HCA INC/TN
Form 10-K
March 04, 2009

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

Form 10-K

(Mark One)

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2008

OR

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from_____to_____

Commission File Number 1-11239

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

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

Registrant s telephone number, Including Area Code: **(615) 344-9551**

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

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

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

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

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

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

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. (Check one):

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

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

As of February 25, 2009, there were approximately 94,371,400 shares of Registrant s common stock outstanding. There is not a market for the Registrant s common stock; therefore, the aggregate market value of the Registrant s common stock held by non-affiliates is not calculable.

DOCUMENTS INCORPORATED BY REFERENCE

None.

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PART I

Item 1. *Business*

General

HCA Inc. is one of the leading health care services companies in the United States. At December 31, 2008, we operated 166 hospitals, comprised of 160 general, acute care hospitals; five psychiatric hospitals; and one rehabilitation hospital. The 166 hospital total includes eight hospitals (seven general, acute care hospitals and one rehabilitation hospital) owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. In addition, we operated 105 freestanding surgery centers, eight of which are owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. Our facilities are located in 20 states and England. The terms Company, HCA, we, our or us, as u herein, refer to HCA Inc. and its affiliates unless otherwise stated or indicated by context. The term affiliates means direct and indirect subsidiaries of HCA Inc. and partnerships and joint ventures in which such subsidiaries are partners. The terms facilities or hospitals refer to entities owned and operated by affiliates of HCA and the term employees refers to employees of affiliates of HCA.

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

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

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

Available Information

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

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information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

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

Business Strategy

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

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

maintain our commitment to ethics and compliance;

leverage our leading local market positions;

expand our presence in key markets;

continue to leverage our scale;

continue to develop enduring physician relationships; and

become the health care employer of choice.

Health Care Facilities

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

At December 31, 2008, we owned and operated 153 general, acute care hospitals with 38,014 licensed beds, and an additional seven general, acute care hospitals with 2,267 licensed beds are operated through joint ventures, which are accounted for using the equity method. Most of our general, acute care hospitals provide medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic services and emergency services. The general, acute care hospitals also provide outpatient services such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology and physical therapy. Each hospital has an organized medical staff and a local board of trustees or governing board, made up of members of the local community.

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

At December 31, 2008, we operated five psychiatric hospitals with 490 licensed beds. Our psychiatric hospitals provide therapeutic programs including child, adolescent and adult psychiatric care, adult and adolescent alcohol and drug abuse treatment and counseling.

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

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

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Sources of Revenue

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

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

	Year Ended December 31,		
	2008	**2007**	**2006**
Medicare	23%	24%	25%
Managed Medicare	6	5	5
Medicaid	5	5	5
Managed Medicaid	3	3	3
Managed care and other insurers	53	54	54
Uninsured	10	9	8
Total	100%	100%	100%

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

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

Medicare

Inpatient Acute Care

Under the Medicare program, we receive reimbursement under a prospective payment system (PPS) for general, acute care hospital inpatient services. Under the hospital inpatient PPS, fixed payment amounts per inpatient discharge are established based on the patient s assigned Medicare severity-diagnosis related group (MS-DRG). Effective October 1, 2007, the Centers for Medicare and Medicaid Services (CMS) began a two-year transition to full implementation of MS-DRGs to replace the previously used Medicare diagnosis related groups (DRGs) in an effort to better recognize severity of illness in Medicare payment rates. This change represents a refinement to the existing DRG system. MS-DRGs classify treatments for illnesses according to the estimated

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

MS-DRG rates are updated and MS-DRG weights are recalibrated each federal fiscal year (which begins October 1). The index used to update the MS-DRG rates (the market basket) gives consideration to the inflation experienced by hospitals and entities outside the health care industry in purchasing goods and services. In federal fiscal year 2008, the MS-DRG rate was increased by the full market basket of 3.3%. For the federal fiscal year 2009, CMS set the MS-DRG rate increase at full market basket of 3.6%.

In August 2006, CMS changed the methodology used to recalibrate the DRG weights from charge-based weights to cost relative weights under a three-year transition period beginning in federal fiscal year 2007. The adoption of the cost relative weights is not anticipated to have a material financial impact on us. Beginning October 1, 2008, MS-DRG weights are calculated using 100% cost relative weights.

Effective October 1, 2007, CMS imposed a documentation and coding adjustment to account for changes in payments under the new MS-DRG system that are not related to changes in case mix. Through legislative refinement, the documentation and coding adjustments for federal fiscal years 2008 and 2009 are reductions to the base payment rate of 0.6% and 0.9%, respectively, for a cumulative reduction of 1.5%. However, Congress has given CMS the ability to determine retrospectively whether the documentation and coding adjustment levels for federal fiscal years 2008 and 2009 were adequate to account for changes in payments not related to changes in case mix. If the levels are found to have been inadequate, CMS can impose an adjustment to payments for federal fiscal years 2010, 2011 and 2012.

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

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provided for DRG rate increases for certain federal fiscal years at full market basket if data for 10 patient care quality indicators were submitted to the Secretary of the Department of Health and Human Services (HHS). The Deficit Reduction Act of 2005 (DRA 2005) expanded and provided for the future expansion of the number of quality measures that must be reported to receive a full market basket update. CMS has published final rules that expand to 44 the number of quality measures that hospitals are required to report, beginning with discharges occurring in calendar year 2009, in order to qualify for the full market basket update to the inpatient prospective payment system in federal fiscal year 2010. Failure to submit the required quality indicators will result in a two percentage point reduction to the market basket update. All of our hospitals paid under Medicare inpatient MS-DRG PPS are participating in the quality initiative by the Secretary of HHS by submitting the requested quality data. While we will endeavor to comply with all data submission requirements as additional requirements continue to be added, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals.

As part of CMS s goal of transforming Medicare from a passive payer to an active purchaser of quality goods and services, beginning October 1, 2007, CMS requires hospitals to submit information on general acute care inpatient Medicare claims specifying whether diagnoses were present on admission (POA). For discharges occurring after October 1, 2008, Medicare no longer assigns an inpatient hospital discharge to a higher paying MS-DRG if a selected hospital-acquired condition (HAC) was not POA. In this situation, the case would be paid as though the secondary

diagnosis was not present. Currently, there are ten categories of conditions on the list of HACs. On January 15, 2009, CMS announced three National Coverage Determinations (NCDs) that prohibit Medicare reimbursement for erroneous surgical procedures performed on an inpatient or outpatient basis. These three erroneous surgical procedures are in addition to the HACs designated in CMS regulations. These changes are not expected to have a material effect on our revenues or cash flows.

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Historically, the Medicare program has set aside 5.10% of Medicare inpatient payments to pay for outlier cases. CMS estimates that outlier payments accounted for 4.64% and 4.65% of total operating DRG payments for federal fiscal years 2007 and 2006, respectively. For federal fiscal year 2008, CMS established an outlier threshold of $22,185, which resulted in outlier payments estimated by CMS to be 4.70% of total operating DRG payments. For federal fiscal year 2009, CMS has established an outlier threshold of $20,045. We do not anticipate that the change to the outlier threshold for federal fiscal year 2009 will have a material impact on our revenues.

Outpatient

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

Hospital outpatient services paid under PPS are classified into groups called ambulatory payment classifications (APCs). Services for each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit. The APC payment rates were updated for calendar years 2008 and 2007 by market baskets of 3.30% and 3.40%, respectively. On November 18, 2008 CMS published a final rule that updated payment rates for calendar year 2009 by the full market basket of 3.60%. CMS continues to require that hospitals submit quality data relating to outpatient care to receive the full market basket increase under the outpatient PPS in calendar year 2010. CMS requires that data on eleven quality measures be submitted in calendar year 2009 for the payment determination in calendar year 2010. Hospitals that fail to submit such data will receive the market basket update minus two percentage points for the outpatient PPS.

Rehabilitation

CMS reimburses inpatient rehabilitation facilities (IRFs) on a PPS basis. Under IRF PPS, patients are classified into case mix groups based upon impairment, age, comorbidities (additional diseases or disorders from which the patient suffers) and functional capability. IRFs are paid a predetermined amount per discharge that reflects the patient s case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. For federal fiscal years 2008 and 2007, CMS updated the PPS rate for rehabilitation hospitals and units by market baskets of 3.2% and 3.3%, respectively. However, CMS also applied a reduction to the standard payment amount of 2.6% for federal fiscal year 2007 to account for coding changes that do not reflect real changes in case mix. The Medicare, Medicaid and State Children s Health Insurance Program (SCHIP) Reauthorization Act of 2007 eliminated the market basket update as of April 1, 2008 and continues the zero update through federal fiscal year 2009. As of December 31, 2008, we had one rehabilitation hospital, which is operated through a joint venture, and 47 hospital rehabilitation units.

On May 7, 2004, CMS published a final rule to change the criteria for being classified as an IRF, commonly known as the 75% rule. If a facility fails to meet the 75% rule or other criteria to be classified as an IRF, it may be paid under the acute care hospital inpatient or outpatient PPS, which generally provide for lower payment amounts. Pursuant to the final 75% rule, a specified percentage of a facility s inpatients over a given year must be treated for at least one of 13 conditions. The final rule provided for a transition period during which the percentage threshold would increase, starting at a 50% compliance threshold and culminating at a 75% threshold, for cost reporting periods beginning on or after July 1, 2007. Since then, several adjustments have been made to the transition period. The passage of the Medicare, Medicaid and SCHIP Reauthorization Act of 2007 set the compliance threshold at 60% for cost reporting periods beginning on or after July 1, 2006. Implementation of the 75% rule has reduced our IRF admissions and can be expected to continue to restrict the treatment of patients whose medical conditions do not meet any of the 13

approved conditions.

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Psychiatric

Inpatient hospital services furnished in psychiatric hospitals and psychiatric units of general, acute care hospitals and critical access hospitals are reimbursed under a prospective payment system (IPF PPS), a per diem payment, with adjustments to account for certain patient and facility characteristics. IPF PPS contains an outlier policy for extraordinarily costly cases and an adjustment to a facility s base payment if it maintains a full-service emergency department. CMS has established the IPF PPS payment rate in a manner intended to be budget neutral and has adopted a July 1 update cycle. The rehabilitation, psychiatric and long-term care (RPL) market basket update is used to update the IPF PPS. The annual RPL market basket update for rate year 2009 is 3.2%. As of December 31, 2008, we had five psychiatric hospitals and 31 hospital psychiatric units.

Ambulatory Surgery Centers

CMS reimburses ambulatory surgery centers (ASCs) using a predetermined fee schedule. Effective January 1, 2007, as a result of DRA 2005, reimbursements for ASC overhead costs were limited to no more than the overhead costs paid to hospital outpatient departments under the Medicare hospital outpatient PPS for the same procedure. On August 2, 2007, CMS issued final regulations that changed payments for procedures performed in an ASC. Effective January 1, 2008, ASC payment groups increased from nine clinically disparate payment groups to an extensive list of covered surgical procedures among the APCs used under the outpatient PPS for these surgical services. CMS estimates that the rates for procedures performed in an ASC setting equal 65% of the corresponding rates paid for the same procedures performed in an outpatient hospital setting. Moreover, if CMS determines that a procedure is commonly performed in a physician s office, the ASC reimbursement for that procedure is limited to the reimbursement allowable under the Medicare Part B Physician Fee Schedule, with limited exceptions. In addition, all surgical procedures, other than those that pose a significant safety risk or generally require an overnight stay, are payable as ASC procedures. This rule expands the number of procedures that Medicare will pay for if performed in an ASC. Because the new payment system has a significant impact on payments for certain procedures, the final rule establishes a four-year transition period for implementing the required payment rates. This change may result in more Medicare procedures that are now performed in hospitals being moved to ASCs, reducing surgical volume in our hospitals. Also, more Medicare procedures that are now performed in ASCs may be moved to physicians offices. Commercial third-party payers may adopt similar policies.

Other

Under PPS, the payment rates are adjusted for the area differences in wage levels by a factor (wage index) reflecting the relative wage level in the geographic area compared to the national average wage level. Beginning in federal fiscal year 2007, CMS adjusted 100% of the wage index factor for occupational mix. The redistributive impact of wage index changes, while slightly negative in the aggregate, is not anticipated to have a material financial impact for 2009.

The Medicare program reimburses 70% of bad debts related to deductibles and coinsurance for patients with Medicare coverage, after the provider has made a reasonable effort to collect these amounts. On March 30, 2006, the United States District Court for the Western District of Michigan entered a final order in *Battle Creek Health System v. Thompson,* which provided that reasonable collection efforts have not been satisfied as long as the Medicare accounts remained with an external collection agency. On appeal, the United States Court of Appeals for the Sixth Circuit upheld the lower court s decision. We incur substantial amounts of Medicare bad debts every year that could be subject to the *Battle Creek* decision. We utilize extensive in-house and external collection efforts for our accounts receivable, including deductible and coinsurance amounts owed by patients with Medicare coverage. We utilize a secondary collection agency after in-house and primary collection agency efforts have been unsuccessful. During 2007, we modified our accounts receivable collection processes to provide us with reasonable collection results and comply with CMS s interpretation of reasonable collection efforts. Possible future changes in judicial and administrative

interpretations of law and regulations governing Medicare could disrupt our collections processes, increase our costs or otherwise adversely affect our business and results of operations.

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As required by the MMA, CMS is implementing contractor reform whereby CMS has competitively bid the Medicare fiscal intermediary and Medicare carrier functions to 15 Medicare Administrative Contractors (MACs). Hospital companies have the option to work with the selected MAC in the jurisdiction where a given hospital is located or, in the case of chain providers, to use the MAC in the jurisdiction where the hospital company s home office is located. For chain providers, either all hospitals in the chain must choose to stay with the MAC chosen for their locality or all hospitals must opt to use the home office MAC. HCA has chosen to use the MACs assigned to the localities in which our hospitals are located. Recently, CMS has completed the process of awarding contracts on all 15 MAC jurisdictions. Individual MAC jurisdictions are in varying phases of transition. For the transition periods and for a potentially unforeseen period thereafter, all of these changes could impact claims processing functions and the resulting cash flow; however, we are unable to predict the impact at this time.

The MMA established the Recovery Audit Contractor (RAC) three-year demonstration program to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. Beginning in 2005, CMS contracted with three different RACs to conduct these reviews in California, Florida and New York. The program was expanded in August 2007 to include Arizona, Massachusetts and South Carolina. Each RAC had discretion over the types of reviews and record requests it would conduct within the states for which it was responsible as long as it followed the CMS-defined Statement of Work. HCA had 46 hospitals located in the demonstration areas, and 44 of these hospitals had a review performed. The Tax Relief and Health Care Act of 2006 made the RAC program permanent and mandated its nationwide expansion by 2010. CMS has awarded contracts to four RACs that will implement the permanent RAC program on a nationwide basis. The final impact of the demonstration program and the permanent, nationwide program cannot be quantified at this time.

Managed Medicare

Managed Medicare plans relate to situations where a private company contracts with CMS to provide members with Medicare Part A, Part B and Part D benefits. Managed Medicare plans can be structured as HMOs, PPOs, or private fee-for-service plans. The Medicare program allows beneficiaries to choose enrollment in certain managed Medicare plans. In 2003 changes to federal law increased reimbursement to managed Medicare plans and limited, to some extent, the financial risk to the companies offering the plans. Following these changes, the number of beneficiaries choosing to receive their Medicare benefits through such plans has increased. However, the Medicare Improvements for Patients and Providers Act of 2008 reduced payments to managed Medicare plans, and CMS has recently proposed additional cuts in payments to managed Medicare plans. Future changes may result in reduced premium payments to managed Medicare plans and may lead to decreased enrollment in such plans.

Medicaid

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

Since many states must operate with balanced budgets and since the Medicaid program is often the state s largest program, states can be expected to adopt or consider adopting legislation designed to reduce their Medicaid expenditures. DRA 2005 includes Medicaid cuts of approximately $4.8 billion over five years. A congressional committee has estimated that additional proposed legislative and regulatory changes, if implemented, would reduce federal Medicaid funding by an additional $49.7 billion over five years. The implementation of many of these

proposed changes is subject to a statutorily mandated moratorium scheduled to expire in July 2009. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems. Future legislation or other changes in the administration or interpretation of government health programs could have a material, adverse effect on our financial position and results of operations.

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Managed Medicaid

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

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

TRICARE

In December 2008, the Department of Defense implemented a prospective payment system for hospital outpatient services furnished to TRICARE beneficiaries similar to that utilized for services furnished to Medicare beneficiaries. Because the Medicare outpatient prospective payment system APC rates have historically been below TRICARE rates, the adoption of this payment methodology for TRICARE beneficiaries will reduce our reimbursement. This change in TRICARE will have a material impact on our revenues from this program; however, TRICARE outpatient services do not represent a significant portion of our patient volumes. The TRICARE outpatient payment rule has been reopened for comment and the effective date delayed until May 1, 2009. Further modification to the new outpatient system may be made.

Annual Cost Reports

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

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

Managed Care and Other Discounted Plans

Most of our hospitals offer discounts from established charges to certain large group purchasers of health care services, including managed care plans and private insurance companies. Admissions reimbursed by commercial managed care and other insurers were 35%, 37% and 36% of our total admissions for the years ended December 31, 2008, 2007 and 2006, respectively. Managed care contracts are typically negotiated for terms between one and three years. While we generally received annual average yield increases of 6% to 7% from managed care payers during 2008, there can be no assurance that we will continue to receive increases in the future.

Hospital Utilization

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

Other factors that impact utilization include the growth in local population, local economic conditions and market penetration of managed care programs.

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

	Years Ended December 31,				
	2008	**2007**	**2006**	**2005**	**2004**
Number of hospitals at end of period (a)	158	161	166	175	182
Number of freestanding outpatient surgery centers at end of period (b)	97	99	98	87	84
Number of licensed beds at end of period (c)	38,504	38,405	39,354	41,265	41,852
Weighted average licensed beds (d)	38,422	39,065	40,653	41,902	41,997
Admissions (e)	1,541,800	1,552,700	1,610,100	1,647,800	1,659,200
Equivalent admissions (f)	2,363,600	2,352,400	2,416,700	2,476,600	2,454,000
Average length of stay (days) (g)	4.9	4.9	4.9	4.9	5.0
Average daily census (h)	20,795	21,049	21,688	22,225	22,493
Occupancy rate (i)	54%	54%	53%	53%	54%
Emergency room visits (j)	5,246,400	5,116,100	5,213,500	5,415,200	5,219,500
Outpatient surgeries (k)	797,400	804,900	820,900	836,600	834,800
Inpatient surgeries (l)	493,100	516,500	533,100	541,400	541,000

(a) Excludes eight facilities in 2008 and 2007 and seven facilities in 2006, 2005 and 2004 that are not consolidated (accounted for using the equity method) for financial reporting purposes.

(b) Excludes eight facilities in 2008, nine facilities in 2007 and 2006, seven facilities in 2005 and eight facilities in 2004 that are not consolidated (accounted for using the equity method) for financial reporting purposes.

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

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

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

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

outpatient volume.

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

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

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

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

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

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

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Competition

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

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

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

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

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

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

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

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

Regulation and Other Factors

Licensure, Certification and Accreditation

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

Certificates of Need

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

State Rate Review

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

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards, are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of

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Medicare and Medicaid patients must be reviewed by quality improvement organizations to assess the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of DRG classifications and the appropriateness of cases of extraordinary length of stay or cost. Quality improvement organizations may deny payment for services provided, may assess fines and also have the authority to recommend to HHS that a provider, which is in substantial noncompliance with the appropriate standards, be excluded from participating in the Medicare program. Most nongovernmental managed care organizations also require utilization review.

Federal Health Care Program Regulations

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

Anti-kickback Statute

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

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

The OIG also issues Special Advisory Bulletins as a means of providing guidance to health care providers. These bulletins, along with the Special Fraud Alerts, have focused on certain arrangements that could be subject to heightened scrutiny by government enforcement authorities, including: (a) contractual joint venture arrangements and

other joint venture arrangements between those in a position to refer business, such as physicians, and those providing items or services for which Medicare or Medicaid pays, and (b) certain gainsharing arrangements, i.e., the practice of giving physicians a share of any reduction in a hospital s costs for patient care attributable in part to the physician s efforts.

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In addition to issuing Special Fraud Alerts and Special Advisory Bulletins, the OIG issues compliance program guidance for certain types of health care providers. In January 2005, the OIG published Supplemental Compliance Guidance for Hospitals, supplementing its 1998 guidance for the hospital industry. In the supplemental guidance, the OIG identifies a number of risk areas under federal fraud and abuse statutes and regulations. These areas of risk include compensation arrangements with physicians, recruitment arrangements with physicians and joint venture relationships with physicians.

As authorized by Congress, the OIG has published safe harbor regulations that outline categories of activities that are deemed protected from prosecution under the Anti-kickback Statute. Currently, there are statutory exceptions and safe harbors for various activities, including the following: investment interests, space rental, equipment rental, practitioner recruitment, personnel services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, freestanding surgery centers, ambulance replenishing, and referral agreements for specialty services. The fact that conduct or a business arrangement does not fall within a safe harbor, or that it is identified in a fraud alert or advisory bulletin or as a risk area in the Supplemental Compliance Guidelines for Hospitals, does not automatically render the conduct or business arrangement illegal under the Anti-kickback Statute. However, such conduct and business arrangements may lead to increased scrutiny by government enforcement authorities.

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

Although the Company believes that its arrangements with physicians and other referral sources have been structured to comply with current law and available interpretations, there can be no assurance that regulatory authorities enforcing these laws will determine these financial arrangements do not violate the Anti-kickback Statute or other applicable laws. An adverse determination could subject the Company to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal health care programs.

Stark Law

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

of a Stark Law exception or the arrangement is in violation of the Stark Law.

CMS has issued three phases of final regulations implementing the Stark Law, as well as final regulations in the 2009 Inpatient Prospective Payment System (IPPS) final rule. Phases I, II and III became effective in January

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2002, July 2004 and December 2007, respectively. Some portions of the 2009 IPPS Stark regulations became effective October 1, 2008, and other portions become effective October 1, 2009. While these regulations help clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. The recent changes to the regulations implementing the Stark Law further restrict the types of arrangements that facilities and physicians may enter, including additional restrictions on certain leases, percentage compensation arrangements, and agreements under which a hospital purchases services under arrangements. We may be required to restructure or unwind some of our arrangements because of these changes. Because many of these laws and their implementing regulations are relatively new, we do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot assure that every relationship complies fully with the Stark Law.

In 2003, Congress passed legislation that modified the hospital ownership exception to the Stark Law by creating an 18-month moratorium on allowing physicians to own interests in new specialty hospitals. The moratorium was extended by regulatory and legislative action and expired on August 8, 2006. At the conclusion of the moratorium, HHS announced that it will require hospitals to disclose certain financial arrangements with physicians. On September 14, 2007, CMS published an information collection request called the Disclosure of Financial Relationships Report (DFRR). HHS will initially select 400 hospitals that will be required to report the financial arrangements with physicians as required in the DFRR. Those hospitals are comprised of 290 hospitals that failed to respond to a previous voluntary CMS questionnaire about investments and compensation relationships and 110 additional hospitals. The DFRR and its supporting documentation are currently under review by the Office of Management and Budget and have not yet been released. CMS has indicated that responding hospitals will have a limited amount of time to compile a significant amount of information relating to their financial relationships with physicians. A hospital may be subject to substantial penalties if it is unable to assemble and report this information within the required time frame or if any applicable government agency determines that the submission is inaccurate or incomplete. Depending on the final format of the DFRR, responding hospitals may be subject to substantial penalties as a result of enforcement actions brought by government agencies and whistleblowers acting pursuant to the FCA and similar state laws, based on such allegations as failure to respond within required deadlines, that the response is inaccurate or contains incomplete information, or that the response indicates a potential violation of the Stark Law or other requirements.

Similar State Laws

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

Other Fraud and Abuse Provisions

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) broadened the scope of certain fraud and abuse laws by adding several criminal provisions for health care fraud offenses that apply to all health benefit programs. The Social Security Act also imposes criminal and civil penalties for making false claims and statements to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered or for misrepresenting actual services rendered in order to obtain higher reimbursement, billing for unnecessary goods and services, and cost report fraud. Federal enforcement officials have the ability to exclude from Medicare and Medicaid any investors, officers and managing employees associated with business entities that have committed health care fraud, even if the officer or managing employee had no knowledge of the fraud. Criminal and civil penalties may be

imposed for a number of other prohibited activities, including failure to return known overpayments, certain gainsharing arrangements, billing Medicare amounts that are substantially in excess of a provider s usual charges, offering remuneration to influence a Medicare or Medicaid beneficiary s selection of a health care provider, contracting with an individual or entity known to be excluded from a federal health care program, making or accepting a payment to induce a physician to reduce or limit services, and soliciting or

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receiving any remuneration in return for referring an individual for an item or service payable by a federal healthcare program. Like the Anti-kickback Statute, these provisions are very broad. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, as well as accurately prepare cost reports.

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

The Federal False Claims Act and Similar State Laws

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

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

HIPAA Administrative Simplification and Privacy and Security Requirements

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

administrative changes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material, adverse effect on our business, financial position or results of operations.

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The privacy and security regulations promulgated pursuant to HIPAA extensively regulate the use and disclosure of individually identifiable health information and require covered entities, including health plans, to implement administrative, physical and technical safeguards to protect the security of such information. Recently, the American Recovery and Reinvestment Act of 2009 (ARRA) broadened the scope of the HIPAA privacy and security regulations. Among other things, the ARRA provides that HHS must issue regulations requiring covered entities to report certain security breaches to individuals affected by the breach and, in some cases, to HHS or to the public via a website. This reporting obligation will apply broadly to breaches involving unsecured protected health information and will become effective 30 days from the date HHS issues these regulations. In addition, the ARRA extends the application of certain provisions of the security and privacy regulations to business associates (entities that handle identifiable health information on behalf of covered entities) and subjects business associates to civil and criminal penalties for violation of the regulations. We enforce a HIPAA compliance plan, which we believe complies with HIPAA privacy and security requirements and under which a HIPAA compliance group monitors our compliance. The privacy regulations and security regulations have and will continue to impose significant costs on our facilities in order to comply with these standards.

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

We remain subject to any state laws that relate to privacy or the reporting of security breaches that are more restrictive than the regulations issued under HIPAA and the requirements of the ARRA. For example, various state laws and regulations may require us to notify affected individuals in the event of a data breach involving certain individually identifiable health or financial information. In addition, the Federal Trade Commission issued a final rule in October 2007 requiring financial institutions and creditors, which may include health providers and health plans, to implement written identity theft prevention programs to detect, prevent, and mitigate identity theft in connection with certain accounts. The compliance date for this rule has been postponed until May 1, 2009.

EMTALA

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

The government broadly interprets EMTALA to cover situations in which individuals do not actually present to a hospital s emergency room, but present for emergency examination or treatment to the hospital s campus, generally, or

to a hospital-based clinic that treats emergency medical conditions or are transported in a hospital-owned ambulance, subject to certain exceptions. EMTALA does not generally apply to individuals admitted for inpatient services. The government also has expressed its intent to investigate and enforce EMTALA violations actively in the future. We believe our hospitals operate in substantial compliance with EMTALA.

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Corporate Practice of Medicine/Fee Splitting

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

Health Care Industry Investigations

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

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

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

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

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

Commencing in 1997, we became aware we were the subject of governmental investigations and litigation relating to our business practices. As part of the investigations, the United States intervened in a number of *qui tam* actions brought by private parties. The investigations related to, among other things, DRG coding, outpatient laboratory billing, home health issues, physician relations, cost report and wound care issues. The investigations were concluded through a series of agreements executed in 2000 and 2003 with the Criminal Division of the Department of Justice, the Civil Division of the Department of Justice, various U.S. Attorneys offices, CMS, a

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negotiating team representing states with claims against us, and others. In January 2001, we entered into an eight year Corporate Integrity Agreement (CIA) with the Office of Inspector General of the Department of Health and Human Services, which expired January 24, 2009. Violation or breach of the CIA or other violation of federal or state laws relating to Medicare, Medicaid or similar programs, could subject us to substantial monetary fines, civil and criminal penalties and/or exclusion from participation in the Medicare and Medicaid programs and other federal and state health care programs. Alleged violations may be pursued by the government or through private qui tam actions. Sanctions imposed against us as a result of such actions could have a material, adverse effect on our results of operations and financial position.

Health Care Reform

Health care is one of the largest industries in the United States and continues to attract much legislative interest and public attention. In recent years, various legislative proposals regarding health care reform have been introduced or proposed in Congress. We anticipate that national health care reform will be a focus at the federal level in the near term. Several states are also considering health care reform measures. This focus on health care reform may increase the likelihood of significant changes affecting the health care industry. Possible future changes in the Medicare, Medicaid, and other state programs, including Medicaid supplemental payments pursuant to upper payment limit programs, may impact reimbursements to health care providers and insurers. In addition, many states have enacted, or are considering enacting, measures designed to reduce their Medicaid expenditures and change private health care insurance. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand states Medicaid systems. Some states, including the states in which we operate, have applied for and have been granted federal waivers from current Medicaid regulations to allow them to serve some or all of their Medicaid participants through managed care providers. Hospital operating margins have been, and may continue to be, under significant pressure because of deterioration in pricing flexibility and payer mix, and growth in operating expenses in excess of the increase in PPS payments under the Medicare program.

General Economic and Demographic Factors

Recently, the United States economy has weakened significantly. Tightening credit markets, depressed consumer spending and higher unemployment rates continue to pressure many industries. During economic downturns, governmental entities often experience budgetary constraints as a result of increased costs and lower than expected tax collections. These budgetary constraints may result in decreased spending for health and human service programs, including Medicare, Medicaid and similar programs, which represent significant payer sources for our hospitals. Other risks we face from general economic weakness include potential declines in the population covered under managed care agreements, patient decisions to postpone or cancel elective and non-emergent health care procedures, potential increases in the uninsured and underinsured populations and further difficulties in our collecting patient copayment and deductible receivables.

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

Compliance Program and Corporate Integrity Agreement

We maintain a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. The program is intended to monitor and raise awareness of various regulatory issues among employees and to emphasize the importance of complying with governmental laws and regulations. As part of the ethics and compliance program, we provide annual ethics and compliance training to our employees and

encourage all employees to report any violations to their supervisor, an ethics and compliance officer or a toll-free telephone ethics line.

Until January 24, 2009, we operated under a CIA, which was structured to assure the federal government of our overall federal health care program compliance and specifically covered DRG coding, outpatient PPS billing and physician relations. We underwent major training efforts to ensure that our employees learned and applied the

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policies and procedures implemented under the CIA and our ethics and compliance program. The CIA had the effect of increasing the amount of information we provided to the federal government regarding our health care practices and our compliance with federal regulations. Under the CIA, we had numerous affirmative obligations, including the requirement to report potential violations of applicable federal health care laws and regulations. Pursuant to this obligation, we reported a number of potential violations of the Stark Law, the Anti-kickback Statute, EMTALA, HIPAA and other laws, most of which we consider to be nonviolations or technical violations. We will submit our final report pursuant to the CIA by April 30, 2009. These reports could result in greater scrutiny by regulatory authorities. The government could determine that our reporting and/or our resolution of reported issues was inadequate. A determination that we breached the CIA and/or a finding of violations of applicable health care laws or regulations could subject us to repayment requirements, substantial monetary penalties, civil penalties, exclusion from participation in the Medicare and Medicaid and other federal and state health care programs and, for violations of certain laws and regulations, criminal penalties. Though the CIA expired on January 24, 2009, we maintain our ethics and compliance program in substantially the same form. However, the audit plans in the CIA have been modified and the reportable events process will be converted to an internal reporting process.

Antitrust Laws

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

Environmental Matters

We are subject to various federal, state and local statutes and ordinances regulating the discharge of materials into the environment. Management does not believe that we will be required to expend any material amounts in order to comply with these laws and regulations or that compliance will materially affect our capital expenditures, results of operations or financial condition.

Insurance

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

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

Employees and Medical Staffs

At December 31, 2008 we had approximately 191,000 employees, including approximately 51,000 part-time employees. References herein to employees refer to employees of affiliates of HCA. We are subject to various state and federal laws that regulate wages, hours, benefits and other terms and conditions relating to employment. Employees at 21 of our hospitals were represented by various labor unions at December 31, 2008 and 2007. We

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consider our employee relations to be satisfactory. Our hospitals, as well as others, have experienced some recent union organizational activity. We had elections at two hospitals in California and one in Missouri during 2007 and no elections during 2008. We expect to have one election in Missouri in 2009 as hospital employees have filed a decertification petition with the National Labor Relations Board. We do not expect such efforts to materially affect our future operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate. In some markets, nurse and medical support personnel availability has become a significant operating issue to health care providers. To address this challenge, we have implemented several initiatives to improve retention, recruiting, compensation programs and productivity.

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

We may be required to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary or contract personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. As the competition increases to hire more people from labor pools that are not growing at a rate sufficient to meet demand, our labor costs could increase. Certain proposed changes in federal labor laws, including the Employee Free Choice Act, may increase the likelihood of employee unionization attempts. To the extent that a significant portion of our employee base unionizes, our costs could increase materially. In addition, union-mandated or state-mandated nurse-staffing ratios could significantly affect labor costs, and have an adverse impact on revenues if we are unable to meet the required ratios and are required to limit patient admissions as a result. The states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse-staffing ratios already in place.

Item 1A. ***Risk Factors***

Risk Factors

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

Our Substantial Leverage Could Adversely Affect Our Ability To Raise Additional Capital To Fund Our Operations, Limit Our Ability To React To Changes In The Economy Or Our Industry, Expose Us To Interest Rate Risk To The Extent Of Our Variable Rate Debt And Prevent Us From Meeting Our Obligations.

Since completing the Recapitalization, we are highly leveraged. As of December 31, 2008, our total indebtedness was $26.989 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;

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

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

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

We May Not Be Able To Generate Sufficient Cash To Service All Of Our Indebtedness And May Not Be Able To Refinance Our Indebtedness On Favorable Terms. If We Are Unable To Do So, We May Be Forced To Take Other Actions To Satisfy Our Obligations Under Our Indebtedness, Which May Not Be Successful.

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

As of December 31, 2008, our substantial indebtedness included $14.052 billion of indebtedness under our senior secured credit facilities that matures in 2012 and 2013, $5.700 billion of second lien notes maturing in 2014 and 2016 and $6.831 billion of unsecured senior notes and debentures that mature on various dates from 2009 to 2095 (including $5.442 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 2009, for example, we issued $310 million of 97/8% Senior Secured Notes due in 2017. We used the net proceeds of that offering to prepay term loans under our senior secured credit facilities, which currently bear 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 crisis. In addition, our ability to incur secured indebtedness (which may 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;

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create liens;

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

enter into certain transactions with our affiliates.

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

Under our senior secured credit facilities we are required to satisfy and maintain specified financial ratios. Our ability to meet those financial ratios can be affected by events beyond our control, and there can be no assurance that we will continue to meet those ratios. A breach of any of these covenants could result in a default under both of our senior secured credit facilities. 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 each such indebtedness. We have pledged a significant portion of our assets as collateral under our senior secured credit facilities and our existing senior secured notes. If any of the lenders under our senior secured credit facilities accelerate the repayment of borrowings, there can be no assurance that we will have sufficient assets to repay our senior secured credit facilities and our outstanding notes.

Our Hospitals Face Competition For Patients From Other Hospitals And Health Care Providers.

The health care business is highly competitive, and competition among hospitals and other health care providers for patients has intensified in recent years. Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. In addition, CMS publicizes on a website performance data related to quality measures and data on patient satisfaction surveys that hospitals submit in connection with their Medicare reimbursement. Federal law provides for the future expansion of the number of quality measures that must be reported. Additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures or on patient satisfaction surveys, patient volumes could decline.

In addition, the number of freestanding specialty hospitals, surgery centers and diagnostic and imaging centers in the geographic areas in which we operate has increased significantly. As a result, most of our hospitals operate in a highly competitive environment. Some of the facilities that compete with our hospitals are owned by governmental agencies or not-for-profit corporations supported by endowments, charitable contributions and/or tax revenues and can finance capital expenditures and operations on a tax-exempt basis. Our hospitals are facing increasing competition from physician-owned specialty hospitals and from both our own and unaffiliated freestanding surgery centers for market share in high margin services and for quality physicians and personnel. If ambulatory surgery centers are better able to compete in this environment than our hospitals, our hospitals may experience a decline in patient volume, and we may experience a decrease in margin, even if those patients use our ambulatory surgery centers. In states that do not require prior regulatory approval, known as a certificate of need (CON), for the purchase, construction or expansion of health care facilities or services, competing health care providers face low barriers to entry and expansion. Further, if our

competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than our hospitals and ambulatory surgery centers, we may experience an overall decline in patient volume. See Item 1, Business Competition.

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The Growth Of Uninsured And Patient Due Accounts And A Deterioration In The Collectibility Of These Accounts Could Adversely Affect Our Results Of Operations.

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

The amount of the provision for doubtful accounts is based upon management s assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal and state governmental and private employer health care coverage, the rate of growth in uninsured patient admissions and other collection indicators. Due to a number of factors, including the recent economic downturn and increase in unemployment, we believe that our facilities may experience growth in bad debts and charity care. At December 31, 2008, our allowance for doubtful accounts represented approximately 93% of the $5.838 billion patient due accounts receivable balance. For the year ended December 31, 2008, the provision for doubtful accounts increased to 12.0% of revenues compared to 11.7% of revenues in 2007.

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.

Changes In Governmental And Judicial Interpretations May Negatively Impact Our Ability To Obtain Reimbursement Of Medicare Bad Debts

The Medicare program reimburses 70% of bad debts related to deductibles and coinsurance for patients with Medicare coverage, after the provider has made a reasonable effort to collect those amounts. We utilize extensive in-house and external collection efforts for our accounts receivable, including deductible and coinsurance amounts owed by patients with Medicare coverage. We use a secondary collection agency after in-house and primary collection agency efforts have been unsuccessful. A recent court case upheld CMS s interpretation that reasonable collection efforts have not been satisfied as long as the Medicare accounts remain with an external collection agency. We incur substantial amounts of Medicare bad debts every year that could be subject to this decision. During 2007, we modified our accounts receivable collection processes to provide reasonable collection results and comply with CMS s interpretation of reasonable collection efforts. Possible future changes in judicial and administrative interpretations of law and regulations governing Medicare could disrupt our collections processes, increase our costs or otherwise adversely affect our business and results of operations.

Changes In Governmental Programs May Reduce Our Revenues.

A significant portion of our patient volumes is derived from government health care programs, principally Medicare and Medicaid, which are highly regulated and subject to frequent and substantial changes. We derived approximately 59% of our admissions from the Medicare and Medicaid programs in 2008. In recent years, legislative and regulatory changes have resulted in limitations on and, in some cases, reductions in levels of payments to health care providers for certain services under these government programs. National health care reform is a focus at the federal level, and we anticipate that it will remain a focus in the near term. Several states are also considering health care reform measures. This focus on health care reform may increase the likelihood of significant changes affecting government health care programs. Possible future changes in the Medicare, Medicaid, and other state programs, may reduce reimbursements to health care providers and insurers and may also increase our operating costs, which could reduce our profitability.

CMS issued final regulations effective January 1, 2008 that increased ASC payment groups from nine clinically disparate payment groups to an extensive list of covered surgical procedures among the APCs used under the outpatient PPS for these surgical services. CMS estimates that the payment rates for procedures performed in an ASC setting equal 65% of the corresponding rates paid for the same procedures performed in an outpatient hospital setting. The final regulation establishes a four-year transition period for implementing the revised payment rates. This regulation significantly expands the number of procedures that Medicare reimburses if performed in an ASC and limits ASC reimbursement for procedures commonly performed in physicians offices. More Medicare

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procedures that are now performed in hospitals, such as ours, may be moved to ASCs, reducing surgical volume in our hospitals. Also, more Medicare procedures that are now performed in ASCs, such as ours, may be moved to physicians offices. Commercial third-party payers may adopt similar policies.

On August 22, 2007, CMS issued a final rule for federal fiscal year 2008 for hospital inpatient PPS. This rule adopts a two-year implementation of MS-DRGs, a Medicare severity-adjusted diagnosis related group system. This change represents a refinement to the existing Medicare DRG system. Realignments in the DRG system could impact the margins we receive for certain services. For federal fiscal year 2009, CMS has provided a 3.6% market basket update for hospitals that submit certain quality patient care indicators and a 1.6% update for hospitals that do not submit this data. While we will endeavor to comply with all quality data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals. Medicare payments to hospitals in fiscal years 2009 and 2008 have been reduced to eliminate what CMS estimates will be the effect of coding or classifications changes as a result of hospitals implementing the MS-DRG system. CMS may retrospectively determine if the adjustment levels for federal fiscal years 2009 and 2008 were adequate and may impose an adjustment in future years if CMS finds that the adjustment was inadequate. Additionally, Medicare payments to hospitals are subject to a number of other adjustments, and the actual impact on payments to specific hospitals may vary. In some cases, commercial third-party payers and other payers such as some state Medicaid programs rely on all or portions of the Medicare DRG system to determine payment rates. The change from traditional Medicare DRGs to MS-DRGs could adversely impact those payment rates if any other payers adopt MS-DRGs.

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

Recently, the Department of Defense implemented a prospective payment system for hospital outpatient services furnished to TRICARE beneficiaries similar to that utilized for services furnished to Medicare beneficiaries. Because the Medicare outpatient prospective payment system APC rates have historically been below TRICARE rates, the adoption of this payment methodology for TRICARE beneficiaries will reduce our reimbursement. This change in TRICARE will have a material impact on our revenues from this program; however, TRICARE outpatient services do not represent a significant portion of our patient volumes. The TRICARE outpatient payment rule has been reopened for comment and the effective date delayed until May 1, 2009. Further modification to the new outpatient payment system may be made.

Changes in laws or regulations regarding government health programs or other changes in the administration of government health programs could have a material, adverse effect on our financial position and results of operations.

If We Are Unable To Retain And Negotiate Favorable Contracts With Nongovernment Payers, Including Managed Care Plans, Our Revenues May Be Reduced.

Our ability to obtain favorable contracts with nongovernment payers, including health maintenance organizations, preferred provider organizations and other managed care plans significantly affects the revenues and operating results of our facilities. Revenues derived from these entities and other insurers accounted for 53% and 54% of our patient revenues for the years ended December 31, 2008 and 2007, respectively. Nongovernment payers, including managed care payers, continue to demand discounted fee structures, and the trend toward consolidation among nongovernment payers tends to increase their bargaining power over fee structures. Our future success will depend, in part, on our

ability to retain and renew our managed care contracts and enter into new managed care contracts on terms favorable to us. Other health care providers may impact our ability to enter into managed care contracts or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of

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managed care companies to contract with us. If we are unable to retain and negotiate favorable contracts with managed care plans or experience reductions in payment increases or amounts received from nongovernment payers, our revenues may be reduced.

Our Performance Depends On Our Ability To Recruit And Retain Quality Physicians.

Physicians generally direct the majority of hospital admissions, and the success of our hospitals depends, therefore, 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. Physicians are often not employees of the hospitals at which they practice and, in many of the markets that we serve, most physicians have admitting privileges at other hospitals in addition to our hospitals. Such physicians may terminate their affiliation with our hospitals at any time. If we are unable to provide adequate support personnel or technologically advanced equipment and hospital facilities that meet the needs of those physicians, they may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline.

Our Hospitals Face Competition For Staffing, Which May Increase Labor Costs And Reduce Profitability.

Our operations are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians, as well as our physicians. We compete with other health care providers in recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our hospitals, including nurses and other nonphysician health care professionals. In some markets, the availability of nurses and other medical support personnel has become 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. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. As the competition increases to hire more people from labor pools that are not growing at a rate sufficient to meet demand, our labor costs could increase. Certain proposed changes in federal labor laws, including the Employee Free Choice Act, may increase the likelihood of employee unionization attempts. To the extent that a significant portion of our employee base unionizes, our costs could increase materially. In addition, union-mandated or state-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenue if we are unable to meet the required ratios and are required to limit admissions as a result. 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 for services;

relationships with physicians and other referral sources;

adequacy of medical care;

quality of medical equipment and services;

qualifications of medical and support personnel;

confidentiality, maintenance and security issues associated with health-related information and medical records;

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

licensure and certification;

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hospital rate or budget review;

operating policies and procedures; and

addition of facilities and services.

Among these laws are the federal Anti-kickback Statute, the federal physician self-referral law (commonly called the Stark Law) and the federal FCA and similar state laws. We have a variety of financial relationships with physicians and others who either refer or influence the referral of patients to our hospitals and other health care facilities, and these laws govern those relationships. The OIG has enacted safe harbor regulations that outline practices that are 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 that 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 assure that every relationship complies fully with the Stark Law. Unlike the Anti-kickback Statute, failure to meet an exception under the Stark Law results in a violation of the Stark Law, even if such violation is technical in nature.

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

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

CMS is proceeding with 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.

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

We Have Been The Subject Of Governmental Investigations, Claims And Litigation, And We Could Be The Subject Of Additional Investigations In The Future.

Commencing in 1997, we became aware that we were the subject of governmental investigations and litigation relating to our business practices. The investigations were concluded through a series of agreements executed in 2000 and 2003. In January 2001, we entered into an eight-year CIA with the OIG, which expired January 24, 2009.

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Under the CIA, we had numerous affirmative obligations, including the requirement to report potential violations of applicable federal health care laws and regulations. Pursuant to these obligations, we reported a number of potential violations of the Stark Law, the Anti-kickback Statute, the EMTALA and other laws, most of which we consider to be nonviolations or technical violations. We will submit our final report pursuant to the CIA by April 30, 2009. The government could determine that our reporting and/or our resolution of reported issues was inadequate. If we are found to have violated the CIA or any applicable health care laws or regulations, we could be subject to repayment requirements, substantial monetary fines, civil penalties, exclusion from participation in the Medicare and Medicaid and other federal and state health care programs, and, for violations of certain laws and regulations, criminal penalties. Any such sanctions or expenses could have a material, adverse effect on our financial position, results of operations or liquidity.

Health care companies are subject to numerous investigations by various governmental agencies. Further, under the federal FCA, private parties have the right to bring *qui tam*, or whistleblower, suits against companies that submit false claims for payments to 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, conduct audits of our health care operations. Private payers may conduct similar post-payment audits, and we also perform internal audits and monitoring. Depending on the nature of the conduct found in such audits and whether the underlying conduct could be considered systemic, the resolution of these audits could have a material, adverse effect on our financial position, results of operations and liquidity.

The MMA established the RAC three-year demonstration program to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. Beginning in 2005, CMS contracted with three different RACs to conduct these reviews in California, Florida and New York. The program was expanded in August 2007 to include Arizona, Massachusetts and South Carolina. We had 46 hospitals located in the demonstration areas and 44 of these hospitals actually had a review performed. The Tax Relief and Health Care Act of 2006 made the RAC program permanent and mandated its nationwide expansion by 2010. Should we be found out of compliance, depending on the nature of the findings, our business, our financial position and our results of operations could be negatively impacted.

Controls Designed To Reduce Inpatient Services May Reduce Our Revenues.

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

Our Overall Business Results May Suffer From The Recent Economic Downturn.

Recently, the United States economy has weakened significantly. Tightening credit markets, depressed consumer spending and higher unemployment rates continue to pressure many industries. During economic downturns, governmental entities often experience budgetary constraints as a result of increased costs and lower than expected tax collections. These budgetary constraints may result in decreased spending for health and human service programs, including Medicare, Medicaid and similar programs, which represent significant payer sources for our hospitals. Other risks we face from general economic weakness include potential declines in the population

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covered under managed care agreements, patient decisions to postpone or cancel elective and non-emergent healthcare procedures, potential increases in the uninsured and underinsured populations and further difficulties in our collecting patient copayment and deductible receivables.

The Industry Trend Towards Value-Based Purchasing May Negatively Impact Our Revenues.

There is a trend in the health care industry toward value-based purchasing of health care services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid require hospitals to report certain quality data to receive full reimbursement updates. In addition Medicare does not reimburse for care related to certain preventable adverse events (also called never events). Many large commercial payers currently require hospitals to report quality data, and several commercial payers do not reimburse hospitals for certain preventable adverse events. Further, we have implemented a policy pursuant to which we do not bill patients or third-party payers for fees or expenses incurred due to certain preventable adverse events. We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenues.

Our Operations Could Be Impaired By A Failure Of Our Information Systems.

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

The performance of our sophisticated 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.

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.

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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 166 hospitals at December 31, 2008, and 72 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities combined revenues represented approximately 51% of our consolidated revenues for the year ended December 31, 2008. This concentration makes us particularly sensitive to regulatory, economic, environmental and competitive conditions and changes in those states. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in those states could have a disproportionate effect on our overall business results.

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

We May Be Subject To Liabilities From Claims By The IRS.

We are currently contesting before the Appeals Division of the Internal Revenue Service (the IRS) certain claimed deficiencies and adjustments proposed by the IRS in connection with its examination of the 2003 and 2004 federal income tax returns for HCA and 17 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.

Eight taxable periods of HCA and its predecessors ended in 1995 through 2002 and the 2002 taxable year of 13 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 or the United States Tax Court as of December 31, 2008. The IRS began an audit of the 2005 and 2006 federal income tax returns for HCA and seven affiliated partnerships during 2008.

We May Be Subject To Liabilities From Claims Brought Against Our Facilities.

We are subject to litigation relating to our business practices, including claims and legal actions by patients and others in the ordinary course of business alleging malpractice, product liability or other legal theories. See Item 3, Legal Proceedings. Many of these actions involve large claims and significant defense costs. We insure a portion of our professional liability risks through a wholly-owned subsidiary. Management believes our reserves for self-insured retentions and insurance coverage are sufficient to cover insured claims arising out of the operation of our facilities. Our wholly-owned insurance subsidiary has entered into certain reinsurance contracts, and the obligations covered by the reinsurance contracts are included in its reserves for professional liability risks, as the subsidiary remains liable to the extent that the reinsurers do not meet their obligations under the reinsurance contracts. If payments for claims exceed actuarially determined estimates, are not covered by insurance or reinsurers, if any, fail to meet their obligations, our results of operations and financial position could be adversely affected.

We Are Exposed To Market Risks Related To Changes In The Market Values Of Securities And Interest Rate Changes.

We are exposed to market risk related to changes in market values of securities. The investments in debt and equity securities of our wholly-owned insurance subsidiary were $1.614 billion and $8 million, respectively, at December 31, 2008. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At December 31, 2008, we had a net unrealized loss of $48 million on

the insurance subsidiary s investment securities.

We are exposed to market risk related to market illiquidity. Liquidity of the investments in debt and equity securities of our wholly-owned insurance subsidiary could be impaired by the inability to access the capital markets. Should the wholly-owned insurance subsidiary require significant amounts of cash in excess of normal cash requirements to pay claims and other expenses on short notice, we may have difficulty selling these investments in a

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timely manner or be forced to sell them at a price less than what we might otherwise have been able to in a normal market environment. At December 31, 2008, our wholly-owned insurance subsidiary, had invested $536 million ($573 million par value) in municipal, tax-exempt student loan auction rate securities which were classified as long-term investments. The auction rate securities (ARS) are publicly issued securities with long-term stated maturities for which the interest rates are reset through a Dutch auction every seven to 35 days. With the liquidity issues experienced in global credit and capital markets, the ARS held by our wholly-owned insurance subsidiary have experienced multiple failed auctions, beginning on February 11, 2008, as the amount of securities submitted for sale exceeded the amount of purchase orders. There is a very limited market for the ARS at this time. We do not currently intend to attempt to sell the ARS as the liquidity needs of our insurance subsidiary are expected to be met by other investments in its investment portfolio. If uncertainties in the credit and capital markets continue or there are ratings downgrades on the ARS held by our insurance subsidiary, we may be required to recognize other-than-temporary impairments on these long-term investments in future periods.

We are also exposed to market risk related to changes in interest rates and 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 interest payments based on the notional amounts in these agreements generally match the timing of the cash flows of the related liabilities. The notional amounts of the swap agreements represent balances used to calculate the exchange of cash flows and are not assets or liabilities of HCA. See Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations Quantitative and Qualitative Disclosures About Market Risk.

Since The Recapitalization, The Investors Control Us And May Have Conflicts Of Interest With Us In The Future.

As of December 31, 2008, the Investors and certain other investors indirectly own 97.3% of our capital stock due to the Recapitalization. As a result, the Investors have control over our decisions to enter into any significant corporate transaction and have the ability to prevent any transaction that requires the approval of shareholders. For example, the Investors could cause us to make acquisitions that increase the amount of our indebtedness or sell assets.

Additionally, the Sponsors are in the business of making investments in companies and may acquire and hold interests in businesses that compete directly or indirectly with us. One or more of the Sponsors may also pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us. So long as investment funds associated with or designated by the Sponsors continue to indirectly own a significant amount of the outstanding shares of our common stock, even if such amount is less than 50%, the Sponsors will continue to be able to strongly influence or effectively control our decisions.

Item 1B. ***Unresolved Staff Comments***

None.

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Item 2. ***Properties***

The following table lists, by state, the number of hospitals (general, acute care, psychiatric and rehabilitation) directly or indirectly owned and operated by us as of December 31, 2008:

State	Hospitals	Beds
Alaska	1	250
California	5	1,511
Colorado	7	2,257
Florida	38	9,673
Georgia	11	1,925
Idaho	2	481
Indiana	1	278
Kansas	4	1,286
Kentucky	2	384
Louisiana	10	1,625
Mississippi	1	130
Missouri	6	1,055
Nevada	3	1,075
New Hampshire	2	295
Oklahoma	2	793
South Carolina	3	740
Tennessee	13	2,287
Texas	34	10,191
Utah	6	968
Virginia	9	2,963
International		
England	6	704
	166	40,871

In addition to the hospitals listed in the above table, we directly or indirectly operate 105 freestanding surgery centers. We also operate medical office buildings in conjunction with some of our hospitals. These office buildings are primarily occupied by physicians who practice at our hospitals. Under our senior secured cash flow credit facility entered into in connection with the Recapitalization, 14 of our general, acute care hospitals were mortgaged as collateral.

We maintain our headquarters in approximately 1,209,000 square feet of space in the Nashville, Tennessee area. In addition to the headquarters in Nashville, we maintain regional service centers related to our shared services initiatives. These service centers are located in markets in which we operate hospitals.

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

Item 3. ***Legal Proceedings***

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

Government Investigations, Claims and Litigation

In January 2001, we entered into an eight-year CIA with the OIG which expired on January 24, 2009. Violation or breach of the CIA, or violation of federal or state laws relating to Medicare, Medicaid or similar programs, could subject us to substantial monetary fines, civil and criminal penalties and/or exclusion from participation in the Medicare and Medicaid programs. Alleged violations may be pursued by the government or through private *qui tam* actions. Sanctions imposed against us as a result of such actions could have a material, adverse effect on our results of operations or financial position.

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ERISA Litigation

On November 22, 2005, Brenda Thurman, a former employee of an HCA affiliate, filed a complaint in the United States District Court for the Middle District of Tennessee on behalf of herself, the HCA Savings and Retirement Program (the Plan), and a class of participants in the Plan who held an interest in our common stock, against our Chairman and Chief Executive Officer, President and Chief Operating Officer, Executive Vice President and Chief Financial Officer, and other unnamed individuals. The lawsuit, filed under sections 502(a)(2) and 502(a)(3) of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1132(a)(2) and (3), alleges that defendants breached their fiduciary duties owed to the Plan and to plan participants and seeks monetary damages and injunctions and other relief.

On January 13, 2006, the court signed an order staying all proceedings and discovery in this matter, pending resolution of a motion to dismiss the consolidated amended complaint in a related federal securities class action against HCA. On January 18, 2006, the magistrate judge signed an order (1) consolidating Thurman s cause of action with all other future actions making the same claims and arising out of the same operative facts, (2) appointing Thurman as lead plaintiff, and (3) appointing Thurman s attorneys as lead counsel and liaison counsel in the case. We have reached an agreement in principle to settle this suit, subject to final court approval.

Merger Litigation in State Court

On October 23, 2006, the Foundation for Seacoast Health (the Foundation) filed a lawsuit against us and one of our affiliates, HCA Health Services of New Hampshire, Inc., in the Superior Court of Rockingham County, New Hampshire. Among other things, the complaint seeks to enforce certain provisions of an asset purchase agreement between the parties, including a purported right of first refusal to purchase a New Hampshire hospital, that allegedly were triggered by the Merger and other prior events. The Foundation initially sought to enjoin the Merger. However, the parties reached an agreement that allowed the Merger to proceed, while preserving the plaintiff s opportunity to litigate whether the Merger triggered the right of first refusal to purchase the hospital and, if so, at what price the hospital could be repurchased. On May 25, 2007, the court granted HCA s motion for summary judgment disposing of the Foundation s central claims. The Foundation filed an appeal from the final judgment. On July 15, 2008, the New Hampshire Supreme Court held that the Merger did not trigger the right of first refusal. The Court remanded to the lower court the claim that the right of first refusal had been triggered by certain intra-corporate transactions in 1999. The Court did not determine the merits of that claim, and we will continue to defend the claim vigorously.

General Liability and Other Claims

On April 10, 2006, a class action complaint was filed against us in the District Court of Kansas alleging, among other matters, nurse understaffing at all of our hospitals, certain consumer protection act violations, negligence and unjust enrichment. The complaint is seeking, among other relief, declaratory relief and monetary damages, including disgorgement of profits of $12.250 billion. A motion to dismiss this action was granted on July 27, 2006, but the plaintiffs appealed this dismissal. While the appeal was pending, the Kansas Supreme Court for the first time construed the Kansas Consumer Protection Act to apply to the provision of medical services. Based on that new ruling, the 10th Circuit reversed the district court s dismissal and remanded the action for further consideration by the trial court. We will continue to defend this claim vigorously.

We are a party to certain proceedings relating to claims for income taxes and related interest in the United States Tax Court. For a description of those proceedings, see Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations Pending IRS Disputes and Note 6 to our consolidated financial statements.

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

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

No matters were submitted to a vote of security holders during the fourth quarter of 2008.

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PART II

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

Our outstanding common stock is privately held, and there is no established public trading market for our common stock. As of February 25, 2009, there were 631 holders of our common stock. See Item 7, Management s Discussion and Analysis of Financial condition and Results of Operations Liquidity and Capital Resources Financing Activities for a description of the restrictions on our ability to pay dividends. We did not pay any dividends in 2007 or 2008.

During the quarter ended December 31, 2008, HCA issued 431,216 shares of common stock in connection with the cashless exercise of stock options for aggregate consideration of $5,498,004 resulting in 217,732 net settled shares. The shares were issued without registration in reliance on the exemptions afforded by Section 4(2) of the Securities Act of 1933, as amended, and Rule 701 promulgated thereunder.

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

The following table provides certain information with respect to our repurchase of common stock from October 1, 2008 through December 31, 2008.

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares That May Yet Be Purchased Under Publicly Announced Plans or Programs
October 1, 2008 through October 31, 2008		$		$
November 1, 2008 through November 30, 2008	6,111	$ 55.86		
December 1, 2008 through December 31, 2008	26,121	$ 55.86		
Total for Fourth Quarter 2008	32,232	$ 55.86		$

During the fourth quarter of 2008, we purchased 32,232 shares pursuant to the terms of the Management Stockholders Agreement and/or separation agreements and stock purchase agreements between former employees and the

Company.

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

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

	2008	2007	2006	2005	2004
Summary of Operations:					
Revenues	**$ 28,374**	$ 26,858	$ 25,477	$ 24,455	$ 23,502
Salaries and benefits	**11,440**	10,714	10,409	9,928	9,419
Supplies	**4,620**	4,395	4,322	4,126	3,901
Other operating expenses	**4,554**	4,241	4,056	4,034	3,769
Provision for doubtful accounts	**3,409**	3,130	2,660	2,358	2,669
Equity in earnings of affiliates	**(223)**	(206)	(197)	(221)	(194)
Gains on investments		(8)	(243)	(53)	(56)
Depreciation and amortization	**1,416**	1,426	1,391	1,374	1,250
Interest expense	**2,021**	2,215	955	655	563
Gains on sales of facilities	**(97)**	(471)	(205)	(78)	
Impairment of long-lived assets	**64**	24	24		12
Transaction costs			442		
	27,204	25,460	23,614	22,123	21,333
Income before minority interests and income taxes	**1,170**	1,398	1,863	2,332	2,169
Minority interests in earnings of consolidated entities	**229**	208	201	178	168
Income before income taxes	**941**	1,190	1,662	2,154	2,001
Provision for income taxes	**268**	316	626	730	755
Net income	**$ 673**	$ 874	$ 1,036	$ 1,424	$ 1,246
Financial Position:					
Assets	**$ 24,280**	$ 24,025	$ 23,675	$ 22,225	$ 21,840
Working capital	**2,391**	2,356	2,502	1,320	1,509
Long-term debt, including amounts due within one year	**26,989**	27,308	28,408	10,475	10,530
Minority interests in equity of consolidated entities	**995**	938	907	828	809
Equity securities with contingent redemption rights	**155**	164	125		
Stockholders (deficit) equity	**(10,255)**	(10,538)	(11,374)	4,863	4,407
Cash Flow Data:					
Cash provided by operating activities	**$ 1,797**	$ 1,396	$ 1,845	$ 2,971	$ 2,954

Cash used in investing activities	**(1,467)**	(479)	(1,307)	(1,681)	(1,688)
Cash used in financing activities	**(258)**	(1,158)	(240)	(1,212)	(1,347)

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	2008	2007	2006	2005	2004
Operating Data:					
Number of hospitals at end of period(a)	**158**	161	166	175	182
Number of freestanding outpatient surgical centers at end of period(b)	**97**	99	98	87	84
Number of licensed beds at end of period(c)	**38,504**	38,405	39,354	41,265	41,852
Weighted average licensed beds(d)	**38,422**	39,065	40,653	41,902	41,997
Admissions(e)	**1,541,800**	1,552,700	1,610,100	1,647,800	1,659,200
Equivalent admissions(f)	**2,363,600**	2,352,400	2,416,700	2,476,600	2,454,000
Average length of stay (days)(g)	**4.9**	4.9	4.9	4.9	5.0
Average daily census(h)	**20,795**	21,049	21,688	22,225	22,493
Occupancy(i)	**54%**	54%	53%	53%	54%
Emergency room visits(j)	**5,246,400**	5,116,100	5,213,500	5,415,200	5,219,500
Outpatient surgeries(k)	**797,400**	804,900	820,900	836,600	834,800
Inpatient surgeries(l)	**493,100**	516,500	533,100	541,400	541,000
Days revenues in accounts receivable(m)	**49**	53	53	50	