HCA INC/TN
Form S-1
May 07, 2010

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As filed with the Securities and Exchange Commission on May 7, 2010
Registration No. 333-

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

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

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

Delaware	**8062**	**75-2497104**
(State or other jurisdiction of incorporation or organization)	*(Primary Standard Industrial Classification Code Number)*	*(I.R.S. Employer Identification Number)*

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

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

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

(212) 701-3000

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

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

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

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

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

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

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

CALCULATION OF REGISTRATION FEE

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

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

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

The registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of

1933, as amended, or until the Registration Statement shall become effective on such date as the Securities and Exchange Commission, acting pursuant to said Section 8(a), may determine.

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

SUBJECT TO COMPLETION, DATED MAY 7, 2010

PRELIMINARY PROSPECTUS

HCA Inc.

Shares

Common Stock
$ per share

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

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

Investing in our common stock involves a high degree of risk. See Risk Factors beginning on page 14 of this prospectus to read about factors you should consider before buying shares of our common stock.

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

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

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

The underwriters expect to deliver the shares against payment in New York, New York on or about , 2010.

Joint Book-Running Managers

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

Barclays Capital

Credit Suisse

Deutsche Bank Securities

Goldman, Sachs & Co.

Morgan Stanley

Wells Fargo Securities

Prospectus dated , 2010.

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

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MARKET, RANKING AND OTHER INDUSTRY DATA

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

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

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PROSPECTUS SUMMARY

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

The terms Company, HCA, we, our or us, as used herein, refer to HCA Inc. and its affiliates unless otherwise sta 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 Company

We are the largest non-governmental hospital operator in the U.S. and a leading comprehensive, integrated provider of health care and related services. We provide these services through a network of acute care hospitals, outpatient facilities, clinics and other patient care delivery settings. As of March 31, 2010, we operated a diversified portfolio of 162 hospitals (with approximately 41,000 beds) and 106 freestanding surgery centers across 20 states throughout the U.S. and in England. As a result of our efforts to establish significant market share in large and growing urban markets with attractive demographic and economic profiles, we currently have a substantial market presence in 14 of the top 25 fastest growing markets in the U.S. and currently maintain the first or second position, based on inpatient admissions, in many of our key markets. We believe our ability to successfully position and grow our assets in attractive markets and execute our operating plan has contributed to the strength of our financial performance over the last several years. For the year ended December 31, 2009, we generated revenues of $30.052 billion, net income attributable to HCA Inc. of $1.054 billion and Adjusted EBITDA of $5.472 billion. For the three months ended March 31, 2010, we generated revenues of $7.544 billion, net income attributable to HCA Inc. of $388 million and Adjusted EBITDA of $1.574 billion.

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

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

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

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

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

Our Industry

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

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

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

Impact of Health Reform Law. The recently enacted Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the Health Reform Law), will change how health care services are covered, delivered and reimbursed. It will do so through expanded coverage of uninsured individuals, significant reductions in the growth of Medicare program payments, material decreases in Medicare and Medicaid disproportionate share hospital (DSH) payments, and the establishment of programs where reimbursement is tied in part to quality and integration. The Health Reform Law is expected to expand health insurance coverage to approximately 32 to 34 million additional individuals through a combination of public program expansion and private sector health insurance reforms. We believe the expansion of private sector and Medicaid coverage will, over time,

increase our reimbursement related to providing services to individuals who were previously uninsured. On the other hand, the reductions in the growth in Medicare payments and the decreases in DSH payments will adversely affect our government

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reimbursement. Because of the many variables involved, we are unable to predict the net impact of the Health Reform Law on us; however, we believe our experienced management team, emphasis on quality care and our diverse service offerings will enable us to capitalize on the opportunities presented by the Health Reform Law, as well as adapt in a timely manner to its challenges.

Our Competitive Strengths

We believe our key competitive strengths include:

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

Reputation for High Quality Patient-Centered Care. Since our founding, we have maintained an unwavering focus on patients and clinical outcomes. We believe clinical quality influences physician and patient choices about health care delivery. We align our quality initiatives throughout the organization by engaging corporate, local, physician and nurse leaders to share best practices and develop standards for delivering high quality care. We have invested extensively in quality of care initiatives, with an emphasis on implementing information technology and adopting industry-wide best practices and clinical protocols. As a result of these measures, we have achieved significant progress in clinical quality, as measured by the CMS HQA Grand Composite Score (based on publicly available data for the twelve months ended June 30, 2009) wherein HCA hospitals achieved 97.3% of the CMS core measures versus the national average of 94.1%, making HCA the best performing non-governmental system in the U.S. Similarly, 88% of the core measure sets performed by our facilities ranked in the top quartile and 65% ranked in the top decile based on publicly available data for the twelve months ended June 30, 2009. In addition, the Health Reform Law establishes a value-based purchasing system and adjusts hospital payment rates based on hospital-acquired conditions and hospital readmissions. We also believe our quality initiatives favorably position us in a payment environment that is increasingly performance-based.

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

Diversified Revenue Base and Payer Mix. We believe our broad geographic footprint, varied service lines and diverse revenue base mitigate our risks in numerous ways. Our diversification limits our exposure to competitive dynamics and economic conditions in any single local market, reimbursement changes in specific service lines and disruptions with respect to payers such as state Medicaid programs or large commercial insurers. We have a diverse portfolio of assets with no single facility contributing more than 2.4% of our revenues and no single metropolitan statistical area contributing more than 7.8% of revenues for the year ended December 31, 2009. We have also developed a highly diversified payer base, including approximately 3,000 managed care contracts, with no single commercial payer

representing more than 8% of revenues for the year ended December 31, 2009. In addition, we are one of the country s largest providers of outpatient services, which accounted for approximately 38% of our revenues for the year ended December 31, 2009. We

believe the geographic diversity of our markets and the scope of our inpatient and outpatient operations help reduce volatility in our operating results.

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

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

Strong Operating Results and Cash Flows. Our leading scale, diversification, favorable market positions, dedication to clinical quality and focus on operational efficiency have enabled us to achieve attractive historical financial performance even during the most recent economic period. In the year ended December 31, 2009, we generated net income attributable to HCA Inc. of $1.054 billion, Adjusted EBITDA of $5.472 billion and cash flows from operating activities of $2.747 billion, while for the three months ended March 31, 2010, we generated net income attributable to HCA Inc. of $388 million, Adjusted EBITDA of $1.574 billion and cash flows from operating activities of $901 million. Our ability to generate strong and consistent cash flow from operations has enabled us to invest in our operations, reduce our debt, enhance earnings per share and continue to pursue attractive growth opportunities.

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

Our Growth Strategy

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

Grow Our Presence in Existing Markets. We believe we are well positioned in a number of large and growing markets that will allow us the opportunity to generate long-term, attractive growth through the expansion of our presence in these markets. We plan to continue recruiting and strategically collaborating with the physician

community and adding attractive service lines such as cardiology, emergency services, oncology and women s services. Additional components of our growth strategy include expanding our footprint through developing various outpatient access points, including surgery centers, rural outreach, freestanding emergency

departments and walk-in clinics. Since our Recapitalization, we have invested significant capital into these markets and expect to continue to see the benefit of this investment.

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

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

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

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

Recent Developments

On April 6, 2010, we entered into an amendment of our senior secured term loan B facility, extending the maturity date for $2.0 billion of loans from November 17, 2013 to March 31, 2017.

On May 5, 2010, our Board of Directors declared a distribution to our existing stockholders and holders of vested stock options of approximately $500 million in the aggregate.

Risk Factors

Investing in our common stock involves substantial risk, and our ability to successfully operate our business is subject to numerous risks, including those that are generally associated with operating in the health care industry. Any of the factors set forth under Risk Factors may limit our ability to successfully execute our business strategy. You should

carefully consider all of the information set forth in this prospectus and, in particular, should evaluate the specific factors set forth under Risk Factors in deciding whether to invest in our common stock. Among these important risks are the following:

our substantial debt could limit our ability to pursue our growth strategy;

our debt agreements contain restrictions that may limit our flexibility in operating our business;

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the current economic climate and general economic factors may adversely affect our performance;

we face intense competition that could limit our growth opportunities;

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

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

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

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

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

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The Offering

Common stock offered by HCA	shares
Common stock offered by selling stockholders	shares
Common stock to be outstanding after this offering	shares (shares if the underwriters exercise their option in full)
Use of Proceeds	We estimate that the net proceeds to us from this offering, after deducting underwriting discounts and estimated offering expenses, will be approximately $ billion, assuming the shares are offered at $ per share, which is the mid-point of the estimated offering price range set forth on the cover page of this prospectus. We intend to use the anticipated net proceeds to repay certain of our existing indebtedness, as will be determined prior to our offering, and for general corporate purposes. We will not receive any proceeds from the sale of shares of our common stock by the selling stockholders.
Underwriters option	We and the selling stockholders have granted the underwriters a 30-day option to purchase up to additional shares of our common stock at the initial public offering price.
Dividend policy	We do not intend to pay dividends on our common stock for the foreseeable future following completion of the offering.
Risk Factors	You should carefully read and consider the information set forth under Risk Factors beginning on page 14 of this prospectus and all other information set forth in this prospectus before investing in our common stock.
Conflicts of Interest	Certain of the underwriters and their respective affiliates have, from time to time, performed, and may in the future perform, various financial advisory, investment banking, commercial banking and other services for us for which they received or will receive customary fees and expenses. See Underwriting. Merrill Lynch, Pierce, Fenner & Smith Incorporated and/or its affiliates indirectly own in excess of 10% of our issued and outstanding common stock, and may therefore be deemed to be one of our affiliates and to have a conflict of interest with us within the meaning of NASD Conduct Rule 2720 (Rule 2720) of the Financial Industry Regulatory Authority, Inc. Therefore, this offering will be conducted in accordance with Rule 2720, which requires that a qualified independent underwriter as defined in Rule 2720 participate in the preparation of the registration statement of which this prospectus forms a part and perform its usual standard of due diligence with respect thereto. See Underwriting

Conflicts of Interest.

Proposed NYSE ticker symbol	HCA

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

- assumes (1) no exercise of the underwriters option to purchase additional shares of our common stock; and (2) an initial public offering price of $ per share, the midpoint of the initial public offering range indicated on the cover of this prospectus;
- reflects the to 1 stock split that we effected on , 2010; and
- does not reflect (1) shares of our common stock issuable upon the exercise of outstanding stock options at a weighted average exercise price of $ per share as of March 31, 2010, of which were then exercisable; and (2) shares of our common stock reserved for future grants under our stock incentive plans.

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Summary Financial Data

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

The summary financial data as of March 31, 2010 and for the three months ended March 31, 2010 and 2009 have been derived from our unaudited condensed consolidated financial statements included elsewhere in this prospectus. The summary financial data as of March 31, 2009 have been derived from our unaudited condensed consolidated financial statements that are not included in this prospectus. The unaudited financial data presented have been prepared on a basis consistent with our audited consolidated financial statements. In the opinion of management, such unaudited financial data reflect all adjustments, consisting only of normal and recurring adjustments, necessary for a fair presentation of the results for those periods. The results of operations for the interim periods are not necessarily indicative of the results to be expected for the full year or any future period.

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

	As of and for the Years Ended December 31,			As of and for the Three Months Ended March 31,	
	2009	2008	2007	2010	2009
				(Unaudited)	
	(Dollars in millions, except per share amounts)				
Income Statement Data:					
Revenues	$ 30,052	$ 28,374	$ 26,858	$ 7,544	$ 7,431
Salaries and benefits	11,958	11,440	10,714	3,072	2,923
Supplies	4,868	4,620	4,395	1,200	1,210
Other operating expenses	4,724	4,554	4,233	1,202	1,102
Provision for doubtful accounts	3,276	3,409	3,130	564	807
Equity in earnings of affiliates	(246)	(223)	(206)	(68)	(68)
Depreciation and amortization	1,425	1,416	1,426	355	353
Interest expense	1,987	2,021	2,215	516	471
Losses (gains) on sales of facilities	15	(97)	(471)		5
Impairments of long-lived assets	43	64	24	18	9
	28,050	27,204	25,460	6,859	6,812
Income before income taxes	2,002	1,170	1,398	685	619
Provision for income taxes	627	268	316	209	187
Net income	1,375	902	1,082	476	432
	321	229	208	88	72

Net income attributable to noncontrolling interests					
Net income attributable to HCA Inc.	$ 1,054	$ 673	$ 874	$ 388	$ 360

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	As of and for the Years Ended December 31,			As of and for the Three Months Ended March 31,	
	2009	2008	2007	2010	2009
				(Unaudited)	
	(Dollars in millions, except per share amounts)				
Earnings per share:					
Basic	$	$	$	$	$
Diluted					
Weighted average shares (shares in thousands):					
Basic					
Diluted					
Statement of Cash Flows Data:					
Cash flows provided by operating activities	$ 2,747	$ 1,990	$ 1,564	$ 901	$ 615
Cash flows used in investing activities	(1,035)	(1,467)	(479)	(181)	(288)
Cash flows used in financing activities	(1,865)	(451)	(1,326)	(644)	(436)
Other Financial Data:					
EBITDA(1)	$ 5,093	$ 4,378	$ 4,831	$ 1,468	$ 1,371
Adjusted EBITDA(1)	5,472	4,574	4,592	1,574	1,457
Capital expenditures	1,317	1,600	1,444	214	337
Operating Data(2):					
Number of hospitals at end of period(3)	155	158	161	154	155
Number of freestanding outpatient surgical centers at end of period(4)	97	97	99	98	97
Number of licensed beds at end of period(5)	38,839	38,504	38,405	38,719	38,763
Weighted average licensed beds(6)	38,825	38,422	39,065	38,687	38,811
Admissions(7)	1,556,500	1,541,800	1,552,700	398,900	396,200
Equivalent admissions(8)	2,439,000	2,363,600	2,352,400	615,500	610,200
Average length of stay (days)(9)	4.8	4.9	4.9	4.9	4.9
Average daily census(10)	20,650	20,795	21,049	21,696	21,701
Occupancy(11)	53%	54%	54%	56%	56%
Emergency room visits(12)	5,593,500	5,246,400	5,116,100	1,367,100	1,359,700
Outpatient surgeries(13)	794,600	797,400	804,900	190,700	194,400
Inpatient surgeries(14)	494,500	493,100	516,500	122,500	122,600
Days revenues in accounts receivable(15)	45	49	53	46	47
Gross patient revenues(16)	$ 115,682	$ 102,843	$ 92,429	$ 31,054	$ 28,742

Outpatient revenues as a percentage of patient revenues(17)	38%	37%	37%	36%	38%

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	As of and for the Years Ended December 31,			As of and for the Three Months Ended March 31,	
	2009	2008	2007	2010	2009
				(Unaudited)	
	(Dollars in millions, except per share amounts)				
Balance Sheet Data:					
Working capital(18)	$ 2,264	$ 2,391	$ 2,356	$ 2,167	$ 2,592
Property, plant and equipment, net	11,427	11,529	11,442	11,252	11,455
Cash and cash equivalents	312	465	393	388	356
Total assets	24,131	24,280	24,025	24,091	24,284
Total debt	25,670	26,989	27,308	26,855	26,567
Equity securities with contingent redemption rights	147	155	164	144	154
Stockholders deficit attributable to HCA Inc.	(8,986)	(10,255)	(10,538)	(10,313)	(9,888)
Noncontrolling interests	1,008	995	938	1,015	1,019
Total stockholders deficit	(7,978)	(9,260)	(9,600)	(9,298)	(8,869)

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

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

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

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

EBITDA and Adjusted EBITDA are calculated as follows:

	Years Ended December 31,			Three Months Ended March 31,	
	2009	2008	2007	2010	2009
				(Unaudited)	
	(Dollars in millions)				
Net income attributable to HCA Inc.	$ 1,054	$ 673	$ 874	$ 388	$ 360
Provision for income taxes	627	268	316	209	187
Interest expense	1,987	2,021	2,215	516	471
Depreciation and amortization	1,425	1,416	1,426	355	353
EBITDA	5,093	4,378	4,831	1,468	1,371
Net income attributable to noncontrolling interests(i)	321	229	208	88	72
Losses (gains) on sales of facilities(ii)	15	(97)	(471)		5
Impairments of long-lived assets(iii)	43	64	24	18	9
Adjusted EBITDA	$ 5,472	$ 4,574	$ 4,592	$ 1,574	$ 1,457

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

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

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

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

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

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

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

(6)

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

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

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

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

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

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

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

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

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

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

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

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

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

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RISK FACTORS

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

Risks Related to Our Business

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

The health care business is highly competitive, and competition among hospitals and other health care providers for patients has intensified in recent years. Generally, other hospitals in the local communities we serve provide services similar to those offered by our hospitals. In addition, the Centers for Medicare & Medicaid Services (CMS) publicizes on its Medicare website performance data related to quality measures and data on patient satisfaction surveys hospitals submit in connection with their Medicare reimbursement. Federal law provides for the future expansion of the number of quality measures that must be reported. Additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes. Further, the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the Health Reform Law) requires all hospitals to annually establish, update and make public a list of the hospital s standard charges for items and services. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures or on patient satisfaction surveys or if our standard charges are higher than our competitors, our patient volumes could decline.

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

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

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

The amount of the provision for doubtful accounts is based upon management s assessment of historical 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. At March 31, 2010, our allowance for doubtful accounts represented approximately 94% of the $4.833 billion patient due accounts receivable balance. The sum of the provision for doubtful accounts, uninsured discounts and charity care increased from $6.134 billion for 2007 to $7.009 billion for 2008 and to $8.362 billion for 2009.

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

Changes in governmental programs may reduce our revenues.

A significant portion of our patient volume is derived from government health care programs, principally Medicare and Medicaid. Specifically, we derived approximately 40% of our revenues from the Medicare and Medicaid programs in 2009. In recent years, legislative and regulatory changes have resulted in limitations on and, in some cases, reductions in levels of payments to health care providers for certain services under the Medicare program. For example, CMS has recently completed a two-year transition to full implementation of the Medicare severity diagnosis-related group (MS-DRG) system, which represents a refinement to the existing diagnosis-related group system. Future realignments in the MS-DRG system could impact the margins we receive for certain services. Further, the Health Reform Law provides for material reductions in the growth of Medicare program spending, including reductions in Medicare market basket updates, and Medicare and Medicaid disproportionate share hospital (DSH) funding. Reductions to our reimbursement under the Medicare and Medicaid programs by the Health Reform Law could adversely affect our business and results of operations to the extent such reductions are not offset by anticipated increases in revenues from providing care to previously uninsured individuals.

Since most states must operate with balanced budgets and since the Medicaid program is often a state s largest program, some states can be expected to enact or consider enacting legislation designed to reduce their Medicaid expenditures. The current economic downturn has increased the budgetary pressures on many states, and these budgetary pressures have resulted, and likely will continue to result, in decreased spending for Medicaid programs and the Children s Health Insurance Program (CHIP) in many states. Further, many states have also adopted, or are considering, legislation designed to reduce coverage, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems. Effective March 23, 2010, the Health Reform Law requires states to at least maintain Medicaid eligibility standards established prior to the enactment of the law for adults until January 1, 2014 and for children until October 1, 2019. However, states with budget deficits may seek exceptions from this requirement to address eligibility standards that apply to adults making more than 133% of the federal poverty level. The Health Reform Law also provides for significant expansions to the Medicaid program, but these changes are not required until 2014. In addition, the Health Reform Law will result in increased state legislative and regulatory changes in order for states to comply with new federal mandates, such as the requirement to establish health insurance exchanges, and to participate in grants and other incentive opportunities.

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

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

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

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

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

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

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

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

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

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

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

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

Medicaid program under contracts with the state;

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

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

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

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

the possibility that implementation of provisions expanding health insurance coverage will be delayed or even blocked due to court challenges or revised or eliminated as a result of efforts to repeal or amend the new law.

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

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

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

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

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

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

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

how successful ACOs, in which we participate, will be at coordinating care and reducing costs;

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

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

reductions to Medicare payments CMS may impose for excessive readmissions.

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

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

Our ability to obtain favorable contracts with nongovernment payers, including health maintenance organizations, preferred provider organizations and other managed care plans significantly affects the revenues and operating results of our facilities. Revenues derived from these entities and other insurers accounted for

53%, 52% and 53% of our patient revenues for the quarter ended March 31, 2010 and the years ended December 31, 2009 and December 31, 2008, respectively. Nongovernment payers, including managed care payers, continue to demand discounted fee structures, and the trend toward consolidation among nongovernment payers tends to increase their bargaining power over fee structures. As various provisions of the Health Reform Law are implemented, including the establishment of the Exchanges, nongovernment payers increasingly may demand reduced fees. Our future success will depend, in part, on our ability to retain and renew our managed care contracts and enter into new managed care contracts on terms favorable to us. Other health care providers may impact our ability to enter into managed care contracts or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. It is not clear what impact, if any, the increased obligations on managed care payers and other payers imposed by the Health Reform Law will have on our ability to negotiate reimbursement increases. If we are unable to retain and negotiate favorable contracts with managed care plans or experience reductions in payment increases or amounts received from nongovernment payers, our revenues may be reduced.

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

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

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

Our operations are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians, as well as our physicians. We compete with other health care providers in recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our hospitals, including nurses and other nonphysician health care professionals. In some markets, the availability of nurses and other medical support personnel has been a significant operating issue to health care providers. We may be required to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary or contract personnel. As a result, our labor costs could increase. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Certain proposed changes in federal labor laws, including the Employee Free Choice Act, could increase the likelihood of employee unionization attempts. To the extent a significant portion of our employee base unionizes, it is possible our 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 revenues if we are required to limit admissions in order to meet the required ratios. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control labor costs, could have a material, adverse effect on our results of operations.

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

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

billing and coding for services and properly handling overpayments;

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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;

activities regarding competitors; and

addition of facilities and services.

Among these laws are the federal Anti-kickback Statute, the federal physician self-referral law (commonly called the Stark Law), the federal False Claims Act (FCA) and similar state laws. We have a variety of financial relationships with physicians and others who either refer or influence the referral of patients to our hospitals and other health care facilities, and these laws govern those relationships. The Office of Inspector General of the Department of Health and Human Services (OIG) has enacted safe harbor regulations that outline practices deemed protected from prosecution under the Anti-kickback Statute. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements, including joint ventures and financial relationships with physicians and other referral sources and persons and entities to which we refer patients, do not qualify for safe harbor protection. Failure to qualify for a safe harbor does not mean the arrangement necessarily violates the Anti-kickback Statute, but may subject the arrangement to greater scrutiny. However, we cannot offer assurance that practices outside of a safe harbor will not be found to violate the Anti-kickback Statute. Allegations of violations of the Anti-kickback Statute may be brought under the federal Civil Monetary Penalty Law, which requires a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute.

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

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

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

CMS published a proposal to collect information from 400 hospitals regarding their ownership, investment and compensation arrangements with physicians. Called the Disclosure of Financial Relationships Report (or DFRR), CMS intends to use this data to monitor compliance with the Stark Law, and CMS may share this information with other government agencies. Many of these agencies have not previously analyzed this

information and have the authority to bring enforcement actions against hospitals filing such reports. The DFRR and its supporting documentation are currently under review by the Office of Management and Budget, and it is unclear when, or if, it will be finalized.

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

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

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

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

As required by statute, CMS is in the process of implementing the Recovery Audit Contractor (RAC) program on a nationwide basis. Under the program, CMS contracts with RACs to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The Health Reform Law expands the RAC program s scope to include managed Medicare plans and to include Medicaid claims by requiring all states to enter into contracts with RACs by December 31, 2010. In addition, CMS employs Medicaid Integrity Contractors (MICs) to perform post-payment audits of Medicaid claims and identify overpayments. Throughout 2010, MIC audits will continue to expand. The Health Reform Law increases federal funding for the MIC program for federal fiscal year 2011 and later years. In addition to RACs and MICs, several other contractors, including the state Medicaid agencies, have increased their review activities.

Should we be found out of compliance with any of these laws, regulations or programs, depending on the nature of the findings, our business, our financial position and our results of operations could be negatively impacted.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare, managed Medicare, Medicaid, managed Medicaid and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as utilization review, have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by health plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be

negatively affected by payer-required preadmission authorization and utilization review and by payer pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. For example, the Health Reform Law potentially expands the use of prepayment review by Medicare contractors

by eliminating statutory restrictions on their use. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

Our overall business results may suffer from the recent economic downturn.

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

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

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

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

The Health Reform Law also requires HHS to implement a value-based purchasing program for inpatient hospital services. Beginning in federal fiscal year 2013, HHS will reduce inpatient hospital payments for all discharges by a percentage specified by statute ranging from 1% to 2% and pool the total amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions.

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

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

Any system failure that causes an interruption in service or availability of our systems could adversely affect operations or delay the collection of revenues. Even though we have implemented network security measures, our

servers are vulnerable to computer viruses, break-ins and similar disruptions from unauthorized tampering. The occurrence of any of these events could result in interruptions, delays, the loss or corruption of data, cessations in the availability of systems or liability under privacy and security laws, all of which could

have a material adverse effect on our financial position and results of operations and harm our business reputation.

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

- accounting and financial reporting;
- billing and collecting accounts;
- coding and compliance;
- clinical systems;
- medical records and document storage;
- inventory management;
- negotiating, pricing and administering managed care contracts and supply contracts; and
- monitoring quality of care and collecting data on quality measures necessary for full Medicare payment updates.

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

As required by the American Recovery and Reinvestment Act of 2009, 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 162 hospitals at March 31, 2010, and 73 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities combined revenues represented approximately 52% and 51%, respectively, of our consolidated revenues for the quarter ended March 31, 2010 and year ended December 31, 2009. This concentration makes us particularly sensitive to regulatory, economic, environmental and competitive conditions and changes in those states. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in those states could have a disproportionate effect on our overall business results.

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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 March 31, 2010, 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 March 31, 2010.

The IRS completed its audit of HCA s 2005 and 2006 federal income tax returns in April 2010. We will contest certain claimed deficiencies and adjustments proposed by the IRS Examination Division in connection with this audit, including the timing of recognition of certain patient service revenues, before the IRS Appeals Division. We anticipate the IRS will begin an audit of the 2007, 2008 and 2009 federal income tax returns for HCA and one or more affiliated partnerships during 2010.

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

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

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

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

We are exposed to market risk related to changes in market values of securities. The investments in debt and equity securities of our wholly-owned insurance subsidiary were $1.296 billion and $7 million, respectively, at March 31, 2010. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At March 31, 2010, we had a net unrealized gain of $22 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

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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 March 31, 2010, our wholly-owned insurance subsidiary had invested $333 million ($336 million par value) in municipal, tax-exempt student loan auction rate securities (ARS). Since February 2008, when multiple failed auctions occurred due to a severe credit and liquidity crisis in the capital markets, the ARS have experienced market illiquidity. It is uncertain if auction-related market liquidity will resume for these securities. We may be required to recognize other-than-temporary impairments on these investments in future periods should issuers default on interest payments or should the fair market valuations of the securities deteriorate due to ratings downgrades or other issue specific factors.

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

Risks Related to Our Indebtedness

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

We are highly leveraged. As of March 31, 2010, our total indebtedness is $26.855 billion. Our high degree of leverage could have important consequences, including:

- increasing our vulnerability to downturns or adverse changes in general economic, industry or competitive conditions and adverse changes in government regulations;
- requiring a substantial portion of cash flow from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flow to fund our operations, capital expenditures and future business opportunities;
- exposing us to the risk of increased interest rates as certain of our unhedged borrowings are at variable rates of interest;
- limiting our ability to make strategic acquisitions or causing us to make nonstrategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, product or service line development, debt service requirements, acquisitions and general corporate or other purposes; and
- limiting our ability to adjust to changing market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged.

We and our subsidiaries have the ability to incur additional indebtedness in the future, subject to the restrictions contained in our senior secured credit facilities and the indentures governing our outstanding notes. If new indebtedness is added to our current debt levels, the related risks that we now face could intensify.

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

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which are subject to prevailing economic and competitive conditions and to certain financial, business and other factors beyond our control. We cannot assure you we will maintain a

level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness.

As of March 31, 2010, our substantial indebtedness included $9.648 billion of indebtedness under our senior secured credit facilities maturing in 2012 and 2013, $4.150 billion aggregate principal amount of first lien notes maturing in 2019 and 2020, $6.088 billion aggregate principal amount of second lien notes maturing in 2014, 2016 and 2017 and $6.723 billion aggregate principal amount of unsecured senior notes and debentures that mature on various dates from 2010 to 2095 (including $5.321 billion maturing through 2016). Because a significant portion of our indebtedness matures in the next few years, we may find it necessary or prudent to refinance that indebtedness with longer-maturity debt at a higher interest rate. In February, April and August of 2009 and in March of 2010, for example, we issued $310 million in aggregate principal amount of 97/8% second lien notes due 2017, $1.500 billion in aggregate principal amount of 81/2% first lien notes due 2019, $1.250 billion in aggregate principal amount of 77/8% first lien notes due 2020 and $1.400 billion in aggregate principal amount of 71/4% first lien notes due 2020, respectively. We used the net proceeds of those offerings to prepay term loans under our cash flow credit facility, which currently bears interest at a lower floating rate. Our ability to refinance our indebtedness on favorable terms, or at all, is directly affected by the current global economic and financial conditions. In addition, our ability to incur secured indebtedness (which would generally enable us to achieve better pricing than the incurrence of unsecured indebtedness) depends in part on the value of our assets, which depends, in turn, on the strength of our cash flows and results of operations, and on economic and market conditions and other factors.

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

Our debt agreements contain restrictions that limit our flexibility in operating our business.

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

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

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

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

Risks Related to this Offering and Ownership of Our Common Stock

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

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

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

Prior investors have paid substantially less per share of our common stock than the price in this offering. The initial public offering price of our common stock is substantially higher than the net tangible book value per share of outstanding common stock prior to completion of the offering. Based on our net tangible book value as of March 31, 2010 and upon the issuance and sale of shares of common stock by us at an assumed initial public offering price of $ per share (the midpoint of the initial public offering price range indicated on the cover of this prospectus), if you purchase our common stock in this offering, you will pay more for your shares than the amounts paid by our existing stockholders for their shares and you will suffer immediate dilution of approximately $ per share in net tangible book value. We also have a large number of outstanding stock options to purchase common stock with exercise prices that are below the estimated initial public offering price of our common stock. To the extent that these options are exercised, you will experience further dilution. See Dilution.

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

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

- quarterly variations in our results of operations;

results of operations that vary from the expectations of securities analysts and investors;

results of operations that vary from those of our competitors;

changes in expectations as to our future financial performance, including financial estimates by securities analysts and investors;

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announcements by us, our competitors or our vendors of significant contracts, acquisitions, joint marketing relationships, joint ventures or capital commitments;

announcements by third parties or governmental entities of significant claims or proceedings against us;

new laws and governmental regulations applicable to the health care industry, including the Health Reform Law;

a default under the agreements governing our indebtedness;

future sales of our common stock by us, directors, executives and significant stockholders; and

changes in domestic and international economic and political conditions and regionally in our markets.

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

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

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

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

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

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

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

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

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

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

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

We are controlled, and after this offering is completed will continue to be controlled, by the Investors. The Investors will indirectly own through their investment in Hercules Holding II, LLC (Hercules Holding) approximately % of our common stock (or % if the underwriters exercise their option to purchase additional shares in full) after the completion of this offering. In addition, representatives of the Investors will have the right to designate a majority of the seats on our Board of Directors. As a result, the Investors will have control over our decisions to enter into any corporate transaction (and the terms thereof) and the ability to prevent any change in the composition of our Board of Directors and any transaction that requires stockholder approval regardless of whether others believe that such change or transaction is in our best interests. So long as the Investors continue to indirectly hold a majority of our outstanding common stock, they will have the ability to control the vote in any election of directors, amend our certificate of incorporation or bylaws or take other actions requiring the vote of our stockholders. Even if such amount is less than 50%, the Investors will continue to be able to strongly influence or effectively control our decisions.

Additionally, Bain Capital Partners, LLC, Kohlberg Kravis Roberts & Co., and BAML Capital Partners, the successor organization to Merrill Lynch Global Private Equity (each a Sponsor, collectively, the Sponsors), are in the business of making investments in companies and may acquire and hold interests in businesses that compete directly or indirectly with us. One or more of the Sponsors may also pursue acquisition opportunities that may be complementary

to our business and, as a result, those acquisition opportunities may not be available to us.

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

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

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

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

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FORWARD-LOOKING STATEMENTS

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

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

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

changes in accounting practices;

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

future divestitures which may result in charges;

changes in business strategy or development plans;

delays in receiving payments for services provided;

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

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

other risk factors described in this prospectus.

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

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

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USE OF PROCEEDS

We estimate that the gross proceeds we will receive from the sale of shares of our common stock sold by us in this offering, excluding the underwriters option to purchase additional shares, will be $2.5 billion. We estimate that the net proceeds we will receive from the sale of shares of our common stock in this offering, after deducting underwriter discounts and commissions and estimated expenses payable by us, will be approximately $ billion (or $ billion if the underwriters exercise the option to purchase additional shares in full). This estimate assumes an initial public offering price of $ per share, the midpoint of the range set forth on the cover page of this prospectus. A $1.00 increase (decrease) in the assumed initial public offering price of $ per share would increase (decrease) the net proceeds to us from this offering by $ million, assuming the number of shares offered by us, as set forth on the cover page of this prospectus, remains the same and after deducting the estimated underwriting discounts and commissions and estimated expenses payable by us. We will not receive any proceeds from the sale of shares of our common stock by the selling stockholders.

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

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DIVIDEND POLICY

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

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

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CAPITALIZATION

The following table sets forth our capitalization as of March 31, 2010:

- on an actual basis; and
- on an as adjusted basis to give effect to (1) the issuance of common stock in this offering and the application of proceeds from the offering as described in Use of Proceeds as if each had occurred on March 31, 2010, (2) the payment of a distribution to our existing stockholders and holders of vested stock options of approximately $500 million in the aggregate as announced on May 5, 2010, (3) the to 1 stock split that we effected on , 2010 and (4) the payment of approximately $ million in fees under our management agreement with the Sponsors in connection with its termination. See Certain Relationships and Related Party Transactions Sponsor Management Agreement.

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

	March 31, 2010	
	Actual	As Adjusted
	(In millions)	
Cash and cash equivalents	$ 388	$
Long-term obligations:		
Senior secured credit facilities(1)	$ 9,648	$
Senior secured first lien notes(2)	4,071	
Senior secured second lien notes(3)	6,079	
Other secured indebtedness	345	
Unsecured indebtedness(4)	6,712	
Total long-term obligations	26,855	
Stockholders deficit:		
Common stock: $.01 par value; authorized shares; outstanding shares	1	
Capital in excess of par value	291	
Accumulated other comprehensive loss	(479)	
Retained deficit	(10,126)	
Stockholders deficit attributable to HCA Inc.	(10,313)	
Noncontrolling interests	1,015	
Total stockholders deficit	(9,298)	
Total capitalization(5)	$ 17,557	$

(1) In connection with the Recapitalization, we entered into (i) a $2.000 billion asset-based revolving credit facility with an original six-year maturity (the asset-based revolving credit facility) ($1.825 billion outstanding at March 31, 2010); (ii) a $2.000 billion senior secured revolving credit facility with an original six-year maturity (the senior secured revolving credit facility) ($229 million outstanding at March 31, 2010, without giving effect to outstanding letters of credit); (iii) a $2.750 billion senior secured term loan A facility with an original six-year maturity ($1.618 billion outstanding at March 31, 2010); (iv) an $8.800 billion senior secured term loan B facility with an original seven-year maturity ($5.525 billion outstanding at March 31, 2010); and (v) a 1.000 billion (334 million, or $451 million-equivalent, outstanding at March 31, 2010), senior secured European term loan facility with an original seven-year maturity.

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We refer to the facilities described under (ii) through (v) above, collectively, as the cash flow credit facility and, together with the asset-based revolving credit facility, the senior secured credit facilities.

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

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

(4) Consists of (i) an aggregate principal amount of $246 million medium-term notes with maturities in 2014 and 2025 and a weighted average interest rate of 8.28%; (ii) an aggregate principal amount of $886 million debentures with maturities ranging from 2015 to 2095 and a weighted average interest rate of 7.55%; (iii) an aggregate principal amount of $5.407 billion senior notes with maturities ranging from 2010 to 2033 and a weighted average interest rate of 6.79%; (iv) £121 million ($184 million-equivalent at March 31, 2010) aggregate principal amount of 8.75% senior notes due 2010; and (v) $11 million of unamortized debt discounts that reduce the existing indebtedness. For more information regarding our unsecured and other indebtedness, see Description of Indebtedness.

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

The table set forth above is based on the number of shares of our common stock outstanding as of March 31, 2010. This table does not reflect:

shares of our common stock issuable upon the exercise of outstanding stock options at a weighted average exercise price of $ per share as of March 31, 2010, of which were then exercisable; and

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

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DILUTION

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

Our net tangible book value as of March 31, 2010 was a deficit of $(12.1) billion or $ per share of our common stock, based on shares of our common stock outstanding. Dilution is determined by subtracting net tangible book value per share of our common stock from the assumed initial public offering price per share of our common stock.

Without taking into account any other changes in such net tangible book value after March 31, 2010, after giving effect to the sale of shares of our common stock in this offering assuming an initial public offering price of $ per share, less the underwriting discounts and commissions and the estimated offering expenses payable by us, our pro forma as adjusted net tangible book value at March 31, 2010 would have been $, or $ per share. This represents an immediate increase in net tangible book value of $ per share of our common stock to the existing stockholders and an immediate dilution in net tangible book value of $ per share of our common stock, to investors purchasing shares of our common stock in this offering. The following table illustrates such dilution per share of our common stock:

Assumed initial public offering price per share of our common stock	$
Net tangible book value per share of our common stock as of March 31, 2010	
Pro forma net tangible book value per share of our common stock after giving effect to this offering	
Amount of dilution in net tangible book value per share of our common stock to new investors in this offering	

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

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

The following table summarizes, on a pro forma basis as of March 31, 2010, the total number of shares of our common stock purchased from us, the total cash consideration paid to us and the average price per share of our common stock paid by purchasers of such shares and by new investors purchasing shares of our common stock in this offering.

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

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

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

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SELECTED FINANCIAL DATA

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

The selected financial data as of March 31, 2010 and for the three months ended March 31, 2010 and 2009 have been derived from our unaudited condensed consolidated financial statements included elsewhere in this prospectus. The selected financial data as of March 31, 2009 have been derived from our unaudited condensed consolidated financial statements that are not included in this prospectus. The unaudited financial data presented have been prepared on a basis consistent with our audited consolidated financial statements. In the opinion of management, such unaudited financial data reflect all adjustments, consisting only of normal and recurring adjustments, necessary for a fair presentation of the results for those periods. The results of operations for the interim periods are not necessarily indicative of the results to be expected for the full year or any future period.

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

	As of and for the Years Ended December 31,					As of and for the Three Months Ended March 31,	
	2009	2008	2007	2006	2005	2010	2009
						(Unaudited)	
	(Dollars in millions, except per share amounts)						
Summary of Operations:							
Revenues	$ 30,052	$ 28,374	$ 26,858	$ 25,477	$ 24,455	$ 7,544	$ 7,431
Salaries and benefits	11,958	11,440	10,714	10,409	9,928	3,072	2,923
Supplies	4,868	4,620	4,395	4,322	4,126	1,200	1,210
Other operating expenses	4,724	4,554	4,233	4,056	4,034	1,202	1,102
Provision for doubtful accounts	3,276	3,409	3,130	2,660	2,358	564	807
Equity in earnings of affiliates	(246)	(223)	(206)	(197)	(221)	(68)	(68)
Gains on sales of investments				(243)	(53)		
	1,425	1,416	1,426	1,391	1,374	355	353

Depreciation and amortization							
Interest expense	1,987	2,021	2,215	955	655	516	471
Losses (gains) on sales of facilities	15	(97)	(471)	(205)	(78)		5
Impairments of long-lived assets	43	64	24	24		18	9
Transaction costs				442			
	28,050	27,204	25,460	23,614	22,123	6,859	6,812
Income before income taxes	2,002	1,170	1,398	1,863	2,332	685	619
Provision for income taxes	627	268	316	626	730	209	187
Net income	1,375	902	1,082	1,237	1,602	476	432
Net income attributable to noncontrolling interests	321	229	208	201	178	88	72
Net income attributable to HCA Inc.	$ 1,054	$ 673	$ 874	$ 1,036	$ 1,424	$ 388	$ 360

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	As of and for the Years Ended December 31,					As of and for the Three Months Ended March 31,	
	2009	2008	2007	2006	2005	2010	2009
						(Unaudited)	
	(Dollars in millions, except per share amounts)						
gs per share:							
	$	$	$	(a)	(a)	$	$
d				(a)	(a)		
ted average shares s in thousands):							
				(a)	(a)		
d				(a)	(a)		
cial Position:							
	$ 24,131	$ 24,280	$ 24,025	$ 23,675	$ 22,225	$ 24,091	$ 24,2
ng capital	2,264	2,391	2,356	2,502	1,320	2,167	2,3
term debt, including ts due within one	25,670	26,989	27,308	28,408	10,475	26,855	26,3
securities with gent redemption	147	155	164	125		144	
ntrolling interests	1,008	995	938	907	828	1,015	1,0
holders (deficit)	(7,978)	(9,260)	(9,600)	(10,467)	5,691	(9,298)	(8,8
Flow Data:							
provided by ing activities	$ 2,747	$ 1,990	$ 1,564	$ 1,988	$ 3,162	$ 901	$
sed in investing ies	(1,035)	(1,467)	(479)	(1,307)	(1,681)	(181)	(2
l expenditures	(1,317)	(1,600)	(1,444)	(1,865)	(1,592)	(214)	(3
sed in financing ies	(1,865)	(451)	(1,326)	(383)	(1,403)	(644)	(4
ating Data:							
er of hospitals at period(b)	155	158	161	166	175	154	
er of freestanding ient surgical centers of period(c)	97	97	99	98	87	98	
er of licensed beds of period(d)	38,839	38,504	38,405	39,354	41,265	38,719	38,7
ted average ed beds(e)	38,825	38,422	39,065	40,653	41,902	38,687	38,8
ssions(f)	1,556,500	1,541,800	1,552,700	1,610,100	1,647,800	398,900	396,2
alent admissions(g)	2,439,000	2,363,600	2,352,400	2,416,700	2,476,600	615,500	610,2
	4.8	4.9	4.9	4.9	4.9	4.9	

ge length of stay (h)							
ge daily census(i)	20,650	20,795	21,049	21,688	22,225	21,696	21,
ancy(j)	53%	54%	54%	53%	53%	56%	
gency room visits(k)	5,593,500	5,246,400	5,116,100	5,213,500	5,415,200	1,367,100	1,359,
tient surgeries(l)	794,600	797,400	804,900	820,900	836,600	190,700	194,
ent surgeries(m)	494,500	493,100	516,500	533,100	541,400	122,500	122,
evenues in nts receivable(n)	45	49	53	53	50	46	
patient revenues(o)	$ 115,682	$ 102,843	$ 92,429	$ 84,913	$ 78,662	$ 31,054	$ 28,
tient revenues as a patient revenues(p)	38%	37%	37%	36%	36%	36%	

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

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(b) Excludes eight facilities in 2010, 2009, 2008 and 2007 and seven facilities in 2006 and 2005 that are not consolidated (accounted for using the equity method) for financial reporting purposes.

(c) Excludes eight facilities in 2010, 2009 and 2008, nine facilities in 2007 and 2006 and seven facilities in 2005 that are not consolidated (accounted for using the equity method) for financial reporting purposes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Overview

We are one of the leading health care services companies in the United States. At March 31, 2010, we operated 162 hospitals, comprised of 156 general, acute care hospitals; five psychiatric hospitals; and one rehabilitation hospital. The 162 hospital total includes eight hospitals (seven general, acute care hospitals and one rehabilitation hospital) owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. In addition, we operated 106 freestanding surgery centers, eight of which are owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. Our facilities are located in 20 states and England. For the year ended December 31, 2009, we generated revenues of $30.052 billion and net income attributable to HCA Inc. of $1.054 billion, and for the quarter ended March 31, 2010, we generated revenues of $7.544 billion and net income attributable to HCA Inc. of $388 million.

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

First Quarter 2010 Operations Summary

Net income attributable to HCA Inc. totaled $388 million for the quarter ended March 31, 2010, compared to $360 million for the quarter ended March 31, 2009. Revenues increased to $7.544 billion in the first quarter of 2010 from $7.431 billion in the first quarter of 2009. First quarter 2010 results include impairments of long-lived assets of $18 million. First quarter 2009 results include losses on sales of facilities of $5 million and impairments of long-lived assets of $9 million.

Revenues increased 1.5% on a consolidated basis and on a same facility basis for the quarter ended March 31, 2010 compared to the quarter ended March 31, 2009. The increase in consolidated revenues can be attributed to the combined impact of a 0.6% increase in revenue per equivalent admission and a 0.9% increase in equivalent admissions. The same facility revenues increase resulted from the combined impact of a 0.4% increase in same facility revenue per equivalent admission and a 1.1% increase in same facility equivalent admissions.

During the quarter ended March 31, 2010, consolidated admissions and same facility admissions increased 0.7% and 0.9%, respectively, compared to the quarter ended March 31, 2009. Inpatient surgeries declined 0.1% on a consolidated basis and declined 0.4% on a same facility basis during the quarter ended March 31, 2010, compared to the quarter ended March 31, 2009. Outpatient surgeries declined 1.9% on a consolidated basis and declined 1.8% on a same facility basis during the quarter ended March 31, 2010, compared to the quarter ended March 31, 2009. Emergency department visits increased 0.5% on a consolidated basis and

increased 1.0% on a same facility basis during the quarter ended March 31, 2010, compared to the quarter ended March 31, 2009.

For the quarter ended March 31, 2010, the provision for doubtful accounts declined $243 million to 7.5% of revenues, from 10.9% of revenues for the quarter ended March 31, 2009. The self-pay revenue deductions for charity care and uninsured discounts increased $55 million and $418 million (we increased our uninsured discount percentages during August 2009), respectively, during the first quarter of 2010, compared to the first quarter of 2009. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of revenues, uninsured discounts and charity care, was 23.5% for the first quarter of 2010, compared to 22.4% for the first quarter of 2009. Same facility uninsured admissions increased 6.8% and same facility uninsured emergency room visits decreased 1.6% for the quarter ended March 31, 2010, compared to the quarter ended March 31, 2009.

The increases in the self-pay revenue deductions result in reductions to both the provision for doubtful accounts and revenues, and were the primary contributing factors to the lower growth rates we experienced in revenues and revenue per equivalent admission during the quarter ended March 31, 2010.

Interest expense increased $45 million to $516 million for the quarter ended March 31, 2010, from $471 million for the quarter ended March 31, 2009. The additional interest expense was due primarily to an increase in the average effective interest rate.

Cash flows from operating activities increased $286 million, from $615 million for the first quarter of 2009 to $901 million for the first quarter of 2010. The increase related primarily to income tax payments, as we received a net refund of $71 million in the first quarter of 2010 and made net payments of $146 million in the first quarter of 2009.

2009 Operations Summary

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

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

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

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

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

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Critical Accounting Policies and Estimates

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

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

Revenues

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

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

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

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

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

Provision for Doubtful Accounts and the Allowance for Doubtful Accounts

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

The amount of the provision for doubtful accounts is based upon management s assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal, state, and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical writeoffs and recoveries at facilities that represent a majority of our revenues and accounts receivable (the hindsight analysis) as a primary source of information in estimating the collectibility of our accounts receivable. We perform the hindsight analysis quarterly, utilizing rolling twelve-months accounts receivable collection and writeoff data. We believe our quarterly updates to the estimated allowance for doubtful accounts at each of our hospital facilities provide reasonable valuations of our accounts receivable. These routine, quarterly changes in estimates have not resulted in material adjustments to our allowance for doubtful accounts, provision for doubtful accounts or period-to-period comparisons of our results of operations. At March 31, 2010 and 2009, the allowance for doubtful accounts represented approximately 94% and 93%, respectively, of the $4.833 billion and $5.266 billion, respectively, patient due accounts receivable balance. At December 31, 2009 and 2008, the allowance for doubtful accounts represented approximately 94% and 92%, respectively, of the $5.176 billion and $5.148 billion, respectively, patient due accounts receivable balance. The patient due accounts receivable balance represents the estimated uninsured portion of our accounts receivable. The estimated uninsured portion of Medicaid pending and uninsured discount pending accounts is included in our patient due accounts receivable balance.

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

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ended December 31, 2009, 2008 and 2007 and for the three months ended March 31, 2010 and 2009 follows (dollars in millions):

	Years Ended December 31,			Three Months Ended March 31,	
	2009	2008	2007	2010	2009
Provision for doubtful accounts	$ 3,276	$ 3,409	$ 3,130	$ 564	$ 807
Uninsured discounts	2,935	1,853	1,474	1,035	617
Charity care	2,151	1,747	1,530	546	491
Totals	$ 8,362	$ 7,009	$ 6,134	$ 2,145	$ 1,915

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 46 days and 47 days at March 31, 2010 and 2009, respectively, and 45 days, 49 days and 53 days at December 31, 2009, 2008 and 2007, respectively. Management expects a continuation of the challenges related to the collection of the patient due accounts. Adverse changes in the percentage of our patients having adequate health care coverage, general economic conditions, patient accounting service center operations, payer mix, or trends in federal, state, and private employer health care coverage could affect the collection of accounts receivable, cash flows and results of operations.

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

	% of Accounts Receivable		
	Under 91 Days	91 180 Days	Over 180 Days
Accounts receivable aging at March 31, 2010:			
Medicare and Medicaid	14%	1%	1%
Managed care and other insurers	19	4	4
Uninsured	14	6	37
Total	47%	11%	42%
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 $56 million and $45 million for the three months ended March 31, 2010 and 2009, respectively, and $211 million, $175 million and $163 million for the years ended December 31, 2009, 2008 and 2007, respectively.

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

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

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

Reserves for professional liability risks were $1.335 billion, $1.322 billion and $1.387 billion at March 31, 2010, December 31, 2009 and 2008, respectively. The current portion of these reserves, $277 million, $265 million and

$279 million at March 31, 2010, December 31, 2009 and 2008, respectively, is included in other accrued expenses. Obligations covered by reinsurance contracts are included in the reserves for professional liability risks, as the insurance subsidiary remains liable to the extent reinsurers do not meet their obligations. Reserves for professional liability risks (net of $49 million, $53 million and $57 million receivable

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under reinsurance contracts at March 31, 2010, December 31, 2009 and 2008, respectively) were $1.286 billion, $1.269 billion and $1.330 billion at March 31, 2010, December 31, 2009 and 2008, respectively. The estimated total net reserves for professional liability risks at March 31, 2010, December 31, 2009 and 2008 are comprised of $736 million, $680 million and $724 million, respectively, of case reserves for known claims and $550 million, $589 million and $606 million, respectively, of reserves for incurred but not reported claims.

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

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

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

Income Taxes

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

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

Results of Operations

Revenue/Volume Trends

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

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Revenues increased 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 and for the three months ended March 31, 2010 and 2009 are set forth below.

	Years Ended December 31,			Three Months Ended March 31,	
	2009	2008	2007	2010	2009
Medicare	34%	35%	35%	35%	35%
Managed Medicare	10	9	7	11	10
Medicaid	9	8	8	9	9
Managed Medicaid	7	7	7	7	7
Managed care and other insurers	34	35	37	32	33
Uninsured	6	6	6	6	6
	100%	100%	100%	100%	100%

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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 and for the three months ended March 31, 2010 and 2009 are set forth below.

	Years Ended December 31,			Three Months Ended March 31,	
	2009	2008	2007	2010	2009
Medicare	31%	31%	32%	32%	33%
Managed Medicare	8	8	7	9	8
Medicaid	8	7	7	9	7
Managed Medicaid	4	4	4	4	4
Managed care and other insurers	44	44	44	44	44
Uninsured	5	6	6	2	4
	100%	100%	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 $169 million and $63 million for the three months ended March 31, 2010 and 2009, respectively, and $474 million, $262 million and $232 million for the years ended December 31, 2009, 2008 and 2007, respectively, of Medicaid supplemental payments pursuant to UPL programs.

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Operating Results Summary

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

	Years Ended December 31						Three Months Ended March 31			
	2009		2008		2007		2010		2009	
	Amount	Ratio	Amount	Ratio	Amount	Ratio	Amount	Ratio	Amount	R
							(Unaudited)			
es	$ 30,052	100.0	$ 28,374	100.0	$ 26,858	100.0	$ 7,544	100.0	$ 7,431	
and benefits	11,958	39.8	11,440	40.3	10,714	39.9	3,072	40.7	2,923	
s	4,868	16.2	4,620	16.3	4,395	16.4	1,200	15.9	1,210	
perating expenses	4,724	15.7	4,554	16.1	4,233	15.7	1,202	15.9	1,102	
on for doubtful s	3,276	10.9	3,409	12.0	3,130	11.7	564	7.5	807	
n earnings of s	(246)	(0.8)	(223)	(0.8)	(206)	(0.8)	(68)	(0.9)	(68)	
ation and ation	1,425	4.8	1,416	5.0	1,426	5.4	355	4.8	353	
expense	1,987	6.6	2,021	7.1	2,215	8.2	516	6.8	471	
(gains) on sales of s	15		(97)	(0.3)	(471)	(1.8)			5	
nents of long-lived	43	0.1	64	0.2	24	0.1	18	0.2	9	
	28,050	93.3	27,204	95.9	25,460	94.8	6,859	90.9	6,812	
before income	2,002	6.7	1,170	4.1	1,398	5.2	685	9.1	619	
on for income	627	2.1	268	0.9	316	1.1	209	2.8	187	
ome	1,375	4.6	902	3.2	1,082	4.1	476	6.3	432	
ome attributable to trolling interests	321	1.1	229	0.8	208	0.8	88	1.1	72	
ome attributable to c.	$ 1,054	3.5	$ 673	2.4	$ 874	3.3	$ 388	5.2	$ 360	
ges from prior										
es	5.9%		5.6%		5.4%		1.5%		4.3%	
before income	71.1		(16.3)		(25.0)		10.6		80.1	
ome attributable to c.	56.7		(23.0)		(15.7)		8.1		111.6	

ions(a)	1.0	(0.7)	(3.6)	0.7	(1.4)
ent admissions(b)	3.2	0.5	(2.7)	0.9	1.5
e per equivalent on	2.6	5.2	8.3	0.6	2.8
acility % changes ior year(c):					
es	6.1	7.0	7.4	1.5	4.6
ions(a)	1.2	0.9	(1.3)	0.9	(0.9)
ent admissions(b)	3.4	1.9	(0.7)	1.1	1.9
e per equivalent on	2.6	5.1	8.1	0.4	2.7

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

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

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

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

The results from operations presented on a cash revenues basis for the quarters ended March 31, 2010 and 2009 follow:

	2010			2009		
	Amount	Non-GAAP % of Cash Revenues Ratios(b)	GAAP % of Revenues Ratios(b)	Amount	Non-GAAP % of Cash Revenues Ratios(b)	GAAP % of Revenues Ratios(b)
Revenues	$ 7,544		100.0	$ 7,431		100.0
Provision for doubtful accounts	564			807		
Cash revenues(a)	6,980	100.0		6,624	100.0	
Salaries and benefits	3,072	44.0	40.7	2,923	44.1	39.3
Supplies	1,200	17.2	15.9	1,210	18.3	16.3
Other operating expenses	1,202	17.3	15.9	1,102	16.6	14.8
% changes from prior year:						
Revenues	1.5%					
Cash revenues	5.4					
Revenue per equivalent admission	0.6					
Cash revenue per equivalent admission	4.5					

(a) Cash revenues is defined as reported revenues less the provision for doubtful accounts. We use cash revenues as an analytical indicator for purposes of assessing the effect of uninsured patient volumes, adjusted for the effect of both the revenue deductions related to uninsured accounts (charity care and uninsured discounts) and the provision for doubtful accounts (which relates primarily to uninsured accounts), on our revenues and certain operating expenses, as a percentage of cash revenues. Variations in the revenue deductions related to uninsured accounts generally have the inverse effect on the provision for doubtful accounts. We increased our uninsured discount percentages during August 2009 and the resulting effects, for the first quarter of 2010, were an increase in uninsured discounts of $418 million and a decline in the provision for doubtful accounts of $243 million, compared to the first quarter of 2009. Cash revenues is commonly used as an analytical indicator within the health care industry. Cash revenues should not be considered as a measure of financial performance under generally accepted accounting principles. Because cash revenues is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, cash revenues, as presented, may not be comparable to other similarly titled measures of other health care companies.

(b) Salaries and benefits, supplies and other operating expenses, as a percentage of cash revenues (a non-GAAP financial measure), present the impact on these ratios due to the adjustment of deducting the provision for doubtful accounts from reported revenues and results in these ratios being non-GAAP financial measures. We

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

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Three Months Ended March 31, 2010 and 2009

Net income attributable to HCA Inc. totaled $388 million for the first quarter of 2010 compared to $360 million for the first quarter of 2009. Revenues increased 1.5% due to the combined impact of revenue per equivalent admission growth of 0.6% and an increase of 0.9% in equivalent admissions for the first quarter of 2010 compared to the first quarter of 2009. Cash revenues (reported revenues less the provision for doubtful accounts) increased 5.4% for the first quarter of 2010 compared to the first quarter of 2009.

For the first quarter of 2010, consolidated admissions and same facility admissions increased 0.7% and 0.9%, respectively, compared to the first quarter of 2009. Outpatient surgical volumes declined 1.9% on a consolidated basis and declined 1.8% on a same facility basis during the first quarter of 2010, compared to the first quarter of 2009. Consolidated inpatient surgeries declined 0.1% and same facility inpatient surgeries declined 0.4% in the first quarter of 2010, compared to the first quarter of 2009. Emergency department visits increased 0.5% on a consolidated basis and increased 1.0% on a same facility basis during the quarter ended March 31, 2010, compared to the quarter ended March 31, 2009.

Salaries and benefits, as a percentage of revenues, were 40.7% in the first quarter of 2010 and 39.3% in the first quarter of 2009. Salaries and benefits, as a percentage of cash revenues, were 44.0% in the first quarter of 2010 and 44.1% in the first quarter of 2009. Salaries and benefits per equivalent admission increased 4.2% in the first quarter of 2010 compared to the first quarter of 2009. Same facility labor rate increases averaged 2.7% for the first quarter of 2010 compared to the first quarter of 2009.

Supplies, as a percentage of revenues, were 15.9% in the first quarter of 2010 and 16.3% in the first quarter of 2009. Supplies, as a percentage of cash revenues, were 17.2% in the first quarter of 2010 and 18.3% in the first quarter of 2009. Supply cost per equivalent admission declined 1.7% in the first quarter of 2010 compared to the first quarter of 2009. Supply costs per equivalent admission increased 3.0% for medical devices, 4.3% for blood products and 4.8% for general medical and surgical items and declined 7.2% for pharmacy supplies in the first quarter of 2010 compared to the first quarter of 2009.

Other operating expenses, as a percentage of revenues, increased to 15.9% in the first quarter of 2010 compared to 14.8% in the first quarter of 2009. Other operating expenses, as a percentage of cash revenues, increased to 17.3% in the first quarter of 2010 compared to 16.6% in the first quarter of 2009. Other operating expenses is primarily comprised of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and nonincome taxes. Other operating expenses include $90 million and $39 million of indigent care costs in certain Texas markets during the first quarters of 2010 and 2009, respectively, and this increase is the primary component of the overall increase in other operating expenses. Provisions for losses related to professional liability risks were $56 million and $45 million for the first quarters of 2010 and 2009, respectively.

Provision for doubtful accounts declined $243 million, from $807 million in the first quarter of 2009 to $564 million in the first quarter of 2010, and as a percentage of revenues, declined to 7.5% in the first quarter of 2010 compared to 10.9% in the first quarter of 2009. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts due directly from patients. The combined self-pay revenue deductions for charity care and uninsured discounts increased $473 million during the first quarter of 2010, compared to the first quarter of 2009. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of revenues, uninsured discounts and charity care, was 23.5% for the first quarter of 2010, compared to 22.4% for the first quarter of 2009. To quantify the total impact of and trends related to uninsured accounts, we believe it is beneficial to review the related revenue deductions and the provision for doubtful accounts in combination, rather than separately. At March 31, 2010, our allowance for doubtful accounts represented approximately 94% of the

$4.833 billion total patient due accounts receivable balance. The patient due accounts receivable balance represents the estimated uninsured portion of our accounts receivable.

Equity in earnings of affiliates was $68 million in each of the first quarters of 2010 and 2009. Equity in earnings of affiliates relates primarily to our Denver, Colorado market joint venture.

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Depreciation and amortization increased $2 million, from $353 million in the first quarter of 2009 to $355 million in the first quarter of 2010.

Interest expense increased from $471 million in the first quarter of 2009 to $516 million in the first quarter of 2010 primarily due to an increase in the average effective interest rate. Our average debt balance was $26.314 billion for the first quarter of 2010 compared to $26.794 billion for the first quarter of 2009. The average effective interest rate for our long term debt increased from 7.1% for the quarter ended March 31, 2009 to 8.0% for the quarter ended March 31, 2010.

During the first quarter of 2010, no gains or losses on sales of facilities were recognized. During the first quarter of 2009, we recorded a net loss on sales of facilities and other investments of $5 million.

During the first quarter of 2010, we recorded asset impairment charges of $18 million to adjust the values of real estate and other investments to estimated fair value. During the first quarter of 2009, we recorded an asset impairment charge of $9 million to adjust the value of certain real estate investments to estimated fair value.

The effective tax rate was 35.0% and 34.1% for the first quarters of 2010 and 2009, respectively. The effective tax rate computations exclude net income attributable to noncontrolling interests as it relates to consolidated partnerships.

Net income attributable to noncontrolling interests increased from $72 million for the first quarter of 2009 to $88 million for the first quarter of 2010. The increase in net income attributable to noncontrolling interests related primarily to growth in operating results of hospital joint ventures in two Texas markets.

Years Ended December 31, 2009 and 2008

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

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

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

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

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

2008.

Other operating expenses, as a percentage of revenues, declined to 15.7% in 2009 from 16.1% in 2008. Other operating expenses are primarily comprised of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and nonincome taxes. The overall decline in other operating expenses, as a percentage of revenues, is comprised of relatively small

reductions in several areas, including utilities, employee recruitment and travel and entertainment. Other operating expenses include $248 million and $144 million of indigent care costs in certain Texas markets during 2009 and 2008, respectively. Provisions for losses related to professional liability risks were $211 million and $175 million for 2009 and 2008, respectively.

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

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

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

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

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

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

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

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

Years Ended December 31, 2008 and 2007

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

Revenues increased 5.6% to $28.374 billion for 2008 from $26.858 billion for 2007. The increase in revenues was due primarily to the combined impact of a 5.2% increase in revenue per equivalent admission

and a 0.5% increase in equivalent admissions compared to 2007. Same facility revenues increased 7.0% due primarily to the combined impact of a 5.1% increase in same facility revenue per equivalent admission and a 1.9% increase in same facility equivalent admissions compared to 2007.

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

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

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

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

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

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

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

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

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

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

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

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

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

Liquidity and Capital Resources

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

Cash provided by operating activities totaled $901 million for the quarter ended March 31, 2010 compared to $615 million for the quarter ended March 31, 2009. The $286 million increase in cash provided by operating activities in the first quarter of 2010 compared to the first quarter of 2009 related primarily to a $239 million decrease in income taxes and a $44 million increase in net income. Working capital totaled $2.167 billion at March 31, 2010. Cash provided by operating activities totaled $2.747 billion in 2009 compared to $1.990 billion in 2008 and $1.564 billion in 2007. Working capital totaled $2.264 billion at December 31, 2009 and $2.391 billion at December 31, 2008. The $757 million increase in cash provided by operating activities for 2009, compared to 2008, related primarily to the $473 million increase in net income and $143 million improvement from changes in operating assets and liabilities and the provision for doubtful accounts. The $426 million increase in cash provided by operating activities for 2008, compared to 2007, relates primarily to changes in working capital items. The changes in accounts receivable (net of the provision for doubtful accounts), inventories and other assets, and accounts payable and accrued expenses contributed $42 million to cash provided by operating activities for 2008 while changes in these items decreased cash provided by operating activities by $485 million for 2007. The net impact of the cash payments for interest and income taxes was an increase in cash payments of $203 million for 2009 compared to 2008 and an increase of $111 million for 2008 compared to 2007.

Cash used in investing activities was $181 million for the quarter ended March 31, 2010 compared to $288 million for the quarter ended March 31, 2009. Excluding acquisitions, capital expenditures were $214 million in the first quarter of 2010 and $337 million in the first quarter of 2009. 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 w