforwards in any one year may be limited and, in certain cases, result in an adjustment to intangible assets. Net deferred tax assets related to such carryforwards are not significant.

At December 31, 2009, we are contesting before the Appeals Division of the 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, were 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.

The following table summarizes the activity related to our unrecognized tax benefits (dollars in millions):

	2009	2008
Balance at January 1	**$ 482**	$ 622
Additions based on tax positions related to the current year	**44**	32
Additions for tax positions of prior years	**11**	55
Reductions for tax positions of prior years	**(33)**	(57)
Settlements	**(8)**	(162)
Lapse of applicable statutes of limitations	**(11)**	(8)
Balance at December 31	**$ 485**	$ 482

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 5 INCOME TAXES (Continued)

During 2008, we reached a settlement with the IRS Appeals Division relating to the deductibility of the 2001 government settlement payment, the timing of recognition of certain patient service revenues for 2001 and 2002, and the amount of insurance expense deducted in 2001 and 2002. As a result of the settlement, $111 million of the $215 million refundable deposit made in 2006 has been applied to tax and interest due for the 2001 and 2002 taxable years.

Our liability for unrecognized tax benefits was $628 million, including accrued interest of $156 million and excluding $13 million that was recorded as reductions of the related deferred tax assets, as of December 31, 2009 ($625 million, $156 million and $13 million, respectively, as of December 31, 2008). Unrecognized tax benefits of $236 million ($264 million as of December 31, 2008) would affect the effective rate, if recognized. The liability for unrecognized tax benefits does not reflect deferred tax assets of $77 million ($81 million as of December 31, 2008) related to deductible interest and state income taxes or a refundable deposit of $104 million, which is recorded in noncurrent assets.

Depending on the resolution of the IRS disputes, the completion of examinations by federal, state or international taxing authorities, or the expiration of statutes of limitation for specific taxing jurisdictions, we believe it is reasonably possible that our liability for unrecognized tax benefits may significantly increase or decrease within the next 12 months. However, we are currently unable to estimate the range of any possible change.

NOTE 6 INVESTMENTS OF INSURANCE SUBSIDIARY

A summary of the insurance subsidiary s investments at December 31 follows (dollars in millions):

	2009			
		Unrealized Amounts		
	Amortized Cost	Gains	Losses	Fair Value
Debt securities:				
States and municipalities	$ 668	$ 30	$ (3)	$ 695
Auction rate securities	401		(5)	396
Asset-backed securities	43		(1)	42
Money market funds	176			176
	1,288	30	(9)	1,309
Equity securities:				
Preferred stocks	6		(2)	4
Common stocks	2	1		3
	8	1	(2)	7

	$ 1,296	$ 31	$ (11)	1,316
Amounts classified as current assets				(150)
Investment carrying value				$ 1,166

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 INVESTMENTS OF INSURANCE SUBSIDIARY (Continued)

	2008			
	Amortized Cost	Unrealized Amounts Gains	Unrealized Amounts Losses	Fair Value
Debt securities:				
States and municipalities	$ 808	$ 20	$ (23)	$ 805
Auction rate securities	576		(40)	536
Asset-backed securities	51	1	(5)	47
Money market funds	226			226
	1,661	21	(68)	1,614
Equity securities:				
Preferred stocks	6		(1)	5
Common stocks	3			3
	9		(1)	8
	$ 1,670	$ 21	$ (69)	1,622
Amounts classified as current assets				(200)
Investment carrying value				$ 1,422

At December 31, 2009 and 2008 the investments of our insurance subsidiary were classified as available-for-sale. Changes in temporary unrealized gains and losses are recorded as adjustments to other comprehensive income (loss). At December 31, 2009 and 2008, $100 million and $119 million, respectively, of our investments were subject to the restrictions included in insurance bond collateralization and assumed reinsurance contracts.

Scheduled maturities of investments in debt securities at December 31, 2009 were as follows (dollars in millions):

	Amortized Cost	Fair Value
Due in one year or less	$ 216	$ 216
Due after one year through five years	310	325
Due after five years through ten years	193	204
Due after ten years	125	126

	844	871
Auction rate securities	401	396
Asset-backed securities	43	42
	$ 1,288	$ 1,309

The average expected maturity of the investments in debt securities at December 31, 2009 was 3.5 years, compared to the average scheduled maturity of 12.3 years. Expected and scheduled maturities may differ because the issuers of certain securities have the right to call, prepay or otherwise redeem such obligations prior to their scheduled maturity date. The average expected maturities for our auction rate and asset-backed securities were derived from valuation models of expected cash flows and involved management s judgment. The average expected maturities for our auction rate and asset-backed securities at December 31, 2009 were 4.7 years and 6.3 years, respectively, compared to average scheduled maturities of 25.4 years and 26.0 years, respectively.

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 INVESTMENTS OF INSURANCE SUBSIDIARY (Continued)

The cost of securities sold is based on the specific identification method. Sales of securities for the years ended December 31 are summarized below (dollars in millions):

	2009	2008	2007
Debt securities:			
Cash proceeds	**$ 141**	$ 23	$ 272
Gross realized gains			8
Gross realized losses	**1**		1
Equity securities:			
Cash proceeds	**$ 3**	$ 4	$ 87
Gross realized gains	**1**	2	1
Gross realized losses		2	

NOTE 7 FINANCIAL INSTRUMENTS

Interest Rate Swap Agreements

We have entered into interest rate swap agreements to manage our exposure to fluctuations in interest rates. These swap agreements involve the exchange of fixed and variable rate interest payments between two parties based on common notional principal amounts and maturity dates. Pay-fixed interest rate swaps effectively convert LIBOR indexed variable rate instruments to fixed interest rate obligations. The net interest payments, based on the notional amounts in these agreements, generally match the timing of the related liabilities. The notional amounts of the swap agreements represent amounts 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.

The following table sets forth our interest rate swap agreements, which have been designated as cash flow hedges, at December 31, 2009 (dollars in millions):

	Notional Amount	Termination Date	Fair Value
Pay-fixed interest rate swap	$ 500	March 2011	$ (13)
Pay-fixed interest rate swaps	8,000	November 2011	(523)
Pay-fixed interest rate swaps (starting November 2011)	2,000	December 2016	8

During the next 12 months, we estimate $364 million will be reclassified from other comprehensive income (OCI) to interest expense.

Cross Currency Swaps

The Company and certain subsidiaries have incurred obligations and entered into various intercompany transactions where such obligations are denominated in currencies other than the functional currencies of the parties executing the trade. In order to better match the cash flows of our obligations and intercompany transactions with cash flows from operations, we entered into various cross currency swaps. Our credit risk related to these agreements is considered low because the swap agreements are with creditworthy financial institutions.

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 FINANCIAL INSTRUMENTS (Continued)

Cross Currency Swaps (Continued)

Certain of our cross currency swaps were not designated as hedges, and changes in fair value are recognized in results of operations. The following table sets forth our cross currency swap agreement, which has not been designated as a hedge, at December 31, 2009 (amounts in millions):

	Notional Amount	Termination Date	Fair Value
Euro United States Dollar Currency Swap	411 Euro	December 2011	$ 79

The following table sets forth our cross currency swap agreements, which have been designated as cash flow hedges, at December 31, 2009 (amounts in millions):

	Notional Amount	Termination Date	Fair Value
GBP United States Dollar Currency Swaps	100 GBP	November 2010	$ (13)

Derivatives Results of Operations

The following tables present the effect of our interest rate and cross currency swaps on our results of operations for the year ended December 31, 2009 (dollars in millions):

Derivatives in Cash Flow Hedging Relationships	Amount of Loss (Gain) Recognized in OCI on Derivatives, Net of Tax	Location of Loss Reclassified from Accumulated OCI into Operations	Amount of Loss Reclassified from Accumulated OCI into Operations
Interest rate swaps	$ 141	Interest expense	$ 345
Cross currency swaps	(8)	Interest expense	
	$ 133		$ 345

Derivatives Not Designated as Hedging Instruments	**Location of Loss Recognized in Operations on Derivatives**	**Amount of Loss Recognized in Operations on Derivatives**	
Cross currency swaps	Other operating expense	$	5

Credit-risk-related Contingent Features

We have agreements with each of our derivative counterparties that contain a provision where we could be declared in default on our derivative obligations if repayment of the underlying indebtedness is accelerated by the lender due to our default on the indebtedness. As of December 31, 2009, we have not been required to post any collateral related to these agreements. If we had breached these provisions at December 31, 2009, we would have been required to settle our obligations under the agreements at their aggregate, estimated termination value of $488 million.

NOTE 8 ASSETS AND LIABILITIES MEASURED AT FAIR VALUE

ASC 820, *Fair Value Measurements and Disclosures* (ASC 820) defines fair value, establishes a framework for measuring fair value, and expands disclosures about fair value measurements. ASC 820 applies to reported balances that are required or permitted to be measured at fair value under existing accounting pronouncements.

ASC 820 emphasizes fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 8 ASSETS AND LIABILITIES MEASURED AT FAIR VALUE (Continued)

measurements, ASC 820 establishes a fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs classified within Levels 1 and 2 of the hierarchy) and the reporting entity s own assumptions about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities. Level 2 inputs are inputs other than quoted prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. Level 2 inputs may include quoted prices for similar assets and liabilities in active markets, as well as inputs observable for the asset or liability (other than quoted prices), such as interest rates, foreign exchange rates, and yield curves observable at commonly quoted intervals. Level 3 inputs are unobservable inputs for the asset or liability, which are typically based on an entity s own assumptions, as there is little, if any, related market activity. In instances where the determination of the fair value measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input significant to the fair value measurement in its entirety. Our assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment, and considers factors specific to the asset or liability.

Cash Traded Investments

Our cash traded investments are generally classified within Level 1 or Level 2 of the fair value hierarchy because they are valued using quoted market prices, broker or dealer quotations, or alternative pricing sources with reasonable levels of price transparency. Certain types of cash traded instruments are classified within Level 3 of the fair value hierarchy because they trade infrequently and therefore have little or no price transparency. Such instruments include auction rate securities (ARS) and limited partnership investments. The transaction price is initially used as the best estimate of fair value.

Our wholly-owned insurance subsidiary had investments in municipal, tax-exempt ARS, that are backed by student loans substantially guaranteed by the federal government, of $396 million ($401 million par value) at December 31, 2009. We do not currently intend to attempt to sell the ARS as the liquidity needs of our insurance subsidiary are expected to be met by other investments in its investment portfolio. These securities continue to accrue and pay interest semi-annually based on the failed auction maximum rate formulas stated in their respective Official Statements. During 2009 and 2008, certain issuers and their broker/dealers redeemed or repurchased $172 million and $93 million, respectively, of our ARS at par value. The valuation of these securities involved management s judgment, after consideration of market factors and the absence of market transparency, market liquidity and observable inputs. Our valuation models derived a fair market value compared to tax-equivalent yields of other student loan backed variable rate securities of similar credit worthiness.

Derivative Financial Instruments

We have entered into interest rate and cross currency swap agreements to manage our exposure to fluctuations in interest rates and foreign currency risks. The valuation of these instruments is determined using widely accepted valuation techniques, including discounted cash flow analysis on the expected cash flows of each derivative. This analysis reflects the contractual terms of the derivatives, including the period to maturity, and uses observable market-based inputs, including interest rate curves, foreign exchange rates and implied volatilities. To comply with the provisions of ASC 820, we incorporate credit valuation adjustments to reflect both our own nonperformance risk and the respective counterparty s nonperformance risk in the fair value measurements.

Although we determined the majority of the inputs used to value our derivatives fall within Level 2 of the fair value hierarchy, the credit valuation adjustments associated with our derivatives utilize Level 3 inputs, such as estimates of current credit spreads to evaluate the likelihood of default by us and our counterparties. We assessed the

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 8 ASSETS AND LIABILITIES MEASURED AT FAIR VALUE (Continued)

Derivative Financial Instruments (Continued)

significance of the impact of the credit valuation adjustments on the overall valuation of our derivative positions and at December 31, 2008, we determined the credit valuation adjustments were significant to the overall valuation of our derivatives; however, we determined the credit valuation adjustments were not significant to the overall valuation of our derivatives at December 31, 2009. As a result, we have reclassified our derivative valuations in their entirety from Level 3 to Level 2 of the fair value hierarchy at December 31, 2009.

The following table summarizes our assets and liabilities measured at fair value on a recurring basis as of December 31, 2009, aggregated by the level in the fair value hierarchy within which those measurements fall (dollars in millions):

		Fair Value Measurements Using		
	Fair Value	**Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Assets:				
Investments of insurance subsidiary	$ 1,316	$ 178	$ 741	$ 397
Less amounts classified as current assets	(150)	(150)		
	1,166	28	741	397
Cross currency swap (Other assets)	79		79	
Liabilities:				
Interest rate swaps (Income taxes and other liabilities)	528		528	
Cross currency swaps (Income taxes and other liabilities)	13		13	

The following table summarizes the activity related to the investments of our insurance subsidiary and our cross currency and interest rate swaps which have fair value measurements based on significant unobservable inputs (Level 3) during the year ended December 31, 2009 (dollars in millions):

	Investments of Insurance Subsidiary	Cross Currency Swaps		Interest Rate Swaps
Asset (liability) balances at December 31, 2008	$ 538	$ 97	$ (26)	$ (657)
Realized losses included in earnings		(5)		341
Unrealized gains (losses) included in other comprehensive income	35		13	(222)
Purchases, issuances and settlements	(176)	(13)		10
Transfers out of Level 3		(79)	13	528
Asset (liability) balances at December 31, 2009	$ 397	$	$	$

The estimated fair value of our long-term debt was $25.659 billion and $20.225 billion at December 31, 2009 and 2008, respectively, compared to carrying amounts aggregating $25.670 billion and $26.989 billion, respectively. The estimates of fair value are generally based upon the quoted market prices or quoted market prices for similar issues of long-term debt with the same maturities.

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 LONG-TERM DEBT

A summary of long-term debt at December 31, including related interest rates at December 31, 2009, follows (dollars in millions):

	2009	2008
Senior secured asset-based revolving credit facility (effective interest rate of 1.7%)	**$ 715**	$ 2,000
Senior secured revolving credit facility		50
Senior secured term loan facilities (effective interest rate of 6.5%)	**8,987**	12,002
Senior secured first lien notes (effective interest rate of 8.9%)	**2,682**	
Other senior secured debt (effective interest rate of 6.8%)	**362**	406
First lien debt	**12,746**	14,458
Senior secured cash-pay notes (effective interest rate of 9.7%)	**4,500**	4,200
Senior secured toggle notes (effective interest rate of 10.0%)	**1,578**	1,500
Second lien debt	**6,078**	5,700
Senior unsecured notes (effective interest rate of 7.2%)	**6,846**	6,831
Total debt (average life of six years, rates averaging 7.6%)	**25,670**	26,989
Less amounts due within one year	**846**	404
	$ 24,824	$ 26,585

Senior Secured Credit Facilities And Other First Lien Debt

In connection with the Recapitalization, we entered into (i) a $2.000 billion senior secured asset-based revolving credit facility with a borrowing base of 85% of eligible accounts receivable, subject to customary reserves and eligibility criteria ($1.280 billion available at December 31, 2009) (the ABL credit facility) and (ii) a senior secured credit agreement (the cash flow credit facility and, together with the ABL credit facility, the senior secured credit facilities), consisting of a $2.000 billion revolving credit facility ($1.901 billion available at December 31, 2009 after giving effect to certain outstanding letters of credit), a $2.750 billion term loan A ($1.908 billion outstanding at December 31, 2009), a $8.800 billion term loan B ($6.515 billion outstanding at December 31, 2009) and a 1.000 billion European term loan (394 million, or $564 million, outstanding at December 31, 2009) under which one of our European subsidiaries is the borrower.

Borrowings under the senior secured credit facilities bear interest at a rate equal to, as determined by the type of borrowing, either 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% or (2) the prime rate of Bank of America or (b) a LIBOR rate for the currency of such borrowing for the relevant interest period, plus, in each case, an applicable margin. 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 ABL credit facility and the $2.000 billion revolving credit facility portion of the cash flow credit facility expire November 2012. The term loan facilities require quarterly installment payments. The final payment under term loan A is in November 2012. The final payments under term loan B and the European term loan are in November 2013. The senior secured credit facilities contain a number of covenants that restrict, subject to certain exceptions, our (and some or all of our subsidiaries) ability to incur additional indebtedness, repay subordinated indebtedness, create liens on assets, sell assets, make investments, loans or advances, engage in certain transactions with affiliates, pay dividends and distributions, and enter into sale and leaseback transactions. In addition, we are required to satisfy and maintain a maximum total leverage ratio covenant under the cash flow credit facility and, in certain situations under the ABL credit facility, a minimum interest coverage ratio covenant.

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 LONG-TERM DEBT (Continued)

Senior Secured Credit Facilities And Other First Lien Debt (Continued)

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 issuances to repay outstanding indebtedness under our senior secured term loan facilities.

We use interest rate swap agreements to manage the variable rate exposure of our debt portfolio. At December 31, 2009, we had entered into effective interest rate swap agreements, in a total notional amount of $8.5 billion, in order to hedge a portion of our exposure to variable rate interest payments associated with the senior secured credit facility. The effect of the interest rate swaps is reflected in the effective interest rates for the senior secured credit facilities.

Senior Secured Notes And Other Second Lien Debt

In November 2006, we issued $4.200 billion of senior secured 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% cash/103/8% in-kind senior secured toggle notes (which allow us, at our option, to pay interest in-kind during the first five years) due 2016, which are subject to certain standard covenants. We made the interest payment for the interest period ended in May 2009 by paying in-kind ($78 million) instead of paying interest in cash.

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. After the payment of related fees and expenses, we used the proceeds to repay outstanding indebtedness under our senior secured term loan facilities.

General Debt Information

The senior secured credit facilities and senior secured notes are fully and unconditionally guaranteed by substantially all existing and future, direct and indirect, wholly-owned material domestic subsidiaries that are Unrestricted Subsidiaries under our Indenture (the 1993 Indenture) dated December 16, 1993 (except for certain special purpose subsidiaries that only guarantee and pledge their assets under our ABL credit facility). In addition, borrowings under the European term loan are guaranteed by all material, wholly-owned European subsidiaries.

All obligations under the ABL credit facility, and the guarantees of those obligations, are secured, subject to permitted liens and other exceptions, by a first-priority lien on substantially all of the receivables of the borrowers and each guarantor under such ABL credit facility (the Receivables Collateral).

All obligations under the cash flow credit facility and the guarantees of such obligations are secured, subject to permitted liens and other exceptions, by:

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

a first-priority lien on substantially all present and future assets of HCA Inc. and of each U.S. guarantor other than (i) Principal Properties (as defined in the 1993 Indenture), (ii) certain other real properties and (iii) deposit accounts, other bank or securities accounts, cash, leaseholds, motor-vehicles and certain other exceptions; and

a second-priority lien on certain of the Receivables Collateral.

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 9 LONG-TERM DEBT (Continued)

General Debt Information (Continued)

Our senior secured first lien notes and the related guarantees are secured by first-priority liens, subject to permitted liens, on our and our subsidiary guarantors assets, subject to certain exceptions, that secure our cash flow credit facility on a first-priority basis and are secured by second priority liens, subject to permitted liens, on our and our subsidiary guarantors assets that secure our ABL credit facility on a first priority basis and our other cash flow credit facility on a second-priority basis.

Our second lien debt and the related guarantees are secured by second-priority liens, subject to permitted liens, on our and our subsidiary guarantors assets, subject to certain exceptions, that secure our cash flow credit facility on a first-priority basis and are secured by third-priority liens, subject to permitted liens, on our and our subsidiary guarantors assets that secure our asset-based revolving credit facility on a first priority basis and our other cash flow credit facility on a second-priority basis.

Maturities of long-term debt in years 2011 through 2014 are $629 million, $3.273 billion, $8.108 billion and $1.646 billion, respectively.

NOTE 10 CONTINGENCIES

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

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

NOTE 11 CAPITAL STOCK

The Company s certificate of incorporation and by-laws were amended and restated, effective March 27, 2008 and March 26, 2008, respectively. The amended and restated certificate of incorporation authorizes the Company to issue up to 125,000,000 shares of common stock, and the amended and restated by-laws set the number of directors constituting the board of directors of the Company at not less than one nor more than 15.

Stockholder Agreements and Equity Securities with Contingent Redemption Rights

The stockholder agreements, among other things, contain agreements among the parties with respect to restrictions on the transfer of shares, including tag along rights and drag along rights, registration rights (including customary indemnification provisions) and other rights. Pursuant to the management stockholder agreements, the applicable employees can elect to have the Company redeem their common stock and vested stock options in the events of death or permanent disability, prior to the consummation of the initial public offering of common stock by the Company. At December 31, 2009, 1,968,400 common shares and 4,207,800 vested stock options were subject to these contingent redemption terms.

NOTE 12 EMPLOYEE BENEFIT PLANS

We maintain contributory, defined contribution benefit plans that are available to employees who meet certain minimum requirements. Certain of the plans require that we match specified percentages of participant contributions up to certain maximum levels (generally, 100% of the first 3% to 9%, depending upon years of vesting

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 EMPLOYEE BENEFIT PLANS (Continued)

service, of compensation deferred by participants for periods subsequent to March 31, 2008, and 50% of the first 3% of compensation deferred by participants for periods prior to April 1, 2008). The cost of these plans totaled $283 million for 2009, $233 million for 2008 and $86 million for 2007. Our contributions are funded periodically during each year.

We maintained a noncontributory, defined contribution retirement plan which covered substantially all employees. Benefits were determined as a percentage of a participant s salary and vest over specified periods of employee service. Benefits expense was $46 million for 2008 and $203 million for 2007. There was no expense for 2009 as the noncontributory plan and the related participant account balances were merged into the contributory HCA 401(k) Plan effective April 1, 2008.

We maintain the noncontributory, nonqualified Restoration Plan to provide certain retirement benefits for eligible employees. Eligibility for the Restoration Plan is based upon earning eligible compensation in excess of the Social Security Wage Base and attaining 1,000 or more hours of service during the plan year. Company credits to participants account balances (the Restoration Plan is not funded) depend upon participants compensation, years of vesting service and certain IRS limitations related to the HCA 401(k) plan. Benefits expense under this plan was $26 million for 2009, $2 million for 2008 and $20 million for 2007. Accrued benefits liabilities under this plan totaled $73 million at December 31, 2009 and $48 million at December 31, 2008.

We maintain a Supplemental Executive Retirement Plan (SERP) for certain executives. The plan is designed to ensure that upon retirement the participant receives the value of a prescribed life annuity from the combination of the SERP and our other benefit plans. Benefits expense under the plan was $24 million for 2009, $20 million for 2008 and $20 million for 2007. Accrued benefits liabilities under this plan totaled $152 million at December 31, 2009 and $133 million at December 31, 2008.

We maintain defined benefit pension plans which resulted from certain hospital acquisitions in prior years. Benefits expense under these plans was $39 million for 2009, $24 million for 2008, and $27 million for 2007. Accrued benefits liabilities under these plans totaled $115 million at December 31, 2009 and $142 million at December 31, 2008.

NOTE 13 SEGMENT AND GEOGRAPHIC INFORMATION

We operate in one line of business, which is operating hospitals and related health care entities. During the years ended December 31, 2009, 2008 and 2007, approximately 23%, 23% and 24%, respectively, of our revenues related to patients participating in the fee-for-service Medicare program.

Our operations are structured into three geographically organized groups: the Eastern Group includes 48 consolidating hospitals located in the Eastern United States, the Central Group includes 46 consolidating hospitals located in the Central United States and the Western Group includes 55 consolidating hospitals located in the Western United States. We also operate six consolidating hospitals in England, and these facilities are included in the Corporate and other group.

Adjusted segment EBITDA is defined as income before depreciation and amortization, interest expense, losses (gains) on sales of facilities, impairment of long-lived assets, income taxes and net income attributable to noncontrolling interests. We use adjusted segment EBITDA as an analytical indicator for purposes of allocating resources to geographic areas and assessing performance. Adjusted segment EBITDA is commonly used as an analytical indicator within the health care industry, and also serves as a measure of leverage capacity and debt service ability. Adjusted segment EBITDA should not be considered as a measure of financial performance under generally accepted accounting principles, and the items excluded from adjusted segment EBITDA are significant components in understanding and assessing financial performance. Because adjusted segment EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 13 SEGMENT AND GEOGRAPHIC INFORMATION (Continued)

varying calculations, adjusted segment EBITDA, as presented, may not be comparable to other similarly titled measures of other companies.

The geographic distributions of our revenues, equity in earnings of affiliates, adjusted segment EBITDA, depreciation and amortization, assets and goodwill are summarized in the following table (dollars in millions):

	For the Years Ended December 31,		
	2009	**2008**	**2007**
Revenues:			
Eastern Group	**$ 8,807**	$ 8,570	$ 8,204
Central Group	**7,225**	6,740	6,302
Western Group	**13,140**	12,118	11,378
Corporate and other	**880**	946	974
	$ 30,052	$ 28,374	$ 26,858
Equity in earnings of affiliates:			
Eastern Group	**$ (3)**	$ (2)	$ (2)
Central Group	**(2)**	(2)	8
Western Group	**(241)**	(219)	(212)
Corporate and other			
	$ (246)	$ (223)	$ (206)
Adjusted segment EBITDA:			
Eastern Group	**$ 1,469**	$ 1,288	$ 1,268
Central Group	**1,325**	1,061	1,082
Western Group	**2,867**	2,270	2,196
Corporate and other	**(189)**	(45)	46
	$ 5,472	$ 4,574	$ 4,592
Depreciation and amortization:			
Eastern Group	**$ 364**	$ 358	$ 369
Central Group	**352**	359	364
Western Group	**578**	552	529
Corporate and other	**131**	147	164
	$ 1,425	$ 1,416	$ 1,426

Adjusted segment EBITDA	**$ 5,472**	$ 4,574	$ 4,592
Depreciation and amortization	**1,425**	1,416	1,426
Interest expense	**1,987**	2,021	2,215
Losses (gains) on sales of facilities	**15**	(97)	(471)
Impairment of long-lived assets	**43**	64	24
Income before income taxes	**$ 2,002**	$ 1,170	$ 1,398

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 13 SEGMENT AND GEOGRAPHIC INFORMATION (Continued)

	As of December 31, 2009	2008
Assets:		
Eastern Group	**$ 5,018**	$ 4,906
Central Group	**5,173**	5,251
Western Group	**8,847**	8,597
Corporate and other	**5,093**	5,526
	$ 24,131	$ 24,280

	Eastern Group	Central Group	Western Group	Corporate and Other	Total
Goodwill:					
Balance at December 31, 2008	$ 602	$ 1,013	$ 754	$ 211	$ 2,580
Acquisitions		5			5
Impairments	(7)		(12)		(19)
Foreign currency translation and other	1			10	11
Balance at December 31, 2009	$ 596	$ 1,018	$ 742	$ 221	$ 2,577

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 14 OTHER COMPREHENSIVE INCOME (LOSS)

The components of accumulated other comprehensive income (loss) are as follows (dollars in millions):

	Unrealized Gains (Losses) on Available-for-Sale Securities	Foreign Currency Translation Adjustments	Defined Benefit Plans	Change in Fair Value of Derivative Instruments	Total
Balances at December 31, 2006	$ 16	$ 49	$ (67)	$ 18	$ 16
Unrealized gains on available-for-sale securities, net of $1 of income taxes	3				3
Foreign currency translation adjustments, net of $3 income tax benefit		(7)			(7)
Defined benefit plans, net of $10 of income taxes			16		16
Change in fair value of derivative instruments, net of $100 income tax benefit				(172)	(172)
(Income) expense reclassified into operations from other comprehensive income, net of $3, $5, $(4) and $12, respectively, of income taxes (benefit)	(5)	(8)	7	(22)	(28)
Balances at December 31, 2007	14	34	(44)	(176)	(172)
Unrealized losses on available-for-sale securities, net of $25 income tax benefit	(44)				(44)
Foreign currency translation adjustments, net of $33 income tax benefit		(62)			(62)
Defined benefit plans, net of $40 income tax benefit			(68)		(68)
Change in fair value of derivative instruments, net of $194 income tax benefit				(334)	(334)
Expense reclassified into operations from other comprehensive income, net of $4 and $42, respectively, income tax benefits			6	70	76
Balances at December 31, 2008	(30)	(28)	(106)	(440)	(604)
Unrealized gains on available-for-sale securities, net of $25 of income taxes	44				44
		25			25

Foreign currency translation adjustments, net of $14 of income taxes					
Defined benefit plans, net of $8 income tax benefit			(10)		(10)
Change in fair value of derivative instruments, net of $76 income tax benefit				(133)	(133)
Expense reclassified into operations from other comprehensive income, net of $6 and $127, respectively, income tax benefits			10	218	228
Balances at December 31, 2009	$ 14	$ (3)	$ (106)	$ (355)	$ (450)

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 15 ACCRUED EXPENSES AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

A summary of other accrued expenses at December 31 follows (dollars in millions):

	2009	2008
Professional liability risks	**$ 265**	$ 279
Interest	**283**	212
Income taxes		224
Taxes other than income	**190**	189
Other	**420**	378
	$ 1,158	$ 1,282

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

	Balance at Beginning of Year	Provision for Doubtful Accounts	Accounts Written off, Net of Recoveries	Balance at End of Year
Allowance for doubtful accounts:				
Year ended December 31, 2007	$ 2,889	$ 3,130	$ (2,308)	$ 3,711
Year ended December 31, 2008	3,711	3,409	(2,379)	4,741
Year ended December 31, 2009	4,741	3,276	(3,157)	4,860

During 2009, we refined our allowance for doubtful accounts estimation process to include separate estimates of pending charity and pending uninsured discount amounts. These amounts were previously included in the allowance for doubtful accounts, but at December 31, 2009, we recorded these estimated amounts as reductions to accounts receivable. This reclassification has no effect on net accounts receivable and the prior year amounts have been reclassified to conform with the 2009 presentation. The incremental, annual amounts reclassified were $135 million, $116 million and $39 million for the years ended December 31, 2009, 2008 and 2007, respectively.

NOTE 16 SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION

The senior secured credit facilities and senior secured notes described in Note 9 are fully and unconditionally guaranteed by substantially all existing and future, direct and indirect, wholly-owned material domestic subsidiaries that are Unrestricted Subsidiaries under our Indenture dated December 16, 1993 (except for certain special purpose subsidiaries that only guarantee and pledge their assets under our ABL credit facility).

Our condensed consolidating balance sheets at December 31, 2009 and 2008 and condensed consolidating statements of income and cash flows for each of the three years in the period ended December 31, 2009, segregating the parent company issuer, the subsidiary guarantors, the subsidiary non-guarantors and eliminations, follow.

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (Continued)

HCA INC.
CONDENSED CONSOLIDATING INCOME STATEMENT
For The Year Ended December 31, 2009
(Dollars in millions)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Revenues	$	$ 17,584	$ 12,468	$	$ 30,052
Salaries and benefits		7,149	4,809		11,958
Supplies		2,846	2,022		4,868
Other operating expenses	14	2,497	2,213		4,724
Provision for doubtful accounts		2,043	1,233		3,276
Equity in earnings of affiliates	(2,540)	(95)	(151)	2,540	(246)
Depreciation and amortization		787	638		1,425
Interest expense	2,356	(500)	131		1,987
Losses (gains) on sales of facilities		17	(2)		15
Impairment of long-lived assets		34	9		43
Management fees		(443)	443		
	(170)	14,335	11,345	2,540	28,050
Income before income taxes	170	3,249	1,123	(2,540)	2,002
Provision for income taxes	(884)	1,189	322		627
Net income	1,054	2,060	801	(2,540)	1,375
Net income attributable to noncontrolling interests		61	260		321
Net income attributable to HCA Inc.	$ 1,054	$ 1,999	$ 541	$ (2,540)	$ 1,054

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (Continued)

HCA INC.
CONDENSED CONSOLIDATING INCOME STATEMENT
For The Year Ended December 31, 2008
(Dollars in millions)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Revenues	$	$ 16,507	$ 11,867	$	$ 28,374
Salaries and benefits		6,846	4,594		11,440
Supplies		2,671	1,949		4,620
Other operating expenses	(6)	2,445	2,115		4,554
Provision for doubtful accounts		2,073	1,336		3,409
Equity in earnings of affiliates	(2,100)	(82)	(141)	2,100	(223)
Depreciation and amortization		776	640		1,416
Interest expense	2,190	(328)	159		2,021
Gains on sales of facilities		(5)	(92)		(97)
Impairment of long-lived assets			64		64
Management fees		(426)	426		
	84	13,970	11,050	2,100	27,204
Income (loss) before income taxes	(84)	2,537	817	(2,100)	1,170
Provision for income taxes	(757)	803	222		268
Net income	673	1,734	595	(2,100)	902
Net income attributable to noncontrolling interests		53	176		229
Net income attributable to HCA Inc.	$ 673	$ 1,681	$ 419	$ (2,100)	$ 673

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (Continued)

HCA INC.
CONDENSED CONSOLIDATING INCOME STATEMENT
For The Year Ended December 31, 2007
(Dollars in millions)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Revenues	$	$ 15,598	$ 11,260	$	$ 26,858
Salaries and benefits		6,441	4,273		10,714
Supplies		2,549	1,846		4,395
Other operating expenses	(2)	2,279	1,956		4,233
Provision for doubtful accounts		1,942	1,188		3,130
Equity in earnings of affiliates	(2,245)	(90)	(116)	2,245	(206)
Depreciation and amortization		779	647		1,426
Interest expense	2,161	(95)	149		2,215
Gains on sales of facilities		(3)	(468)		(471)
Impairment of long-lived assets			24		24
Management fees		(392)	392		
	(86)	13,410	9,891	2,245	25,460
Income before income taxes	86	2,188	1,369	(2,245)	1,398
Provision for income taxes	(788)	712	392		316
Net income	874	1,476	977	(2,245)	1,082
Net income attributable to noncontrolling interests		28	180		208
Net income attributable to HCA Inc.	$ 874	$ 1,448	$ 797	$ (2,245)	$ 874

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (Continued)

HCA INC.
CONDENSED CONSOLIDATING BALANCE SHEET
DECEMBER 31, 2009
(Dollars in millions)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$	$ 95	$ 217	$	$ 312
Accounts receivable, net		2,135	1,557		3,692
Inventories		489	313		802
Deferred income taxes	1,192				1,192
Other	81	148	350		579
	1,273	2,867	2,437		6,577
Property and equipment, net		7,034	4,393		11,427
Investments of insurance subsidiary			1,166		1,166
Investments in and advances to affiliates		244	609		853
Goodwill		1,641	936		2,577
Deferred loan costs	418				418
Investments in and advances to subsidiaries	21,830			(21,830)	
Other	963	19	131		1,113
	$ 24,484	$ 11,805	$ 9,672	$ (21,830)	$ 24,131
LIABILITIES AND STOCKHOLDERS (DEFICIT) EQUITY					
Current liabilities:					
Accounts payable	$	$ 908	$ 552	$	$ 1,460
Accrued salaries		542	307		849
Other accrued expenses	282	293	583		1,158
Long-term debt due within one year	802	9	35		846

	1,084	1,752	1,477		4,313
Long-term debt	24,427	103	294		24,824
Intercompany balances	6,636	(10,387)	3,751		
Professional liability risks			1,057		1,057
Income taxes and other liabilities	1,176	421	171		1,768
	33,323	(8,111)	6,750		31,962
Equity securities with contingent redemption rights	147				147
Stockholders (deficit) equity attributable to HCA Inc.	(8,986)	19,787	2,043	(21,830)	(8,986)
Noncontrolling interests		129	879		1,008
	(8,986)	19,916	2,922	(21,830)	(7,978)
	$ 24,484	$ 11,805	$ 9,672	$ (21,830)	$ 24,131

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (Continued)

HCA INC.
CONDENSED CONSOLIDATING BALANCE SHEET
DECEMBER 31, 2008
(Dollars in millions)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$	$ 134	$ 331	$	$ 465
Accounts receivable, net		2,214	1,566		3,780
Inventories		455	282		737
Deferred income taxes	914				914
Other		140	265		405
	914	2,943	2,444		6,301
Property and equipment, net		7,122	4,407		11,529
Investments of insurance subsidiary			1,422		1,422
Investments in and advances to affiliates		243	599		842
Goodwill		1,643	937		2,580
Deferred loan costs	458				458
Investments in and advances to subsidiaries	19,290			(19,290)	
Other	1,050	31	67		1,148
	$ 21,712	$ 11,982	$ 9,876	$ (19,290)	$ 24,280
LIABILITIES AND STOCKHOLDERS (DEFICIT) EQUITY					
Current liabilities:					
Accounts payable	$	$ 881	$ 489	$	$ 1,370
Accrued salaries		549	305		854
Other accrued expenses	435	284	563		1,282
Long-term debt due within one year	355		49		404

	790	1,714	1,406		3,910
Long-term debt	26,089	99	397		26,585
Intercompany balances	3,663	(8,136)	4,473		
Professional liability risks			1,108		1,108
Income taxes and other liabilities	1,270	379	133		1,782
	31,812	(5,944)	7,517		33,385
Equity securities with contingent redemption rights	155				155
Stockholders (deficit) equity attributable to HCA Inc.	(10,255)	17,788	1,502	(19,290)	(10,255)
Noncontrolling interests		138	857		995
	(10,255)	17,926	2,359	(19,290)	(9,260)
	$ 21,712	$ 11,982	$ 9,876	$ (19,290)	$ 24,280

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (Continued)

HCA INC.
CONDENSED CONSOLIDATING STATEMENT OF CASH FLOWS
For The Year Ended December 31, 2009
(Dollars in millions)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities:					
Net income	$ 1,054	$ 2,060	$ 801	$ (2,540)	$ 1,375
Adjustments to reconcile net income to net cash provided by (used in) operating activities:					
Change in operating assets and liabilities	90	(1,882)	(1,299)		(3,091)
Provision for doubtful accounts		2,043	1,233		3,276
Depreciation and amortization		787	638		1,425
Income taxes	(520)				(520)
Losses (gains) on sales of facilities		17	(2)		15
Impairment of long-lived assets		34	9		43
Amortization of deferred loan costs	80				80
Share-based compensation	40				40
Pay-in-kind interest	58				58
Equity in earnings of affiliates	(2,540)			2,540	
Other	50	(2)	(2)		46
Net cash provided by (used in) operating activities	(1,688)	3,057	1,378		2,747
Cash flows from investing activities:					
Purchase of property and equipment		(720)	(597)		(1,317)
Acquisition of hospitals and health care entities		(38)	(23)		(61)
Disposal of hospitals and health care entities		21	20		41
Change in investments		(7)	310		303
Other			(1)		(1)
Net cash used in investing activities		(744)	(291)		(1,035)

Cash flows from financing activities:					
Issuances of long-term debt	2,979				2,979
Net change in revolving bank credit facilities	(1,335)				(1,335)
Repayment of long-term debt	(2,972)	(7)	(124)		(3,103)
Distributions to noncontrolling interests		(70)	(260)		(330)
Payment of debt issuance costs	(70)				(70)
Changes in intercompany balances with affiliates, net	3,107	(2,275)	(832)		
Other	(21)		15		(6)
Net cash provided by (used in) financing activities	1,688	(2,352)	(1,201)		(1,865)
Change in cash and cash equivalents		(39)	(114)		(153)
Cash and cash equivalents at beginning of period		134	331		465
Cash and cash equivalents at end of period	$	$ 95	$ 217	$	$ 312

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (Continued)

HCA INC.
CONDENSED CONSOLIDATING STATEMENT OF CASH FLOWS
For The Year Ended December 31, 2008
(Dollars in millions)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities:					
Net income	$ 673	$ 1,734	$ 595	$ (2,100)	$ 902
Adjustments to reconcile net income to net cash provided by (used in) operating activities:					
Change in operating assets and liabilities	(11)	(2,085)	(1,271)		(3,367)
Provision for doubtful accounts		2,073	1,336		3,409
Depreciation and amortization		776	640		1,416
Income taxes	(448)				(448)
Gains on sales of facilities		(5)	(92)		(97)
Impairment of long-lived assets			64		64
Amortization of deferred loan costs	79				79
Share-based compensation	32				32
Equity in earnings of affiliates	(2,100)			2,100	
Other		(19)	19		
Net cash provided by (used in) operating activities	(1,775)	2,474	1,291		1,990
Cash flows from investing activities:					
Purchase of property and equipment		(927)	(673)		(1,600)
Acquisition of hospitals and health care entities		(34)	(51)		(85)
Disposal of hospitals and health care entities		27	166		193
Change in investments		(26)	47		21
Other		(4)	8		4
Net cash used in investing activities		(964)	(503)		(1,467)
Cash flows from financing activities:					

Net change in revolving bank credit facilities	700				700
Repayment of long-term debt	(851)	(4)	(105)		(960)
Distributions to noncontrolling interests		(32)	(146)		(178)
Changes in intercompany balances with affiliates, net	1,935	(1,505)	(430)		
Other	(9)		(4)		(13)
Net cash provided by (used in) financing activities	1,775	(1,541)	(685)		(451)
Change in cash and cash equivalents		(31)	103		72
Cash and cash equivalents at beginning of period		165	228		393
Cash and cash equivalents at end of period	$	$ 134	$ 331	$	$ 465

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HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (Continued)

HCA INC.
CONDENSED CONSOLIDATING STATEMENT OF CASH FLOWS
For The Year Ended December 31, 2007
(Dollars in millions)

	Parent Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities:					
Net income	$ 874	$ 1,476	$ 977	$ (2,245)	$ 1,082
Adjustments to reconcile net income to net cash provided by (used in) operating activities:					
Change in operating assets and liabilities	(6)	(2,127)	(1,482)		(3,615)
Provision for doubtful accounts		1,942	1,188		3,130
Depreciation and amortization		779	647		1,426
Income taxes	(105)				(105)
Gains on sales of facilities		(3)	(468)		(471)
Impairment of long-lived assets			24		24
Amortization of deferred loan costs	78				78
Share-based compensation	24				24
Equity in earnings of affiliates	(2,245)			2,245	
Other	7	18	(34)		(9)
Net cash provided by (used in) operating activities	(1,373)	2,085	852		1,564
Cash flows from investing activities:					
Purchase of property and equipment		(640)	(804)		(1,444)
Acquisition of hospitals and health care entities		(11)	(21)		(32)
Disposal of hospitals and health care entities		24	743		767
Change in investments		3	204		207
Other		(8)	31		23
Net cash provided by (used in) investing activities		(632)	153		(479)
Cash flows from financing activities:					
Net change in revolving bank credit facilities	(520)				(520)

Repayment of long-term debt	(255)	(4)	(491)		(750)
Distributions to noncontrolling interests		(12)	(140)		(152)
Issuances of common stock	100				100
Changes in intercompany balances with affiliates, net	2,059	(1,554)	(505)		
Other	(11)		7		(4)
Net cash provided by (used in) financing activities	1,373	(1,570)	(1,129)		(1,326)
Change in cash and cash equivalents		(117)	(124)		(241)
Cash and cash equivalents at beginning of period		282	352		634
Cash and cash equivalents at end of period	$	$ 165	$ 228	$	$ 393

Healthtrust, Inc. The Hospital Company (Healthtrust) is the first-tier subsidiary of HCA Inc. The common stock of Healthtrust has been pledged as collateral for the senior secured credit facilities and senior secured notes described in Note 9. Rule 3-16 of Regulation S-X under the Securities Act requires the filing of separate financial statements for any affiliate of the registrant whose securities constitute a substantial portion of the collateral for any class of securities registered or being registered. We believe the separate financial statements requirement applies to Healthtrust due to the pledge of its common stock as collateral for the senior secured notes. Due to the corporate structure relationship of HCA and Healthtrust, HCA s operating subsidiaries are also the operating subsidiaries of Healthtrust. The corporate structure relationship, combined with the application of push-down accounting in Healthtrust s consolidated financial statements related to HCA s debt and financial instruments, results in the consolidated financial statements of Healthtrust being substantially identical to the consolidated

HCA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 16 SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (Continued)

financial statements of HCA. The consolidated financial statements of HCA and Healthtrust present the identical amounts for revenues, expenses, net income, assets, liabilities, total stockholders deficit, net cash provided by operating activities, net cash used in investing activities and net cash used in financing activities. Certain individual line items in the HCA consolidated statements of stockholders deficit and cash flows are combined into one line item in the Healthtrust consolidated statements of stockholder s deficit and cash flows.

Reconciliations of the HCA Inc. Consolidated Statements of Stockholders Deficit and Consolidated Statements of Cash Flows presentations to the Healthtrust, Inc. The Hospital Company Consolidated Statements of Stockholder s Deficit and Consolidated Statements of Cash Flows presentations for the years ended December 31, 2009, 2008 and 2007 are as follows (dollars in millions):

	2009	2008	2007
Presentation in HCA Inc. Consolidated Statements of Stockholders Deficit:			
Equity contributions	**$**	$	$ 60
Share-based benefit plans	**47**	40	24
Other	**14**	2	28
Presentation in Healthtrust, Inc. The Hospital Company Consolidated Statements of Stockholder s Deficit:			
Distributions from HCA Inc., net of contributions to HCA Inc.	**$ 61**	$ 42	$ 112
Presentation in HCA Inc. Consolidated Statements of Cash Flows (cash flows from financing activities):			
Issuances of common stock	**$**	$	$ 100
Other		(9)	(2)
Presentation in Healthtrust Inc. The Hospital Company Consolidated Statements of Cash Flows (cash flows from financing activities):			
Net cash distributions (to) from HCA Inc.	**$**	$ (9)	$ 98

Due to the consolidated financial statements of Healthtrust being substantially identical to the consolidated financial statements of HCA, except for the items presented in the tables above, the separate consolidated financial statements of Healthtrust are not presented.

NOTE 17 SUBSEQUENT EVENT

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 option plans, the holders of nonvested stock options received a $17.50 per share reduction to the exercise price of their share-based awards.

HCA INC.
QUARTERLY CONSOLIDATED FINANCIAL INFORMATION
(UNAUDITED)
(Dollars in millions)

	2009			
	First	Second	Third	Fourth
Revenues	$ 7,431	$ 7,483	$ 7,533	$ 7,605
Net income	$ 432(a)	$ 365(b)	$ 274(c)	$ 304(d)
Net income attributable to HCA Inc.	$ 360(a)	$ 282(b)	$ 196(c)	$ 216(d)

	2008			
	First	Second	Third	Fourth
Revenues	$ 7,127	$ 6,980	$ 7,002	$ 7,265
Net income	$ 225(e)	$ 197(f)	$ 136(g)	$ 344(h)
Net income attributable to HCA Inc.	$ 170(e)	$ 141(f)	$ 86(g)	$ 276(h)

(a) First quarter results include $3 million of losses on sales of facilities (See NOTE 3 of the notes to consolidated financial statements) and $6 million of costs related to the impairment of long-lived assets (See NOTE 4 of the notes to consolidated financial statements).

(b) Second quarter results include $2 million of losses on sales of facilities (See NOTE 3 of the notes to consolidated financial statements) and $2 million of costs related to the impairment of long-lived assets (See NOTE 4 of the notes to consolidated financial statements).

(c) Third quarter results include $2 million of costs related to the impairment of long-lived assets (See NOTE 4 of the notes to consolidated financial statements).

(d) Fourth quarter results include $4 million of losses on sales of facilities (See NOTE 3 of the notes to consolidated financial statements) and $24 million of costs related to the impairment of long-lived assets (See NOTE 4 of the notes to consolidated financial statements).

(e) First quarter results include $30 million of gains on sales of facilities (See NOTE 3 of the notes to consolidated financial statements).

(f) Second quarter results include $6 million of losses on sales of facilities (See NOTE 3 of the notes to consolidated financial statements) and $6 million of costs related to the impairment of long-lived assets (See NOTE 4 of the notes to consolidated financial statements).

(g) Third quarter results include $29 million of gains on sales of facilities (See NOTE 3 of the notes to consolidated financial statements) and $28 million of costs related to the impairment of long-lived assets (See NOTE 4 of the notes to consolidated financial statements).

(h) Fourth quarter results include $5 million of gains on sales of facilities (See NOTE 3 of the notes to consolidated financial statements) and $6 million of costs related to the impairment of long-lived assets (See NOTE 4 of the notes to consolidated financial statements).

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Exhibit 10.20

FORM OF

STOCK OPTION AGREEMENT

THIS AGREEMENT, dated as of ___, 2010 (the Grant Date) is made by and between HCA Inc., a Delaware corporation (hereinafter referred to as the Company), and the individual whose name is set forth on the signature page hereof, who is an employee of the Company or a Subsidiary or Affiliate of the Company, hereinafter referred to as the Optionee . Any capitalized terms herein not otherwise defined in Article I shall have the meaning set forth in the 2006 Stock Incentive Plan for Key Employees of HCA Inc. and its Affiliates (the Plan).

WHEREAS, the Company wishes to carry out the Plan, the terms of which are hereby incorporated by reference and made a part of this Agreement; and

WHEREAS, the Compensation Committee of the Board of Directors of the Company (or, if no such committee is appointed, the Board of Directors of the Company) (the Committee) has determined that it would be to the advantage and best interest of the Company and its shareholders to grant the Option provided for herein to the Optionee as an incentive for increased efforts during his term of office with the Company or its Subsidiaries or Affiliates, and has advised the Company thereof and instructed the undersigned officers to issue said Option;

NOW, THEREFORE, in consideration of the mutual covenants herein contained and other good and valuable consideration, receipt of which is hereby acknowledged, the parties hereto do hereby agree as follows:

ARTICLE I

DEFINITIONS

Whenever the following terms are used in this Agreement, they shall have the meaning specified below unless the context clearly indicates to the contrary.

Section 1.2. Cause

Cause shall mean Cause as such term may be defined in any employment agreement or change-in-control agreement in effect at the time of termination of employment between the Optionee and the Company or any of its Subsidiaries or Affiliates, or, if there is no such employment or change-in-control agreement, Cause shall mean (i) willful and continued failure by Optionee (other than by reason of a Permanent Disability) to perform his or her material duties with respect to the Company or it Subsidiaries which continues beyond ten (10) business days after a written demand for substantial performance is delivered to Optionee by the Company (the Cure Period); (ii) willful or intentional engaging by Optionee in material misconduct

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that causes material and demonstrable injury, monetarily or otherwise, to the Company, the Investors or their respective Affiliates; (iii) conviction of, or a plea of nolo contendere to, a crime constituting (x) a felony under the laws of the United States or any state thereof or (y) a misdemeanor for which a sentence of more than six months imprisonment is imposed; or (iv) willful and material breach of the Management Stockholder s Agreement or related agreements, or Optionee s engaging in any action in breach of restrictive covenants made by Optionee under the Management Stockholder s Agreement or any employment or change-in-control agreement between the Optionee and the Company or any of its Subsidiaries, which continues beyond the Cure Period (to the extent that, in the Board s reasonable judgment, such breach can be cured).

Section 1.3. Closing Date

Closing Date shall mean November 17, 2006.

Section 1.4. Fiscal Year

Fiscal Year shall mean each of 2010, 2011, 2012, 2013, and 2014 fiscal years of the Company (which, for the avoidance of doubt, ends on December 31 of any given calendar year).

Section 1.5. Good Reason

Good Reason shall mean Good Reason as such term may be defined in any employment agreement or change-in-control agreement in effect at the time of termination of employment between the Optionee and the Company or any of its Subsidiaries or Affiliates, or, if there is no such employment or change-in-control agreement, Good Reason shall mean (i) (A) a reduction in Optionee s base salary (other than a general reduction in base salary that affects all similarly situated employees (defined as all employees within the same Company pay grade as that of Optionee) in substantially the same proportions that the Board implements in good faith after consultation with the Chief Executive Officer (CEO) and Chief Operating Officer of the Company); (B) a reduction in Optionee s annual incentive compensation opportunity; or (C) the reduction of benefits payable to Optionee under the Company s Supplemental Executive Retirement Plan (if Optionee is a participant in such plan), in each case other than any isolated, insubstantial and inadvertent failure by the Company that is not in bad faith and is cured within ten (10) business days after Optionee gives the Company written notice of such event; provided that the events described in (i)(A) or (i)(B) above will not be deemed to give rise to Good Reason if employment is terminated, but Optionee declines an offer of employment involving a loss of compensation of less than 15% from a purchaser, transferee, outsourced vendor, new operating entity or affiliated employer; (ii) a substantial diminution in Optionee s title, duties and responsibilities, other than any isolated, insubstantial and inadvertent failure by the Company that is not in bad faith and is cured within ten (10) business days after Optionee gives the Company written notice of such event; or (iii) a transfer of Optionee s primary workplace to a location that is more than twenty (20) miles from his or her workplace as of the date of this Agreement; provided that Good Reason shall not be deemed to occur merely because Optionee s willful decision to change position or status within the Company or any of its Subsidiaries causes one or more of the occurrences described in (i), (ii), or (iii) to come about.

Section 1.6. Investor Return

Investor Return shall mean, on any date, as determined on a fully diluted, per Share basis, all cash proceeds actually received by the Investors after the Closing Date in respect of their shares of Common Stock, including the receipt of any cash dividends or other cash distributions thereon. The Fair Market Value of any shares of Common Stock distributed by the Investors to their limited partners shall be deemed to be cash proceeds for purposes of this definition.

Section 1.7. Management Stockholder s Agreement

Management Stockholder s Agreement shall mean that certain Management Stockholder s Agreement between the Optionee and the Company.

Section 1.8. Option

Option shall mean the Option granted under Section 2.1 of this Agreement.

Section 1.9. Permanent Disability

Permanent Disability shall mean Disability as such term is defined in any employment agreement between Optionee and the Company or any of its Subsidiaries, or, if there is no such employment agreement, Disability as defined in the long-term disability plan of the Company.

Section 1.10. Retirement

Retirement shall mean Optionee s resignation (other than for Good Reason) from service with the Company and its Service Recipients (i) after attaining 65 years of age or (ii) after attaining 60 years of age and completing thirty-six (36) months of service with the Company or any Service Recipients following the Closing Date.

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Section 1.11. Secretary

Secretary shall mean the Secretary of the Company.

Section 1.12. Vesting Date

Vesting Date means the date on which a percentage of the Option will become exercisable, subject to the conditions of Article III.

ARTICLE II
GRANT OF OPTIONS

Section 2.1. Grant of Options

For good and valuable consideration, on and as of the date hereof the Company irrevocably grants to the Optionee the Option, on the terms and conditions set forth in this Agreement.

Section 2.2. Exercise Price

Subject to Section 2.4, the exercise price of the shares of Common Stock covered by the Option (the Exercise Price) shall be as set forth on the signature page hereof.

Section 2.3. No Guarantee of Employment

Nothing in this Agreement or in the Plan shall confer upon the Optionee any right to continue in the employ of the Company or any Subsidiary or Affiliate or shall interfere with or restrict in any way the rights of the Company and its Subsidiaries or Affiliates, which are hereby expressly reserved, to terminate the employment of the Optionee at any time for any reason whatsoever, with or without cause, subject to the applicable provisions of, if any, the Optionee s employment agreement with the Company or offer letter provided by the Company to the Optionee.

Section 2.4. Adjustments to Option

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The Option shall be subject to the adjustment provisions of Sections 8 and 9 of the Plan, provided, however, that in the event of the payment of an extraordinary dividend by the Company to its stockholders, then; first, the Exercise Prices of the Option shall be reduced by the amount of the dividend paid, but only to the extent the Committee determines it to be permitted under applicable tax laws and it will not have adverse tax consequences to the Optionee; and, if such reduction cannot be fully effected due to such tax laws, second, the Company shall pay to the Optionee a cash payment, on a per Share basis, equal to the balance of the amount of the dividend not permitted to be applied to reduce the Exercise Price of the applicable Option as follows: (a) for each Share subject to a vested Option, immediately upon the date of such dividend payment; and (b), for each Share subject to an unvested Option, on the date on which such Option becomes vested and exercisable with respect to such Share.

ARTICLE III
PERIOD OF EXERCISABILITY

Section 3.1. Commencement of Exercisability

(a) The Option shall be exercisable, subject to the Optionee continuing to be employed by the Company or any other Service Recipient, through the applicable Vesting Date, as to the applicable percentage of the Option as set forth below:

Vesting Date	Percentage of Option Exercisable
February 10, 2012	25%
February 10, 2013	25%
February 10, 2014	25%
February 10, 2015	25%
Total:	100%

(b) Notwithstanding the foregoing, upon the occurrence of a Change in Control: the Option shall become immediately exercisable as to 100% of the shares of Common Stock subject to such Option immediately prior to a Change in Control (but only to the extent such Option has not otherwise terminated or become exercisable);

(c) Notwithstanding the foregoing, no Option shall become exercisable as to any additional shares of Common Stock following the termination of employment of the Optionee for any reason and any Option, which is unexercisable as of the Optionee s termination of employment, shall immediately expire without payment therefor.

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Section 3.2. Expiration of Option

Except as otherwise provided in Section 6 or 7 of the Management Stockholder s Agreement, the Optionee may not exercise the Option to any extent after the first to occur of the following events:

(a) The tenth anniversary of the Grant Date so long as the Optionee remains employed with the Company or any Service Recipient through such date;

(b) The third anniversary of the date of the Optionee s termination of employment with the Company and all Service Recipients, if the Optionee s employment is terminated by reason of death or Permanent Disability (unless earlier terminated as provided in Section 3.20 below);

(c) Immediately upon the date of the Optionee s termination of employment by the Company and all Service Recipients for Cause;

(d) One hundred and eighty (180) days after the date of an Optionee s termination of employment by the Company and all Service Recipients without Cause (for any reason other than as set forth in Section 3.2(b));

(e) One hundred and eighty (180) days after the date of an Optionee s termination of employment with the Company and all Service Recipients by the Optionee for Good Reason;

(f) One hundred and eighty (180) days after the date of an Optionee s termination of employment with the Company and all Service Recipients by the Optionee upon Retirement.

(g) Thirty (30) days after the date of an Optionee s termination of employment with the Company and all Service Recipients by the Optionee without Good Reason (except due to Retirement, death or Permanent Disability);

(h) The date the Option is terminated pursuant to Section 6 or 7 of the Management Stockholder s Agreement; or

(i) At the discretion of the Company, if the Committee so determines pursuant to Section 9 of the Plan.

ARTICLE IV

EXERCISE OF OPTION

Section 4.1. Person Eligible to Exercise

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During the lifetime of the Optionee, only the Optionee (or his or her duly authorized legal representative) may exercise an Option or any portion thereof. After the death of the Optionee, any exercisable portion of an Option may, prior to the time when an Option becomes unexercisable under Section 3.2, be exercised by his personal representative or by any person empowered to do so under the Optionee s will or under the then applicable laws of descent and distribution.

Section 4.2. Partial Exercise

Any exercisable portion of an Option or the entire Option, if then wholly exercisable, may be exercised in whole or in part at any time prior to the time when the Option or portion thereof becomes unexercisable under Section 3.2; provided, however, that any partial exercise shall be for whole shares of Common Stock only.

Section 4.3. Manner of Exercise

An Option, or any exercisable portion thereof, may be exercised solely by delivering to the Secretary or his office all of the following prior to the time when the Option or such portion becomes unexercisable under Section 3.2:

(a) Notice in writing signed by the Optionee or the other person then entitled to exercise the Option or portion thereof, stating that the Option or portion thereof is thereby exercised, such notice complying with all applicable rules established by the Committee;

(b) (i) Full payment (in cash or by check or by a combination thereof) for the shares with respect to which such Option or portion thereof is exercised or (ii) indication that the Optionee elects to have the number of Shares that would otherwise be issued to the Optionee reduced by a number of Shares having an equivalent Fair Market Value to the payment that would otherwise be made by Optionee to the Company pursuant to clause (i) of this subsection (b);

(c) (i) Full payment (in cash or by check or by a combination thereof) to satisfy the minimum withholding tax obligation with respect to which such Option or portion thereof is exercised or (ii) indication that the Optionee elects to have the number of Shares that would otherwise be issued to the Optionee upon exercise of such Option (or portion thereof) reduced by a number of Shares having an aggregate Fair Market Value, on the date of such exercise, equal to the payment to satisfy the minimum withholding tax obligation that would otherwise be required to be made by the Optionee to the Company pursuant to clause (i) of this subsection (c);

(d) A bona fide written representation and agreement, in a form satisfactory to the Committee, signed by the Optionee or other person then entitled to exercise such Option or portion thereof, stating that the shares of Common Stock are being acquired for his own account, for investment and without any present intention of distributing or reselling said shares or any of them except as may be permitted under the Securities Act of 1933, as amended (the Act), and then applicable rules and regulations thereunder, and that the Optionee or other person then entitled to exercise such Option or portion thereof will indemnify the Company against and hold it free and harmless from any loss, damage, expense or liability resulting to the Company if any sale or distribution of the shares by such person is contrary to the representation and agreement referred to above; provided, however, that the Committee may, in its reasonable discretion, take whatever additional actions it deems reasonably necessary to ensure the observance and performance of such representation and agreement and to effect compliance with the Act and any other federal or state securities laws or regulations; and

(e) In the event the Option or portion thereof shall be exercised pursuant to Section 4.1 by any person or persons other than the Optionee, appropriate proof of the right of such person or persons to exercise the option.

Without limiting the generality of the foregoing, the Committee may require an opinion of counsel acceptable to it to the effect that any subsequent transfer of shares acquired on exercise of an Option does not violate the Act, and may issue stop-transfer orders covering such shares. Share certificates evidencing stock issued on exercise of this Option shall bear an appropriate legend referring to the provisions of subsection (d) above and the agreements herein. The written representation and agreement referred to in subsection (d) above shall, however, not be required if the shares to be issued pursuant to such exercise have been registered under the Act, and such registration is then effective in respect of such shares.

Section 4.4. Conditions to Issuance of Stock Certificates

The shares of stock deliverable upon the exercise of an Option, or any portion thereof, may be either previously authorized but unissued shares or issued shares, which have then been reacquired by the Company. Such shares shall be fully paid and nonassessable. The Company shall not be required to issue or deliver any certificate or certificates for shares of stock purchased upon the exercise of an Option or portion thereof prior to fulfillment of all of the following conditions:

(a) The obtaining of approval or other clearance from any state or federal governmental agency which the Committee shall, in its reasonable and good faith discretion, determine to be necessary or advisable;

(b) The execution by the Optionee of the Management Stockholder s Agreement and a Sale Participation Agreement; and

(c) The lapse of such reasonable period of time following the exercise of the Option as the Committee may from time to time establish for reasons of administrative convenience or as may otherwise be required by applicable law.

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Section 4.5. Rights as Stockholder

Except as otherwise provided in Section 2.4 of this Agreement, the holder of an Option shall not be, nor have any of the rights or privileges of, a stockholder of the Company in respect of any shares purchasable upon the exercise of the Option or any portion thereof unless and until certificates representing such shares shall have been issued by the Company to such holder.

ARTICLE V
MISCELLANEOUS

Section 5.1. Administration

The Committee shall have the power to interpret the Plan and this Agreement and to adopt such rules for the administration, interpretation and application of the Plan as are consistent therewith and to interpret or revoke any such rules. All actions taken and all interpretations and determinations made by the Committee shall be final and binding upon the Optionee, the Company and all other interested persons. No member of the Committee shall be personally liable for any action, determination or interpretation made in good faith with respect to the Plan or the Option. In its absolute discretion, the Board may at any time and from time to time exercise any and all rights and duties of the Committee under the Plan and this Agreement.

Section 5.2. Option Not Transferable

Neither the Option nor any interest or right therein or part thereof shall be liable for the debts, contracts or engagements of the Optionee or his successors in interest or shall be subject to disposition by transfer, alienation, anticipation, pledge, encumbrance, assignment or any other means whether such disposition be voluntary or involuntary or by operation of law by judgment, levy, attachment, garnishment or any other legal or equitable proceedings (including bankruptcy), and any attempted disposition thereof shall be null and void and of no effect; provided, however, that this Section 5.2 shall not prevent transfers by will or by the applicable laws of descent and distribution.

Section 5.3. Notices

Any notice to be given under the terms of this Agreement to the Company shall be addressed to the Company in care of its Secretary, and any notice to be given to the Optionee shall be addressed to him at the address given beneath his signature hereto.

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By a notice given pursuant to this Section 5.3, either party may hereafter designate a different address for notices to be given to him. Any notice, which is required to be given to the Optionee, shall, if the Optionee is then deceased, be given to the Optionee s personal representative if such representative has previously informed the Company of his status and address by written notice under this Section 5.3. Any notice shall have been deemed duly given when (i) delivered in person, (ii) enclosed in a properly sealed envelope or wrapper addressed as aforesaid, deposited (with postage prepaid) in a post office or branch post office regularly maintained by the United States Postal Service, or (iii) enclosed in a properly sealed envelope or wrapper addressed as aforesaid, deposited (with fees prepaid) in an office regularly maintained by FedEx, UPS, or comparable non-public mail carrier.

Section 5.4. Titles; Pronouns

Titles are provided herein for convenience only and are not to serve as a basis for interpretation or construction of this Agreement. The masculine pronoun shall include the feminine and neuter, and the singular the plural, where the context so indicates.

Section 5.5. Applicability of Plan, Management Stockholder s Agreement and Sale Participation Agreement

The Option and the shares of Common Stock issued to the Optionee upon exercise of the Option shall be subject to all of the terms and provisions of the Plan, the Management Stockholder s Agreement and a Sale Participation Agreement, to the extent applicable to the Option and such Shares.

Section 5.6. Amendment

Subject to Section 10 of the Plan, this Agreement may be amended only by a writing executed by the parties hereto, which specifically states that it is amending this Agreement.

Section 5.7 Governing Law

The laws of the State of Delaware shall govern the interpretation, validity and performance of the terms of this Agreement regardless of the law that might be applied under principles of conflicts of laws.

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Section 5.8 Arbitration

In the event of any controversy among the parties hereto arising out of, or relating to, this Agreement which cannot be settled amicably by the parties, such controversy shall be finally, exclusively and conclusively settled by mandatory arbitration conducted expeditiously in accordance with the American Arbitration Association rules, by a single independent arbitrator. Such arbitration process shall take place within the Nashville, Tennessee metropolitan area. The decision of the arbitrator shall be final and binding upon all parties hereto and shall be rendered pursuant to a written decision, which contains a detailed recital of the arbitrator s reasoning. Judgment upon the award rendered may be entered in any court having jurisdiction thereof. Each party shall bear its own legal fees and expenses, unless otherwise determined by the arbitrator. If the Optionee substantially prevails on any of his or her substantive legal claims, then the Company shall reimburse all legal fees and arbitration fees incurred by the Optionee to arbitrate the dispute.

[*Signatures on next page*.]

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IN WITNESS WHEREOF, this Agreement has been executed and delivered by the parties hereto.

HCA INC.

By:

Title:

Option Grants:

Aggregate number of shares of Common Stock for which the **Option** granted hereunder is exercisable (100% of number of shares):	______________________________
Exercise Price of Options:	$ per share
Grant Date:	____

OPTIONEE:

____

Address

____

____

[Signature Page of Stock Option Agreement]

Exhibit 10.28(b)

**FIRST AMENDMENT TO THE
JANUARY 1, 2008 RESTATEMENT OF THE
HCA RESTORATION PLAN**

Amendment made this 17th day of December, 2008 by an officer of HCA and member of the Benefits Oversight Committee of HCA Inc., effective as of January 1, 2008, except where otherwise noted.

W I T N E S S E T H

WHEREAS, HCA maintains the HCA Restoration Plan (the Plan) for the benefit of its employees and the employees of certain of its subsidiaries;

WHEREAS, the Plan was restated effective January 1, 2008;

WHEREAS, the Compensation Committee of the Board of Directors of HCA Inc. (the Committee) is authorized to make changes to the Plan;

WHEREAS, during October of 2008, via resolutions, the Committee approved a restated Plan, and authorized any officer of HCA Inc. to execute a restated Plan that included certain provisions;

WHEREAS, October 2008 resolutions of the Committee authorized any officer of HCA Inc. to execute a restated Plan document that included the certain specified provisions and permitted the officer to include in the restated Plan any other provisions not inconsistent therewith that the officer believed to be necessary or prudent;

WHEREAS, incident to those Committee resolutions, Sabrina Ruderer, Vice-President, Employee Benefits, HCA Inc., signed a restated Plan document on October 22, 2008;

WHEREAS, the restated Plan erroneously failed to include a desired provision that participants would be allocated benefits for a Plan year only if they: (a) were employed on the first day of the plan year; (b) performed 1,000 hours of service during the year; and (c) were employed by an HCA affiliate on the last day of the plan year;

WHEREAS, adding the foregoing conditions to entitlement to benefits for a year would not contradict the certain specified provisions authorized by the Committee; and

WHEREAS, the undersigned officer desires to execute this amendment to the Plan to specify that Participants will be allocated benefits for a Plan year only if they: (a) were employed on the first day of the plan year; (b) performed 1,000 hours of service during the year; and (c) were employed by an HCA affiliate on the last day of the plan year.

NOW, THEREFORE, IT IS RESOLVED that the Plan is amended as follows, effective on the date set forth in the first paragraph above:

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1.

A new definition, of Active Participant, is added to the definitions in article I, to read as follows:

Active Participant means a Participant who: (a) is employed on the first day of the Plan Year; (b) performs 1,000 or more hours of service during the Plan Year (with hours of service defined under the HCA 401(k) Plan); and (c) is employed on the last day of the Plan Year.

2.

The first sentence of Section 2.2, relating to Eligibility, is revised to read as follows:

Except as provided in the next sentence and subject to the timing provision of Section 2.3, an Employee who is an Active Participant for the Plan Year and whose Compensation exceeds the Social Security wage Base for a Plan Year will be a Participant for that Plan Year and will be entitled to an allocation of benefits to be received in the future.

3.

In Section 3.1, the term Participant is replaced with Active Participant each place that the word Participant appears The syntax of the words of Section 3.1 is revised as necessary to accommodate this change (e.g. the word a is changed to an in the first sentence immediately below the chart).

4.

All provisions of the Plan not inconsistent herewith are hereby ratified and confirmed.

IN WITNESS WHEREOF, the undersigned Officer of HCA Inc. and member of the Benefits Oversight Committee of HCA Inc. has caused this First Amendment to the January 1, 2008 restatement of the Plan to be executed on the date set forth in the first paragraph above.

HCA INC.

By: **/s/ Sabrina Ruderer**
Title: V.P. HR Compensation & Benefits

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Exhibit 10.28(c)

SECOND AMENDMENT TO THE
JANUARY 1, 2008 RESTATEMENT OF THE
HCA RESTORATION PLAN

Amendment made this 23rd day of December, 2009 by the undersigned officer of HCA, Inc. and member of the Benefits Oversight Committee of HCA Inc., effective as of January 1, 2010, except where otherwise noted.

W I T N E S S E T H

WHEREAS, HCA maintains the HCA Restoration Plan (the Plan) for the benefit of its employees and the employees of certain of its subsidiaries;

WHEREAS, the Plan was restated effective January 1, 2008;

WHEREAS, the Compensation Committee of the Board of Directors of HCA Inc. (the Committee) is authorized to make changes to the Plan;

WHEREAS, the Compensation Committee has authorized the undersigned officer to execute this amendment to the Plan to: (a) clarify that only employees eligible to receive dollar-for-dollar matching contributions under the HCA 401(k) Plan are eligible to participate in the Plan; (b) eliminate future elections to receive installment distributions; (c) modify the Plan provisions regarding the date eligible employees commence participation in the Plan; (d) provide that the Plan accounts of Participants who are also participants in the HCA Supplemental Executive Retirement Plan will not be credited with earnings and losses following the determination of their SERP benefit; (e) allow Participants to designate death beneficiaries and contingent beneficiaries; (f) eliminate the requirement that terminated Participants (other than Division CFOs and above) who perform services for any health organization forfeit or repay Plan benefits; and (g) remove an extraneous drafting comment included in the First Amendment to the restated Plan;

NOW, THEREFORE, IT IS RESOLVED that the Plan is amended as follows, effective as of January 1, 2010, unless otherwise set forth below:

1.

The bold parenthetical drafting comment that followed the first and only sentence of the definition of Active Participant (added in the First Amendment to the Plan) is deleted effective as of January 1, 2008.

2.

The definition of Employee in Article I is amended to read as follows effective January 1, 2008:

Employee means a common law employee of Employer, excluding any individual who is classified by Employer as an independent contractor or leased employee or who is otherwise not classified by Employer as a common law employee in accordance with Employer s normal payroll practices, regardless of whether such classification is in error.

3.

The definition of Participation Date in Article I is amended to read as follows:

Participation Date means the first day of the Plan Year following the initial Plan Year for which an individual meets the eligibility criteria of Section 2.2

4.

Section 2.2, relating to eligibility to participate (as amended by the First Amendment to the Plan), is revised in its entirety to read as follows effective January 1, 2008:

2.2 Eligibility. Subject to the following provisions of this section and the timing provision of Section 2.3, an Employee will be entitled to an allocation of benefits to be received in the future for a Plan Year only if: (a) he is eligible to receive matching contributions for the Plan Year under the HCA 401(k) Plan in an amount equal to 100% of eligible salary deferral contributions; (b) he is an Active Participant for the Plan Year; and (c) his Compensation for the Plan Year exceeds the Social Security Wage Base for the Plan Year. With the exceptions of physicians who are contractually entitled to participate in the Plan and physicians with an Account as of December 31, 2007, any person who either is hired (or rehired) after 2007 and works as a physician for a Subsidiary or an affiliate of HCA that is part of the Physician Services Group or was hired (or rehired) before 2008 and works as a physician for a Subsidiary or an affiliate of HCA that is part of the Physician Services Group and did not have an Account on December 31, 2007 will not participate in the Plan. Also, with the exceptions of physicians who are contractually entitled to participate in the Plan and physicians with an Account as of December 31, 2007, any person employed by a Subsidiary or HCA affiliate that is not part of the Physicians Services Group who transfers employment after 2007 to a Subsidiary or affiliate of HCA that is part of the Physician Services Group and works as a physician will not participate in the Plan. An Employee need not take any action in order to participate. No benefit will accrue for a Plan Year for any individual with respect to whom a benefit accrues under the HCA Supplemental Executive Retirement Plan for such Plan Year or any part thereof.

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5.

The following sentence is added to the end of Section 4.2:

Notwithstanding anything in Section 4.1 or in this Section 4.2 to the contrary, no Participant may elect to receive benefits in installments, provided that any installment election made prior to January 1, 2010, shall remain in effect, subject to the last sentence of Section 4.1.

6.

The following sentence is added to the end of Section 5.2:

Notwithstanding the foregoing, in the case of a Participant who is also a participant in the HCA Supplemental Executive Retirement Plan (the SERP), the Participant s Account will cease to be credited with earnings and debited with losses after the date as of which the value of the Participant s Account under the Plan is determined for purposes of calculating the benefit payable under the SERP to the Participant or his beneficiary.

7.

The first sentence of Section 6.1, relating to death benefits, is replaced with the following provisions effective January 1, 2009:

Each Participant may designate one or more death beneficiaries and contingent beneficiaries. The beneficiary or beneficiaries who survive the Participant will receive the Participant s Account (or remaining Account, if installments were in the process of being paid at the time of death). However, if no beneficiary survives the Participant, then the contingent beneficiary or beneficiaries who survive the Participant will receive his Account (or remaining Account, in installments were in the process of being paid at the time of death). Regardless of whether a payment form was chosen for death benefits, if installments were being paid at the time of death, the installment payments in process will continue to be made to the beneficiary or beneficiaries or to the contingent beneficiary or beneficiaries (as applicable). In the event of divorce of a married participant who previously named his spouse as beneficiary or contingent beneficiary, any designation of spouse as beneficiary will be void upon divorce and any amount that would have been paid to the spouse but for voiding will be paid as if the spouse did not survive the Participant. Marriage of a single Participant will void existing beneficiary and contingent beneficiary elections. If no beneficiary is named or if no beneficiary or contingent beneficiary survives the Participant, then death benefits will be paid pursuant to the hierarchy applicable under the HCA 401(k) Plan when no beneficiary is named.

8.

Section 7.3 is amended to read as follows:

7.3 Noncompete. Subject to the second sentence of Section 6.4, a Participant who is classified by the Company as a Division CFO or above who renders services for any health care organization at any time within the five (5) year period immediately following Disability, Termination, or Retirement shall forfeit his right to any further payments or benefits from the Plan and shall repay to the Employer the total amount of payments already made to him from (or with respect to) the Plan. All or part of the provisions of the preceding sentence may be waived by: (a) the Chairman of the Board, with respect to Participants who are not executive officers; and (b) the Committee, with respect to any Participant.

9.

All provisions of the Plan not inconsistent herewith are hereby ratified and confirmed.

IN WITNESS WHEREOF, the undersigned officer of HCA Inc. has executed this Second Amendment to the January 1, 2008 restatement of the Plan on the date set forth in the first paragraph above.

HCA INC.

By: /s/ Sabrina Ruderer
Sabrina Ruderer
Vice President of Human Resources, Compensation and Benefits of HCA Inc.

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Exhibit 10.35

INDEMNIFICATION PRIORITY AND INFORMATION SHARING AGREEMENT

This INDEMNIFICATION PRIORITY AND INFORMATION SHARING AGREEMENT, dated as of November 1, 2009 (this Agreement), between the management companies and other entities set forth on Annex II (the Management Companies), and HCA, Inc., a Delaware corporation (the Company).

WHEREAS, the Company has entered into one or more monitoring, stockholder, indemnification and other agreements (any such agreement or agreements, collectively, the Company Indemnification Agreements) providing for, among other things, the indemnification of and advancement of expenses incurred by the funds set forth on Annex I (the Funds), the Management Companies, and their respective directors, members, managers, partners, affiliates and controlling persons for certain matters described therein (the Funds, the Management Companies and their respective directors, members, managers, partners, affiliates and controlling persons, collectively, the Sponsor Indemnified Parties);

WHEREAS, one or more executives of the Management Companies or their respective affiliates may serve as a directors, officers or consultants of the Company and one or more other persons (who are not executives of the Management Companies or their respective affiliates) may serve as a directors, officers or consultants of the Company as an appointee or designee of the Funds or the Management Companies (any such person or persons, the Designated Directors);

WHEREAS, the Designated Directors may have entered into indemnification agreements with the Company providing for indemnification and advancement of expenses for the Designated Directors in connection with their service as a director of the Company and the Designated Directors may, in their capacities as directors of the Company, be indemnified and/or entitled to advancement of expenses under the Company s certificate or articles of incorporation, by-laws, limited liability company operating agreement, limited partnership agreement or other organizational documents (in each case, a Company Director Indemnity);

WHEREAS, the Funds, the Management Companies and/or their respective affiliates and controlling persons (in this capacity, collectively, the Sponsor Indemnitors) have (i) entered into one or more limited partnership agreements, limited liability company operating agreements and other agreements or arrangements, (ii) certificates and articles of incorporation, by-laws, and other organizational documents and (iii) obtained insurance (any such agreements, documents or insurance, collectively, the Sponsor Indemnification Agreements), in each case, providing for, among other things, indemnification of and advancement of expenses for the Designated Directors designated by such Sponsor Indemnitor for, among other things, the same matters that are subject to indemnification and advancement of expenses under the Company Indemnification Agreements and the Company Director Indemnity; and

WHEREAS, the Company, the Funds and the Management Companies wish to clarify certain matters regarding the indemnification and advancement of expenses provided under the Company Indemnification Agreements and the Company Director Indemnity as it relates to the indemnification and advancement of expenses provided for under the Sponsor Indemnification Agreements.

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NOW, THEREFORE, in consideration of the foregoing recitals and the premises hereinafter set forth, the Company, the Funds and the Management Companies hereby agree as follows.

1. The Company hereby acknowledges and agrees that the obligation of the Company under either any Company Indemnification Agreements or the Company Director Indemnity to indemnify or advance expenses to any Designated Director for the matters covered thereby shall be the primary source of indemnification and advancement of such Designated Director in connection therewith and any obligation on the part of any Sponsor Indemnitor under any Sponsor Indemnification Agreement to indemnify or advance expenses to such Designated Director shall be secondary to the Company s obligation and shall be reduced by any amount that the Designated Director may collect as indemnification or advancement from the Company. In the event that the Company fails to indemnify or advance expenses to a Designated Director as required or contemplated by any Company Indemnification Agreement or Company Director Indemnity (such amounts, the Unpaid Director Indemnity Amounts) and any Sponsor Indemnitor makes any payment to such Designated Director in respect of indemnification or advancement of expenses under any Sponsor Indemnification Agreement on account of such Unpaid Director Indemnity Amounts, such Sponsor Indemnitor shall be subrogated to the rights of such Designated Director under any Company Indemnification Agreement or Company Director Indemnity, as the case may be, in respect of such Unpaid Director Indemnity Amounts.

2. The Company hereby agrees that, to the fullest extent permitted by applicable law, its obligation to indemnify Sponsor Indemnified Parties under the Company Indemnification Agreements shall include any amounts expended by any Sponsor Indemnitor under the Sponsor Indemnification Agreements in respect of indemnification or advancement of expenses to any Designated Director in connection with litigation or other proceedings involving his or her service as a director of the Company to the extent such amounts expended by such Sponsor Indemnitor are on account of any Unpaid Director Indemnity Amounts.

3. The Company hereby agrees that it will not amend any Company Director Indemnity as in effect on the date hereof to alter the rights of any Designated Director in any manner that would alter any Designated Director s rights with respect to conduct pre-dating the date of any such amendment without the consent of each of the Management Companies.

4. The Company hereby consents to (i) the Designated Directors sharing any information such Designated Directors receive in their capacity as directors of the Company and (ii) representatives of the Management Companies sharing any information sent to such representatives by or on behalf the Company, in either case, with officers, directors, members, employees and representatives of such Management Company and its affiliates (other than portfolio companies) provided that such Management Company maintain internal procedures with respect to the use and safekeeping of such information.

5. Except as otherwise provided herein, this Agreement may be amended or modified only by a writing executed by each of the parties hereto.

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6. The provisions of this Agreement shall inure to the benefit and be binding upon the parties hereto and (i) the provisions of Section 3 shall inure to the benefit of the Designated Directors and (ii) all of the provisions of this Agreement shall inure to the benefit of the Funds, all of whom are intended to be third party beneficiaries hereof.

7. This Agreement shall be governed by and construed in accordance with the laws of the state of incorporation of the Company regardless of the law that might be applied under principles of conflict of laws to the extent such principles would require or permit the application of the laws of another jurisdiction. No suit, action or proceeding with respect to this Agreement may be brought in any court or before any similar authority other than in a court of competent jurisdiction in the state of incorporation of the Company, and the parties hereto hereby submit to the exclusive jurisdiction of such courts for the purpose of such suit, proceeding or judgment. Each party irrevocably waives trial by jury in any legal action or proceeding in relation to this Agreement and for any counterclaim therein.

8. Wherever possible, each provision of this Agreement shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be invalid, illegal or unenforceable in any respect under applicable law or rule in any jurisdiction, such invalidity, illegality or unenforceability shall not affect any other provision or any other jurisdiction, but this Agreement shall be reformed, construed and enforced in such jurisdiction as if such invalid, illegal or unenforceable provision had never been contained herein.

9. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, and all of which together shall constitute one and the same instrument. A signature of a party transmitted by facsimile or other electronic means shall constitute an original for all purposes.

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date set forth in the first paragraph hereof.

KOHLBERG KRAVIS ROBERTS & CO. L.P.

By: /s/ David Sorkin
Name: David Sorkin
Title: Member

BAIN CAPITAL PARTNERS, LLC

By: /s/ Christopher Gordon
Name: Christopher Gordon
Title: Managing Director

MERRILL LYNCH GLOBAL PRIVATE EQUITY, INC.

By: /s/ Christopher Birosak
Name: Christopher Birosak
Title: Vice President and Managing Director

FRISCO, INC.

By: /s/ Patricia C. Frist
Name: Patricia C. Frist
Title: Authorized Person

FRISCO PARTNERS

By: /s/ Thomas F. Frist, Jr.
Name: Thomas F. Frist, Jr.
Title: Authorized Person

HCA INC.

By: /s/ R. Milton Johnson
Name: R. Milton Johnson
Title: Executive Vice President & Chief Financial Officer

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ANNEX II MANAGEMENT COMPANIES AND OTHER ENTITIES

Kohlberg Kravis Roberts & Co. L.P.
Bain Capital Partners, LLC
Merrill Lynch Global Private Equity, Inc.
Frisco, Inc.
Frisco Partners

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Exhibit 21

ALABAMA

CareOne Home Health Services, Inc.
Four Rivers Medical Center PHO, Inc.
Selma Medical Center Hospital, Inc.

ALASKA

Chugach PT, Inc.
Columbia Behavioral Healthcare, Inc.
Columbia North Alaska Healthcare, Inc.

ARKANSAS

Columbia Health System of Arkansas, Inc.

BERMUDA

Parthenon Insurance Company, Limited

CALIFORNIA

Center for Advanced Imaging, LLC
CFC Investments, Inc.
CH Systems
Chino Community Hospital Corporation, Inc.
Columbia ASC Management, L.P.
Columbia Riverside, Inc.
Columbia/HCA San Clemente, Inc.
Encino Hospital Corporation, Inc.
Far West Division, Inc.
Galen-Soch, Inc.
Good Samaritan Surgery Center, L.P.
HCA Health Services of California, Inc.
Healdsburg General Hospital, Inc.
L E Corporation
Las Encinas Hospital
Los Gatos Surgical Center, a California Limited Partnership
    Los Gatos Surgical Center
Los Robles Regional Medical Center
    Los Robles Hospital & Medical Center
Los Robles SurgiCenter, LLC
    Los Robles SurgiCenter
MCA Investment Company
Mission Bay Memorial Hospital, Inc.
Neuro Affiliates Company
Riverside Healthcare System, L.P.
    Riverside Community Hospital
Riverside Holdings, Inc.
Riverside Surgicenter, L.P.
San Joaquin Surgical Center, Inc.
San Jose Pathology Outreach, LLC
Southwest Surgical Clinic, Inc.
Surgicare of Good Samaritan, LLC
Surgicare of Los Gatos, Inc.
Surgicare of Los Robles, LLC

Surgicare of Riverside, LLC
Surgicare of West Hills, Inc.
West Hills Hospital
West Hills Hospital & Medical Center

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West Hills Surgical Center, Ltd.
  West Hills Surgical Center
West Los Angeles Physicians Hospital, Inc.
Westminster Community Hospital
Westside Hospital Limited Partnership

CAYMAN ISLANDS

Health Midwest Insurance Company, Ltd.

COLORADO

Altitude Mid Level Providers, LLC
Centrum Surgery Center, Ltd.
  Centrum Surgical Center
Clear Creek Surgery Center, LLC
Colorado Health Systems, Inc.
Columbine Psychiatric Center, Inc.
Continental Division I, Inc.
Denver Mid-Town Surgery Center, Ltd.
  Midtown Surgical Center
Diagnostic Mammography Services, G.P.
Galen of Aurora, Inc.
HCA-HealthONE LLC
  North Suburban Medical Center
  Presbyterian/St. Luke s Medical Center
  Rose Medical Center
  Sky Ridge Medical Center
  Swedish Medical Center
  The Medical Center of Aurora
Health Care Indemnity, Inc.
HealthONE at Breckenridge, LLC
HealthONE Clear Creek, LLC
HealthONE Clinic Services Bariatric Medicine, LLC
HealthONE Clinic Services Behavioral Health, LLC
HealthONE Clinic Services Cardiovascular, LLC
HealthONE Clinic Services Medical Specialties, LLC
HealthONE Clinic Services Neurosciences, LLC
HealthONE Clinic Services Obstetrics and Gynecology, LLC
HealthONE Clinic Services Occupational Medicine, LLC
HealthONE Clinic Services Oncology Hematology, LLC
HealthONE Clinic Services Otolaryngology Specialists, LLC
HealthONE Clinic Services Pediatric Specialties, LLC
HealthONE Clinic Services Primary Care, LLC
HealthONE Clinic Services Surgical Specialties, LLC
HealthONE Clinic Services LLC
HealthONE High Street Primary Care Center, LLC
HealthOne Lincoln Investment, LLC
HealthONE Lowry, LLC
HealthONE of Denver, Inc.
HealthONE Urologic, LLC
HealthOne Westside Investment, LLC
Hospital-Based CRNA Services, Inc.

Lakewood Outpatient Surgical Center, Ltd.
Lakewood Surgicare, Inc.
Lowry Surgery Center, LLC
Mountain View MRI Associates, Ltd.
MOVCO, Inc.

New Rose Holding Company, Inc.
North Suburban Spine Center, L.P.
    Musculoskeletal Surgery Center
North Suburban Surgery Center, L.P.
    North Suburban Surgery Center
Outpatient Surgery Center of Lakewood, L.P.
    Lakewood Surgical Center
P/SL Hyperbaric Partnership
Rocky Mountain Pediatric Hematology Oncology, LLC
Rocky Mountain Surgery Center, LLC
Rose Ambulatory Surgery Center, L.P.
    Rose Surgical Center
Rose Health Partners, LLC
Rose Medical Plaza, Ltd.
Rose POB, Inc.
Sky Ridge Surgery Center, L.P.
    Sky Ridge Surgical Center
Southwest Medpro, Ltd.
Surgicare of Denver Mid-Town, Inc.
Surgicare of North Suburban, LLC
Surgicare of Rose, LLC
Surgicare of Sky Ridge, LLC
Surgicare of Southeast Denver, Inc.
Surgicare of Swedish, LLC
Surgicare of Thornton, LLC
Swedish Medpro, Inc.
Swedish MOB I, Ltd.
Swedish MOB II, Inc.
Swedish MOB III, Inc.
Swedish MOB IV, Inc.
Swedish MOB, LLC
Urology Surgery Center of Colorado, LLC

DELAWARE

AC Med, LLC
Aligned Business Consortium Group, L.P.
Alpharetta Imaging Services, LLC
Alternaco, LLC
American Medicorp Development Co.
Ami-Point GA, LLC
AOGN, LLC
Appledore Medical Group, Inc.
AR Holding 1, LLC
AR Holding 2, LLC
AR Holding 3, LLC
AR Holding 4, LLC
AR Holding 5, LLC
AR Holding 6, LLC
AR Holding 7, LLC
AR Holding 8, LLC

AR Holding 9, LLC
AR Holding 10, LLC
AR Holding 11, LLC
AR Holding 12, LLC
AR Holding 13, LLC

AR Holding 14, LLC
AR Holding 15, LLC
AR Holding 16, LLC
AR Holding 17, LLC
AR Holding 18, LLC
AR Holding 19, LLC
AR Holding 20, LLC
AR Holding 21, LLC
AR Holding 22, LLC
AR Holding 23, LLC
AR Holding 24, LLC
AR Holding 25, LLC
AR Holding 26, LLC
AR Holding 27, LLC
AR Holding 28, LLC
AR Holding 29, LLC
AR Holding 30, LLC
Arkansas Medical Park, LLC
ASD Shared Services, LLC
Atlanta Healthcare Management, L.P.
Atlanta Market GP, Inc.
Atlanta Orthopaedic Surgical Center, Inc.
Aventura Cancer Center Manager, LLC
Bayshore Partner, LLC
Belton Family Practice Clinic, LLC
Blake Imaging, LLC
Boca Raton Open Imaging Center, LLC
Boynton Beach EFL Imaging Center, LLC
Bradenton Outpatient Services, LLC
Brandon Imaging Manager, LLC
Brandon Regional Cancer Center, LLC
Brandon SRS Management Services, LLC
C/HCA Capital, Inc.
C/HCA, Inc.
California Imaging Center Manager, LLC
Cancer Centers of North Florida, LLC
Cancer Services of Aventura, LLC
Cardiovascular Center of Fort Worth, L.P.
Cardiovascular Ventures of Fort Worth, LLC
Carolina Forest Imaging Manager, LLC
Centennial CyberKnife Center, LLC
Centennial CyberKnife Manager, LLC
Centerpoint Medical Center of Independence, LLC
    Centerpoint Medical Center
Central Florida Diagnostic Cardiology Center, LLC
Central Florida Imaging Services, LLC
Central Health Holding Company, Inc.
Central Health Services Hospice, Inc.
Chattanooga ASC, LLC

CHC Finance Co.
CHC Payroll Agent, Inc.
CHCA Bayshore, L.P.
    Bayshore Medical Center
CHCA Clear Lake, L.P.
    Clear Lake Regional Medical Center

CHCA Conroe, L.P.
Conroe Regional Medical Center
CHCA Hospital LP, Inc.
CHCA Mainland, L.P.
Mainland Medical Center
CHCA Palmyra Partner, Inc.
CHCA West Houston, L.P.
West Houston Medical Center
CHCA Woman s Hospital, L.P.
Woman s Hospital of Texas
Cheray and Samuels, LLC
Clear Lake Cardiac Catheterization Center, L.P.
Clear Lake Cardiac GP, LLC
Clear Lake Merger, LLC
Clear Lake Regional Partner, LLC
ClinicServ, LLC
Clipper Cardiovascular Associates, Inc.
CMS GP, LLC
Coastal Bend Hospital, Inc.
Coastal Healthcare Services, Inc.
Cobb Imaging Services, LLC
Coliseum Health Group, LLC
Coliseum Medical Center, LLC
Coliseum Medical Centers
Coliseum Psychiatric Center, LLC
Coliseum Psychiatric Center
Coliseum Surgery Center, L.L.C.
Columbia Behavioral Health, LLC
Columbia Hospital (Palm Beaches) Limited Partnership
Columbia Hospital
Columbia Hospital Corporation of Fort Worth
Columbia Hospital Corporation of Houston
Columbia Hospital Corporation-Delaware
Columbia Palm Beach GP, LLC
Columbia Rio Grande Healthcare, L.P.
Rio Grande Regional Hospital
Columbia Valley Healthcare System, L.P.
Valley Regional Medical Center
Columbia Westbank Healthcare, L.P.
Columbia/HCA Middle East Management Company
Columbia-SDH Holdings, Inc.
Columbus Cath Lab, Inc.
Columbus Cath Lab, LLC
Concept EFL Imaging Center, LLC
Concept West EFL Imaging Center, LLC
Conroe Partner, LLC
CoralStone Management, Inc.
COSCORP, LLC
CPS TN Processor 1, Inc.

CRMC-M, LLC
Dallas/Ft. Worth Physician, LLC
Danforth Hospital, Inc.
Delray EFL Imaging Center, LLC
Delta Division, Inc.
Doctors Hospital of Augusta, LLC
    Doctors Hospital

Douglasville Imaging Services, LLC
Drake Management Company
East Florida Imaging Holdings, LLC
Edmond Regional Medical Center, LLC
Edmond Medical Center
EMMC, LLC
EP Health, LLC
EP Holdco, LLC
EPIC Development, Inc.
EPIC Diagnostic Centers, Inc.
EPIC Healthcare Management Company
EPIC Surgery Centers, Inc.
Extendicare Properties, Inc.
Fairview Park GP, LLC
Fairview Partner, LLC
Family Care of E. Jackson County, LLC
FHAL, LLC
Forest Park Surgery Pavilion, Inc.
Forest Park Surgery Pavilion, L.P.
Fort Bend Hospital, Inc.
Galen (Kansas) Merger, LLC
Galen BH, Inc.
Galen Finance, LLC
Galen Global Finance, Inc.
Galen GOK, LLC
Galen Holdco, LLC
Galen Hospital Alaska, Inc.
Alaska Regional Hospital
Galen International Capital, Inc.
Galen International Holdings, Inc.
Galen KY, LLC
Galen LA, LLC
Galen MCS, LLC
Galen Medical Corporation
Galen MRMC, LLC
Galen NMC, LLC
Galen NSH, LLC
Galen SOM, LLC
Galen SSH, LLC
Galendeco, Inc.
GalTex, LLC
Garden Park Community Hospital Limited Partnership
Gardens EFL Imaging Center, LLC
General Healthserv, LLC
Georgia Health Holdings, Inc.
Georgia, L.P.
GHC-Galen Health Care, LLC
Good Samaritan Hospital, L.P.

Good Samaritan Hospital
Good Samaritan Hospital, LLC
Goppert-Trinity Family Care, LLC
GPCH-GP, Inc.
Garden Park Medical Center
Grand Strand Regional Medical Center, LLC
Grand Strand Regional Medical Center
Grandview Health Care Clinic, LLC

H.H.U.K., Inc.
HCA IT&S Field Operations, Inc.
HCA IT&S Inventory Management, Inc.
HCA IT&S TN Field Operations, Inc.
HCA Health Services of Midwest, Inc.
HCA Holdco, LLC
HCA Imaging Services of North Florida, Inc.
HCA International Finance LLP
HCA Management Services, L.P.
HCA Outpatient Imaging Services Group, Inc.
HCA Property GP, LLC
HCA Psychiatric Company
HCA Squared, LLC
HCA Switzerland Holding Sàrl
HCA Wesley Rehabilitation Hospital, Inc.
HCAPS Anesthesia Manager, LLC
Health Services (Delaware), Inc.
Health Services Merger, Inc.
Healthcare Technology Assessment Corporation
Healthco, LLC
Healthnet of Kentucky, LLC
Healthserv Acquisition, LLC
Healthtrust MOB Tennessee, LLC
Healthtrust MOB, LLC
Healthtrust Purchasing Group, L.P.
Healthtrust, Inc. The Hospital Company
Hearthstone Home Health, Inc.
Heathrow Imaging, LLC
Hendersonville ODC, LLC
Henrico Doctors Hospital Forest Campus Property, LLC
HHNC, LLC
Highway 50 Real Estate, LLC
HM OMCOS, LLC
Hospital Corp., LLC
Hospital Development Properties, Inc.
Hospital Partners Merger, LLC
Houston Healthcare Holdings, Inc.
Houston Woman s Hospital Partner, LLC
HSS Holdco, LLC
HSS Systems VA, LLC
HSS Systems, LLC
HTI Hospital Holdings, Inc.
Imaging Centers of California, L.P.
Imaging Services of Appomattox, LLC
Imaging Services of Jacksonville, LLC
Imaging Services of Louisiana Manager, LLC
Imaging Services of Louisiana, LLC
Imaging Services of Orlando, LLC

Imaging Services of Richmond, LLC
Imaging Services of Roanoke, LLC
Imaging Services of West Boynton, LLC
Independence Regional Medical Group, LLC
Indian Path, LLC
Indianapolis Hospital Partner, LLC
Integrated Regional Laboratories, LLP
Jackson County Medical Group, LLC

JCSH, LLC
JCSHLP, LLC
JFK Medical Center Limited Partnership
JFK Medical Center
Jupiter EFL Imaging Center, LLC
JV Investor, LLC
Kansas Healthserv, LLC
Katy Medical Center, Inc.
Kendall Regional Medical Center, LLC
Lakeland Medical Center, LLC
Lakeside Radiology, LLC
Lakeview Medical Center, LLC
Lakeview Regional Medical Center
Laredo Medco, LLC
Lee s Summit Family Care, LLC
Lewis-Gale Medical Center, LLC
Lewis-Gale Medical Center
Low Country Health Services, Inc. of the Southeast
Macon Healthcare, LLC
Macon Northside Health Group, LLC
Macon Northside Hospital, LLC
Coliseum Northside Hospital
Mainland Partner, LLC
Management Services Holdings, Inc.
Management Services LP, LLC
Mayhill Cancer Center, LLC
Medical Arts Hospital of Texarkana, Inc.
Medical Care America, LLC
Medical Care Financial Services Corp.
Medical Care Real Estate Finance, Inc.
Medical Center of Plano Partner, LLC
Medical Centers of Oklahoma, LLC
Medical City Dallas Partner, LLC
Medical Corporation of America
Medical Office Buildings of Kansas, LLC
Medical Specialties, Inc.
MediStone Healthcare Ventures, Inc.
MediVision of Mecklenburg County, Inc.
MediVision of Tampa, Inc.
MediVision, Inc.
Memorial Southside Cancer Center, LLC
Miami Beach EFL Imaging Center, LLC
MidAmerica Oncology, LLC
Mid-Continent Health Services, Inc.
Middle Georgia Hospital, LLC
Midtown Diagnostics, LLC
Midwest Division ACH, LLC
Allen County Hospital

Midwest Division CMC, LLC
Midwest Division LRHC, LLC
Lafayette Regional Health Center
Midwest Division LSH, LLC
Lee s Summit Medical Center
Midwest Division MCI, LLC
Midwest Division MII, LLC

Midwest Division MMC, LLC
Menorah Medical Center
Midwest Division OPRMC, LLC
Overland Park Regional Medical Center
Midwest Division PFC, LLC
Midwest Division RMC, LLC
Research Medical Center
Midwest Division RPC, LLC
Research Psychiatric Center
Midwest Division TLM, LLC
Midwest Holdings, Inc.
Midwest Medicine Associates, LLC
Midwest Metropolitan Physicians Group, LLC
Mira Healthcare, LLC
Mobile Corps., Inc.
MRT&C, Inc.
Nashville Shared Services General Partnership
North Augusta Imaging Management, LLC
North Augusta Imaging Services, LLC
North Brandon Imaging, LLC
North Florida Cancer Center Lake City, LLC
North Florida Cancer Center Live Oak, LLC
North Florida Cancer Center Tallahassee, LLC
North Florida Radiation Oncology, LLC
North Miami Beach Surgery Center Limited Partnership
North Miami Beach Surgical Center
North Miami Beach Surgical Center, LLC
North Tampa Imaging, LLC
North Texas Medical Center, Inc.
Northeast Florida Cancer Services, LLC
Northwest Fla. Home Health Agency, Inc.
Notami Hospitals, LLC
Notami, LLC
Notco, LLC
NTGP, LLC
NTMC Ambulatory Surgery Center, L.P.
NTMC Management Company
NTMC Venture, Inc.
Ocala Stereotactic Radiosurgery Partner, LLC
Ocala Stereotactic Radiosurgery, LLC
OHH Imaging Services, LLC
Oncology Services of Corpus Christi Manager, LLC
Oncology Services of Corpus Christi, LLC
Orlando Outpatient Surgical Center, Inc.
Outpatient Cardiovascular Center of Central Florida, LLC
Outpatient GP, LLC
Outpatient LP, LLC
Outpatient Services LAD, LLC

Outpatient Services Holdings, Inc.
Palm Beach EFL Imaging Center, LLC
Palms West Hospital Limited Partnership
Palms West Hospital
Palmyra Park GP, Inc.
Paragon SDS, Inc.
Paragon WSC, Inc.
Parkland Physician Services, Inc.

Parkway Hospital, Inc.
Pearland Partner, LLC
Pinellas Medical, LLC
Pioneer Medical, LLC
Plano Heart Institute, L.P.
Plano Heart Management, LLC
Plantation General Hospital, L.P.
Plantation General Hospital
PMM, Inc.
POH Holdings, LLC
Portsmouth Regional Ambulatory Surgery Center, LLC
Portsmouth Regional Ambulatory Surgery Center
Preferred Works WC, LLC
Primary Care Acquisition, Inc.
Primary Medical Management, Inc.
Radiation Oncology Manager, LLC
RCH, LLC
Red Rock at Maryland Parkway, LLC
Red Rock at Smoke Ranch, LLC
Red Rock Holdco, LLC
Reston Hospital Center, LLC
Reston Hospital Center
RHA MSO, LLC
Riverside Hospital, Inc.
Riverside Imaging, LLC
RMC HBP, LLC
Round Rock Hospital, Inc.
Samaritan, LLC
San Bernardino Imaging, LLC
San Jose Healthcare System, LP
Regional Medical Center of San Jose
San Jose Hospital, L.P.
San Jose Medical Center, LLC
San Jose, LLC
Sarah Cannon Research Institute, LLC
SCRI Holdings, LLC
SJMC, LLC
Sleep Lab at Menorah Medical Center, LLC
SMCH, LLC
South Bay Imaging, LLC
South Brandon Imaging, LLC
South Valley Hospital, L.P.
Southtown Women s Clinic, LLC
Spalding Rehabilitation L.L.C.
Spalding Rehabilitation Hospital
Spring Branch GP, LLC
Spring Branch LP, LLC
Spring Hill Imaging, LLC

Springview KY, LLC
Stereotactic Radiosurgery Systems of Brandon, LLC
Stones River Hospital, LLC
Suburban Medical Center at Hoffman Estates, Inc.
Summit General Partner, Inc.
Summit Medical Assoc., LLC
Summit Outpatient Diagnostic Center, LLC
Sun Bay Medical Office Building, Inc.

Sun City Imaging, LLC
Sun-Med, LLC
Sunrise Hospital and Medical Center, LLC
Sunrise Hospital & Medical Center
Surgicare of Denton, Inc.
Surgicare of Plano, Inc.
Surgico, LLC
Swedish MOB Acquisition, Inc.
TBHI Outpatient Services, LLC
Terre Haute Hospital GP, Inc.
Terre Haute Hospital Holdings, Inc.
Terre Haute Regional Hospital, L.P.
Terre Haute Regional Hospital
The Medical Group of Kansas City, LLC
Total Imaging Parsons, LLC
Town Plaza Family Practice, LLC
Trident Medical Center, LLC
Trident Medical Center
Tuckahoe Surgery Center, LP
Parham Surgery Center
Ultra Imaging Management Services, LLC
Ultra Imaging of Tampa, LLC
Utah Medco, LLC
Value Health Management, Inc.
VHSC Plantation, LLC
Vicksburg Diagnostic Services, L.P.
Washington Holdco, LLC
Wesley Cath Lab, LLC
Wesley Manager, LLC
Wesley Medical Center, LLC
Wesley Medical Center
West Boynton Beach Open Imaging Center, LLC
West Florida Imaging Services, LLC
West Florida PET Services, LLC
West Houston, LLC
Westbury Hospital, Inc.
WHG Medical, LLC
WJHC, LLC
Woman s Hospital Merger, LLC
Women s Hospital Indianapolis GP, Inc.
Women s Hospital Indianapolis, L.P.

FLORIDA

AAL Holdings, Inc.
All About Learning, LLC
All About Staffing, Inc.
Ambulatory Laser Associates, GP
Ambulatory Surgery Center Group, Ltd.

Ambulatory Surgery Center
Atlantis Surgicare, LLC
Aventura Comprehensive Cancer Research Group of Florida, Inc.
Aventura Healthcare Specialists LLC
Aventura Neurosurgery, LLC
BAMI Property, LLC
Bannerman Family Care, LLC
Bay Hospital, Inc.

Gulf Coast Medical Center
Bayonet Point Surgery Center, Ltd.
Bayonet Point Surgery and Endoscopy Center
Beach Primary Care, LLC
Belleair Surgery Center, Ltd.
Belleair Surgery Center
Big Cypress Medical Center, Inc.
Bonita Bay Surgery Center, Inc.
Bonita Bay Surgery Center, Ltd.
Brandon Surgi-Center, Ltd.
Brandon Surgery Center
Broward Cardiovascular Surgeons, LLC
Broward Healthcare System, Inc.
Broward Neurosurgeons, LLC
Cape Coral Surgery Center, Inc.
Cape Coral Surgery Center, Ltd.
Capital Regional Healthcare, LLC
Cardiovascular Consultants of Ocala, LLC
CCH-GP, Inc.
Cedarcare, Inc.
Cedars BTW Program, Inc.
Cedars Cardiovascular Surgeons, LLC
Cedars Gastroenterologists, LLC
Cedars Healthcare Group, Ltd.
Cedars International Cardiology Consultants, LLC
Cedars Medical Center Hospitalists, LLC
Cedars Neurosurgery, LLC
Central Florida Cardiology Interpretations, LLC
Central Florida Division Practice, Inc.
Central Florida Obstetrics & Gynecology Associates, LLC
Central Florida Physician Network, LLC
Central Florida Radiology, LLC
Central Florida Regional ENT, LLC
Central Florida Regional Hospital, Inc.
Central Florida Regional Hospital
Coastal Cardiac Diagnostics, Ltd.
Collier County Home Health Agency, Inc.
Columbia Behavioral Health, Ltd.
Columbia Behavioral Healthcare of South Florida, Inc.
Columbia Central Florida Division, Inc.
Columbia Development of Florida, Inc.
Columbia Eye and Specialty Surgery Center, Ltd.
Tampa Eye & Specialty Surgery Center
Columbia Florida Group, Inc.
Columbia Hospital Corporation of Central Miami
Columbia Hospital Corporation of Kendall
Columbia Hospital Corporation of Miami
Columbia Hospital Corporation of Miami Beach

Columbia Hospital Corporation of North Miami Beach
Columbia Hospital Corporation of South Broward
Westside Regional Medical Center
Columbia Hospital Corporation of South Dade
Columbia Hospital Corporation of South Florida
Columbia Hospital Corporation of South Miami
Columbia Hospital Corporation of Tamarac
Columbia Hospital Corporation-SMM

Columbia Jacksonville Healthcare System, Inc.
Columbia Lake Worth Surgical Center Limited Partnership
Columbia Midtown Joint Venture
Columbia North Central Florida Health System Limited Partnership
Columbia North Florida Regional Medical Center Limited Partnership
Columbia Ocala Regional Medical Center Physician Group, Inc.
Columbia Palm Beach Healthcare System Limited Partnership
Columbia Park Healthcare System, Inc.
Columbia Park Medical Center, Inc.
Columbia Physician Services Florida Group, Inc.
Columbia Primary Care, LLC
Columbia Resource Network, Inc.
Columbia Tampa Bay Division, Inc. Columbia-Osceola Imaging Center, Inc.
Community Hospital Family Practice, LLC Coral Springs Surgi-Center, Ltd.
Surgery Center at Coral Springs
Countryside Surgery Center, Ltd.
Countryside Surgery Center
Daytona Medical Center, Inc.
Destin Primary Care, LLC
Diagnostic Breast Center, Inc.
Doctors Hospital Physician-Hospital Organization, Inc.
Doctors Osteopathic Medical Center, Inc.
Doctors Same Day Surgery Center, Inc.
Doctors Same Day Surgery Center, Ltd.
Doctors Same Day Surgery Center
DOMC Property, LLC
East Florida Division, Inc.
East Florida Hospitalists, LLC
East Florida Primary Care, LLC
East Pointe Hospital, Inc.
Edward White Hospital, Inc.
Edward White Hospital
Englewood Community Hospital, Inc.
Englewood Community Hospital
Fawcett Memorial Hospital, Inc.
Fawcett Memorial Hospital
Florida Home Health Services-Private Care, Inc.
Florida Outpatient Surgery Center, Ltd.
Florida Surgery Center
Fort Myers Market, Inc.
Fort Pierce Immediate Care Center, Inc.
Fort Pierce Orthopaedics, LLC
Fort Pierce Surgery Center, Ltd.
Fort Walton Beach Medical Center, Inc.
Fort Walton Beach Medical Center
Freeport Family Medicine, LLC
Ft. Pierce Surgicare, LLC
Ft. Walton Beach Anesthesia Services, LLC

Ft. Walton Beach Internal Medicine, LLC
Gainesville GYN Oncology of North Florida Regional Medical Center, LLC
Gainesville Physicians, LLC
Galen Diagnostic Multicenter, Ltd.
Galen Hospital-Pembroke Pines, Inc.

Galen of Florida, Inc.
St. Petersburg General Hospital
Galencare, Inc.
Brandon Regional Hospital
Northside Hospital
Gateway Surgical Group, LLC
Grant Center Hospital of Ocala, Inc.
Gulf Coast General Surgery, LLC
Gulf Coast Inpatient Specialists, LLC
Gulf Coast Medical Center Primary Care, LLC
Hamilton Memorial Hospital, Inc.
HCA Viera AFL, LLC
HCA WHS Progressive, LLC
HCA WHS Services, LLC
HCA Family Care Center, Inc.
HCA Health Services of Florida, Inc.
Blake Medical Center
Oak Hill Hospital
Regional Medical Center Bayonet Point
St. Lucie Medical Center
HD&S Corp. Successor, Inc.
HealthCoast Physician Group, LLC
Heathrow Internal Medicine, LLC
Heritage Family Care, LLC
Homecare North, Inc.
Hospital Corporation of Lake Worth
Hyperbaric and Wound Care Services of Ocala, LLC
Integrated Regional Lab, LLC
Internal Medicine Services of Osceola, LLC
Jacksonville Multispecialty Services, LLC
Jacksonville Physician Practices, Ltd.
Jacksonville Specialists, LLC
Jacksonville Surgery Center, Ltd.
Jacksonville Surgery Center
JFK Internal Medicine Faculty Practice, LLC
JFK Occupational Medicine, LLC
JFK Orthopedics, LLC
JFK Real Properties, Ltd.
Kendall Healthcare Group, Ltd.
Kendall Regional Medical Center
Kendall Medical Specialists, LLC
Kendall Vascular Surgery, LLC
Kingsley Family Care, LLC
Kissimmee Surgicare, Ltd.
Kissimmee Surgery Center
LAD Imaging, LLC
Lakewood Park Walk-In Clinic, LLC
Largo Cardiology, LLC

Largo Medical Center, Inc.
Largo Medical Center
Largo Physician Group, LLC
Laurel Grove Surgery Center, LLC
Lawnwood Cardiovascular Surgery, LLC
Lawnwood Healthcare Specialists, LLC
Lawnwood Medical Center, Inc.
Lawnwood Regional Medical Center & Heart Institute

Lawnwood Pavilion Physician Services, LLC
Live Oak Immediate Care Center, LLC
M & M of Ocala, Inc.
Manatee Surgicare, Ltd.
Gulf Coast Surgery Center
Marion Community Hospital, Inc.
Ocala Regional Medical Center
Medical Associates of Ocala, LLC
Medical Center of Port St. Lucie, Inc.
Medical Center of Santa Rosa, Inc.
Medical Imaging Center of Ocala
Medical Partners of North Florida, LLC
Memorial Family Practice Associates, LLC
Memorial Healthcare Group, Inc.
Memorial Hospital Jacksonville
Specialty Hospital
Memorial Neurosurgery Group, LLC
Memorial Primary Care, LLC
Memorial Surgicare, Ltd.
Plaza Surgery Center II
Memorial Urgent Care Mandarin, LLC
MHS Partnership Holdings JSC, Inc.
MHS Partnership Holdings SDS, Inc.
Miami Beach Healthcare Group, Ltd.
Aventura Hospital and Medical Center
Miami Lakes Surgery Center, Ltd.
Miami Lakes Surgery Center
Navarre Family Care, LLC
Network MS of Florida, Inc.
New Port Richey Hospital, Inc.
Community Hospital
New Port Richey Surgery Center, Ltd.
New Port Richey Surgery Center
Niceville Family Practice, LLC
Niceville General Surgery, LLC
North Central Florida Health System, Inc.
North Florida Division I, Inc.
North Florida Division Practice, Inc.
North Florida GI Center GP, Inc.
North Florida GI Center, Ltd.
North Florida Endoscopy Center
North Florida Immediate Care Center Springhill, LLC
North Florida Immediate Care Center, Inc.
North Florida Neurosurgery, LLC
North Florida Outpatient Imaging Center, Ltd.
North Florida Physician Services, Inc.
North Florida Physicians, LLC
North Florida Regional Investments, Inc.

North Florida Regional Medical Center, Inc.
North Florida Regional Medical Center
North Florida Regional Otolaryngology, LLC
North Florida Rehab Investments, LLC
North Florida Surgical Associates, LLC
North Palm Beach County Surgery Center, Ltd.
North County Surgicenter
Northside MRI, Inc.

Northwest Broward Neurosurgery and Spine, LLC
Northwest Florida Cardiology, LLC
Northwest Florida Healthcare Systems, Inc.
Northwest Florida Multispecialty Physicians, LLC
Northwest Florida Primary Care, LLC
Northwest Florida Women s Cancer Care, LLC
Northwest Medical Center, Inc.
Northwest Medical Center
Notami Hospitals of Florida, Inc.
Lake City Medical Center
Oak Hill Acquisition, Inc.
Oak Hill Family Care, LLC
Oak Hill Hospitalists, LLC
Ocala Regional Outpatient Services, Inc.
Okaloosa Hospital, Inc.
Twin Cities Hospital
Okeechobee Hospital, Inc.
Raulerson Hospital
OneSource Health Network of South Florida, Inc.
Orange Park Hospitalists, LLC
Orange Park Medical Center, Inc.
Orange Park Medical Center
Orlando Surgicare, Ltd.
Same Day Surgicenter of Orlando
Osceola Neurological Associates, LLC
Osceola Regional Hospital, Inc.
Osceola Regional Medical Center
Osceola Regional Hospitalists, LLC
Osceola Surgical Associates, LLC
Outpatient Surgical Services, Ltd.
Outpatient Surgical Services
P&L Associates
Pace Obstetrics and Gynecology, LLC
Palm Beach General Surgery, LLC
Palm Beach Healthcare System, Inc.
Palm Beach Hospitalists Program, LLC
Palms West Gastroenterology, LLC
Palms West Pediatric Neurosurgery, Inc.
Palms West Surgery Center, Ltd.
Palms West Surgicenter
Park South Imaging Center, Ltd.
Pensacola Primary Care, Inc.
Pinellas Surgery Center, Ltd.
Center for Special Surgery
Port St. Lucie Surgery Center, Ltd.
St. Lucie Surgery Center
Premier Medical Management, Ltd.
Primary Care Medical Associates, Inc.

Putnam Hospital, Inc.
Raulerson Gastroenterology, LLC
Raulerson GYN, LLC
Raulerson Primary Care, LLC
Sarasota Doctors Hospital, Inc.
Doctors Hospital of Sarasota
South Broward Practices, Inc.
South Florida Division Practice, Inc.

South Vero Walk-In Clinic, LLC
Southwest Florida Health System, Inc.
Southwest Florida Regional Medical Center, Inc.
Space Coast Surgical Center, Ltd.
Merritt Island Surgery Center
Spinal Disorder and Pain Treatment Institute, LLC
St. Lucie General Surgery, LLC
St. Lucie Hospitalists, LLC
St. Lucie Medical Center Walk-In Clinic, LLC
St. Lucie Medical Specialists, LLC
St. Lucie West Primary Care, LLC
St. Petersburg General Surgery, LLC
Sun City Hospital, Inc.
South Bay Hospital
Surgery Center of Atlantis, LLC
Atlantis Outpatient Center
Surgery Center of Aventura, Ltd.
Surgery Center of Aventura
Surgery Center of Ft. Pierce, Ltd
Surgery Center of Ft. Pierce
Surgery Center of Port Charlotte, Ltd.
Gulf Pointe Surgery Center
Surgical Park Center, Ltd.
Surgical Park Center
Surgicare America Winter Park, Inc.
Surgicare of Altamonte Springs, Inc.
Surgicare of Aventura, LLC
Surgicare of Bayonet Point, Inc.
Surgicare of Brandon, Inc.
Surgicare of Central Florida, Inc.
Surgicare of Central Florida, Ltd.
Central Florida Surgicenter
Surgicare of Countryside, Inc.
Surgicare of Florida, Inc.
Surgicare of Ft. Pierce, Inc.
Surgicare of Kissimmee, Inc.
Surgicare of Laurel Grove, LLC
Surgicare of Manatee, Inc.
Surgicare of Merritt Island, Inc.
Surgicare of Miami Lakes, LLC
Surgicare of New Port Richey, Inc.
Surgicare of Orange Park, Inc.
Surgicare of Orange Park, Ltd.
Orange Park Surgery Center
Surgicare of Orlando, Inc.
Surgicare of Palms West, LLC
Surgicare of Pinellas, Inc.
Surgicare of Plantation, Inc.

Surgicare of Port Charlotte, LLC
Surgicare of Port St. Lucie, Inc.
Surgicare of St. Andrews, Inc.
Surgicare of St. Andrews, Ltd.
Surgery Center at St. Andrews
Surgicare of Stuart, Inc.
Surgicare of Tallahassee, Inc.
Tallahassee Community Network, Inc.

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Tallahassee Gyn-Oncology, LLC
Tallahassee Imaging Services, LLC
Tallahassee Medical Center, Inc.
Capital Regional Medical Center
Tallahassee Orthopedic Surgery Partners, Ltd.
Tallahassee Outpatient Surgery Center
Tampa Bay Health System, Inc.
Tampa Surgi-Centre, Inc.
The Neurohealth Sciences Center, LLC
Total Imaging Hudson, LLC
Total Imaging North St. Petersburg, LLC
Travel Medicine and Infections, LLC
Treasure Coast Physician Practices, Ltd.
Twin Cities Primary Care Destin, LLC
Twin Cities Primary Care, LLC
University Healthcare Specialists, LLC
University Hospital, Ltd.
University Hospital and Medical Center
Venture Ambulatory Surgery Center, LLC
Venture Ambulatory Surgery Center
Venture Medical Management, LLC
West Florida Behavioral Health, Inc.
West Florida Division, Inc.
West Florida HealthWorks, LLC
West Florida Internal Medicine, LLC
West Florida Physician Network, LLC
West Florida Regional Medical Center, Inc.
West Florida Hospital
West Florida Specialty Physicians, LLC
West Jacksonville Medical Center, Inc.
Westside Surgery Center, Ltd.
Parkside Surgery Center
Wildwood Medical Center, Inc.
Women s Health Center of Central Florida, LLC
Wound and Hyperbaric Center, LLC

GEORGIA

Acworth Immediate Care, LLC
Albany Family Practice, LLC
Albany Neurosurgery Center, LLC
AOSC Sports Medicine, Inc.
Atlanta Home Care, L.P.
Atlanta Outpatient Surgery Center, Inc.
Atlanta Surgery Center, Ltd.
Atlanta Outpatient Peachtree Dunwoody Center
Atlanta Outpatient Surgery Center
Pediatric Outpatient Surgery Center of Atlanta
Augusta Inpatient Services, LLC

Augusta Multispecialty Services, LLC
Augusta Primary Care Services, LLC
Buckhead Surgical Services, L.P.
Byron Family Practice, LLC
Cartersville Medical Center, LLC
Cartersville Medical Center
Cartersville Occupational Medicine Center, LLC
Cartersville Physician Practice I, LLC

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Cartersville Urgent Care, LLC
Center for Colorectal Care, LLC
Chatsworth Hospital Corp.
Church Street Partners
Coliseum Health Group, Inc.
Coliseum Park Hospital, Inc.
Coliseum Primary Care Services, LLC
Coliseum Primary Healthcare Macon, LLC
Coliseum Primary Healthcare Riverside, LLC
Coliseum Professional Associates, LLC
Coliseum Same Day Surgery Center, L.P.
Coliseum Same Day Surgery Center
Columbia Coliseum Same Day Surgery Center, Inc.
Columbia Polk General Hospital, Inc.
Polk Medical Center
Columbia Surgicare of Augusta, Ltd.
Augusta Surgical Center
Columbia-Georgia PT, Inc.
Columbus Cardiology, Inc.
Columbus Doctors Hospital, Inc.
Diagnostic Services, G.P.
Doctors Hospital Center for Occupational Medicine, LLC
Doctors Hospital Columbus GA-Joint Venture
Doctors Hospital of Augusta Neurology, LLC
Doctors Hospital Surgery Center, L.P.
Evans Surgery Center
Doctors-I, Inc.
Doctors-II, Inc.
Doctors-III, Inc.
Doctors-IV, Inc.
Doctors-V, Inc.
Doctors-VI, Inc.
Doctors-VII, Inc.
Doctors-VIII, Inc.
Doctors-IX, Inc.
Doctors-X, Inc.
Dublin Community Hospital, LLC
Dublin Heart Specialists, LLC
Dublin Multispecialty, LLC
Dunwoody Physician Practice Network, Inc.
Eastside General Surgery, LLC
EHCA Diagnostics, LLC
EHCA Eastside Occupational Medicine Center, LLC
EHCA Eastside, LLC
Emory Eastside Medical Center
EHCA Johns Creek Holdings, LLC
EHCA Johns Creek Radiation Therapy, LLC
EHCA Johns Creek, LLC

Emory Johns Creek Hospital
EHCA Metropolitan, LLC
EHCA Parkway, LLC
EHCA Peachtree, LLC
EHCA West Paces, LLC
EHCA, LLC
Emory Johns Creek Obstetrics and Gynecology, LLC
Emory Johns Creek Physicians, LLC

Fairview Park, Limited Partnership
Fairview Park Hospital
Georgia Psychiatric Company, Inc.
Grace Family Practice, LLC
Grayson Primary Care, LLC
Greater Gwinnett Internal Medicine Associates, LLC
Greater Gwinnett Physician Corporation
Gwinnett Community Hospital, Inc.
HCA Health Services of Georgia, Inc.
HCOL, Inc.
Heritage Medical Care, LLC
Hospitalists at Fairview Park, LLC
Hughston Hospital Services, LLC
Infectious Diseases Consultants of Southwest Georgia, LLC
Johns Creek Family Physicians, LLC
Johns Creek Physician Services Corporation
Marietta Outpatient Medical Building, Inc.
Marietta Outpatient Surgery, Ltd.
Marietta Surgical Center
Marietta Surgical Center, Inc.
Med Corp., Inc.
MedFirst, Inc.
Medical Center West, Inc.
MOSC Sports Medicine, Inc.
North Georgia Primary Care Group, LLC
Northlake Medical Center, LLC
Northlake MultiSpecialty Associates, LLC
Northlake Physician Practice Network, Inc.
Northlake Surgical Center, L.P.
Northlake Surgical Center
Northlake Surgicare, Inc.
Orthopaedic Specialty Associates, L.P.
Orthopaedic Sports Specialty Associates, Inc.
Palmyra Brain & Spine Center, LLC
Palmyra Park Hospital, Inc.
Palmyra Medical Centers
Palmyra Park, Limited Partnership
Palmyra Professional Fees, LLC
Redmond Anesthesia Services, LLC
Redmond Hospital Services, LLC
Redmond Neurosurgery, LLC
Redmond Park Health Services, Inc.
Redmond Park Hospital, LLC
Redmond Regional Medical Center
Redmond Physician Practice Company
Redmond Physician Practice Company II
Redmond Physician Practice Company III
Redmond Physician Practice XI, LLC

Rockbridge Primary Care, LLC
Rome Imaging Center Limited Partnership
Surgery Center of Rome, L.P.
The Surgery Center of Rome
Surgicare of Augusta, Inc.
Surgicare of Buckhead, LLC
Surgicare of Evans, Inc.
Surgicare of Rome, Inc.

The Rankin Foundation
Urology Center of North Georgia, LLC
West Paces Services, Inc.

IDAHO

East Falls Plastic Surgery, LLC
Eastern Idaho Health Services, Inc.
Eastern Idaho Regional Medical Center
Eastern Idaho Regional Medical Center Physician Services, LLC
Idaho Physician Services, Inc.
Patients First Neonatology, LLC
Patients First Neurology, LLC
West Valley Internal Medicine, LLC
West Valley Medical Center, Inc.
West Valley Medical Center
West Valley Professional Fee Billing, LLC
West Valley Therapy Services, LLC

ILLINOIS

Chicago Grant Hospital, Inc.
Columbia Chicago Division, Inc.
Columbia LaGrange Hospital, Inc.
Columbia Surgicare North Michigan Ave., L.P.
Galen of Illinois, Inc.
Illinois Psychiatric Hospital Company, Inc.
Smith Laboratories, Inc.

INDIA

All About Staffing (India) Private Limited

INDIANA

Advanced Neurosurgery, LLC
Advanced Orthopedics, LLC
Advanced Plastic Surgery Center of Terre Haute, LLC
Advanced Radiation Oncology Care, LLC
Basic American Medical, Inc.
Family Medicine of Terre Haute, LLC
Hospitalists of the Wabash Valley, LLC
Jeffersonville MediVision, Inc.
Regional Hospital Healthcare Partners, LLC
Surgicare of Indianapolis, Inc.
Surgicare of Terre Haute, LLC
Terre Haute Heart Lung Vascular Associates, LLC
Terre Haute MOB, L.P.
Terre Haute Obstetrics and Gynecology, LLC
Wabash Cardiology Associates, LLC
Wabash Valley Hospitalists, LLC

KANSAS

Care for Women, LLC
Johnson County Neurology, LLC
Johnson County Surgery Center, L.P.
Surgicenter of Johnson County
Johnson County Surgicenter, L.L.C.
Kansas Pulmonary and Sleep Physicians, LLC

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Kansas Trauma and Critical Care Specialists, LLC
Mid-America Surgery Center, LLC
Mid-America Surgery Institute, LLC
Mid-America Surgery Institute
Midwest Cardiology Specialists, LLC
Midwest Cardiovascular and Thoracic Surgeons of Kansas, LLC
Midwest Division, Inc.
Midwest Oncology Associates, LLC
Mill Creek Outpatient Services, LLC
MMC Sleep Lab Management, LLC
Neuroscience Associates of Kansas City, LLC
OPRMC-HBP, LLC
Overland Park Cardiovascular, Inc.
Overland Park Medical Specialists, LLC
Overland Park Orthopedics, LLC
Overland Park Surgical Specialties, LLC
Paragyn Surgical, LLC
Pediatric Specialty Clinic LLC
Physician Associates of Corporate Woods, LLC
Quivira Internal Medicine, Inc.
Statland Medical Group, LLC
Surgery Center of Overland Park, L.P.
Overland Park Surgery Center
Surgicare of Overland Park, LLC
Surgicare of Wichita, Inc.
Surgicare of Wichita, Ltd.
Surgicare of Wichita
Surgicenter of Johnson County, Ltd.
Wesley Physician Services, LLC

KENTUCKY

CHCK, Inc.
Commonwealth Specialists of Kentucky, LLC
Frankfort Hospital, Inc.
Frankfort Regional Medical Center
Frankfort Orthopedics, LLC
Frankfort Wound Care, LLC
Galen of Kentucky, Inc.
Greenview Hospital, Inc.
Greenview Regional Hospital
Greenview PrimeCare, LLC
Hospitalists at Greenview Regional Hospital, LLC
Southern Kentucky Medicine Associates, LLC
Southern Kentucky Neurosurgical Associates, LLC
Southern Kentucky Urology, LLC
Surgery Center of Greenview, L.P.
Surgicare of Greenview, Inc.
Tri-County Community Hospital, Inc.

Western Kentucky Gastroenterology, LLC

LOUISIANA

Acadiana Care Center, Inc.
Acadiana Practice Management, Inc.
Acadiana Regional Pharmacy, Inc.
Avoyelles Family Care (A Medical Limited Liability Company)
Center for Digestive Diseases, LLC

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Children s Multi-Specialty Group, LLC
CLASC Manager, LLC
Columbia Healthcare System of Louisiana, Inc.
Columbia West Bank Hospital, Inc.
Columbia/HCA Healthcare Corporation of Central Louisiana, Inc.
Columbia/HCA of Baton Rouge, Inc.
Columbia/HCA of New Orleans, Inc.
Dauterive Hospital Corporation
Dauterive Hospital
Dauterive Physicians, LLC
Doctors Hospital of Opelousas Limited Partnership
HCA Health Services of Louisiana, Inc.
Lafayette OB Hospitalists, LLC
Lafayette Pediatric Neurology Center, LLC
Lafayette Surgery Center Limited Partnership
Lafayette Surgicare
Lafayette Surgicare, Inc.
Lafayette Urogynecology & Urology Center, LLC
Lakeside Women s Services, LLC
Lakeview Multispecialty Group, LLC
Louisiana Psychiatric Company, Inc.
Medical Center of Baton Rouge, Inc.
Metairie Primary Care Associates, LLC
Notami (Opelousas), Inc.
Notami Hospitals of Louisiana, Inc.
Rapides Healthcare System, L.L.C.
Rapides Regional Medical Center
Rapides Regional Physician Group Primary Care, LLC
Rapides Regional Physician Group Specialty Care, LLC
Rapides Regional Physician Group, LLC
Rapides Surgery Center, LLC
Southwest Medical Center Family Practice, LLC
Southwest Medical Center Multi-Specialty Group, LLC
Southwest Medical Center Surgical Group, LLC
Surgicare Merger Company of Louisiana
Surgicare of Lakeview, Inc.
Surgicare Outpatient Center of Baton Rouge, Inc.
Surgicenter of East Jefferson, Inc.
The Regional Health System of Acadiana, LLC
The Regional Medical Center of Acadiana
TUHC Anesthesiology Group, LLC
TUHC Hospitalist Group, LLC
TUHC Physician Group, LLC
TUHC Primary Care and Pediatrics Group, LLC
TUHC Radiology Group, LLC
Tulane Clinic, LLC
Tulane Professionals Management, L.L.C.
University Healthcare System, L.C.

Tulane University Hospital and Clinic
Uptown Primary Care Associates, LLC
WGH, Inc.
Women s & Children s Pediatric Hematology/Oncology Center, LLC
Women s & Children s Pediatric Orthopedic Center, LLC
Women s & Children s Pulmonology Clinic, LLC
Women s and Children s Professional Management, L.L.C.

LUXEMBOURG

HCA Luxembourg 1 Sarl
HCA Luxembourg 2 Sarl

MASSACHUSETTS

Columbia Hospital Corporation of Massachusetts, Inc.
Orlando Outpatient Surgical Center, Ltd.

MISSISSIPPI

Brookwood Medical Center of Gulfport, Inc.
Coastal Imaging Center of Gulfport, Inc.
Coastal Imaging Center, L.P.
Galen of Mississippi, Inc.
Garden Park Hospitalist Program, LLC
Garden Park Investments, L.P.
Garden Park Physician Services Corporation
Gulf Coast Medical Ventures, Inc.
HTI Health Services, Inc.
Orange Grove Surgical Associates, LLC
Southern Urology Associates, LLC
VIP, Inc.

MISSOURI

Baptist Lutheran HBP, LLC
Cedar Creek Medical Group, LLC
Centerpoint Cardiology Services, LLC
Centerpoint Hospital Based Physicians, LLC
Centerpoint Orthopedics, LLC
Centerpoint Physicians Group, LLC
Clinishare, Inc.
Endocrinology Associates of Lee s Summit, LLC
Eye Care Surgicare, Ltd.
Eye Surgicare of Independence, LLC
Family Care at Arbor Walk, LLC
Family Health Specialists of Lee s Summit, LLC
Foot & Ankle Specialty Services, LLC
HCA Midwest Comprehensive Care, Inc.
Health Midwest Medical Group, Inc.
Health Midwest Office Facilities Corporation
Health Midwest Ventures Group, Inc.
HEI Missouri, Inc.
HM Acquisition, LLC
Independence Neurosurgery Services, LLC
Independence Surgicare, Inc.
Kansas City Neurology Associates, LLC
Kansas City Perfusion Services, Inc.
Kansas City Pulmonology Practice, LLC
Kansas City Vascular & General Surgery Group, LLC
Lee s Summit Urgent Care, LLC
Medical Center Imaging, Inc.
Metropolitan Multispecialty Physicians Group, Inc.
Mid-States Financial Services, Inc.

Midwest Cardiovascular & Thoracic Surgery, LLC
Midwest Division RBH, LLC
Research Belton Hospital
Midwest Division Spine Care, LLC

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Midwest Doctor s Group, LLC
Midwest Infectious Disease Specialists, LLC
Midwest Newborn Care, LLC
Midwest Specialty Care Lee s Summit, LLC
Midwest Trauma Services, LLC
Midwest Women s Healthcare Specialists, LLC
Missouri Healthcare System, L.P.
National Association of Senior Friends
Notami Hospitals of Missouri, Inc.
Nuclear Diagnosis, Inc.
Ozarks Medical Services, Inc.
Precise Imaging, Inc.
Raymore Medical Group, LLC
Research Cardiology Associates, LLC
Research Family Physicians, LLC
Research GYN/Oncology Associates, LLC
Research Internal Medicine, LLC
Research Multi-Specialty Physicians Group, LLC
Research Neurology Associates, LLC
Research Psychiatric 1500, LLC
RMC Pulmonary, LLC
RMC Transplant Physicians, LLC
Surgery Center of Independence, L.P.
    Centerpoint Ambulatory Surgery Center
Surgicare of Kansas City, LLC
Surgicenter of Kansas City, L.L.C.
    Surgicenter of Kansas City
Women s Center at Brookside, LLC

NEVADA

CHC Holdings, Inc.
CHC Venture Co.
CIS Holdings, Inc.
Columbia Hospital Corporation of West Houston
Fremont Women s Health, LLC
Health Service Partners, Inc.
Las Vegas ASC, LLC
Las Vegas Physical Therapy, Inc.
Las Vegas Surgical Center, a Nevada limited partnership
Las Vegas Surgicare, Inc.
Las Vegas Surgicare, Ltd.
    Las Vegas Surgery Center
Nevada Surgery Center of Southern Hills, L.P.
Nevada Surgicare of Southern Hills, LLC
Rhodes Limited-Liability Company
Sahara Outpatient Surgery Center, Ltd.
    Sahara Surgery Center
Southern Hills Medical Center, LLC
    Southern Hills Hospital & Medical Center
Specialty Surgicare of Las Vegas, LP

Specialty Surgery Center
Sunrise Anesthesia Services, LLC
Sunrise Flamingo Surgery Center, Limited Partnership
Flamingo Surgery Center
Sunrise Mountainview Hospital, Inc.
MountainView Hospital

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Sunrise Neuro Sciences, LLC
Sunrise Outpatient Services, Inc.
Sunrise Physician Services, LLC
Sunrise Trauma Services, LLC
Surgicare of Las Vegas, Inc.
Value Health Holdings, Inc.
VH Holdco, Inc.
VH Holdings, Inc.
Western Plains Capital, Inc.

NEW HAMPSHIRE

Appledore Medical Group II, Inc.
Derry ASC, Inc.
HCA Health Services of New Hampshire, Inc.
 Parkland Medical Center
 Portsmouth Regional Hospital
Med-Point of New Hampshire, Inc.
Parkland Hospitalists Program, LLC
Parkland Oncology, LLC
PRH Oncology, LLC
Salem Surgery Center, Limited Partnership
 Salem Surgery Center
Surgicare of Salem, LLC

NORTH CAROLINA

Brunswick Anesthesia, LLC
CareOne Home Health Services, Inc.
Cumberland Medical Center, Inc.
HCA Raleigh Community Hospital, Inc.
Heritage Hospital, Inc.
HTI Health Services of North Carolina, Inc.
Mecklenburg Surgical Land Development, Ltd.
Raleigh Community Medical Office Building, Ltd.
Wake Psychiatric Hospital, Inc.

OHIO

Columbia/HCA Healthcare Corporation of Northern Ohio
Columbia-CSA/HS Greater Canton Area Healthcare System, L.P.
Columbia-CSA/HS Greater Cleveland Area Healthcare System, L.P.
Lorain County Surgery Center, Ltd.
Surgicare of Lorain County, Inc.
Surgicare of Westlake, Inc.
Westlake Surgicare, L.P.

OKLAHOMA

Columbia Doctors Hospital of Tulsa, Inc.
Columbia Oklahoma Division, Inc.
Columbia/Edge Mobile Medical, L.L.C.
Edmond General Surgery, LLC
Edmond Hospitalists, LLC
Edmond Intensivists, LLC
Edmond Physician Hospital Organization, Inc.
Edmond Physician Services, LLC

Edmond Podiatry Associates, LLC
Edmond Spine and Orthopedic Services, LLC
Family Medicine Associates of Edmond, LLC

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HCA Health Services of Oklahoma, Inc.
    OU Medical Center
Healthcare Oklahoma, Inc.
Medi Flight of Oklahoma, LLC
Medical Imaging, Inc.
Millenium Health Care of Oklahoma, Inc.
Oklahoma Outpatient Surgery Limited Partnership
    Oklahoma Surgicare
Oklahoma Surgicare, Inc.
Oklahoma Transplant Physicians, LLC
Plains Healthcare System, Inc.
Presbyterian Office Building, Ltd.
Rogers County PHO, Inc.
Stephenson Laser Center, L.L.C.
Surgicare of Northwest Oklahoma Limited Partnership
Surgicare of Tulsa, Inc.
SWMC, Inc.

PENNSYLVANIA

Basic American Medical Equipment Company, Inc.
Chestnut Hill Surgical Investors, Ltd.
Surgicare of Philadelphia, Inc.

PHILIPPINES

All About Staffing Philippines, Inc.
Career Staffing U.S.A.

SOUTH CAROLINA

C/HCA Development, Inc.
Carolina Forest Imaging Center, LLC
Carolina Regional Surgery Center, Inc.
Carolina Regional Surgery Center, Ltd.
    Grande Dunes Surgery Center
Coastal Carolina Home Care, Inc.
Coastal Carolina MultiSpecialty Associates, LLC
Coastal Carolina Primary Care, LLC
Coastal Inpatient Physicians, LLC
Colleton Ambulatory Care, LLC
    Colleton Ambulatory Surgery Center
Colleton Diagnostic Center, LLC
Colleton Medical Anesthesia, LLC
Colleton Medical Hospitalists, LLC
Colleton Neurology Associates, LLC
Colleton Otolaryngology, Head and Neck Surgery, LLC
Columbia/HCA Healthcare Corporation of South Carolina
Columbia-CSA/HS Greater Columbia Area Healthcare System, LP
Doctors Hospital North Augusta Imaging Center, LLC
Doctor s Memorial Hospital of Spartanburg, L.P.
Edisto Multispecialty Associates, Inc.
Grand Strand Senior Health Center, LLC
Grand Strand Surgical Specialists, LLC
North Augusta Rehab Health Center, LLC

North Charleston Diagnostic Imaging Center, LLC
Providence Eye Care, Inc.
South Atlantic Division, Inc.

South Carolina Imaging Employer Corp.
Trident Behavioral Health Services, LLC
Trident Eye Surgery Center, L.P.
Trident Eye Surgery Center
Trident Medical Services, Inc.
Trident MRI Associates, L.P.
Trident Neonatology Services, LLC
Walterboro Community Hospital, Inc.
Colleton Medical Center

SWITZERLAND

Glemm SA
HCA Switzerland Finance Sarl
HCA Switzerland Holding Sarl

TENNESSEE

Arthritis Specialists of Nashville, Inc.
Athens Community Hospital, Inc.
Atrium Surgery Center, Ltd.
Atrium Memorial Surgery Center
Centennial Cardiovascular Consultants, LLC
Centennial Heart, LLC
Centennial Neuroscience, LLC
Centennial Primary Care, LLC
Centennial Psychiatric Associates, LLC
Centennial Surgery Center, L.P.
Centennial Surgery Center
Centennial Surgical Associates, LLC
Central Tennessee Hospital Corporation
Horizon Medical Center
Chattanooga Diagnostic Associates, LLC
Chattanooga Healthcare Network Partner, Inc.
Chattanooga Healthcare Network, L.P.
Columbia Integrated Health Systems, Inc.
Columbia Medical Group Centennial, Inc.
Columbia Medical Group Daystar, Inc.
Columbia Medical Group Parkridge, Inc.
Columbia Medical Group Southern Hills, Inc.
Columbia Medical Group The Frist Clinic, Inc.
Dickson Corporate Health Services, LLC
Dickson Surgery Center, L.P.
First Onsite, LLC
Frist Clinic Express, LLC
Gastroenterology Specialists of Middle Tennessee, LLC
HCA Information Technology & Services, Inc.
HCA Central Group, Inc.
HCA Chattanooga Market, Inc.
HCA Development Company, Inc.
HCA Eastern Group, Inc.
HCA Health Services of Tennessee, Inc.
Centennial Medical Center

Centennial Medical Center at Ashland City
Southern Hills Medical Center
StoneCrest Medical Center
Summit Medical Center
HCA Home and Clinical Services, Inc.

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Health to You, LLC
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Healthtrust, Inc. The Hospital Company
Hendersonville Hospital Corporation
    Hendersonville Medical Center
Hendersonville Hospitalist Services, Inc.
Hendersonville OB/GYN, LLC
Hendersonville Primary Care, LLC
Hermitage Primary Care, LLC
Holly Hill/Charter Behavioral Health System, L.L.C.
Hometrust Management Services, Inc.
Horizon Orthopedics, LLC
Horizon Surgical, LLC
Hospital Corporation of Tennessee
Hospital Realty Corporation
Hospitalists at Centennial Medical Center, LLC
Hospitalists at Horizon Medical Center, LLC
Hospitalists at Parkridge, LLC
Hospitalists at StoneCrest, LLC
HTI Memorial Hospital Corporation
    Skyline Medical Center
Indian Path Hospital, Inc.
Indian Path Rehabilitation Center, Inc.
Internal Medicine Associates of Southern Hills, LLC
Lookout Valley Medical Center, LLC
Madison Behavioral Health, LLC
Madison Internal Medicine, LLC
McMinnville Cardiology, LLC
Med Group Southern Hills Hospitalists, LLC
Medical Group Dickson, Inc.
Medical Group Southern Hills of Brentwood, LLC
Medical Group Southern Hills of Nolensville, LLC
Medical Group Stonecrest FP, Inc.
Medical Group Stonecrest Pulmonology, LLC
Medical Group StoneCrest, Inc.
Medical Group Summit, Inc.
Medical Plaza Ambulatory Surgery Center Associates, L.P.
    Plaza Day Surgery
Medical Plaza MRI, L.P.
Medical Resource Group, Inc.
Middle Tennessee Neurology LLC
Mid-State Physicians, LLC
Nashville Psychiatric Company, Inc.
Natchez Surgery Center, LLC
Network Management Services, Inc.
Neurology Associates of Hendersonville, LLC

North Florida Regional Freestanding Surgery Center, L.P.
    North Florida Surgical Pavilion
North Nashville Family Health Center, LLC
Old Fort Village, LLC
OneSourceMed, Inc.
Palmer Medical Center, LLC
Parkridge East Specialty Associates, LLC

Parkridge Hospitalists, Inc.
Parkridge Medical Associates, LLC
Parkridge Medical Center, Inc.
    Parkridge Medical Center
Parkridge Professionals, Inc.
Parkside Surgery Center, Inc.
Plano Ambulatory Surgery Associates, L.P.
    Surgery Center of Plano
Portland Primary Care, LLC
Portland Surgical, LLC
Pulmonary Medicine of Dickson, LLC
Rio Grande Surgery Center Associates, L.P.
    Rio Grande Surgery Center
SCRI Services, LLC
Shelbyville Cardiology, LLC
Signal Mountain Primary Care, LLC
Skyline Medical Group, LLC
Skyline Neuroscience Associates, LLC
Skyline Primary Care, LLC
Skyline Rehab Associates, LLC
Skyline Riverside Medical Group, LLC
Southeast Surgical Solutions, LLC
Southern Hills Neurology Consultants, LLC
Southern Hills Orthopaedic Consultants, LLC
Specialist Group at Centennial, LLC
Spring Hill Hospital, Inc.
Spring Hill Physicians, LLC
SRS Acquisition, Inc.
St. Mark s Ambulatory Surgery Associates, L.P.
    St. Mark s Outpatient Surgery Center
Sterling Primary Care Associates, LLC
Stonecrest Medical Group Family Practice of Murfreesboro, LLC
Stonecrest Medical Group SC Murfreesboro Family Practice, LLC
Sullins Surgical Center, Inc.
Summit Convenient Care at Lebanon, LLC
Summit Heart, LLC
Summit Research Solutions, LLC
Summit Surgery Center, L.P.
    Summit Surgery Center
Summit Surgical Associates, LLC
Surgery Center of Chattanooga, L.P.
    Surgery Center of Chattanooga
Surgicare of Chattanooga, LLC
Surgicare of Dickson, LLC
Surgicare of Madison, Inc.
Surgicare of Natchez, LLC
Surgicare of Southern Hills, Inc.
Surgicare of Wilson County, LLC
Surgicare Outpatient Center of Jackson, Inc.

Sycamore Shoals Hospital, Inc.
TCMC Madison-Portland, Inc.
Tennessee Healthcare Management, Inc.
Tennessee Valley Outpatient Diagnostic Center, LLC
The Charter Cypress Behavioral Health System, L.L.C.
Trident Ambulatory Surgery Center, L.P.
    Trident Surgery Center

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TriStar Health System, Inc.
TriStar OB/GYN, LLC
Vascular and Endovascular Specialists, LLC
Wilson County Outpatient Surgery Center, L.P.

TEXAS

Administrative Physicians of North Texas, PLLC
All About Staffing of Texas, Inc.
Ambulatory Endoscopy Clinic of Dallas, Ltd.
Ambulatory Endoscopy Clinic of Dallas
Arlington Diagnostic South, Inc.
Arlington Neurosurgeons, PLLC
Arlington Primary Care, PLLC
Arlington Primary Medicine, PLLC
Arlington Vascular Surgery, PLLC
Austin Heart Cardiology MSO, LLC
Austin Heart, PLLC
Austin Medical Center, Inc.
Austin Physicians Management, LLC
Bailey Square Ambulatory Surgical Center, Ltd.
Bailey Square Surgery Center
Bailey Square Outpatient Surgical Center, Inc.
Barrow Medical Center CT Services, Ltd.
Bay Area Healthcare Group, Ltd.
Corpus Christi Medical Center
Bay Area Surgical Center Investors, Ltd.
Bay Area Surgicare Center, Inc.
Bayshore Occupational and Family Medicine, PLLC
Bayshore Surgery Center, Ltd.
Bayshore Surgery Center
Bedford-Northeast Community Hospital, Inc.
Bellaire Imaging, Inc.
Brownsville Specialists of Texas, PLLC
Brownsville Surgical Specialists, PLLC
Brownsville-Valley Regional Medical Center, Inc.
Calloway Creek Surgery Center, L.P.
Calloway Creek Surgery Center
Calloway Creek Surgicare, LLC
Capital Area Cardiology
Capital Area Occupational Medicine, PLLC
Capital Area Primary Care, PLLC
Capital Area Providers
Capital Area Specialists, PLLC
Capital Area Surgeons, PLLC
Cardio Vascular Surgeons of North Texas, PLLC
Central San Antonio Surgical Center Investors, Ltd.
Central Texas Cardiac Arrhythmia Physicians, PLLC
CHC Management, Ltd.
CHC Payroll Company

CHC Realty Company
CHCA Pearland, L.P.
CHC-El Paso Corp.
CHC-Miami Corp.
Clear Lake Family Physicians, PLLC
Clear Lake Multi-Specialty Group, PLLC
Clear Lake Regional Medical Center, Inc.

Clear Lake Surgicare, Ltd.
Bay Area Surgicare Center
Coastal Bend Hospital CT Services, Ltd.
Collin County Diagnostic Associates, PLLC
COL-NAMC Holdings, Inc.
Columbia Ambulatory Surgery Division, Inc.
Columbia Bay Area Realty, Ltd.
Columbia Call Center, Inc.
Columbia Central Group, Inc.
Columbia Champions Treatment Center, Inc.
Columbia GP of Mesquite, Inc.
Columbia Greater Houston Division Healthcare Network, Inc.
Columbia Hospital at Medical City Dallas Subsidiary, L.P.
Medical City Dallas Hospital
Columbia Hospital Corporation at the Medical Center
Columbia Hospital Corporation of Arlington
Columbia Hospital Corporation of Bay Area
Columbia Hospital Corporation of Corpus Christi
Columbia Hospital Securities Corporation
Columbia Hospital-Arlington (WC), Ltd.
Columbia Hospital-El Paso, Ltd.
Columbia Medical Arts Hospital Subsidiary, L.P.
Columbia Medical Center at Lancaster Subsidiary, L.P.
Columbia Medical Center Dallas Southwest Subsidiary, L.P.
Columbia Medical Center of Arlington Subsidiary, L.P.
Medical Center of Arlington
Columbia Medical Center of Denton Subsidiary, L.P.
Denton Regional Medical Center
Columbia Medical Center of Las Colinas, Inc.
Las Colinas Medical Center
Columbia Medical Center of Lewisville Subsidiary, L.P.
Medical Center of Lewisville
Columbia Medical Center of McKinney Subsidiary, L.P.
Medical Center of McKinney
Columbia Medical Center of Plano Subsidiary, L.P.
Medical Center of Plano
Columbia North Hills Hospital Subsidiary, L.P.
North Hills Hospital
Columbia North Texas Healthcare System, L.P.
Columbia North Texas Subsidiary GP, LLC
Columbia North Texas Surgery Center Subsidiary, L.P.
Columbia Northwest Medical Center Partners, Ltd.
Columbia Northwest Medical Center, Inc.
Columbia Plaza Medical Center of Fort Worth Subsidiary, L.P.
Plaza Medical Center of Fort Worth
Columbia Psychiatric Management Co.
Columbia South Texas Division, Inc.
Columbia Specialty Hospital of Dallas Subsidiary, L.P.

Columbia Specialty Hospitals, Inc.
Columbia Surgery Group, Inc.
Columbia/HCA Healthcare Corporation of Central Texas
Columbia/HCA Heartcare of Corpus Christi, Inc.
Columbia/HCA International Group, Inc.
Columbia/HCA of Houston, Inc.
Columbia/HCA of North Texas, Inc.
Columbia/HCA Physician Hospital Organization Medical Center Hospital

Columbia-Quantum, Inc.
Comprehensive Radiology Management Services, Ltd.
Congenital Heart Surgery Center, PLLC
Conroe Hospital Corporation
Conroe Specialists of Texas, PLLC
Corpus Christi Healthcare Group, Ltd.
Corpus Christi Surgery Center, L.P.
Corpus Christi Surgery, Ltd.
Corpus Surgicare, Inc.
Dallas CardioThoracic Surgery Consultants, PLLC
Dallas Neuro-Stroke Affiliates, PLLC
Deep Purple Investments, LLC
Denton County Hospitalist Program, PLLC
Denton Pediatric Physicians, PLLC
Denton Primary Care, PLLC
Denton Regional Ambulatory Surgery Center, L.P.
Day Surgery Center at Denton Regional Medical Center
DFW Physicians Group, PLLC
Doctors Bay Area Physician Hospital Organization
Doctors Hospital (Conroe), Inc.
E.P. Physical Therapy Centers, Inc.
El Paso Healthcare Provider Network
El Paso Healthcare System, Ltd.
Del Sol Medical Center
Las Palmas Medical Center
El Paso Nurses Unlimited, Inc.
El Paso Primary Care, PLLC
El Paso Surgery Centers, L.P.
East El Paso Surgery Center
Surgical Center of El Paso
El Paso Surgicenter, Inc.
Eldridge Family Practitioners, PLLC
Elite Family Health of Plano, PLLC
Elite OB-GYN Services of El Paso, PLLC
Elite Orthopaedics of El Paso, PLLC
Elite Orthopaedics of Irving, PLLC
Elite Orthopaedics of Plano, PLLC
Emergency Psychiatric Medicine, PLLC
Endoscopy Clinic of Dallas, Inc.
Endoscopy of Plano, L.P.
Endoscopy of Plano
Endoscopy Surgicare of Plano, LLC
EPIC Properties, Inc.
EPSC, L.P.
Family Practitioners of Pearland, PLLC
Flower Mound Surgery Center, Ltd.
Fort Worth Investments, Inc.
Frisco Warren Parkway 91, Inc.

Galen Hospital of Baytown, Inc.
General and Cardiovascular Surgeons of Conroe, PLLC
General Surgeons of Pasadena, PLLC
GI Associates of Denton, PLLC
Gramercy Surgery Center, Ltd.
Gramercy Outpatient Surgery Center
Greater Houston Preferred Provider Option, Inc.

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Green Oaks Hospital Subsidiary, L.P.
Green Oaks Hospital
Gulf Coast Division, Inc.
Gulf Coast Physician Administrators, Inc.
HCA Central/West Texas Physicians Management, LLC
HCA Health Services of Texas, Inc.
HCA HEI Sealy, Inc.
HCA Med Plus of El Paso, Inc.
HCA Pearland GP, Inc.
HCA Plano Imaging, Inc.
HCA Western Group, Inc.
Heartcare of Texas, Ltd.
Hidalgo County Family Practitioners, PLLC
Houston Northwest Surgical Partners, Inc.
Houston Pediatric Pulmonary Associates, PLLC
HPG Energy, L.P.
HPG GP, LLC
HTI Gulf Coast, Inc.
Kingwood Multi-Specialty Group, PLLC
Kingwood Surgery Center, Ltd.
KPH-Consolidation, Inc.
Kingwood Medical Center
Kyle Primary Care, PLLC
Las Colinas Primary Care, PLLC
Las Colinas Surgery Center, Ltd.
Las Colinas Surgery Center
Leadership Healthcare Holdings II L.P., L.L.P.
Leadership Healthcare Holdings L.P., L.L.P.
Longview Regional Physician Hospital Organization, Inc.
M. Jamshidi, D.O., PLLC
Mainland Family Medicine, PLLC
Mainland Multi-Specialty Group, PLLC
Maternal Fetal Medicine Specialists of Corpus Christi, PLLC
Med City Dallas Outpatient Surgery Center, L.P.
Medical City Ambulatory Surgery Center
Med-Center Hosp./Houston, Inc.
Medical Care Surgery Center, Inc.
Medical City Dallas Hospital, Inc.
MediPurchase, Inc.
Methodist Healthcare System of San Antonio, Ltd., L.L.P.
Methodist Ambulatory Surgery Hospital Northwest
Methodist Children s Hospital of South Texas
Methodist Hospital
Methodist Specialty and Transplant Hospital
Methodist Stone Oak Hospital
Metropolitan Methodist Hospital
Northeast Methodist Hospital
Methodist Medical Center ASC, L.P.

Methodist Ambulatory Surgery Center Medical Center
Metroplex Surgicenters, Inc.
MGH Medical, Inc.
MHS SC Partner, L.L.C.
MHS Surgery Centers, L.P.
Mid-Cities Surgi-Center, Inc.
National Patient Account Services, Inc.
Navarro Memorial Hospital, Inc.

Neurological Eye Specialists of North Texas, PLLC
Neurological Specialists of McKinney, PLLC
Neurological Specialists, PLLC
Neurosurgical Specialists of El Paso, PLLC
North Austin Maternal Fetal Medicine, PLLC
North Austin Surgery Center, L.P.
North Austin Surgery Center
North Central Methodist ASC, L.P.
Methodist Ambulatory Surgery Center North Central
North Hills Cardiac Catheterization Center, L.P.
North Hills Catheterization Lab, LLC
North Hills Primary Care, PLLC
North Hills Surgicare, L.P.
Texas Pediatric Surgery Center
North Shore Specialists of Texas, PLLC
North Texas Cardiology, PLLC
North Texas Division, Inc.
North Texas General, L.P.
North Texas Geriatrics, PLLC
North Texas Pulmonary Critical Care, PLLC
North Texas Sports and Orthopedics Center, PLLC
North Texas Stroke Center, PLLC
Northeast Methodist Surgicare, Ltd.
Northeast PHO, Inc.
Oakwood Surgery Center, Ltd., LLP
Oakwood Surgery Center
OB/Gyn Associates of Denton, PLLC
Occupational and Family Medicine of South Texas
Orthopedic Hospital, Ltd.
Texas Orthopedic Hospital
Outpatient Women s and Children s Surgery Center, Ltd.
Fannin Surgicare
Paragon of Texas Health Properties, Inc.
Paragon Physicians Hospital Organization of South Texas, Inc.
Paragon Surgery Centers of Texas, Inc.
Park Central Surgical Center, Ltd.
Park Central Surgical Center
Parkway Cardiac Center, Ltd.
Parkway Surgery Services, Ltd.
Pasadena Bayshore Hospital, Inc.
Pediatric Cardiac Intensivists of North Texas, PLLC
Pediatric Hospitalists of Conroe, PLLC
Pediatric Intensivists of El Paso, PLLC
Pediatric Specialists of Clear Lake, PLLC
Pediatric Surgicare, Inc.
Physicians Ambulatory Surgery Center, LLC
Physicians Endoscopy Center
Plano Urology, PLLC

Plaza Primary Care, PLLC
Primary Care Plano, PLLC
Primary Care South, PLLC
Primary Care West, PLLC
Primary Health Network of South Texas
Quantum/Bellaire Imaging, Ltd.
Rim Building Partners, L.P.
Rio Grande Healthcare MSO, Inc.

Rio Grande NP, Inc.
Rio Grande Regional Hospital, Inc.
Rio Grande Regional Investments, Inc.
Rosewood Medical Center, Inc.
Rosewood Professional Building, Ltd.
Royal Oaks Surgery Center, L.P.
S.A. Medical Center, Inc.
San Antonio Division, Inc.
San Antonio Regional Hospital, Inc.
Sante Fe Family Practitioners, PLLC
SAPN, LLC
South Austin Surgery Center, Ltd.
Surgicare of South Austin
South Texas Surgicare, Inc.
Southern Texas Physicians Network
Spring Branch Family Practitioners, PLLC
Spring Branch Medical Center, Inc.
Spring Branch Medical Center
St. David s Healthcare Partnership, L.P., LLP
North Austin Medical Center
Round Rock Medical Center
South Austin Hospital
St. David s Georgetown Hospital
St. David s Medical Center
St. David s OB Hospitalist, PLLC
STPN Manager, LLC
Sugar Land Surgery Center, Ltd.
Sugar Land Surgery Center
Sun Towers/Vista Hills Holding Co.
Surgical Center of Irving, Inc.
Surgical Facility of West Houston, L.P.
Surgical Specialists of Clear Lake, PLLC
Surgical Specialists of Corpus Christi, PLLC
Surgicare of Arlington, LLC
Surgicare of Central San Antonio, Inc.
Surgicare of Flower Mound, Inc.
Surgicare of Fort Worth Co-GP, LLC
Surgicare of Fort Worth, Inc.
Surgicare of Gramercy, Inc.
Surgicare of Houston Women s, Inc.
Surgicare of Kingwood, Inc.
Surgicare of McKinney, Inc.
Surgicare of Medical City Dallas, LLC
Surgicare of North Austin, LLC
Surgicare of North San Antonio, Inc.
Surgicare of Northeast San Antonio, Inc.
Surgicare of Pasadena, Inc.
Surgicare of Round Rock, Inc.

Surgicare of Royal Oaks, LLC
Surgicare of South Austin, Inc.
Surgicare of Southwest Houston, LLC
Surgicare of Sugar Land, Inc.
Surgicare of Travis Center, Inc.
Tarrant County Surgery Center, L.P.
Trinity Park Surgery Center
Texas Medical Technologies, Inc.

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Texas Psychiatric Company, Inc.
The West Texas Division of Columbia, Inc.
THN Physicians Association, Inc.
Travis Surgery Center, L.P.
Urology Services of El Paso, PLLC
Village Oaks Medical Center, Inc.
W & C Hospital, Inc.
West Houston ASC, Inc.
West Houston Healthcare Group, Ltd.
West Houston Internal Specialists, PLLC
West Houston Outpatient Medical Facility, Inc.
West Houston Surgicare, Inc.
West LPN Fort Worth Oncology, PLLC
West LPN, Inc.
West McKinney Imaging Services, LLC
West Park Surgery Center, L.P.
McKinney Surgery Center
WHMC, Inc.
Woman s Hospital of Texas, Incorporated
Women Practitioners of Houston, PLLC
Women Specialists of Bayshore, PLLC

UNITED KINGDOM

Columbia U.K. Finance Limited
HCA Finance, LP
HCA International Holdings Limited
HCA International Limited
Princess Grace Hospital
The Harley Street Clinic
The Portland Hospital for Women and Children
The Wellington Hospital
HCA Staffing Limited
HCA UK Capital Limited
HCA UK Holdings Limited
HCA UK Investments Limited
HCA UK Services, Ltd.
HCA United Kingdom Limited
La Tour Finance Limited Partnership
London Radiography & Radiotherapy Services Limited
St. Martins Healthcare Limited
Lister Hospital
London Bridge Hospital
St. Martins Ltd.
The Harley Street Cancer Clinic Limited

UTAH

Bountiful Surgery Center, LLC
Lakeview Endoscopy Center

Brigham City Community Hospital Physician Services, LLC
Brigham City Community Hospital, Inc.
Brigham City Community Hospital
Brigham City Health Plan, Inc.
Columbia Ogden Medical Center, Inc.
Ogden Regional Medical Center
East Layton Internal Medicine, LLC
General Hospitals of Galen, Inc.

Healthtrust Utah Management Services, Inc.
Hospital Corporation of Utah
Lakeview Hospital
HTI Physician Services of Utah, Inc.
Jordan Family Health, L.L.C.
Lakeview Hospital Physician Services, LLC
Lakeview Internal Medicine, LLC
Lakeview Neurosurgery Clinic, LLC
Lakeview Professional Billing, LLC
Lakeview Urology & General Surgery, LLC
Layton Family Practice, LLC
Lone Peak General Surgery, LLC
Lone Peak Primary Care, LLC
Maternal Fetal Services of Utah, LLC
Mountain Division, Inc.
Mountain View Hospital, Inc.
Mountain View Hospital
Mountain View Medical Office Building, Ltd.
MountainStar Brigham General Surgery, LLC
Mountainstar Brigham OBGYN, LLC
MountainStar Canyon Surgical Clinic, LLC
Mountainstar Cardiovascular Services, LLC
MountainStar Farr West Family Medicine, LLC
Mountainstar Odgen Pediatrics, LLC
MountainStar Primary Care, LLC
Northern Utah Healthcare Corporation
St. Mark s Hospital
Northern Utah Healthcare Imaging Holdco, LLC
Northern Utah Imaging, L.P.
Ogden Adult and Senior Medicine, LLC
Ogden Imaging, LLC
Ogden Internal Medicine & Urology, LLC
Ogden Regional Health Plan, Inc.
Ogden Regional Medical Center Professional Billing, LLC
Ogden Senior Center, LLC
Salt Lake City Surgicare, Inc.
Shadow Mountain Family Medicine, LLC
St. Mark s Gynecology Oncology Care, LLC
St. Mark s Investments, Inc.
St. Mark s Lone Peak Hospital, Inc.
St. Mark s Millcreek Primary Care, LLC
St. Mark s Physicians, Inc.
St. Mark s Professional Services, LLC
St. Mark s South Jordan Family Practice, LLC
Surgicare of Bountiful, LLC
Surgicare of Utah, LLC
The Wasatch Endoscopy Center, Ltd.
Wasatch Endoscopy Center

Timpanogos Pain Specialists, LLC
Timpanogos Regional Medical Services, Inc.
Timpanogos Regional Hospital
Utah Imaging GP, LLC
Utah Surgery Center, L.P.
South Towne Surgery Center
West Jordan Hospital Corporation
West Valley Imaging, LLC

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VIRGINIA

Alleghany General and Bariatric Services, LLC
Alleghany Hospitalists, LLC
Alleghany Primary Care, Inc.
Alleghany Specialists, LLC
Ambulatory Services Management Corporation of Chesterfield County, Inc.
Appomattox Imaging, LLC
Arlington Surgery Center, L.P.
Arlington Surgicare, LLC
Ashburn ASC, LLC
Ashburn Imaging, LLC
Atrium Surgery Center, L.P.
Atrium Surgicare, LLC
Blacksburg Family Care, LLC
Buford Road Imaging, L.L.C.
Capital Anesthesia Services, LLC
Capital Division, Inc.
Cardiac Surgical Associates, LLC
Cardiothoracic Surgeons of Roanoke Valley, LLC
Carlin Springs Urgent Care, LLC
Central Shared Services, LLC
Chesterfield Imaging, LLC
Chippenham & Johnston-Willis Hospitals, Inc.
CJW Medical Center
Chippenham & Johnston-Willis Sports Medicine, LLC
Chippenham Ambulatory Surgery Center, LLC
Chippenham Pediatric Specialists, LLC
Christiansburg Family Medicine, LLC
Christiansburg Internal Medicine, LLC
CJW Infectious Disease, LLC
Colonial Heights Ambulatory Surgery Center, L.P.
Colonial Heights Surgicare, LLC
Columbia Arlington Healthcare System, L.L.C.
Columbia Healthcare of Central Virginia, Inc.
Columbia Medical Group Southwest Virginia, Inc.
Columbia Pentagon City Hospital, L.L.C.
Columbia/Alleghany Regional Hospital, Incorporated
Alleghany Regional Hospital
Columbia/HCA John Randolph, Inc.
John Randolph Medical Center
Commonwealth Perinatal Services, LLC
CVMC Property, LLC
Daleville Imaging Manager, LLC
Daleville Imaging, L.P.
Dominion Hospital Physicians Group, LLC
Fairfax Surgical Center, L.P.
Fairfax Surgical Center
Family Medicine of Blacksburg, LLC

Family Practice at Forest Hill, LLC
Family Practice at Retreat, LLC
Fort Chiswell Family Practice, LLC
Galen of Virginia, Inc.
Galen Property, LLC
Galen Virginia Hospital Corporation
Generations Family Practice, Inc.

GYN-Oncology of Southwest Virginia, LLC
Hanover Outpatient Surgery Center, L.P.
Hanover Outpatient Surgery Center
HCA Health Services of Virginia, Inc.
Henrico Doctors   Hospital
HCA Richmond Division, Inc.
HDH Thoracic Surgeons, LLC
Henrico Doctors   Family Medicine, LLC
Henrico Doctors   Neurology Associates, LLC
Henrico Radiation Oncology, LLC
Henrico Surgical Specialists, LLC
HSS Virginia, L.P.
Institute of Advanced ENT Surgery, LLC
Internal Medicine of Blacksburg, LLC
James River Internists, LLC
John Randolph Family Practice, LLC
John Randolph OB/GYN, LLC
John Randolph Surgeons, LLC
Lewis Gale Physicians Specialists, LLC
Lewis-Gale Hospital, Incorporated
Lewis-Gale Physicians, LLC
LGMC Ambulatory Surgery Center, LLC
Loudoun Surgery Center, L.P.
Loudoun Surgery Center, LLC
Management Services of the Virginias, Inc.
Montgomery Cancer Center, LLC
Montgomery Hospitalists, LLC
Montgomery Regional Hospital, Inc.
Montgomery Regional Hospital
Montgomery Surgery Associates, LLC
Northern Virginia Community Hospital, LLC
Northern Virginia Hospital Corporation
Orthopedics Specialists, LLC
Pediatric Specialists for CJW, LLC
Preferred Hospitals, Inc.
Primary Care of West End, LLC
Primary Health Group, Inc.
Pulaski Community Hospital, Inc.
Pulaski Community Hospital
Pulaski Radiologists, LLC
Pulaski Urology, LLC
Quick Care Centers, LLC
Radford Family Medicine, LLC
Reston Hospitalists, LLC
Reston Surgery Center, L.P.
Reston Surgery Center
Retreat Cardiology, LLC
Retreat Hospital, Inc.

Retreat Internal Medicine, LLC
Retreat Surgical Associates, LLC
Richmond Imaging Employer Corp.
Richmond Multi-Specialty, LLC
Richmond Pediatric Surgeon s, LLC
Roanoke Imaging, LLC
Roanoke Neurosurgery, LLC

Roanoke Surgery Center, L.P.
Blue Ridge Surgery Center
Roanoke Valley Gynecology, LLC
Salem Hospitalists, LLC
Short Pump Imaging, LLC
Southwest Virginia Fertility Center, LLC
Southwest Virginia Orthopedics and Spine, LLC
Specialty Physicians of Northern Virginia, LLC
Spotsylvania Medical Center, Inc.
Spotsylvania Multi-Specialty Group, LLC
Spotsylvania Regional Surgery Center, LLC
Stafford Imaging, LLC
Surgical Associates of Southwest Virginia, LLC
Surgical Associates of the New River Valley, LLC
Surgicare of Ashburn, LLC
Surgicare of Fairfax, Inc.
Surgicare of Hanover, Inc.
Surgicare of Reston, Inc.
Surgicare of Roanoke, LLC
Surgicare of Spotsylvania, LLC
Surgicare of Tuckahoe, Inc.
Tri-City Multi-Specialty, LLC
Urology Specialists of Richmond, LLC
Virginia Gynecologic Oncology, LLC
Virginia Hematology & Oncology Associates, Inc.
Virginia Hospitalists, Inc.
Virginia Psychiatric Company, Inc.
Dominion Hospital
West Creek Ambulatory Surgery Center, LLC
West Creek Medical Center, Inc.
Women s & Children s Center, LLC
Women s Health Center of SWVA, LLC

WASHINGTON

ACH, Inc.
Capital Network Services, Inc.

WEST VIRGINIA

Columbia Parkersburg Healthcare System, LLC
Columbia/HCA WVMS Member, Inc.
Galen of West Virginia, Inc.
HCA Health Services of West Virginia, Inc.
Hospital Corporation of America
Parkersburg SJ Holdings, Inc.
Teays Valley Health Services, LLC
Tri Cities Health Services Corp.

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EXHIBIT 31.1

CERTIFICATIONS

I, Richard M. Bracken, certify that:

1. I have reviewed this annual report on Form 10-K of HCA Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant s other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant s disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant s internal control over financial reporting that occurred during the registrant s most recent fiscal quarter (the registrant s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant s internal control over financial reporting; and

5. The registrant s other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant s auditors and the audit and compliance committee of the registrant s board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant s ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant s internal control over financial reporting.

By: /s/ Richard M. Bracken

Richard M. Bracken
Chairman of the Board
and Chief Executive Officer

Date: March 1, 2010

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EXHIBIT 31.2

CERTIFICATIONS

I, R. Milton Johnson, certify that:

1. I have reviewed this annual report of Form 10-K of HCA Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant s other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant s disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant s internal control over financial reporting that occurred during the registrant s most recent fiscal quarter (the registrant s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant s internal control over financial reporting; and

5. The registrant s other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant s auditors and the audit and compliance committee of the registrant s board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant s ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant s internal control over financial reporting.

By: /s/ R. Milton Johnson

R. Milton Johnson
Executive Vice President and Chief Financial Officer

Date: March 1, 2010

EXHIBIT 32

**CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of HCA Inc. (the Company) on Form 10-K for the year ended December 31, 2009, as filed with the Securities and Exchange Commission on the date hereof (the Report), each of the undersigned certifies, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

By: /s/ Richard M. Bracken

Richard M. Bracken
Chairman of the Board
and Chief Executive Officer

March 1, 2010

By: /s/ R. Milton Johnson

R. Milton Johnson
Executive Vice President and Chief Financial Officer

March 1, 2010