LARGE FILING SEPARATOR SHEET

CASE NUMBER 11-1095-GA-AGG

FILE DATE 3-4-2013

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DESCRIPTION OF DOCUMENT Renewal App.

JV Investor, LLC
Kansas Healthserv, LLC
Katy Medical Center, Inc.
Kendall Regional Medical Center, LLC
Lake City Imaging, LLC
Lakeland Medical Center, LLC
Lakeside Radiology, LLC
Lakeview Medical Center, LLC
    Lakeview Regional Medical Center
Laredo Medco, LLC
Lee's Summit Family Care, LLC
Lewis-Gale Medical Center, LLC
    Lewis-Gale Medical Center
Low Country Health Services, Inc. of the Southeast
Macon Healthcare, LLC
Macon Northside Health Group, LLC
Macon Northside Hospital, LLC
    Coliseum Northside Hospital
Management Services Holdings, Inc.
Mayhill Cancer Center, LLC
Medical Arts Hospital of Texarkana, Inc.
Medical Care America, LLC
Medical Care Financial Services Corp.
Medical Care Real Estate Finance, Inc.
Medical Center of Plano Partner, LLC
Medical Centers of Oklahoma, LLC
Medical City Dallas Partner, LLC
Medical Corporation of America
Medical Office Buildings of Kansas, LLC
Medical Specialties, Inc.
MediStone Healthcare Ventures, Inc.
MediVision of Mecklenburg County, Inc.
MediVision of Tampa, Inc.
MediVision, Inc.
Miami Beach EFL Imaging Center, LLC
MidAmerica Oncology, LLC
Mid-Continent Health Services, Inc.
Middle Georgia Hospital, LLC
Midtown Diagnostics, LLC
Midwest Division - ACH, LLC
    Allen County Hospital
Midwest Division - CMC, LLC
Midwest Division - LRHC, LLC
    Lafayette Regional Health Center
Midwest Division - LSH, LLC
    Lee's Summit Medical Center
Midwest Division - MCI, LLC
Midwest Division - MII, LLC
Midwest Division - MMC, LLC
    Menorah Medical Center
Midwest Division - OPRMC, LLC
    Overland Park Regional Medical Center
Midwest Division - PFC, LLC

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

Parkway Hospital, Inc.
Pearland Partner, LLC
Pinellas Medical, LLC
Pioneer Medical, LLC
Plano Heart Institute, L.P.
Plano Heart Management, LLC
Plantation General Hospital, L.P.
    Mercy Hospital, a Campus of Plantation General Hospital
    Plantation General Hospital
PMM, Inc.
POH Holdings, LLC
Portsmouth Regional Ambulatory Surgery Center, LLC
    Portsmouth Regional Ambulatory Surgery Center
Preferred Works WC, LLC
Primary Care Acquisition, Inc.
Primary Medical Management, Inc.
Radiation Oncology Manager, LLC
RCH, LLC
Red Rock at Maryland Parkway, LLC
Red Rock at Smoke Ranch, LLC
Red Rock Holdco, LLC
Reston Hospital Center, LLC
    Reston Hospital Center
RHA MSO, LLC
Riverside CyberKnife Manager, LLC
Riverside CyberKnife, LLC
Riverside Hospital, Inc.
Riverside Imaging, LLC
RMC HBP, LLC
Round Rock Hospital, Inc.
Samaritan, LLC
San Bernardino Imaging, LLC
San Jose Healthcare System, LP
    Regional Medical Center of San Jose
San Jose Hospital, L.P.
San Jose Medical Center, LLC
San Jose, LLC
Sarah Cannon Research Institute, LLC
SCRI Holdings, LLC
Sino American Healthcare Consulting, LLC
SJMC, LLC
SMCH, LLC
South Bay Imaging, LLC
South Brandon Imaging, LLC
South Valley Hospital, L.P.
Southtown Women's Clinic, LLC
Spalding Rehabilitation L.L.C.
    Spalding Rehabilitation Hospital
Spring Hill Imaging, LLC
Springview KY, LLC
Stereotactic Radiosurgery Systems of Brandon, LLC
Stiles Road Imaging LLC
Stones River Hospital, LLC
Suburban Medical Center at Hoffman Estates, Inc.

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

FLORIDA

Access 2 Health Care Physicians, LLC
Access Health Care Physicians, LLC
Access Management Co., LLC
Ace Leasing II, LLC
All About Staffing, Inc.
Ambulatory Laser Associates, GP

Ambulatory Surgery Center Group, Ltd.
    Ambulatory Surgery Center
Atlantis Surgicare, LLC
Aventura Comprehensive Cancer Research Group of Florida, Inc.
Aventura Healthcare Specialists LLC
Aventura Neurosurgery, LLC
BAMI Property, LLC
Bannerman Family Care, LLC
Bay Hospital, Inc.
    Gulf Coast Medical Center
Bayonet Point Surgery Center, Ltd.
    Bayonet Point Surgery and Endoscopy Center
Bayside Ambulatory Center, LLC
Beach Primary Care, LLC
Behavioral Health Sciences of West Florida, LLC
Belleair Surgery Center, Ltd.
    Belleair Surgery Center
Big Cypress Medical Center, Inc.
Bonita Bay Surgery Center, Inc.
Bonita Bay Surgery Center, Ltd.
Bradenton Cardiology Physician Network, LLC
Brandon Surgi-Center, Ltd.
    Brandon Surgery Center
Broward Cardiovascular Surgeons, LLC
Broward Healthcare System, Inc.
Broward Neurosurgeons, LLC
Cape Coral Surgery Center, Inc.
Cape Coral Surgery Center, Ltd.
Capital Regional Healthcare, LLC
CCH-GP, Inc.
Cedarcare, Inc.
Cedars BTW Program, Inc.
Cedars Gastroenterologists, LLC
Cedars Healthcare Group, Ltd.
Cedars International Cardiology Consultants, LLC
Cedars Medical Center Hospitalists, LLC
Central Florida Cardiology Interpretations, LLC
Central Florida Division Practice, Inc.
Central Florida Obstetrics & Gynecology Associates, LLC
Central Florida Physician Network, LLC
Central Florida Regional Hospital, Inc.
    Central Florida Regional Hospital
Collier County Home Health Agency, Inc.
Columbia Behavioral Health, Ltd.
Columbia Behavioral Healthcare of South Florida, Inc.
Columbia Central Florida Division, Inc.
Columbia Development of Florida, Inc.
Columbia Eye and Specialty Surgery Center, Ltd.
    Tampa Eye & Specialty Surgery Center
Columbia Florida Group, Inc.
Columbia Hospital Corporation of Central Miami
Columbia Hospital Corporation of Kendall
Columbia Hospital Corporation of Miami
Columbia Hospital Corporation of Miami Beach

Columbia Hospital Corporation of North Miami Beach
Columbia Hospital Corporation of South Broward
    Westside Regional Medical Center
Columbia Hospital Corporation of South Dade
Columbia Hospital Corporation of South Florida
Columbia Hospital Corporation of South Miami
Columbia Hospital Corporation of Tamarac
Columbia Hospital Corporation-SMM
Columbia Jacksonville Healthcare System, Inc.
Columbia Lake Worth Surgical Center Limited Partnership
Columbia Midtown Joint Venture
Columbia North Central Florida Health System Limited Partnership
Columbia North Florida Regional Medical Center Limited Partnership
Columbia Ocala Regional Medical Center Physician Group, Inc.
Columbia Palm Beach Healthcare System Limited Partnership
Columbia Park Healthcare System, Inc.
Columbia Park Medical Center, Inc.
Columbia Physician Services - Florida Group, Inc.
Columbia Primary Care, LLC
Columbia Resource Network, Inc.
Columbia Tampa Bay Division, Inc.
Columbia-Osceola Imaging Center, Inc.
Community Hospital Family Practice, LLC
Coral Springs Surgi-Center, Ltd.
    Surgery Center at Coral Springs
Countryside Surgery Center, Ltd.
    Countryside Surgery Center
Daytona Medical Center, Inc.
Diagnostic Breast Center, Inc.
Doctors Osteopathic Medical Center, Inc.
Doctors Same Day Surgery Center, Inc.
Doctors Same Day Surgery Center, Ltd.
    Doctors Same Day Surgery Center
DOMC Property, LLC
East Florida Behavioral Health Network, LLC
East Florida Division, Inc.
East Florida Emergency Physician Group, LLC
East Florida Hospitalists, LLC
East Florida Primary Care, LLC
East Pointe Hospital, Inc.
Edward White Hospital, Inc.
    Edward White Hospital
Emergency Providers Group LLC
Englewood Community Hospital, Inc.
    Englewood Community Hospital
Family Care Partners, LLC
Fawcett Memorial Hospital, Inc.
    Fawcett Memorial Hospital
Florida Home Health Services-Private Care, Inc.
Florida Outpatient Surgery Center, Ltd.
    Florida Surgery Center
Fort Myers Market, Inc.
Fort Pierce Immediate Care Center, Inc.
Fort Pierce Orthopaedics, LLC

Fort Pierce Surgery Center, Ltd.
Fort Walton Beach Medical Center, Inc.
    Fort Walton Beach Medical Center
Freeport Family Medicine, LLC
Ft. Pierce Surgicare, LLC
Ft. Walton Beach Anesthesia Services, LLC
Gainesville GYN Oncology of North Florida Regional Medical Center, LLC
Gainesville Physicians, LLC
Galen Diagnostic Multicenter, Ltd.
Galen Hospital-Pembroke Pines, Inc.
Galen of Florida, Inc.
    St. Petersburg General Hospital
Galencare, Inc.
    Brandon Regional Hospital
    Northside Hospital
Grant Center Hospital of Ocala, Inc.
Gulf Coast Inpatient Specialists, LLC
Gulf Coast Medical Center Primary Care, LLC
Gulf Coast Multispecialty Services, LLC
Hamilton Memorial Hospital, Inc.
HCA - Viera ALF, LLC
HCA - WHS Progressive, LLC
HCA - WHS Services, LLC
HCA Family Care Center, Inc.
HCA Health Services of Florida, Inc.
    Blake Medical Center
    Oak Hill Hospital
    Regional Medical Center Bayonet Point
    St. Lucie Medical Center
HCA Health Services of Miami, Inc.
HCA Outpatient Clinic Services of Miami, Inc.
HD&S Corp. Successor, Inc.
HealthCoast Physician Group, LLC
Heathrow Internal Medicine, LLC
Heritage Family Care, LLC
Homecare North, Inc.
Hospital Corporation of Lake Worth
ICC Healthcare, LLC
Integrated Regional Lab, LLC
Integrated Regional Laboratories Pathology Services, LLC
Intensive Care Consortium, Inc.
Internal Medicine Services of Osceola, LLC
Jacksonville Multispecialty Services, LLC
Jacksonville Specialists, LLC
Jacksonville Surgery Center, Ltd.
    Jacksonville Surgery Center
JFK Internal Medicine Faculty Practice, LLC
JFK Occupational Medicine, LLC
JFK Real Properties, Ltd.
Kendall Healthcare Group, Ltd.
    Kendall Regional Medical Center
Kendall Vascular Surgery, LLC
Kingsley Family Care, LLC

Kissimmee Surgicare, Ltd.
    Kissimmee Surgery Center
LAD Imaging, LLC
Lake City Regional Medical Group, LLC
Lake Nona Hospital, Inc.
Largo Cardiology, LLC
Largo Medical Center, Inc.
    Largo Medical Center
    Largo Medical Center - Indian Rocks
Largo Physician Group, LLC
Laurel Grove Surgery Center, LLC
Lawnwood Cardiovascular Surgery, LLC
Lawnwood Healthcare Specialists, LLC
Lawnwood Medical Center, Inc.
    Lawnwood Regional Medical Center & Heart Institute
Lawnwood Pavilion Physician Services, LLC
Live Oak Immediate Care Center, LLC
M & M of Ocala, Inc.
Manatee Surgicare, Ltd.
    Gulf Coast Surgery Center
Marion Community Hospital, Inc.
    Ocala Regional Medical Center
Medical Associates of Ocala, LLC
Medical Center of Port St. Lucie, Inc.
Medical Center of Santa Rosa, Inc.
Medical Imaging Center of Ocala [General Partnership]
Medical Partners of North Florida, LLC
Memorial Family Practice Associates, LLC
Memorial Health Primary Care at St. Johns Bluff, LLC
Memorial Healthcare Group, Inc.
    Memorial Hospital Jacksonville
    Specialty Hospital
Memorial Neurosurgery Group, LLC
Memorial Surgicare, Ltd.
    Plaza Surgery Center II
Mercy ASC, LLC
MHS Partnership Holdings JSC, Inc.
MHS Partnership Holdings SDS, Inc.
Miami Beach Healthcare Group, Ltd.
    Aventura Hospital and Medical Center
Miami Lakes Surgery Center, Ltd.
    Miami Lakes Surgery Center
Navarre Family Care, LLC
Network MS of Florida, Inc.
New Port Richey Hospital, Inc.
    Community Hospital
New Port Richey Surgery Center, Ltd.
    New Port Richey Surgery Center
Niceville Family Practice, LLC
North Central Florida Health System, Inc.
North Florida Division I, Inc.
North Florida Division Practice, Inc.
North Florida GI Center GP, Inc.

North Florida GI Center, Ltd.
North Florida Endoscopy Center
North Florida Immediate Care Center, Inc.
North Florida Neurosurgery, LLC
North Florida Outpatient Imaging Center, Ltd.
North Florida Physician Services, Inc.
North Florida Physicians, LLC
North Florida Regional Medical Center, Inc.
North Florida Regional Medical Center
North Florida Regional Medical Center, Inc.
North Florida Regional Otolaryngology, LLC
North Florida Rehab Investments, LLC
North Florida Surgical Associates, LLC
North Palm Beach County Surgery Center, LLC
North County Surgicenter
North River Physician Network, LLC
North Transfer Center, LLC
Northside MRI, Inc.
Northwest Florida Cardiology, LLC
Northwest Florida Healthcare Systems, Inc.
Northwest Florida Multispecialty Physicians, LLC
Northwest Florida Primary Care, LLC
Northwest Medical Center, Inc.
Northwest Medical Center
Notami Hospitals of Florida, Inc.
Lake City Medical Center
Oak Hill Acquisition, Inc.
Oak Hill Family Care, LLC
Oak Hill Hospitalists, LLC
Ocala Health Imaging Services, LLC
Ocala Health Primary Care, LLC
Ocala Health Surgical Group, LLC
Ocala Regional Outpatient Services, Inc.
Okaloosa Hospital, Inc.
Twin Cities Hospital
Okeechobee Hospital, Inc.
Raulerson Hospital
Orange Park Hospitalists, LLC
Orange Park Medical Center, Inc.
Orange Park Medical Center
Orlando Surgicare, Ltd.
Same Day Surgicenter of Orlando
Osceola Neurological Associates, LLC
Osceola Physician Network, LLC
Osceola Regional Hospital, Inc.
Osceola Regional Medical Center
Osceola Regional Hospitalists, LLC
Osceola Surgical Associates, LLC
Outpatient Surgical Services, Ltd.
Outpatient Surgical Services
P&L Associates
Palm Beach General Surgery, LLC
Palm Beach Healthcare System, Inc.
Palm Beach Hospitalists Program, LLC

Palms West Gastroenterology, LLC
Palms West Pediatric Neurosurgery, Inc.
Palms West Surgery Center, Ltd.
    Palms West Surgicenter
Park South Imaging Center, Ltd.
Pediatric Intensivist Group, LLC
Pensacola Primary Care, Inc.
Pinellas Surgery Center, Ltd.
    Center for Special Surgery
Pinnacle Physician Network, LLC
Port St. Lucie Surgery Center, Ltd.
    St. Lucie Surgery Center
Premier Medical Management, Ltd.
Primary Care Medical Associates, Inc.
Pulmonary Renal Intensivist Group, LLC
Putnam Hospital, Inc.
Raulerson Gastroenterology, LLC
Raulerson GYN, LLC
Raulerson Primary Care, LLC
Sarasota Doctors Hospital, Inc.
    Doctors Hospital of Sarasota
South Broward Practices, Inc.
South Florida Division Practice, Inc.
South Transfer Center, LLC
Southwest Florida Health System, Inc.
Southwest Florida Regional Medical Center, Inc.
Space Coast Surgical Center, Ltd.
    Merritt Island Surgery Center
Specialty Hospitalists at Ft. Walton Beach, LLC
Spinal Disorder and Pain Treatment Institute, LLC
St. Lucie Hospitalists, LLC
St. Lucie Medical Center Hyperbarics, LLC
St. Lucie Medical Center Walk-In Clinic, LLC
St. Lucie Medical Specialists, LLC
St. Lucie West Primary Care, LLC
St. Petersburg General Surgery, LLC
Sun City Hospital, Inc.
    South Bay Hospital
Surgery Center of Atlantis, LLC
    Atlantis Outpatient Center
Surgery Center of Aventura, Ltd.
    Surgery Center of Aventura
Surgery Center of Ft. Pierce, Ltd
Surgery Center of Port Charlotte, Ltd.
    Gulf Pointe Surgery Center
Surgical Park Center, Ltd.
    Surgical Park Center
Surgicare America - Winter Park, Inc.
Surgicare of Altamonte Springs, Inc.
Surgicare of Aventura, LLC
Surgicare of Bayonet Point, Inc.
Surgicare of Bayside, LLC
Surgicare of Brandon, Inc.
Surgicare of Central Florida, Inc.

Surgicare of Countryside, Inc.
Surgicare of Florida, Inc.
Surgicare of Ft. Pierce, Inc.
Surgicare of Kissimmee, Inc.
Surgicare of Laurel Grove, LLC
Surgicare of Manatee, Inc.
Surgicare of Merritt Island, Inc.
Surgicare of Miami Lakes, LLC
Surgicare of New Port Richey, Inc.
Surgicare of Orange Park, Inc.
Surgicare of Orange Park, Ltd.
    Orange Park Surgery Center
Surgicare of Orlando, Inc.
Surgicare of Palms West, LLC
Surgicare of Pinellas, Inc.
Surgicare of Plantation, Inc.
Surgicare of Port Charlotte, LLC
Surgicare of Port St. Lucie, Inc.
Surgicare of St. Andrews, Inc.
Surgicare of St. Andrews, Ltd.
    Surgery Center at St. Andrews
Surgicare of Stuart, Inc.
Surgicare of Tallahassee, Inc.
Tallahassee Community Network, Inc.
Tallahassee Medical Center, Inc.
    Capital Regional Medical Center
Tallahassee Orthopedic Surgery Partners, Ltd.
    Tallahassee Outpatient Surgery Center
Tampa Bay Health System, Inc.
Tampa Surgi-Centre, Inc.
The Neurohealth Sciences Center, LLC
Total Imaging - Hudson, LLC
Total Imaging - North St. Petersburg, LLC
Travel Medicine and Infections, LLC
University Healthcare Specialists, LLC
University Hospital, Ltd.
    University Hospital and Medical Center
Venture Ambulatory Surgery Center, LLC
    Venture Ambulatory Surgery Center
Venture Medical Management, LLC
West Florida Behavioral Health, Inc.
West Florida Cardiology Network, LLC
West Florida Division, Inc.
West Florida Gulf Coast Primary Care, LLC
West Florida HealthWorks, LLC
West Florida Internal Medicine, LLC
West Florida Physician Network, LLC
West Florida Regional Medical Center, Inc.
    West Florida Hospital
West Florida Specialty Physicians, LLC
West Florida Trauma Network, LLC
West Jacksonville Medical Center, Inc.
Westside Surgery Center, Ltd.
    Parkside Surgery Center

Wildwood Medical Center, Inc.
Women's Health Center of Central Florida, LLC

GEORGIA

Acworth Immediate Care, LLC
Albany Family Practice, LLC
Albany Neurosurgery Center, LLC
AOSC Sports Medicine, Inc.
Atlanta Home Care, L.P.
Atlanta Outpatient Surgery Center, Inc.
Atlanta Surgery Center, Ltd.
    Atlanta Outpatient Peachtree Dunwoody Center
    Atlanta Outpatient Surgery Center
    Pediatric Surgery Center at Atlanta Outpatient
Augusta Inpatient Services, LLC
Augusta Multispecialty Services, LLC
Augusta Primary Care Services, LLC
Augusta Specialty Hospitalists, LLC
Buckhead Surgical Services, L.P.
Byron Family Practice, LLC
Cartersville Medical Center, LLC
    Cartersville Medical Center
Cartersville Occupational Medicine Center, LLC
Cartersville Physician Practice I, LLC
Cartersville Urgent Care, LLC
CCBH Psychiatric Hospitalists, LLC
Center for Colorectal Care, LLC
Chatsworth Hospital Corp.
Church Street Partners
Coliseum Health Group, Inc.
Coliseum Park Hospital, Inc.
Coliseum Primary Care Services, LLC
Coliseum Primary Healthcare - Macon, LLC
Coliseum Primary Healthcare - Riverside, LLC
Coliseum Professional Associates, LLC
Coliseum Same Day Surgery Center, L.P.
    Coliseum Same Day Surgery Center
Columbia Coliseum Same Day Surgery Center, Inc.
Columbia Polk General Hospital, Inc.
    Polk Medical Center
Columbia Surgicare of Augusta, Ltd.
    Augusta Surgical Center
Columbia-Georgia PT, Inc.
Columbus Cardiology, Inc.
Columbus Doctors Hospital, Inc.
Diagnostic Services, G.P.
Doctors Hospital Center for Occupational Medicine, LLC
Doctors Hospital Columbus GA-Joint Venture
Doctors Hospital of Augusta Neurology, LLC
Doctors Hospital Surgery Center, L.P.
    Evans Surgery Center
Doctors-I, Inc.
Doctors-II, Inc.

Doctors-III, Inc.
Doctors-IV, Inc.
Doctors-IX, Inc.
Doctors-V, Inc.
Doctors-VI, Inc.
Doctors-VII, Inc.
Doctors-VIII, Inc.
Doctors-X, Inc.
Dublin Community Hospital, LLC
Dublin Heart Specialists, LLC
Dublin Multispecialty, LLC
Dunwoody Physician Practice Network, Inc.
Eastside General Surgery, LLC
Eastside Medical Center, LLC
    Eastside Medical Center
Eastside Surgery Center, LLC
EHCA Diagnostics, LLC
EHCA Eastside Occupational Medicine Center, LLC
EHCA Metropolitan, LLC
EHCA Parkway, LLC
EHCA Peachtree, LLC
EHCA West Paces, LLC
EHCA, LLC
Fairview Medical Services, LLC
Fairview Park, Limited Partnership
    Fairview Park Hospital
Georgia Psychiatric Company, Inc.
Grace Family Practice, LLC
Grayson Primary Care, LLC
Greater Gwinnett Internal Medicine Associates, LLC
Greater Gwinnett Physician Corporation
Gwinnett Community Hospital, Inc.
HCA Health Services of Georgia, Inc.
HCOL, Inc.
Heritage Medical Care, LLC
Hospitalists at Fairview Park, LLC
Hughston Hospital Services, LLC
Infectious Diseases Consultants of Southwest Georgia, LLC
Johns Creek Physician Services Corporation
Marietta Outpatient Medical Building, Inc.
Marietta Outpatient Surgery, Ltd.
    Marietta Surgical Center
Marietta Surgical Center, Inc.
Med Corp., Inc.
MedFirst, Inc.
Medical Center - West, Inc.
Medical Oncology Associates, LLC
MOSC Sports Medicine, Inc.
North Georgia Primary Care Group, LLC
Northlake Medical Center, LLC
Northlake MultiSpecialty Associates, LLC
Northlake Physician Practice Network, Inc.
Northlake Surgical Center, L.P.
    Northlake Surgical Center

Northlake Surgicare, Inc.
Orthopaedic Specialty Associates, L.P.
Orthopaedic Sports Specialty Associates, Inc.
Palmyra Brain & Spine Center, LLC
Palmyra Park Hospital, LLC
Palmyra Professional Fees, LLC
Redmond Anesthesia Services, LLC
Redmond Hospital Services, LLC
Redmond Neurosurgery, LLC
Redmond Park Health Services, Inc.
Redmond Park Hospital, LLC
    Redmond Regional Medical Center
Redmond Physician Practice Company
Redmond Physician Practice Company II
Redmond Physician Practice Company III
Redmond Physician Practice XI, LLC
Rockbridge Primary Care, LLC
Rome Imaging Center Limited Partnership
Surgery Center of Rome, L.P.
    The Surgery Center of Rome
Surgicare of Augusta, Inc.
Surgicare of Buckhead, LLC
Surgicare of Eastside, LLC
Surgicare of Evans, Inc.
Surgicare of Rome, Inc.
The Rankin Foundation
Urology Center of North Georgia, LLC
West Paces Services, Inc.

IDAHO

East Falls Cardiovascular and Thoracic Surgery, LLC
East Falls OBGYN, LLC
East Falls Plastic Surgery, LLC
Eastern Idaho Health Services, Inc.
    Eastern Idaho Regional Medical Center
Eastern Idaho Regional Medical Center Physician Services, LLC
EIRMC Hospitalist Services, LLC
Idaho Physician Services, Inc.
Patients First Neonatology, LLC
Patients First Neurology, LLC
West Valley Medical Center, Inc.
    West Valley Medical Center
West Valley Medical Group, LLC
West Valley Professional Fee Billing, LLC
West Valley Therapy Services, LLC

ILLINOIS

Chicago Grant Hospital, Inc.
Columbia Chicago Division, Inc.
Columbia LaGrange Hospital, Inc.
Columbia Surgicare - North Michigan Ave., L.P.
Galen of Illinois, Inc.

Illinois Psychiatric Hospital Company, Inc.
Smith Laboratories, Inc.

INDIA

All About Staffing (India) Private Limited

INDIANA

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

KANSAS

Care for Women, LLC
Family Health Medical Group of Overland Park, LLC
Galichia Anesthesia Services, LLC
Galichia Emergency Physicians, LLC
Heartland Women's Group at Wesley, LLC
Johnson County Neurology, LLC
Johnson County Surgery Center, L.P.
    Surgicenter of Johnson County
Johnson County Surgicenter, L.L.C.
Kansas Pulmonary and Sleep Specialists, LLC
Kansas Trauma and Critical Care Specialists, LLC
Menorah Medical Group, LLC
Menorah Urgent Care, LLC
Mid-America Surgery Center, LLC
Mid-America Surgery Institute, LLC
    Mid-America Surgery Institute
Midwest Cardiology Specialists, LLC
Midwest Cardiovascular and Thoracic Surgeons of Kansas, LLC
Midwest Division, Inc.
Midwest Oncology Associates, LLC
Mill Creek Outpatient Services, LLC
MMC Sleep Lab Management, LLC
Neurology Associates of Kansas, LLC
Neuroscience Associates of Kansas City, LLC
OPRMC-HBP, LLC
Overland Park Cardiovascular, Inc.
Overland Park Medical Specialists, LLC

Overland Park Orthopedics, LLC
Overland Park Surgical Specialties, LLC
Paragyn Surgical, LLC
Pediatric Specialty Clinic LLC
Physician Associates of Corporate Woods, LLC
Quivira Internal Medicine, Inc.
Statland Medical Group, LLC
Surgery Center of Overland Park, L.P.
    Overland Park Surgery Center
Surgicare of Overland Park, LLC
Surgicare of Wichita, Inc.
Surgicare of Wichita, LLC
    Surgicare of Wichita
Surgicenter of Johnson County, Ltd.
Wesley Physician Services, LLC
Wesley Physicians - Anesthesiologist, LLC
Wesley Physicians - Cardiovascular, LLC
Wesley Physicians - Medical Specialties LLC
Wesley Physicians - Obstetrics and Gynecology LLC
Wesley Physicians - Primary Care LLC
Wesley Physicians - Surgical Specialties LLC

KENTUCKY

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

LOUISIANA

Acadiana Care Center, Inc.
Acadiana Practice Management, Inc.
Acadiana Regional Pharmacy, Inc.
Avoyelles Family Care (A Medical Limited Liability Company)
Center for Digestive Diseases, LLC
Children's Multi-Specialty Group, LLC
CLASC Manager, LLC
Columbia Healthcare System of Louisiana, Inc.
Columbia West Bank Hospital, Inc.

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

LUXEMBOURG

HCA Luxembourg 1 Sarl
HCA Luxembourg 2 Sarl

MASSACHUSETTS

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

MISSISSIPPI

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

MISSOURI

AB TIC Investments, LLC
Bone & Joint Specialists Physician Group, LLC
Cardiology Associates Medical Group, LLC
Cedar Creek Medical Group, LLC
Centerpoint Cardiology Services, LLC
Centerpoint Clinic of Blue Springs, LLC
Centerpoint Hospital Based Physicians, LLC
Centerpoint Medical Specialists, LLC
Centerpoint Orthopedics, LLC
Centerpoint Physicians Group, LLC
Centerpoint Women's Services, LLC
Clinishare, Inc.
Endocrinology Associates of Lee's Summit, LLC
Eye Care Surgicare, Ltd.
Eye Surgicare of Independence, LLC
Family Care at Arbor Walk, LLC
Family Health Specialists of Lee's Summit, LLC
Foot & Ankle Specialty Services, LLC
Harrisonville Family Medicine Group, LLC
HCA Midwest Comprehensive Care, Inc.
Health Midwest Medical Group, Inc.
Health Midwest Office Facilities Corporation
Health Midwest Ventures Group, Inc.
HEI Missouri, Inc.
HM Acquisition, LLC
Independence Neurosurgery Services, LLC
Independence Surgicare, Inc.

Kansas City Neurology Associates, LLC
Kansas City Perfusion Services, Inc.
Kansas City Pulmonology Practice, LLC
Kansas City Vascular & General Surgery Group, LLC
Lee's Summit Urgent Care, LLC
Medical Center Imaging, Inc.
Metropolitan Multispecialty Physicians Group, Inc.
Mid-States Financial Services, Inc.
Midwest Cardiovascular & Thoracic Surgery, LLC
Midwest Division - RBH, LLC
    Research Belton Hospital
Midwest Division Spine Care, LLC
Midwest Doctor's Group, LLC
Midwest Infectious Disease Specialists, LLC
Midwest Specialty Care - Lee's Summit, LLC
Midwest Trauma Services, LLC
Midwest Women's Healthcare Specialists, LLC
Missouri Healthcare System, L.P.
National Association of Senior Friends
Notami Hospitals of Missouri, Inc.
Nuclear Diagnosis, Inc.
Ozarks Medical Services, Inc.
Precise Imaging, Inc.
Raymore Medical Group, LLC
Research Cardiology Associates, LLC
Research Family Physicians, LLC
Research Internal Medicine, LLC
Research Multi-Specialty Physicians Group, LLC
Research Neurology Associates, LLC
Research Neuroscience Institute, LLC
Research Psychiatric - 1500, LLC
RMC - Pulmonary, LLC
RMC Transplant Physicians, LLC
Surgery Center of Independence, L.P.
    Centerpoint Ambulatory Surgery Center
Surgical Care Medical Group, LLC
Surgicare of Kansas City, LLC
Surgicenter of Kansas City, L.L.C.
    Surgicenter of Kansas City
Women's Center at Brookside, LLC

NEVADA

CHC Holdings, Inc.
CHC Venture Co.
CIS Holdings, Inc.
Columbia Hospital Corporation of West Houston
Fremont Women's Health, LLC
Health Service Partners, Inc.
Las Vegas ASC, LLC
Las Vegas Physical Therapy, Inc.
Las Vegas Surgical Center, a Nevada limited partnership
Las Vegas Surgicare, Inc.

Las Vegas Surgicare, Ltd.
Las Vegas Surgery Center
Nevada Surgery Center of Southern Hills, L.P.
Nevada Surgicare of Southern Hills, LLC
Rhodes Limited-Liability Company
Sahara Outpatient Surgery Center, Ltd.
Sahara Surgery Center
Southern Hills Medical Center, LLC
Southern Hills Hospital & Medical Center
Specialty Surgicare of Las Vegas, LP
Specialty Surgery Center
Sunrise Flamingo Surgery Center, Limited Partnership
Flamingo Surgery Center
Sunrise Mountainview Hospital, Inc.
MountainView Hospital
Sunrise Neuro Sciences, LLC
Sunrise Outpatient Services, Inc.
Sunrise Physician Services, LLC
Sunrise Trauma Services, LLC
Surgicare of Las Vegas, Inc.
Value Health Holdings, Inc.
VH Holdco, Inc.
VH Holdings, Inc.
Western Plains Capital, Inc.

NEW HAMPSHIRE

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

NORTH CAROLINA

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

OHIO

Columbia/HCA Healthcare Corporation of Northern Ohio
Columbia-CSA/HS Greater Canton Area Healthcare System, L.P.

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

OKLAHOMA

Columbia Doctors Hospital of Tulsa, Inc.
Columbia Oklahoma Division, Inc.
Edmond General Surgery, LLC
Edmond Hospitalists, LLC
Edmond Intensivists, LLC
Edmond Physician Hospital Organization, Inc.
Edmond Physician Services, LLC
Edmond Podiatry Associates, LLC
Edmond Spine and Orthopedic Services, LLC
Family Medicine Associates of Edmond, LLC
HCA Health Services of Oklahoma, Inc.
    OU Medical Center
    OU Medical Center Edmond
Healthcare Oklahoma, Inc.
Medi Flight of Oklahoma, LLC
Medical Imaging, Inc.
Millenium Health Care of Oklahoma, Inc.
Oklahoma Outpatient Surgery Limited Partnership
    Oklahoma Surgicare
Oklahoma Physicians - Medical Specialties LLC
Oklahoma Physicians - Obstetrics and Gynecology LLC
Oklahoma Physicians - Primary Care LLC
Oklahoma Physicians - Surgical Specialties LLC
Oklahoma Surgicare, Inc.
Oklahoma Transplant Physicians, LLC
Plains Healthcare System, Inc.
Stephenson Laser Center, L.L.C.
Surgicare of Northwest Oklahoma Limited Partnership
Surgicare of Tulsa, Inc.
SWMC, Inc.

PHILIPPINES

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

SOUTH CAROLINA

C/HCA Development, Inc.
Carolina Regional Surgery Center, Inc.
Carolina Regional Surgery Center, Ltd.
    Grande Dunes Surgery Center
Coastal Carolina Home Care, Inc.
Coastal Carolina Multispecialty Associates, LLC
Coastal Carolina Primary Care, LLC
Coastal Inpatient Physicians, LLC

Colleton Ambulatory Care, LLC
Colleton Ambulatory Surgery Center
Colleton Diagnostic Center, LLC
Colleton Medical Anesthesia, LLC
Colleton Medical Hospitalists, LLC
Colleton Neurology Associates, LLC
Colleton Otolaryngology, Head and Neck Surgery, LLC
Columbia/HCA Healthcare Corporation of South Carolina
Columbia-CSA/HS Greater Columbia Area Healthcare System, L.P.
Doctors Hospital North Augusta Imaging Center, LLC
Doctor's Memorial Hospital of Spartanburg, L.P.
Edisto Multispecialty Associates, Inc.
Grand Strand Senior Health Center, LLC
Grand Strand Specialty Associates, LLC
Grand Strand Surgical Specialists, LLC
North Augusta Rehab Health Center, LLC
North Charleston Diagnostic Imaging Center, LLC
South Atlantic Division, Inc.
South Carolina Imaging Employer Corp.
Tri-County Surgical Specialists, LLC
Trident Behavioral Health Services, LLC
Trident Eye Surgery Center, L.P.
Trident Eye Surgery Center
Trident Medical Services, Inc.
Trident Neonatology Services, LLC
Walterboro Community Hospital, Inc.
Colleton Medical Center

SWITZERLAND

Glemm SA
HCA Switzerland Finance Sarl
HCA Switzerland Holding Sarl

TENNESSEE

Arthritis Specialists of Nashville, Inc.
Athens Community Hospital, Inc.
Atrium Surgery Center, Ltd.
Centennial Cardiovascular Consultants, LLC
Centennial Heart, LLC
Centennial Neuroscience, LLC
Centennial Primary Care, LLC
Centennial Psychiatric Associates, LLC
Centennial Surgery Center, L.P.
Centennial Surgery Center
Centennial Surgical Associates, LLC
Centennial Surgical Clinic, LLC
Central Tennessee Hospital Corporation
Horizon Medical Center
Chattanooga Diagnostic Associates, LLC
Chattanooga Healthcare Network Partner, Inc.
Chattanooga Healthcare Network, L.P.
Columbia Integrated Health Systems, Inc.

Columbia Medical Group - Centennial, Inc.
Columbia Medical Group - Daystar, Inc.
Columbia Medical Group - Parkridge, Inc.
Columbia Medical Group - Southern Hills, Inc.
Columbia Medical Group - The Frist Clinic, Inc.
Dickson Corporate Health Services, LLC
Dickson Surgery Center, L.P.
Frist Clinic Express, LLC
Gastroenterology Specialists of Middle Tennessee, LLC
H2U Wellness Centers, LLC
HCA - Information Technology & Services, Inc.
HCA - IT&S PBS Field Operations, Inc.
HCA ASD Financial Operations, LLC
HCA ASD Sales Services, LLC
HCA Central Group, Inc.
HCA Chattanooga Market, Inc.
HCA Development Company, Inc.
HCA Eastern Group, Inc.
HCA Health Services of Tennessee, Inc.
    Centennial Medical Center
    Centennial Medical Center at Ashland City
    Southern Hills Medical Center
    StoneCrest Medical Center
    Summit Medical Center
HCA Long Term Health Services of Miami, Inc.
    Sister Emmanuel Hospital
HCA Medical Services, Inc.
HCA Physician Services, Inc.
HCA Realty, Inc.
Health to You, LLC
Healthcare Sales National Management Services Group, LLC
Healthtrust, Inc. - The Hospital Company
Hendersonville Hospital Corporation
    Hendersonville Medical Center
Hendersonville Hospitalist Services, Inc.
Hendersonville OB/GYN, LLC
Hendersonville Primary Care, LLC
Hermitage Primary Care, LLC
Holly Hill/Charter Behavioral Health System, L.L.C.
Hometrust Management Services, Inc.
Horizon Orthopedics, LLC
Horizon Surgical, LLC
Hospital Corporation of Tennessee
Hospital Realty Corporation
Hospitalists at Centennial Medical Center, LLC
Hospitalists at Horizon Medical Center, LLC
Hospitalists at Parkridge, LLC
Hospitalists at StoneCrest, LLC
HTI Memorial Hospital Corporation
    Skyline Madison Campus
    Skyline Medical Center
Indian Path Hospital, Inc.
Indian Path Rehabilitation Center, Inc.
Internal Medicine Associates of Southern Hills, LLC

Lookout Valley Medical Center, LLC
Madison Behavioral Health, LLC
Madison Internal Medicine, LLC
McMinnville Cardiology, LLC
Med Group - Southern Hills Hospitalists, LLC
Medical Group - Dickson, Inc.
Medical Group - Southern Hills of Brentwood, LLC
Medical Group - Southern Hills of Nolensville, LLC
Medical Group - Stonecrest FP, Inc.
Medical Group - Stonecrest Pulmonology, LLC
Medical Group - StoneCrest, Inc.
Medical Group - Summit, Inc.
Medical Plaza Ambulatory Surgery Center Associates, L.P.
    Plaza Day Surgery
Medical Plaza MRI, L.P.
Middle Tennessee Neurology LLC
Mid-State Physicians, LLC
Nashville Psychiatric Company, Inc.
Natchez Surgery Center, LLC
Network Management Services, Inc.
Neurology Associates of Hendersonville, LLC
North Florida Regional Freestanding Surgery Center, L.P.
    North Florida Surgical Pavilion
North Nashville Family Health Center, LLC
NPAS Affiliate, Inc.
NPAS Solutions, LLC
NPAS, Inc.
Old Fort Village, LLC
OneSourceMed, Inc.
Palmer Medical Center, LLC
Parallon Business Solutions, LLC
Parallon Credentialing Solutions, LLC
Parallon Employer, LLC
Parallon Health Information Solutions, LLC
Parallon Payroll Solutions, LLC
Parallon Physician Services, LLC
Parallon Workforce Management Solutions, LLC
Park View Insurance Company
Parkridge East Specialty Associates, LLC
Parkridge Hospitalists, Inc.
Parkridge Medical Associates, LLC
Parkridge Medical Center, Inc.
    Parkridge East Hospital
    Parkridge Medical Center
    Parkridge Valley Hospital
Parkridge Professionals, Inc.
Parkside Surgery Center, Inc.
Plano Ambulatory Surgery Associates, L.P.
    Surgery Center of Plano
Portland Primary Care, LLC
Portland Surgical, LLC
Premier ASC, LLC
Pulmonary Medicine of Dickson, LLC

Rio Grande Surgery Center Associates, L.P.
    Rio Grande Surgery Center
SCRI Services, LLC
Shelbyville Cardiology, LLC
Signal Mountain Primary Care, LLC
Skyline Medical Group, LLC
Skyline Neuroscience Associates, LLC
Skyline Primary Care, LLC
Skyline Rehab Associates, LLC
Skyline Riverside Medical Group, LLC
Southeast Surgical Solutions, LLC
Southern Hills Neurology Consultants, LLC
Southern Hills Orthopaedic Consultants, LLC
Specialist Group at Centennial, LLC
Spring Hill Hospital, Inc.
Spring Hill Physicians, LLC
SRS Acquisition, Inc.
St. Mark's Ambulatory Surgery Associates, L.P.
    St. Mark's Outpatient Surgery Center
Sterling Primary Care Associates, LLC
Stonecrest Medical Group - Family Practice of Murfreesboro, LLC
Stonecrest Medical Group - SC Murfreesboro Family Practice, LLC
Sullins Surgical Center, Inc.
Summit Convenient Care at Lebanon, LLC
Summit Heart, LLC
Summit Research Solutions, LLC
Summit Surgery Center, L.P.
    Summit Surgery Center
Summit Surgical Associates, LLC
Summit Walk-in Clinic, LLC
Surgery Center of Chattanooga, L.P.
    Surgery Center of Chattanooga
Surgicare of Chattanooga, LLC
Surgicare of Dickson, LLC
Surgicare of Madison, Inc.
Surgicare of Natchez, LLC
Surgicare of Premier Orthopaedic, LLC
Surgicare of Southern Hills, Inc.
Surgicare of Wilson County, LLC
Surgicare Outpatient Center of Jackson, Inc.
Sycamore Shoals Hospital, Inc.
TCMC Madison-Portland, Inc.
Tennessee Healthcare Management, Inc.
Tennessee Valley Outpatient Diagnostic Center, LLC
The Charter Cypress Behavioral Health System, L.L.C.
Trident Ambulatory Surgery Center, L.P.
    Trident Ambulatory Surgery Center
TriStar Cardiovascular Surgery, LLC
TriStar Health System, Inc.
TriStar Medical Group - Centennial Primary Care, LLC
TriStar OB/GYN, LLC
Vascular and Endovascular Specialists, LLC
Vision Holdings, LLC
Wilson County Outpatient Surgery Center, L.P.

TEXAS

Administrative Physicians of North Texas, PLLC
All About Staffing of Texas, Inc.
Ambulatory Endoscopy Clinic of Dallas, Ltd.
    Ambulatory Endoscopy Clinic of Dallas
Arlington Diagnostic South, Inc.
Arlington Neurosurgeons, PLLC
Arlington Primary Care, PLLC
Arlington Primary Medicine, PLLC
Arlington Vascular Surgery, PLLC
Austin Heart Cardiology MSO, LLC
Austin Heart, PLLC
Austin Medical Center, Inc.
Austin Physicians Management, LLC
Austin Urogynecology, PLLC
Bailey Square Ambulatory Surgical Center, Ltd.
    Bailey Square Surgery Center
Bailey Square Outpatient Surgical Center, Inc.
Barrow Medical Center CT Services, Ltd.
Bay Area Healthcare Group, Ltd.
    Corpus Christi Medical Center
Bay Area Surgical Center Investors, Ltd.
Bay Area Surgicare Center, Inc.
Bayshore Occupational and Family Medicine, PLLC
Bayshore Surgery Center, Ltd.
Bedford-Northeast Community Hospital, Inc.
Bellaire Imaging, Inc.
Brownsville Specialists of Texas, PLLC
Brownsville Surgical Specialists, PLLC
Brownsville-Valley Regional Medical Center, Inc.
C. Medrano, M.D., PLLC
Calder Urgent Care, PLLC
Calloway Creek Surgery Center, L.P.
Calloway Creek Surgicare, LLC
Capital Area Cardiology
Capital Area Occupational Medicine, PLLC
Capital Area Primary Care, PLLC
Capital Area Providers
Capital Area Specialists, PLLC
Capital Area Surgeons, PLLC
Cardio Vascular Surgeons of North Texas, PLLC
Cardiology Specialists of North Texas, PLLC
Central San Antonio Surgical Center Investors, Ltd.
Central Texas Cardiac Arrhythmia Physicians, PLLC
CHC Management, Ltd.
CHC Payroll Company
CHC Realty Company
CHCA Pearland, L.P.
CHC-El Paso Corp.
CHC-Miami Corp.
Christina Cano-Gonzalez, M.D., PLLC
Clear Lake Family Physicians, PLLC
Clear Lake Multi-Specialty Group, PLLC

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

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

Family Practitioners of Montgomery, PLLC
Family Practitioners of Pearland, PLLC
Flower Mound Surgery Center, Ltd.
Fort Worth Investments, Inc.
Frisco Warren Parkway 91, Inc.
G. Rowe, M.D. , PLLC
G. Schnider, M.D., PLLC
Galen Hospital of Baytown, Inc.
General and Cardiovascular Surgeons of Conroe, PLLC
General Surgeons of Houston, PLLC
General Surgeons of North Richland Hills, PLLC
General Surgeons of Pasadena, PLLC
GI Associates of Denton, PLLC
Gramercy Surgery Center, Ltd.
    Gramercy Outpatient Surgery Center
Greater Houston Preferred Provider Option, Inc.
Green Oaks Hospital Subsidiary, L.P.
    Green Oaks Hospital
Gulf Coast Division, Inc.
Gulf Coast Physician Administrators, Inc.
H2U Wellness Centers - PISD, PLLC
H2U Wellness Centers - San Benito CISD, PLLC
HCA Central/West Texas Physicians Management, LLC
HCA Health Services of Texas, Inc.
HCA Pearland GP, Inc.
HCA Plano Imaging, Inc.
HCA Western Group, Inc.
HCAPS Conroe Affiliation, Inc.
Heart Specialist of North Texas, PLLC
Heartcare of Texas, Ltd.
Hidalgo County Family Practitioners, PLLC
Hidden Lakes Health Center, PLLC
Hip & Joint Specialists of North Texas, PLLC
Houston Northwest Surgical Partners, Inc.
Houston Pediatric Specialty Group, PLLC
HPG Energy, L.P.
HPG GP, LLC
HTI Gulf Coast, Inc.
HWCA, PLLC
Internal Medicine Associates of Huntsville, PLLC
J. M. Garcia, M.D., PLLC
Kathy L. Summers, M.D., PLLC
Kennedale Primary Care PLLC
Kingwood Multi-Specialty Group, PLLC
Kingwood Surgery Center, LLC
    Humble Kingwood Endoscopy Center
KPH-Consolidation, Inc.
    Kingwood Medical Center
Kyle Primary Care, PLLC
Las Colinas Primary Care, PLLC
Las Colinas Surgery Center, Ltd.
    Las Colinas Surgery Center
Leadership Healthcare Holdings II L.P., L.L.P.
Leadership Healthcare Holdings L.P., L.L.P.

Leslie Cohan, M.D., PLLC
Longview Regional Physician Hospital Organization, Inc.
M. Jamshidi, D.O., PLLC
Mainland Family Medicine, PLLC
Mainland Multi-Specialty Group, PLLC
Mainland Primary Care Physicians, PLLC
Mark Gottesman, M.D., PLLC
Mary Alice Cowan, M.D., PLLC
Maternal Fetal Medicine Specialists of Corpus Christi, PLLC
McKinney Surgeons, PLLC
MEC Endoscopy, LLC
Med City Dallas Outpatient Surgery Center, L.P.
    Medical City Dallas Ambulatory Surgery Center
Med-Center Hosp./Houston, Inc.
Medical Care Surgery Center, Inc.
Medical City Dallas Hospital, Inc.
MediPurchase, Inc.
Methodist Healthcare System of San Antonio, Ltd., L.L.P.
    Methodist Ambulatory Surgery Hospital - Northwest
    Methodist Hospital
    Methodist Specialty and Transplant Hospital
    Methodist Stone Oak Hospital
    Methodist Texsan Hospital, a Methodist Hospital facility
    Metropolitan Methodist Hospital
    Northeast Methodist Hospital
Methodist Medical Center ASC, L.P.
    Methodist Ambulatory Surgery Center - Medical Center
Metroplex Surgicenters, Inc.
MGH Medical, Inc.
MHS SC Partner, L.L.C.
MHS Surgery Centers, L.P.
Mid-Cities Surgi-Center, Inc.
Movement Disorders of North Texas, PLLC
National Patient Account Services, Inc.
Navarro Memorial Hospital, Inc.
Neuro Texas, PLLC
Neuro-Hospitalist of Clear Lake, PLLC
Neurological Eye Specialists of North Texas, PLLC
Neurological Specialists of McKinney, PLLC
Neurological Specialists, PLLC
Neurosurgical Specialists of El Paso, PLLC
Neurosurgical Specialists of North Texas, PLLC
North Austin Maternal Fetal Medicine, PLLC
North Austin Plastic Surgery Associates, PLLC
North Austin Surgery Center, L.P.
    North Austin Surgery Center
North Central Methodist ASC, L.P.
    Methodist Ambulatory Surgery Center - North Central
North Hills Cardiac Catheterization Center, L.P.
North Hills Catheterization Lab, LLC
North Hills Primary Care, PLLC
North Hills Surgicare, L.P.
    Texas Pediatric Surgery Center
North Shore Specialists of Texas, PLLC

North Texas Cardiology, PLLC
North Texas Craniofacial Fellowship Program, PLLC
North Texas Division, Inc.
North Texas General, L.P.
North Texas Geriatrics, PLLC
North Texas Heart Surgery Center, PLLC
North Texas Internal Medicine Specialists, PLLC
North Texas Neuro Stroke OP, PLLC
North Texas of Hope, PLLC
North Texas Pulmonary Critical Care, PLLC
North Texas Sports and Orthopedics Center, PLLC
North Texas Stroke Center, PLLC
Northeast Methodist Surgicare, Ltd.
Northeast PHO, Inc.
Oakwood Surgery Center, Ltd., LLP
    Oakwood Surgery Center
OB Hospitalists of Woman's Hospital, PLLC
OB/Gyn Associates of Denton, PLLC
OB/GYN of Brownsville, PLLC
Occupational and Family Medicine of South Texas
Orthopedic Hospital, Ltd.
    Texas Orthopedic Hospital
Outpatient Women's and Children's Surgery Center, Ltd.
    Fannin Surgicare
Paragon of Texas Health Properties, Inc.
Paragon Physicians Hospital Organization of South Texas, Inc.
Paragon Surgery Centers of Texas, Inc.
Park Central Surgical Center, Ltd.
    Park Central Surgical Center
Parkway Cardiac Center, Ltd.
Parkway Surgery Services, Ltd.
Pasadena Bayshore Hospital, Inc.
Pediatric Cardiac Intensivists of North Texas, PLLC
Pediatric Hospitalists of Conroe, PLLC
Pediatric Intensivists of El Paso, PLLC
Pediatric Specialists of Clear Lake, PLLC
Pediatric Surgicare, Inc.
Physicians Ambulatory Surgery Center, LLC
    Physicians Endoscopy Center
Plano Surgery Center - GP, LLC
Plano Urology, PLLC
Plaza Primary Care, PLLC
Plaza Transplant Center, PLLC
Primary Care Plano, PLLC
Primary Care South, PLLC
Primary Care West, PLLC
Primary Health Network of South Texas
Quantum/Bellaire Imaging, Ltd.
Rim Building Partners, L.P.
Rio Grande Healthcare MSO, Inc.
Rio Grande NP, Inc.
Rio Grande Regional Hospital, Inc.
Rio Grande Regional Investments, Inc.
Rio Grande Valley Cardiology, PLLC

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

Surgicare of Sugar Land, Inc.
Surgicare of Travis Center, Inc.
Tarrant County Surgery Center, L.P.
    Trinity Park Surgery Center
Texas Psychiatric Company, Inc.
The West Texas Division of Columbia, Inc.
THN Physicians Association, Inc.
Travis Surgery Center, L.P.
Tuscan Imaging Center at Las Colinas, LLC
Urological Specialists of Arlington, PLLC
Urology Services of El Paso, PLLC
Village Oaks Medical Center, Inc.
W & C Hospital, Inc.
West Houston ASC, Inc.
West Houston Healthcare Group, Ltd.
West Houston Internal Specialists, PLLC
West Houston Outpatient Medical Facility, Inc.
West Houston Surgicare, Inc.
West LPN Fort Worth Oncology, PLLC
West LPN, Inc.
West McKinney Imaging Services, LLC
West Park Surgery Center, L.P.
    McKinney Surgery Center
WHMC, Inc.
Woman's Health Group, PLLC
Woman's Hospital of Texas, Incorporated
Women Practitioners of Houston, PLLC
Women Specialists of Bayshore, PLLC
Women Specialists of Mainland, PLLC
Women's Link Specialty Obstetrical Referral Clinic, PLLC
Women'sLink Center of Wylie - A Medical Center of Plano Facility, LLC

UNITED KINGDOM

All About Staffing (UK) Limited
Carriford Management Limited
Chelsea Outpatient Centre LLP
Enhancecorp Limited
Galen Health Partners Limited
Hamsard 3160 Limited
Hamsard 3214 LLP
Harley Street Clinic @ The Groves LLP
HCA Finance, LP
HCA International Holdings Limited
HCA International Limited
    Princess Grace Hospital
    The Harley Street Clinic
    The Portland Hospital for Women and Children
    The Wellington Hospital
HCA Luxembourg Finance Limited
HCA Purchasing Limited
HCA Staffing Limited
HCA UK Capital Limited
HCA UK Holdings Limited

HCA UK Investments Limited
HCA UK Limited
HCA UK Services, Ltd.
Healthtrust-Europe Company Limited
Healthtrust-Europe LLP
Indemed Managed Services Limited
La Tour Finance Limited Partnership
Leaders in Oncology Care Limited
Leaders in Oncology Care Network Limited
LOC @ The Christie LLP
LOC @ The London Bridge Hospital LLP
LOC @ The Wellington Hospital LLP
    Platinum Medical Centre
LOC Partnership LLP
London Back Limited
London Radiography & Radiotherapy Services Limited
PET CT LLP
Robotic Radiosurgery LLP
Roodlane Medical Limited
Sarah Cannon Research UK Limited
SCRI Global Services Limited
St. Martins Healthcare Limited
    Lister Hospital
    London Bridge Hospital
St. Martins Ltd.
St. Martins Medical Services Limited
The Christie Clinic LLP
The Harley Street Cancer Clinic Limited
The London Stone Centre Limited
Twenty Seven Welbeck Street Limited
Wellington Diagnostic Services LLP

UTAH

Alta Internal Medicine, LLC
Bountiful Surgery Center, LLC
    Lakeview Endoscopy Center
Brigham City Community Hospital Physician Services, LLC
Brigham City Community Hospital, Inc.
    Brigham City Community Hospital
Brigham City Health Plan, Inc.
Columbia Ogden Medical Center, Inc.
    Ogden Regional Medical Center
East Layton Internal Medicine, LLC
General Hospitals of Galen, Inc.
Gynecology Specialists of Utah, LLC
Healthtrust Utah Management Services, Inc.
Hospital Corporation of Utah
    Lakeview Hospital
HTI Physician Services of Utah, Inc.
Jordan Family Health, L.L.C.
Lakeview Hospital Physician Services, LLC
Lakeview Internal Medicine, LLC
Lakeview Neurosurgery Clinic, LLC

Lakeview Professional Billing, LLC
Lakeview Urology & General Surgery, LLC
Layton Family Practice, LLC
Lone Peak General Surgery, LLC
Lone Peak Hospital, Inc.
Maternal Fetal Services of Utah, LLC
Mountain Division, Inc.
Mountain View Hospital, Inc.
    Mountain View Hospital
Mountain View Medical Office Building, Ltd.
Mountain West Surgery Center, LLC
    Mountain West Surgery Center
MountainStar Brigham General Surgery, LLC
Mountainstar Brigham OBGYN, LLC
MountainStar Canyon Surgical Clinic, LLC
MountainStar Cardiology Ogden Regional, LLC
MountainStar Cardiology St. Marks, LLC
Mountainstar Cardiovascular Services, LLC
MountainStar Medical Group - Brigham City Community Hospital, LLC
MountainStar Medical Group - Ogden Regional Medical Center, LLC
MountainStar Medical Group - St. Mark's Hospital, LLC
MountainStar Medical Group Neurosurgery - St. Mark's, LLC
Mountainstar Ogden Pediatrics, LLC
MVH Professional Services, LLC
Northern Utah Healthcare Corporation
    St. Mark's Hospital
Northern Utah Healthcare Imaging Holdco, LLC
Northern Utah Imaging, LLC
Ogden Imaging, LLC
Ogden Internal Medicine & Urology, LLC
Ogden Regional Health Plan, Inc.
Ogden Regional Medical Center Professional Billing, LLC
Ogden Senior Center, LLC
Salt Lake City Surgicare, Inc.
Shadow Mountain Family Medicine, LLC
St. Mark's Gynecology Oncology Care, LLC
St. Mark's Investments, Inc.
St. Mark's Physicians, Inc.
St. Mark's Professional Services, LLC
St. Mark's South Jordan Family Practice, LLC
Surgicare of Bountiful, LLC
Surgicare of Mountain West, LLC
Surgicare of Utah, LLC
Surgicare of Wasatch Front, LLC
The Wasatch Endoscopy Center, Ltd.
    Wasatch Endoscopy Center
Timpanogos Pain Specialists, LLC
Timpanogos Professional Services, LLC
Timpanogos Regional Medical Services, Inc.
    Timpanogos Regional Hospital
Utah Imaging GP, LLC
Utah Surgery Center, L.P.
    South Towne Surgery Center

Wasatch Front Surgery Center, LLC
Utah Surgical Center
West Jordan Hospital Corporation
West Valley Imaging, LLC

VIRGINIA

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

Fairfax Surgical Center, L.P.
    Fairfax Surgical Center
Family Medicine of Blacksburg, LLC
Family Practice at Forest Hill, LLC
Family Practice at Retreat, LLC
Fort Chiswell Family Practice, LLC
Galen of Virginia, Inc.
Galen Property, LLC
Galen Virginia Hospital Corporation
Generations Family Practice, Inc.
GYN-Oncology of Southwest Virginia, LLC
Hanover Outpatient Surgery Center, L.P.
    Hanover Outpatient Surgery Center
HCA Health Services of Virginia, Inc.
    Henrico Doctors' Hospital
    Henrico Doctors' Hospital-Forest Campus
    Parham Doctors' Hospital - A Campus of Henrico Doctors' Hospital
    Retreat Doctors' Hospital - A Campus of Henrico Doctors' Hospital
HCA Richmond Division, Inc.
HDH Thoracic Surgeons, LLC
Henrico Doctors' Family Medicine, LLC
Henrico Doctors' Neurology Associates, LLC
Henrico Doctor's OB GYN Specialists, LLC
Henrico Radiation Oncology, LLC
Henrico Surgical Specialists, LLC
HSS Virginia, L.P.
Institute of Advanced ENT Surgery, LLC
Internal Medicine of Blacksburg, LLC
James River Internists, LLC
John Randolph Family Practice, LLC
John Randolph OB/GYN, LLC
John Randolph Surgeons, LLC
Lewis Gale Physicians Specialists, LLC
Lewis-Gale Hospital, Incorporated
Lewis-Gale Physicians, LLC
LGMC Ambulatory Surgery Center, LLC
Loudoun Surgery Center, L.P.
Loudoun Surgery Center, LLC
Management Services of the Virginias, Inc.
Mechanicsville Imaging, LLC
Montgomery Cancer Center, LLC
Montgomery Hospitalists, LLC
Montgomery Regional Hospital, Inc.
    LewisGale Hospital Montgomery
Montgomery Surgery Associates, LLC
Northern Virginia Community Hospital, LLC
Northern Virginia Hospital Corporation
Orthopedics Specialists, LLC
Pediatric Specialists for CJW, LLC
Preferred Hospitals, Inc.
Primary Care of West End, LLC
Primary Health Group, Inc.
Pulaski Community Hospital, Inc.
    LewisGale Hospital Pulaski

Pulaski Radiologists, LLC
Pulaski Urology, LLC
Quick Care Centers, LLC
Radford Family Medicine, LLC
Reston Hospitalists, LLC
Reston Surgery Center, L.P.
    Reston Surgery Center
Retreat Cardiology, LLC
Retreat Hospital, LLC
Retreat Internal Medicine, LLC
Retreat Surgical Associates, LLC
Richmond Imaging Employer Corp.
Richmond Multi-Specialty, LLC
Richmond Pediatric Surgeon's, LLC
Roanoke Imaging, LLC
Roanoke Neurosurgery, LLC
Roanoke Surgery Center, L.P.
    Blue Ridge Surgery Center
Roanoke Valley Gynecology, LLC
Salem Hospitalists, LLC
Short Pump Imaging, LLC
Southwest Virginia Fertility Center, LLC
Southwest Virginia Orthopedics and Spine, LLC
Specialty Physicians of Northern Virginia, LLC
Spotsylvania Condominium Property, LLC
Spotsylvania Medical Center, Inc.
    Spotsylvania Regional Medical Center
Spotsylvania Multi-Specialty Group, LLC
Spotsylvania Regional Surgery Center, LLC
Stafford Imaging, LLC
Surgical Associates of Southwest Virginia, LLC
Surgical Associates of the New River Valley, LLC
Surgicare of Ashburn, LLC
Surgicare of Chippenham, LLC
Surgicare of Fairfax, Inc.
Surgicare of Hanover, Inc.
Surgicare of Reston, Inc.
Surgicare of Roanoke, LLC
Surgicare of Spotsylvania, LLC
Surgicare of Tuckahoe, Inc.
Tri-City Multi-Specialty, LLC
Urology Specialists of Richmond, LLC
Virginia Gynecologic Oncology, LLC
Virginia Hematology & Oncology Associates, Inc.
Virginia Hospitalists, Inc.
Virginia Psychiatric Company, Inc.
    Dominion Hospital
West Creek Ambulatory Surgery Center, LLC
West Creek Medical Center, Inc.
Women's & Children's Center, LLC
Women's Health Center of SWVA, LLC

WASHINGTON

ACH, Inc.
Capital Network Services, Inc.

WEST VIRGINIA

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

Exhibit 23

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-8 No. 333-173866) pertaining to the HCA-Hospital Corporation of America Nonqualified Initial Option Plan, HCA, Inc. 2000 Equity Incentive Plan and HCA 2005 Equity Incentive Plan,

(2) Registration Statement (Form S-8 No. 333-172887) pertaining to the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated of HCA Holdings, Inc.,

(3) Registration Statement (Form S-8 No. 333-150714) pertaining to the 2006 Stock Incentive Plan for Key Employees of HCA Inc. and its Affiliates, and

(4) Registration Statement (Form S-3 No. 333-175791) of HCA Holdings, Inc.;

of our reports dated February 23, 2012, with respect to the consolidated financial statements of HCA Holdings, Inc. and the effectiveness of internal control over financial reporting of HCA Holdings, Inc., included in this Annual Report (Form 10-K) of HCA Holdings, Inc. for the year ended December 31, 2011.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 23, 2012

EXHIBIT 31.1

CERTIFICATIONS

I, Richard M. Bracken, certify that:

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

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

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

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

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

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

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

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

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

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

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

By: /S/ RICHARD M. BRACKEN
Richard M. Bracken
Chairman of the Board and Chief Executive Officer

Date: February 23, 2012

EXHIBIT 31.2

CERTIFICATIONS

I, R. Milton Johnson, certify that:

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

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

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

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

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

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

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

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

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

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

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

By: /S/ R. MILTON JOHNSON
R. Milton Johnson
President and Chief Financial Officer

Date: February 23, 2012

EXHIBIT 32

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

In connection with the Annual Report of HCA Holdings, Inc. (the "Company") on Form 10-K for the year ended December 31, 2011, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned certifies, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

By: /S/ RICHARD M. BRACKEN
Richard M. Bracken
Chairman of the Board and Chief Executive Officer

February 23, 2012

By: /S/ R. MILTON JOHNSON
R. Milton Johnson
President and Chief Financial Officer

February 23, 2012

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

Form 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2010

OR

☐ **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 HOLDINGS, INC.

(Exact Name of Registrant as Specified in its Charter)

Delaware	**27-3865930**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)
One Park Plaza **Nashville, Tennessee**	**37203**
(Address of Principal Executive Offices)	(Zip Code)

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

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

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

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

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 ☐ No ☑

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 ☑ No ☐

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

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. ☐

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

Large accelerated filer ☐	Accelerated filer ☐	Non-accelerated filer ☑ (Do not check if a smaller reporting company)	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 ☐ No ☑

As of February 1, 2011, there were approximately 94,889,400 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

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

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PART I

Item 1. *Business*

General

HCA Holdings, Inc. is one of the leading health care services companies in the United States. At December 31, 2010, we operated 164 hospitals, comprised of 158 general, acute care hospitals; five psychiatric hospitals; and one rehabilitation hospital. The 164 hospital total includes eight hospitals (seven general, acute care hospitals and one rehabilitation hospital) owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. In addition, we operated 106 freestanding surgery centers, nine 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 used herein and unless otherwise stated or indicated by context, refer to HCA Inc. and its affiliates prior to the Corporate Reorganization (as defined below) and to HCA Holdings, Inc. and its affiliates after the Corporate Reorganization. The term "affiliates" means direct and indirect subsidiaries of HCA Holdings, Inc. and partnerships and joint ventures in which such subsidiaries are partners. The terms "facilities" or "hospitals" refer to entities owned and operated by affiliates of HCA and the term "employees" refers to employees of affiliates of HCA.

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.

On November 17, 2006, HCA Inc. was acquired by a private investor group comprised of affiliates of or funds sponsored by Bain Capital Partners, LLC ("Bain Capital"), Kohlberg Kravis Roberts & Co. ("KKR") and Merrill Lynch Global Private Equity ("MLGPE"), now BAML Capital Partners (each a "Sponsor"), Citigroup Inc. and Bank of America Corporation (the "Sponsor Assignees") and HCA founder Dr. Thomas F. Frist, Jr. (the "Frist Entities"), a group we collectively refer to as the "Investors," and by members of management and certain other investors. We refer to the merger, the financing transactions related to the merger and other related transactions collectively as the "Recapitalization." The merger was accounted for as a recapitalization in our financial statements, with no adjustments to the historical basis of our assets and liabilities. As a result of the Recapitalization, our outstanding capital stock is owned by the Investors, certain members of management and key employees. On April 29, 2008, we registered our common stock pursuant to Section 12(g) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), 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.

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.

Corporate Reorganization

On November 22, 2010, HCA Inc. reorganized by creating a new holding company structure (the "Corporate Reorganization"). We are the new parent company, and HCA Inc. is now our wholly-owned direct subsidiary. As part of the Corporate Reorganization, HCA Inc.'s outstanding shares of capital stock were automatically converted, on a share for share basis, into identical shares of our common stock. Our amended and restated certificate of incorporation, amended and restated by-laws, executive officers and board of directors are the same as HCA Inc.'s in effect immediately prior to the Corporate Reorganization, and the rights, privileges and interests of HCA Inc.'s stockholders remain the same with respect to us as the new holding company. Additionally, as a result of the

Corporate Reorganization, we are deemed the successor registrant to HCA Inc. under the Exchange Act, and shares of our common stock are deemed registered under Section 12(g) of the Exchange Act. As part of the Corporate Reorganization, we will become a guarantor but will not assume the debt of HCA Inc.'s outstanding secured notes.

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

Available Information

We file certain reports with the Securities and Exchange Commission ("the SEC"), including annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. The public may read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Washington, DC 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. We are an electronic filer, and the SEC maintains an Internet site at http://www.sec.gov that contains the reports, proxy and information statements and other information we file electronically. Our website address is www.hcahealthcare.com. Please note that our website address is provided as an inactive textual reference only. We make available free of charge, through our website, our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and all amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act, as soon as reasonably practicable after such material is electronically filed with or furnished to the SEC. The information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

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

Business Strategy

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

- grow our presence in existing markets;
- achieve industry-leading performance in clinical and satisfaction measures;
- recruit and employ physicians to meet need for high quality health services;
- continue to leverage our scale and market positions to enhance profitability; and
- selectively pursue a disciplined development strategy.

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, 2010, we owned and operated 151 general, acute care hospitals with 38,321 licensed beds, and an additional seven general, acute care hospitals with 2,269 licensed beds are operated through joint ventures, which are accounted for using the equity method. Most of our general, acute care hospitals provide medical and

surgical services, including inpatient care, intensive care, cardiac care, diagnostic services and emergency services. The general, acute care hospitals also provide outpatient services such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology and physical therapy. Each hospital has an organized medical staff and a local board of trustees or governing board, made up of members of the local community.

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

At December 31, 2010, we operated five psychiatric hospitals with 506 licensed beds. Our psychiatric hospitals provide therapeutic programs including child, adolescent and adult psychiatric care, adult and adolescent alcohol and drug abuse treatment and counseling.

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

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

Sources of Revenue

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

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

	Year Ended December 31,		
	2010	2009	2008
Medicare	24%	23%	23%
Managed Medicare	7	7	6
Medicaid	6	6	5
Managed Medicaid	4	4	3
Managed care and other insurers	53	52	53
Uninsured	6	8	10
Total	100%	100%	100%

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

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

Medicare

Inpatient Acute Care

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

MS-DRG rates are updated and MS-DRG weights are recalibrated using cost relative weights each federal fiscal year (which begins October 1). The index used to update the MS-DRG rates (the "market basket") gives consideration to the inflation experienced by hospitals and entities outside the health care industry in purchasing goods and services. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Health Reform Law") provides for annual decreases to the market basket, including a 0.25% reduction in 2010 for discharges occurring on or after April 1, 2010. The Health Reform Law also provides for the following reductions to the market basket update for each of the following federal fiscal years: 0.25% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. For federal fiscal year 2012 and each subsequent federal fiscal year, the Health Reform Law provides for the annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, the Department of Health and Human Services ("HHS") will use the Bureau of Labor Statistics ("BLS") 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. Based upon the latest available data, federal fiscal year 2012 market basket reductions resulting from this productivity adjustment are likely to range from 1.0% to 1.4%. CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the inpatient PPS by $112.6 billion from 2010 to 2019. A decrease in payments rates or an increase in rates that is below the increase in our costs may adversely affect the results of our operations.

For federal fiscal year 2010, CMS initially set the MS-DRG rate increase at the full market basket of 2.1%, but CMS reduced the increase to 1.85% for discharges occurring on or after April 1, 2010, as required by the Health Reform Law. For federal fiscal year 2011, CMS increased the MS-DRG rate for federal fiscal year 2011 by 2.35%, representing the full market basket of 2.6% minus the 0.25% reduction required by the Health Reform Law. CMS also applied a documentation and coding adjustment of negative 2.9% in federal fiscal year 2011 to account for

increases in aggregate payments during implementation of the MS-DRG system. This reduction represents half of the documentation and coding adjustment that CMS intends to implement. CMS plans to recover the remaining 2.9% and interest in federal fiscal year 2012. The market basket update and the documentation and coding adjustment together result in an aggregate market basket adjustment for federal fiscal year 2011 of negative 0.55%. CMS has also announced that an additional prospective negative adjustment of 3.9% will be needed to avoid increased Medicare spending unrelated to patient severity of illness. CMS did not implement this additional 3.9% reduction in federal fiscal year 2011 but has stated that it will be required in the future.

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

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") provides for hospitals to receive a 2% reduction to their market basket updates if they fail to submit data for patient care quality indicators to the Secretary of HHS. As required by the Deficit Reduction Act of 2005 ("DRA 2005"), CMS has expanded, through a series of rulemakings, the number of quality measures that must be reported to avoid the market basket reduction. In federal fiscal year 2011, CMS requires hospitals to report 55 quality measures in order to avoid the market basket reduction for inpatient PPS payments in federal fiscal year 2012. All of our hospitals paid under the Medicare inpatient PPS are participating in the quality initiative by submitting the requested quality data. While we will endeavor to comply with all data submission requirements as additional requirements continue to be added, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals.

As part of CMS' goal of transforming Medicare from a passive payer to an active purchaser of quality goods and services, for discharges occurring after October 1, 2008, Medicare no longer assigns an inpatient hospital discharge to a higher paying MS-DRG if a selected hospital acquired condition ("HAC") was not present on admission. In this situation, the case is paid as though the secondary diagnosis was not present. Currently, there are ten categories of conditions on the list of HACs. In addition, CMS has established three National Coverage Determinations that prohibit Medicare reimbursement for erroneous surgical procedures performed on an inpatient or outpatient basis. The Health Reform Law provides for reduced payments based on a hospital's HAC rates. Beginning in federal fiscal year 2015, the 25% of hospitals with the worst national risk-adjusted HAC rates in the previous year will receive a 1% reduction in their total inpatient operating Medicare payments. In addition, effective July 1, 2011, the Health Reform Law prohibits the use of federal funds under the Medicaid program to reimburse providers for medical services provided to treat HACs.

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

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

purchasing program. On January 7, 2011, CMS issued a proposed rule for the value-based purchasing program that would use 17 clinical process of care measures and eight dimensions of a patient's experience of care using the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") survey to determine incentive payments for federal fiscal year 2013. As proposed, the incentive payments would be calculated based on a combination of measures of hospitals' achievement of the performance standards and their improvement in meeting the performance standards compared to prior periods. To determine payments in federal fiscal year 2013, the baseline performance period (measurement standard) as proposed would be July 1, 2009 through March 31, 2010. To determine whether hospitals meet performance standards, CMS would compare each hospital's performance in the period July 1, 2011 through March 31, 2012 to its performance in the baseline performance period. CMS has not yet proposed specific threshold values for the performance standards. CMS also proposes to add three outcome measures for federal fiscal year 2014, for which the performance period would be July 1, 2011 through December 31, 2012 and the baseline performance period would be July 1, 2008 through December 31, 2009.

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

Outpatient

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

Hospital outpatient services paid under PPS are classified into groups called ambulatory payment classifications ("APCs"). Services for each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit. The APC payment rates were updated for calendar years 2008 and 2009 by market baskets of 3.30% and 3.60%, respectively. CMS updated payment rates for calendar year 2010 by the full market basket of 2.1%. However, the Health Reform Law includes a 0.25% reduction to the market basket for 2010. The Health Reform Law also provides for the following reductions to the market basket update for each of the following calendar years: 0.25% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. For calendar year 2011, CMS implemented a market basket update of 2.6%. With the 0.25% reduction required by the Health Reform Law, this update results in a market basket increase of 2.35%. For calendar year 2012 and each subsequent calendar year, the Health Reform Law provides for an annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the BLS 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. However, CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the outpatient PPS by $26.3 billion from 2010 to 2019. CMS continues to require hospitals to submit quality data relating to outpatient care to avoid receiving a 2% reduction to the market basket update under the outpatient PPS. CMS required hospitals to report data on 11 quality measures in calendar year 2010 for the payment determination in calendar year 2011 and requires hospitals to report 15 quality measures in calendar year 2011 to avoid reduced payments in calendar year 2012.

Rehabilitation

CMS reimburses inpatient rehabilitation facilities ("IRFs") on a PPS basis. Under IRF PPS, patients are classified into case mix groups based upon impairment, age, comorbidities (additional diseases or disorders from which the patient suffers) and functional capability. IRFs are paid a predetermined amount per discharge that reflects the patient's case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. CMS provided for a market basket update of 2.5% for federal fiscal year 2010. However, the Health

Reform Law requires a 0.25% reduction to the market basket for 2010 for discharges occurring on or after April 1, 2010. The Health Reform Law also provides for the following reductions to the market basket update for each of the following federal fiscal years: 0.25% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. For federal fiscal year 2011, CMS implemented a market basket update of 2.5%. With the 0.25% reduction required by the Health Reform Law, this update results in a market basket increase of 2.25% for federal fiscal year 2011. For federal fiscal year 2012 and each subsequent federal fiscal year, the Health Reform Law provides for the annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the BLS 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. However, CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the IRF PPS by $5.7 billion from 2010 to 2019. Beginning in federal fiscal year 2014, IRFs will be required to report quality measures to CMS or will receive a two percentage point reduction to the market basket update. As of December 31, 2010, we had one rehabilitation hospital, which is operated through a joint venture, and 43 hospital rehabilitation units.

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

Psychiatric

Inpatient hospital services furnished in psychiatric hospitals and psychiatric units of general, acute care hospitals and critical access hospitals are reimbursed under a prospective payment system ("IPF PPS"), a per diem payment, with adjustments to account for certain patient and facility characteristics. IPF PPS contains an "outlier" policy for extraordinarily costly cases and an adjustment to a facility's base payment if it maintains a full-service emergency department. CMS has established the IPF PPS payment rate in a manner intended to be budget neutral and has adopted a July 1 update cycle, with each twelve month period referred to as a "rate year." CMS issued a proposed rule that includes changing the IPF PPS from the rate year update cycle to a fiscal year schedule. If implemented as proposed, the rates for 2012 would be effective from July 1, 2011 through September 30, 2012, with future updates coinciding with the federal fiscal year (from October 1 through September 30). The rehabilitation, psychiatric and long-term care ("RPL") market basket update is used to update the IPF PPS. The annual RPL market basket update for rate year 2010 was 2.1%, and the annual RPL market basket update for rate year 2011 is 2.4%. However, the Health Reform Law includes a 0.25% reduction to the market basket for rate year 2010 and again in 2011. The Health Reform Law also provides for the following reductions to the market basket update for rate years that begin in the following calendar years: 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016 and 0.75% in 2017, 2018 and 2019. For rate year 2012 and each subsequent rate year, the Health Reform Law provides for the annual market basket update to be further reduced by a productivity adjustment. The amount of that reduction will be the projected, nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the BLS 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old). The Health Reform Law does not contain guidelines for use by HHS in projecting the productivity figure. However, CMS estimates that the combined market basket and productivity adjustments will reduce Medicare payments under the IPF PPS by $4.3 billion from 2010 to 2019. In a proposed rule, CMS proposes a market basket update of 3.0% for rate year 2012. If implemented as proposed, and with the 0.25% reduction

required by the Health Reform Law, this would result in a market basket update of 2.75%. As of December 31, 2010, we had five psychiatric hospitals and 35 hospital psychiatric units.

Ambulatory Surgery Centers

CMS reimburses ASCs using a predetermined fee schedule. Reimbursements for ASC overhead costs are limited to no more than the overhead costs paid to hospital outpatient departments under the Medicare hospital outpatient PPS for the same procedure. Effective January 1, 2008, ASC payment groups increased from nine clinically disparate payment groups to an extensive list of covered surgical procedures among the APCs used under the outpatient PPS for these surgical services. Because the new payment system has a significant impact on payments for certain procedures, for services previously in the nine payment groups, CMS has established a four-year transition period for implementing the required payment rates. Moreover, if CMS determines that a procedure is commonly performed in a physician's office, the ASC reimbursement for that procedure is limited to the reimbursement allowable under the Medicare Part B Physician Fee Schedule, with limited exceptions. In addition, all surgical procedures, other than those that pose a significant safety risk or generally require an overnight stay, are payable as ASC procedures. As a result, more Medicare procedures now performed in hospitals may be moved to ASCs, reducing surgical volume in our hospitals. Also, more Medicare procedures now performed in ASCs may be moved to physicians' offices. Commercial third-party payers may adopt similar policies. The Health Reform Law requires HHS to issue a plan by January 1, 2011 for developing a value-based purchasing program for ASCs, but HHS has not yet publicly issued this plan. Such a program may further impact Medicare reimbursement of ASCs or increase our operating costs in order to satisfy the value-based standards. For federal fiscal year 2011 and each subsequent federal fiscal year, the Health Reform Law provides for the annual market basket update to be reduced by a productivity adjustment. The amount of that reduction will be the projected nationwide productivity gains over the preceding 10 years. To determine the projection, HHS will use the BLS 10-year moving average of changes in specified economy-wide productivity (the BLS data is typically a few years old).

Physician Services

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

The PFS rates are adjusted each year, and reductions in both current and future payments are anticipated. The SGR formula, if implemented as mandated by statute, would result in significant reductions to payments under the PFS. Since 2003, the U.S. Congress has passed multiple legislative acts delaying application of the SGR to the PFS. For calendar year 2011, CMS issued a final rule that would have applied the SGR and resulted in an aggregate reduction of 24.9% to all physician payments under the PFS for federal fiscal year 2011. On December 15, 2010, President Obama signed legislation delaying application of the SGR until January 1, 2012. We cannot predict whether the U.S. Congress will intervene to prevent this reduction to payments in the future.

Other

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

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

As required by the MMA, CMS is implementing contractor reform whereby CMS has competitively bid the Medicare fiscal intermediary and Medicare carrier functions to 15 Medicare Administrative Contractors ("MACs"), which are geographically assigned and service both Part A and Part B providers within a given jurisdiction. Although CMS has awarded initial contracts to all 15 MAC jurisdictions, full transition to the MAC jurisdictions has been delayed due to CMS resoliciting some bids and implementing other corrective actions in response to filed protests. While chain providers had the option of having all hospitals use one home office MAC, HCA chose to use the MACs assigned to the geographic areas in which our hospitals are located. The individual MAC jurisdictions are in varying phases of transition. During the transition periods and for a potentially unforeseen period thereafter, all of these changes could impact claims processing functions and the resulting cash flow; however, we are unable to predict the impact at this time.

Under the Recovery Audit Contractor ("RAC") program, CMS contracts with RACs on a contingency basis to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The RAC program was originally limited to certain states, but in 2010, CMS implemented the RAC program on a permanent, nationwide basis as required by statute.

The U.S. Congress has not permanently addressed the SGR reductions in physician compensation under the PFS. Any repeal of the SGR may be offset by reductions in Medicare payments to other types of providers.

Managed Medicare

Managed Medicare plans relate to situations where a private company contracts with CMS to provide members with Medicare Part A, Part B and Part D benefits. Managed Medicare plans can be structured as HMOs, PPOs or private fee-for-service plans. The Medicare program allows beneficiaries to choose enrollment in certain managed Medicare plans. In 2003, MMA increased reimbursement to managed Medicare plans and expanded Medicare beneficiaries' health care options. Since 2003, the number of beneficiaries choosing to receive their Medicare benefits through such plans has increased. However, the Medicare Improvements for Patients and Providers Act of 2008 imposed new restrictions and implemented focused cuts to certain managed Medicare plans. In addition, the Health Reform Law reduces, over a three year period, premium payments to managed Medicare plans such that CMS' managed care per capita premium payments are, on average, equal to traditional Medicare. The Health Reform Law also implements fee payment adjustments based on service benchmarks and quality ratings. The Congressional Budget Office ("CBO") has estimated that, as a result of these changes, payments to plans will be reduced by $138 billion between 2010 and 2019, while CMS has estimated the reduction to be $145 billion. In addition, the Health Reform Law expands the RAC program to include managed Medicare plans. In light of the current economic downturn and the Health Reform Law, managed Medicare plans may experience reduced premium payments, which may lead to decreased enrollment in such plans.

Medicaid

Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid program payments are made under a PPS or are based on negotiated payment levels with individual hospitals. Medicaid reimbursement is often less than a hospital's cost of services. The Health Reform Law also requires states to expand Medicaid coverage to all individuals under age 65 with incomes up to 133% of the federal poverty level ("FPL") by 2014. However, the Health Reform Law also requires states to apply a "5% income disregard" to the Medicaid eligibility standard, so that Medicaid eligibility will effectively be extended to those with incomes up to 138% of the FPL. In addition, effective July 1, 2011, the Health Reform Law will prohibit the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs.

Since most states must operate with balanced budgets and since the Medicaid program is often the state's largest program, states can be expected to adopt or consider adopting legislation designed to reduce their Medicaid expenditures. The current economic downturn has increased the budgetary pressures on most states, and these budgetary pressures have resulted and likely will continue to result in decreased spending, or decreased spending growth, for Medicaid programs in many states. The American Recovery and Reinvestment Act of 2009 ("ARRA") allocated approximately $87.0 billion to temporarily increase the share of program costs paid by the federal government to fund each state's Medicaid program.

Although initially scheduled to expire at the end of 2010, Congress has allocated additional funds to extend this increased federal funding to states through June 2011. These funds have helped avoid more extensive program and reimbursement cuts, but the expiration of the increased federal funding could result in significant reductions to state Medicaid programs.

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

Through DRA 2005, Congress has expanded the federal government's involvement in fighting fraud, waste and abuse in the Medicaid program by creating the Medicaid Integrity Program. Among other things, DRA 2005 requires CMS to employ private contractors, referred to as Medicaid Integrity Contractors ("MICs"), to perform post-payment audits of Medicaid claims and identify overpayments. MICs are assigned to five geographic regions and have commenced audits in states assigned to those regions. The Health Reform Law increases federal funding for the MIC program for federal fiscal year 2011 and later years. In addition to MICs, several other contractors and state Medicaid agencies have increased their review activities. The Health Reform Law expands the RAC program's scope to include Medicaid claims.

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.

Electronic Health Records

ARRA provides for Medicare and Medicaid incentive payments beginning in federal fiscal year 2011 for eligible hospitals and calendar year 2011 for eligible professionals that adopt and meaningfully use certified electronic health record ("EHR") technology. A total of at least $20 billion in incentives is being made available through the Medicare and Medicaid EHR incentive programs to eligible hospitals and eligible professionals in the adoption of EHRs.

Under the Medicare incentive program, acute care hospitals that demonstrate meaningful use will receive incentive payments for up to four fiscal years. The Medicare incentive payment amount is the product of three factors: (1) an initial amount comprised of a base amount of $2,000,000 plus $200 for each acute care inpatient discharge during a payment year, beginning with a hospital's 1,150th discharge of the year and ending with a hospital's 23,000th discharge of the year; (2) the "Medicare share," which is the sum of Medicare Part A and Part C acute care inpatient-bed-days divided by the product of the total inpatient-bed-days and a charity care factor; and (3) a transition factor applicable to the payment year. In order to maximize their incentive payments, acute care hospitals must participate in the incentive program by federal fiscal year 2013. Beginning in federal fiscal year 2015, acute care hospitals that fail to demonstrate meaningful use of certified EHR technology will receive reduced market basket updates under inpatient PPS.

Eligible professionals who demonstrate meaningful use are entitled to incentive payments for up to five payment years in an amount equal to 75% of their estimated Medicare allowed charges for covered professional services furnished during the relevant calendar year, subject to an annual limit. Eligible professionals must participate in the incentive payment program by calendar year 2012 in order to maximize their incentive payments and must participate by calendar year 2014 in order to receive any incentive payments. Beginning in calendar year

2015, eligible professionals who do not demonstrate meaningful use of certified EHR technology will face Medicare payment reductions.

The Medicaid EHR incentive program is voluntary for states to implement. For participating states, the Medicaid EHR incentive program will provide incentive payments for acute care hospitals and eligible professionals that meet certain volume percentages of Medicaid patients as well as children's hospitals. Providers may only participate in a single state's Medicaid EHR incentive program. Eligible professionals can only participate in either the Medicaid incentive program or the Medicare incentive program and can change this election only one time. Hospitals may participate in both the Medicare and Medicaid incentive programs.

To qualify for incentive payments under the Medicaid program, providers must adopt, implement, upgrade or demonstrate meaningful use of, certified EHR technology during their first participation year or successfully demonstrate meaningful use of certified EHR technology in subsequent participation years. Payments may be received for up to six participation years. For hospitals, the aggregate Medicaid EHR incentive amount is the product of two factors: (1) the overall EHR amount which is comprised of a base amount of $2,000,000 plus a discharge-related amount, multiplied by the Medicare share (which is set at one by statute) multiplied by a transition factor, and (2) the "Medicaid share," which is the estimated Medicaid inpatient-bed days plus estimated Medicaid managed care inpatient bed-days, divided by the product of the estimated total inpatient bed-days and a charity care factor. Under the Medicaid incentive program, eligible professionals may receive payments based on their EHR costs, up to total amount of $63,750, or for pediatricians, $42,500. There is no penalty for hospitals or professionals under Medicaid for failing to meet EHR meaningful use requirements.

Accountable Care Organizations and Pilot Projects

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

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

Disproportionate Share Hospital Payments

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

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

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

TRICARE

TRICARE is the Department of Defense's health care program for members of the armed forces. For inpatient services, TRICARE reimburses hospitals based on a DRG system modeled on the Medicare inpatient PPS. The Department of Defense has also implemented a PPS for hospital outpatient services furnished to TRICARE beneficiaries similar to that utilized for services furnished to Medicare beneficiaries. Because the Medicare outpatient PPS APC rates have historically been below TRICARE rates, the adoption of this payment methodology for TRICARE beneficiaries has reduced our reimbursement; however, TRICARE outpatient services do not represent a significant portion of our patient volumes.

Annual Cost Reports

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

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

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 32%, 34% and 35% of our total admissions for the years ended December 31, 2010, 2009 and 2008, respectively. Managed care contracts are typically negotiated for terms between one and three years. While we generally received annual average yield increases of 5% to 6% from managed care payers during 2010, there can be no assurance that we will continue to receive increases in the future. It is not clear what impact, if

any, the increased obligations on managed care payers and other health plans imposed by the Health Reform Law will have on our ability to negotiate reimbursement increases.

Uninsured and Self-Pay Patients

A high percentage of our uninsured patients are initially admitted through our emergency rooms. For the year ended December 31, 2010, approximately 82% of our admissions of uninsured patients occurred through our emergency rooms. The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the individual to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment. The Health Reform Law requires health plans to reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place. Further, as enacted, the Health Reform Law contains provisions that seek to decrease the number of uninsured individuals, including requirements and incentives, which do not become effective until 2014, for individuals to obtain, and large employers to provide, insurance coverage. These mandates may reduce the financial impact of screening for and stabilizing emergency medical conditions. However, many factors are unknown regarding the impact of the Health Reform Law, including how many previously uninsured individuals will obtain coverage as a result of the law or the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals and the payer mix. In addition, it is difficult to predict the full impact of the Health Reform Law due to the law's complexity, lack of implementing regulations or interpretive guidance, gradual and potentially delayed implementation, pending court challenges and possible amendment or repeal.

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

- screening all patients, including the uninsured, through our emergency screening protocol, to determine the appropriate care setting in light of their condition, while reducing the potential for bad debt; and
- increasing up-front collections from patients subject to co-pay and deductible requirements and uninsured patients.

Hospital Utilization

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

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

	Years Ended December 31,				
	2010	2009	2008	2007	2006
Number of hospitals at end of period(a)	156	155	158	161	166
Number of freestanding outpatient surgery centers at end of period(b)	97	97	97	99	98
Number of licensed beds at end of period(c)	38,827	38,839	38,504	38,405	39,354
Weighted average licensed beds(d)	38,655	38,825	38,422	39,065	40,653
Admissions(e)	1,554,400	1,556,500	1,541,800	1,552,700	1,610,100
Equivalent admissions(f)	2,468,400	2,439,000	2,363,600	2,352,400	2,416,700
Average length of stay (days)(g)	4.8	4.8	4.9	4.9	4.9
Average daily census(h)	20,523	20,650	20,795	21,049	21,688
Occupancy rate(i)	53%	53%	54%	54%	53%
Emergency room visits(j)	5,706,200	5,593,500	5,246,400	5,116,100	5,213,500
Outpatient surgeries(k)	783,600	794,600	797,400	804,900	820,900
Inpatient surgeries(l)	487,100	494,500	493,100	516,500	533,100

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

(b) Excludes nine facilities in 2010, 2007 and 2006 and eight facilities in 2009 and 2008 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) Represents the average number of licensed beds, weighted based on periods owned.

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

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

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

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

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

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

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

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

Competition

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

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

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

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

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

State certificate of need ("CON") laws, which place limitations on a hospital's ability to expand hospital services and facilities, make capital expenditures and otherwise make changes in operations, may also have the effect of restricting competition. We currently operate health care facilities in a number of states with CON laws. Before issuing a CON, these states consider the need for additional or expanded health care facilities or services. In

those states which have no CON laws or which set relatively high levels of expenditures before they become reviewable by state authorities, competition in the form of new services, facilities and capital spending is more prevalent. See Item 1, "Business — Regulation and Other Factors."

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

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

Regulation and Other Factors

Licensure, Certification and Accreditation

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

Certificates of Need

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

State Rate Review

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

Federal Health Care Program Regulations

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

Anti-kickback Statute

A section of the Social Security Act known as the "Anti-kickback Statute" prohibits providers and others from directly or indirectly soliciting, receiving, offering or paying any remuneration with the intent of generating referrals or orders for services or items covered by a federal health care program. Courts have interpreted this statute broadly and held that there is a violation of the Anti-kickback Statute if just one purpose of the remuneration is to generate referrals, even if there are other lawful purposes. Furthermore, the Health Reform Law provides that knowledge of the law or the intent to violate the law is not required. Violations of the Anti-kickback Statute may be punished by a criminal fine of up to $25,000 for each violation or imprisonment, civil money penalties of up to $50,000 per violation and damages of up to three times the total amount of the remuneration and/or exclusion from participation in federal health care programs, including Medicare and Medicaid. The Health Reform Law provides that submission of a claim for services or items generated in violation of the Anti-kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal False Claims Act ("FCA").

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

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

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

As authorized by Congress, the OIG has published safe harbor regulations that outline categories of activities deemed protected from prosecution under the Anti-kickback Statute. Currently, there are statutory exceptions and

safe harbors for various activities, including the following: certain investment interests, space rental, equipment rental, practitioner recruitment, personnel services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, freestanding surgery centers, ambulance replenishing, and referral agreements for specialty services.

The fact that conduct or a business arrangement does not fall within a safe harbor, or it is identified in a Special Fraud Alert or Advisory Bulletin or as a risk area in the Supplemental Compliance Guidelines for Hospitals, does not necessarily render the conduct or business arrangement illegal under the Anti-kickback Statute. However, such conduct and business arrangements may lead to increased scrutiny by government enforcement authorities.

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

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

Stark Law

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

Through a series of rulemakings, CMS has issued final regulations implementing the Stark Law. Additional changes to these regulations, which became effective October 1, 2009, further restrict the types of arrangements facilities and physicians may enter, including additional restrictions on certain leases, percentage compensation arrangements, and agreements under which a hospital purchases services "under arrangements." While these regulations were intended to clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. CMS has indicated it is considering

additional changes to the Stark Law regulations. We do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot assure that every relationship complies fully with the Stark Law.

Similar State Laws

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

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

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

The Federal False Claims Act and Similar State Laws

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

reimbursement to the federal government. The FCA defines the term "knowingly" broadly. Though simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity constitutes a "knowing" submission under the FCA and, therefore, will qualify for liability. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Health Reform Law, the FCA is implicated by the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later. Further, the Health Reform Law expands the scope of the FCA to cover payments in connection with the Exchanges to be created by the Health Reform Law, if those payments include any federal funds.

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

HIPAA Administrative Simplification and Privacy and Security Requirements

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

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

As required by ARRA, HHS published an interim final rule on August 24, 2009, that requires covered entities to report breaches of unsecured protected health information to affected individuals without unreasonable delay but

not to exceed 60 days of discovery of the breach by a covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than 500 individuals. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information.

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

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. For example, the Federal Trade Commission ("FTC") issued a final rule in October 2007 requiring financial institutions and creditors, which arguably included health providers and health plans, to implement written identity theft prevention programs to detect, prevent and mitigate identity theft in connection with certain accounts. The FTC delayed enforcement of this rule until December 31, 2010. In addition, on December 18, 2010, the Red Flag Program Clarification Act of 2010 became law, restricting the definition of a "creditor." This law may exempt many hospitals from complying with the rule.

EMTALA

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

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

Corporate Practice of Medicine/Fee Splitting

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

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

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

In addition to national enforcement initiatives, federal and state investigations have addressed a wide variety of routine health care operations such as: cost reporting and billing practices, including for Medicare outliers; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. We engage in many of these routine health care operations and other activities that could be the subject of governmental investigations or inquiries. For example, we have significant Medicare and Medicaid billings, numerous financial arrangements with physicians who are referral sources to our hospitals, and joint venture arrangements involving physician investors. Certain of our individual facilities have received, and other facilities may receive, government inquiries from, and may be subject to investigation by, 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 DOJ, the Civil Division of the DOJ, various U.S. Attorneys' offices, CMS, a negotiating team representing states with claims against us, and others. In January 2001, we entered into an eight-year Corporate Integrity Act ("CIA") with the Office of Inspector General of the Department of Health and Human Services, which expired January 24, 2009. We submitted our final report pursuant to the CIA on April 30, 2009, and in April 2010, we received notice from the OIG that our final report was accepted, relieving us of future obligations under the CIA. If the government were to

determine that we violated or breached the CIA or other federal or state laws relating to Medicare, Medicaid or similar programs, we could be subject to substantial monetary fines, civil and criminal penalties and/or exclusion from participation in the Medicare and Medicaid programs and other federal and state health care programs. Alleged violations may be pursued by the government or through private *qui tam* actions. Sanctions imposed against us as a result of such actions could have a material, adverse effect on our results of operations and financial position.

Health Care Reform

As enacted, the Health Reform Law will change how health care services are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced growth in Medicare program spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs where reimbursement is tied to quality and integration. In addition, the law reforms certain aspects of health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality, and contains provisions intended to strengthen fraud and abuse enforcement. More than 20 challenges to the Health Reform Law have been filed in federal courts. Some federal district courts have upheld the constitutionality of the Health Reform Law or dismissed cases on procedural grounds. Others have held unconstitutional the requirement that individuals maintain health insurance or pay a penalty and have either found the Health Reform Law void in its entirety or left the remainder of the Health Reform Law intact. These lawsuits are subject to appeal, and several are currently on appeal, including those that hold the law unconstitutional. It is unclear how these lawsuits will be resolved. Further, Congress is considering bills that would repeal or revise the Health Reform Law.

Expanded Coverage

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

Medicaid Expansion

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

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

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

The Health Reform Law also provides that the federal government will subsidize states that create non- Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL.

Approved state plans will be eligible to receive federal funding. The amount of that funding per individual will be equal to 95% of subsidies that would have been provided for that individual had he or she enrolled in a health plan offered through one of the Exchanges, as discussed below.

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

Private Sector Expansion

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

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

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

To facilitate the purchase of health insurance by individuals and small employers, each state must establish an Exchange by January 1, 2014. Based on CBO and CMS estimates, between 29 and 31 million individuals will obtain their health insurance coverage through an Exchange by 2019. Of that amount, an estimated 16 million will be individuals who were previously uninsured, and 13 to 15 million will be individuals who switched from their prior insurance coverage to a plan obtained through the Exchange. The Health Reform Law requires that the Exchanges be designed to make the process of evaluating, comparing and acquiring coverage simple for consumers. For example, each state's Exchange must maintain an internet website through which consumers may access health plan ratings that are assigned by the state based on quality and price, view governmental health program eligibility requirements and calculate the actual cost of health coverage. Health insurers participating in an Exchange must offer a set of minimum benefits to be defined by HHS and may offer more benefits. Health insurers must offer at least two, and up to five, levels of plans that vary by the percentage of medical expenses that must be paid by the enrollee. These levels are referred to as platinum, gold, silver, bronze and catastrophic plans, with gold and silver being the two mandatory levels of plans. Each level of plan must require the enrollee to share the following percentages of medical expenses up to the deductible/co-payment limit: platinum, 10%; gold, 20%; silver, 30%; bronze, 40%; and catastrophic, 100%. Health insurers may establish varying deductible/co-payment levels, up to the statutory maximum (estimated to be between $6,000 and $7,000 for an individual). The health insurers must

cover 100% of the amount of medical expenses in excess of the deductible/co-payment limit. For example, an individual making 100% to 200% of the FPL will have co-payments and deductibles reduced to about one-third of the amount payable by those with the same plan with incomes at or above 400% of the FPL.

Public Program Spending

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

Payments for Hospitals and Ambulatory Surgery Centers

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

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

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

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

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

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

must achieve in order to meet the quality performance measures, and the methodology for calculating payments to hospitals that meet the required quality threshold. HHS will also determine how much money each hospital will receive from the pool of dollars created by the reductions related to the value-based purchasing program as described above. Because the Health Reform Law provides that the pool will be fully distributed, hospitals that meet or exceed the quality performance standards set by HHS will receive greater reimbursement under the value-based purchasing program than they would have otherwise. On the other hand, hospitals that do not achieve the necessary quality performance will receive reduced Medicare inpatient hospital payments. On January 7, 2011, CMS issued a proposed rule for the value-based purchasing program that would use 17 clinical process of care measures and eight dimensions of a patient's experience of care using the HCAHPS survey to determine incentive payments for federal fiscal year 2013. As proposed, the incentive payments would be calculated based on a combination of measures of hospitals' achievement of the performance standards and their improvement in meeting the performance standards compared to prior periods. To determine payments in federal fiscal year 2013, the baseline performance period (measurement standard) as proposed would be July 1, 2009 through March 31, 2010. To determine whether hospitals meet performance standards, CMS would compare each hospital's performance in the period July 1, 2011 through March 31, 2012 to its performance in the baseline performance period. CMS has not yet proposed specific threshold values for the performance standards. CMS also proposes to add three outcome measures for federal fiscal year 2014, for which the performance period would be July 1, 2011 through December 31, 2012 and the baseline performance period would be July 1, 2008 through December 31, 2009.

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

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

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

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

It is difficult to predict the full impact of the Medicare DSH reductions, and CBO and CMS estimates differ by $38 billion. The Health Reform Law does not mandate what data source HHS must use to determine the reduction, if any, in the uninsured population nationally. In addition, the Health Reform Law does not contain a definition of "uncompensated care." As a result, it is unclear how a hospital's share of the Medicare DSH payment pool will be calculated. CMS could use the definition of "uncompensated care" used in connection with hospital cost reports.

However, in July 2009, CMS proposed material revisions to the definition of "uncompensated care" used for cost report purposes. Those revisions would exclude certain significant costs that had historically been covered, such as unreimbursed costs of Medicaid services. CMS has not issued a final rule, and the Health Reform Law does not require HHS to use this definition, even if finalized, for DSH purposes. How CMS ultimately defines "uncompensated care" for purposes of these DSH funding provisions could have a material effect on a hospital's Medicare DSH reimbursements.

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

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

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

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

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

premium revenue. The Health Reform Law reduces, over a three year period, premium payments to the MA plans such that CMS' managed care per capita premium payments are, on average, equal to traditional Medicare. In addition, the Health Reform Law implements fee payment adjustments based on service benchmarks and quality ratings. As a result of these changes, payments to MA plans are estimated to be reduced by $138 to $145 billion between 2010 and 2019. These reductions to MA plan premium payments may cause some plans to raise premiums or limit benefits, which in turn might cause some Medicare beneficiaries to terminate their MA coverage and enroll in traditional Medicare.

Specialty Hospital Limitations

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

Program Integrity and Fraud and Abuse

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

Impact of Health Reform Law on the Company

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

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

- how many previously uninsured individuals will obtain coverage as a result of the Health Reform Law (while the CBO estimates 32 million, CMS estimates almost 34 million; both agencies made a number of assumptions to derive that figure, including how many individuals will ignore substantial subsidies and decide to pay the penalty rather than obtain health insurance and what percentage of people in the future will meet the new Medicaid income eligibility requirements);
- what percentage of the newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states will enroll new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;

- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the rate paid by state governments under the Medicaid program for newly covered individuals;
- how the value-based purchasing and other quality programs will be implemented;
- the percentage of individuals in the Exchanges who select the high deductible plans, since health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- whether the net effect of the Health Reform Law, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs at or above a specified minimum percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and
- the possibility that implementation of the provisions expanding health insurance coverage or the entire Health Reform Law will be delayed due to court challenges or revised or eliminated as a result of court challenges and efforts to repeal or amend the law. More than 20 challenges to the Health Reform Law have been filed in federal courts. Some federal district courts have upheld the constitutionality of the Health Reform Law or dismissed cases on procedural grounds. Others have held unconstitutional the requirement that individuals maintain health insurance or pay a penalty and have either found the entire Health Reform Law void in its entirety or left the remainder of the Health Reform Law intact. These lawsuits are subject to appeal, and several are currently on appeal, including those that hold the law unconstitutional.

On the other hand, the Health Reform Law provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. Since 40.7% of our revenues in 2010 were from Medicare and Medicaid, reductions to these programs may significantly impact the Company and could offset any positive effects of the Health Reform Law. It is difficult to predict the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues the Company will generate from Medicare and Medicaid business when the reductions are implemented;
- whether reductions required by the Health Reform Law will be changed by statute or by judicial decision prior to becoming effective;
- the size of the Health Reform Law's annual productivity adjustment to the market basket beginning in 2012 payment years;
- the amount of the Medicare DSH reductions that will be made, commencing in federal fiscal year 2014;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in federal fiscal year 2014;
- what the losses in revenues will be, if any, from the Health Reform Law's quality initiatives;
- how successful ACOs, in which we anticipate participating, will be at coordinating care and reducing costs or whether they will decrease reimbursement;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs;

- whether the Company's revenues from upper payment limit ("UPL") programs will be adversely affected, because there may be fewer indigent, non-Medicaid patients for whom the Company provides services pursuant to UPL programs; and
- reductions to Medicare payments CMS may impose for "excessive readmissions."

Because of the many variables involved, we are unable to predict the net effect on the Company of the expected increases in insured individuals using our facilities, the reductions in Medicare spending and reductions in Medicare and Medicaid DSH Funding, and numerous other provisions in the Health Reform Law that may affect the Company. Further, it is unclear how efforts to repeal or revise the Health Reform Law and federal lawsuits challenging its constitutionality will be resolved or what the impact would be of any resulting changes to the law.

General Economic and Demographic Factors

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

The health care industry is impacted by the overall United States economy. 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

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

Antitrust Laws

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

Environmental Matters

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

Insurance

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

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

Employees and Medical Staffs

At December 31, 2010, we had approximately 194,000 employees, including approximately 48,000 part-time employees. References herein to "employees" refer to employees of our affiliates. We are subject to various state and federal laws that regulate wages, hours, benefits and other terms and conditions relating to employment. At December 31, 2010, employees at 32 of our hospitals are represented by various labor unions. It is possible additional hospitals may unionize in the future. We consider our employee relations to be good and have not experienced work stoppages that have materially, adversely affected our business or results of operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate. In some markets, nurse and medical support personnel availability has become a significant operating issue to health care providers. To address this challenge, we have implemented several initiatives to improve retention, recruiting, compensation programs and productivity.

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

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

Executive Officers of the Registrant

As of February 11, 2011, our executive officers were as follows:

Name	Age	
Richard M. Bracken	58	Chairman of the Board and Chief Executive Officer
R. Milton Johnson	54	President, Chief Financial Officer and Director
David G. Anderson	63	Senior Vice President — Finance and Treasurer
Victor L. Campbell	64	Senior Vice President
Jana J. Davis	52	Senior Vice President — Communications
Jon M. Foster	49	Group President
Charles J. Hall	57	Group President
Samuel N. Hazen	50	President — Operations
A. Bruce Moore, Jr.	50	Group President — Service Line and Operations Integration
Jonathan B. Perlin, M.D.	49	President — Clinical and Physician Services Group and Chief Medical Officer
W. Paul Rutledge	56	Group President
Joseph A. Sowell, III	54	Senior Vice President — Development
Joseph N. Steakley	56	Senior Vice President — Internal Audit Services
John M. Steele	55	Senior Vice President — Human Resources
Donald W. Stinnett	54	Senior Vice President and Controller
Juan Vallarino	50	Senior Vice President — Strategic Pricing and Analytics
Beverly B. Wallace	60	President — NewCo Business Solutions
Robert A. Waterman	57	Senior Vice President, General Counsel and Chief Labor Relations Officer
Noel Brown Williams	55	Senior Vice President and Chief Information Officer
Alan R. Yuspeh	61	Senior Vice President and Chief Ethics and Compliance Officer

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

R. Milton Johnson has served as President and Chief Financial Officer of the Company since February 2011 and was appointed as a director in December 2009. Mr. Johnson served as Executive Vice President and Chief Financial Officer from July 2004 to February 2011 and as Senior Vice President and Controller of the Company from July 1999 until July 2004. Mr. Johnson served as Vice President and Controller of the Company from November 1998 to July 1999. Prior to that time, Mr. Johnson served as Vice President — Tax of the Company from April 1995 to October 1998. Prior to that time, Mr. Johnson served as Director of Tax for Healthtrust, Inc. — The Hospital Company from September 1987 to April 1995.

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

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

Jana J. Davis was appointed Senior Vice President — Communications in February 2011. Prior to that time, she served as Vice President of Communications for the Company from November 1997 to February 2011. Ms. Davis joined HCA in 1997 from Burson-Marsteller, where she was a Managing Director and served as Corporate Practice Chair for Latin American operations. Ms. Davis also held a number of Public Affairs positions in the George H.W. Bush and Reagan Administrations. Ms. Davis is an attorney and serves as chair of the Public Relations Committee for the Federation of American Hospitals.

Jon M. Foster was appointed Group President in February 2011. Prior to that, Mr. Foster served as Division President for the Central and West Texas Division from January 2006 to February 2011. Mr. Foster joined HCA in March 2001 as President and CEO of St. David's HealthCare in Austin, Texas and served in that position until February 2011. Prior to joining the company, Mr. Foster served in various executive capacities within the Baptist Health System, Knoxville, Tennessee and The Methodist Hospital System in Houston, Texas.

Charles J. Hall was appointed Group President in October 2006; his formal title prior to February 2011 was President — Eastern Group. Prior to that time, Mr. Hall had served as President — North Florida Division since April 2003. Mr. Hall had previously served the Company as President of the East Florida Division from January 1999 until April 2003, as a Market President in the East Florida Division from January 1998 until December 1998, as President of the South Florida Division from February 1996 until December 1997, and as President of the Southwest Florida Division from October 1994 until February 1996, and in various other capacities since 1987.

Samuel N. Hazen was appointed President — Operations of the Company in February 2011. Mr. Hazen served as President — Western Group from July 2001 to February 2011 and as Chief Financial Officer — Western Group of the Company from August 1995 to July 2001. Mr. Hazen served as Chief Financial Officer — North Texas Division of the Company from February 1994 to July 1995. Prior to that time, Mr. Hazen served in various hospital and regional Chief Financial Officer positions with Humana Inc. and Galen Health Care, Inc.

A. Bruce Moore, Jr. was appointed Group President — Service Line and Operations Integration in February 2011. Mr. Moore had served as President — Outpatient Services Group since January 2006. Mr. Moore served as Senior Vice President and as Chief Operating Officer — Outpatient Services Group from July 2004 to January 2006 and as Senior Vice President — Operations Administration from July 1999 until July 2004. Mr. Moore served as Vice President — Operations Administration of the Company from September 1997 to July 1999, as Vice President — Benefits from October 1996 to September 1997, and as Vice President — Compensation from March 1995 until October 1996.

Dr. Jonathan B. Perlin was appointed President — Clinical and Physician Services Group and Chief Medical Officer in February 2011. Dr. Perlin had served as President — Clinical Services Group and Chief Medical Officer from November 2007 to February 2011 and as Chief Medical Officer and Senior Vice President — Quality of the Company from August 2006 to November 2007. Prior to joining the Company, Dr. Perlin served as Under Secretary for Health in the U.S. Department of Veterans Affairs since April 2004. Dr. Perlin joined the Veterans Health Administration in November 1999 where he served in various capacities, including as Deputy Under Secretary for Health from July 2002 to April 2004, and as Chief Quality and Performance Officer from November 1999 to September 2002.

W. Paul Rutledge was appointed as Group President in October 2005; his formal title prior to February 2011 was President — Central Group. Mr. Rutledge had served as President of the MidAmerica Division since January 2001. He served as President of TriStar Health System from June 1996 to January 2001 and served as President of Centennial Medical Center from May 1993 to June 1996. He has served in leadership capacities with HCA for more than 28 years, working with hospitals in the United States and London, England.

Joseph A. Sowell, III was appointed as Senior Vice President and Chief Development Officer of the Company in December 2009. From 1987 to 1996 and again from 1999 to 2009, Mr. Sowell was a partner at the law firm of

Waller Lansden Dortch & Davis where he specialized in the areas of health care law, mergers and acquisitions, joint ventures, private equity financing, tax law and general corporate law. He also co-managed the firm's corporate and commercial transactions practice. From 1996 to 1999, Mr. Sowell served as the head of development, and later as the Chief Operating Officer of Arcon Healthcare.

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

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

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

Juan Vallarino was appointed Senior Vice President — Strategic Pricing and Analytics in February 2011. Prior to that time, Mr. Vallarino had served as Vice President — Strategic Pricing and Analytics since October 2006. Prior to that, Mr. Vallarino served as Vice President of Managed Care for the Western Group of the Company from January 1998 to October 2006.

Beverly B. Wallace was appointed President — NewCo Business Solutions in February 2011. From March 2006 until February 2011, Ms. Wallace served as President — Shared Services Group, and from January 2003 until March 2006, Ms. Wallace served as President — Financial Services Group. Ms. Wallace served as Senior Vice President — Revenue Cycle Operations Management of the Company from July 1999 to January 2003. Ms. Wallace served as Vice President — Managed Care of the Company from July 1998 to July 1999. From 1997 to 1998, Ms. Wallace served as President — Homecare Division of the Company. From 1996 to 1997, Ms. Wallace served as Chief Financial Officer — Nashville Division of the Company. From 1994 to 1996, Ms. Wallace served as Chief Financial Officer — Mid-America Division of the Company.

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

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

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

Item 1A. *Risk Factors*

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

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

We are highly leveraged. As of December 31, 2010, our total indebtedness was $28.225 billion. As of December 31, 2010, we had availability of $1.189 billion under our senior secured revolving credit facility and $125 million under our asset-based revolving credit facility, after giving effect to letters of credit and borrowing base limitations. Our high degree of leverage could have important consequences, including:

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

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

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

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

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

We may find it necessary or prudent to refinance our outstanding indebtedness with longer-maturity debt at a higher interest rate. In February, April and August of 2009 and in March of 2010, for example, we issued $310 million in aggregate principal amount of 9 7/8% second lien notes due 2017, $1.500 billion in aggregate principal amount of 8 1/2% first lien notes due 2019, $1.250 billion in aggregate principal amount of 7 7/8% first lien notes due 2020 and $1.400 billion in aggregate principal amount of 7 1/4% first lien notes due 2020, respectively. The net proceeds of those offerings were used to prepay term loans under our cash flow credit facility, which currently bears interest at a lower floating rate. Our ability to refinance our indebtedness on favorable terms, or at all, is

directly affected by the current global economic and financial conditions. In addition, our ability to incur secured indebtedness (which would generally enable us to achieve better pricing than the incurrence of unsecured indebtedness) depends in part on the value of our assets, which depends, in turn, on the strength of our cash flows and results of operations, and on economic and market conditions and other factors.

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

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

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

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

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

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

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

The health care business is highly competitive, and competition among hospitals and other health care providers for patients has intensified in recent years. Generally, other hospitals in the local communities we serve provide services similar to those offered by our hospitals. In addition, CMS publicizes on its Hospital Compare website performance data related to quality measures and data on patient satisfaction surveys hospitals submit in connection with their Medicare reimbursement. Federal law provides for the future expansion of the number of

quality measures that must be reported. Additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes. Further, the Health Reform Law requires all hospitals to annually establish, update and make public a list of the hospital's standard charges for items and services. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures or on patient satisfaction surveys or if our standard charges are higher than our competitors, our patient volumes could decline.

In addition, the number of freestanding specialty hospitals, surgery centers and diagnostic and imaging centers in the geographic areas in which we operate has increased significantly. As a result, most of our hospitals operate in a highly competitive environment. Some of the facilities that compete with our hospitals are owned by governmental agencies or not-for-profit corporations supported by endowments, charitable contributions and/or tax revenues and can finance capital expenditures and operations on a tax-exempt basis. Our hospitals face increasing competition from specialty hospitals, some of which are physician-owned, and from both our own and unaffiliated freestanding surgery centers for market share in high margin services and for quality physicians and personnel. If ambulatory surgery centers are better able to compete in this environment than our hospitals, our hospitals may experience a decline in patient volume, and we may experience a decrease in margin, even if those patients use our ambulatory surgery centers. In states that do not require a CON for the purchase, construction or expansion of health care facilities or services, competition in the form of new services, facilities and capital spending is more prevalent. Further, if our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than our hospitals and ambulatory surgery centers, we may experience an overall decline in patient volume. See Item 1, "Business — Competition."

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

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

The amount of the provision for doubtful accounts is based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal and state governmental and private employer health care coverage, the rate of growth in uninsured patient admissions and other collection indicators. At December 31, 2010, our allowance for doubtful accounts represented approximately 93% of the $4.249 billion patient due accounts receivable balance. The sum of the provision for doubtful accounts, uninsured discounts and charity care increased from $7.009 billion for 2008 to $8.362 billion for 2009 and to $9.626 billion for 2010.

A continuation of the trends that have resulted in an increasing proportion of accounts receivable being comprised of uninsured accounts and a deterioration in the collectibility of these accounts will adversely affect our collection of accounts receivable, cash flows and results of operations. Prior to the Health Reform Law being fully implemented, our facilities may experience growth in bad debts, uninsured discounts and charity care as a result of a number of factors, including the economic downturn and increase in unemployment. The Health Reform Law seeks to decrease, over time, the number of uninsured individuals. As enacted, the Health Reform Law will, effective January 1, 2014, expand Medicaid and incentivize employers to offer, and require individuals to carry, health insurance or be subject to penalties. More than 20 challenges to the Health Reform Law have been filed in federal courts. Some federal courts have upheld the constitutionality of the Health Reform Law or dismissed cases on procedural grounds. Others have held unconstitutional the requirement that individuals maintain health insurance or pay a penalty and have either found the Health Reform Law void in its entirety or left the remainder of the law intact. These lawsuits are subject to appeal, and several are currently on appeal, including those that hold the law unconstitutional. It is difficult to predict the full impact of the Health Reform Law due to the law's complexity, lack of implementing regulations or interpretive guidance, gradual and potentially delayed implementation, pending court challenges and possible amendment or repeal, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the law. In addition, even after implementation of the Health Reform Law, we may continue to experience bad debts and have to provide uninsured discounts and charity care for

undocumented aliens who are not permitted to enroll in a health insurance exchange or government health care programs and certain others who may not have insurance coverage.

Changes in government health care programs may reduce our revenues.

A significant portion of our patient volume is derived from government health care programs, principally Medicare and Medicaid. Specifically, we derived approximately 41% of our revenues from the Medicare and Medicaid programs in 2010. Changes in government health care programs may reduce the reimbursement we receive and could adversely affect our business and results of operations.

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

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

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

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

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

As enacted, the Health Reform Law will change how health care services are covered, delivered, and reimbursed through expanded coverage of uninsured individuals, reduced growth in Medicare program spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. In addition, the law reforms certain aspects of health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality, and contains provisions intended to strengthen fraud and abuse enforcement. The expansion of health insurance coverage under the Health Reform Law may result in a material increase in the number of patients using our facilities who have either private or public program coverage. In addition, a disproportionately large percentage of the new Medicaid coverage is likely to be in

states that currently have relatively low income eligibility requirements. Two such states are Texas and Florida, where about one-half of the Company's licensed beds are located. The Company also has a significant presence in other relatively low income eligibility states, including Georgia, Kansas, Louisiana, Missouri, Oklahoma and Virginia. Further, the Health Reform Law provides for a value-based purchasing program, the establishment of ACOs and bundled payment pilot programs, which will create possible sources of additional revenue.

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

- how many previously uninsured individuals will obtain coverage as a result of the Health Reform Law (while the CBO estimates 32 million, CMS estimates almost 34 million; both agencies made a number of assumptions to derive that figure, including how many individuals will ignore substantial subsidies and decide to pay the penalty rather than obtain health insurance and what percentage of people in the future will meet the new Medicaid income eligibility requirements);
- what percentage of the newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states will enroll new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the rate paid by state governments under the Medicaid program for newly covered individuals;
- how the value-based purchasing and other quality programs will be implemented;
- the percentage of individuals in the Exchanges who select the high deductible plans, since health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- whether the net effect of the Health Reform Law, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs at or above a specified minimum percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and
- the possibility that implementation of the provisions expanding health insurance coverage or the entire Health Reform Law will be delayed due to court challenges or revised or eliminated as a result of court challenges and efforts to repeal or amend the law. More than 20 challenges to the Health Reform Law have been filed in federal courts. Some federal district courts have upheld the constitutionality of the Health Reform Law or dismissed cases on procedural grounds. Others have held unconstitutional the requirement that individuals maintain health insurance or pay a penalty and have either found the Health Reform Law void in its entirety or left the remainder of the law intact. These lawsuits are subject to appeal, and several are currently on appeal, including those that hold the law unconstitutional.

On the other hand, the Health Reform Law provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments and the establishment of programs where reimbursement is tied to quality and integration. Since 40.7% of our revenues in 2010 were from Medicare and Medicaid, reductions to these programs may significantly impact the Company and could offset any positive effects of the Health Reform Law. It is difficult to predict the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

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

- whether reductions required by the Health Reform Law will be changed by statute or by judicial decision prior to becoming effective;
- the size of the Health Reform Law's annual productivity adjustment to the market basket beginning in 2012 payment years;
- the amount of the Medicare DSH reductions that will be made, commencing in federal fiscal year 2014;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in federal fiscal year 2014;
- what the losses in revenues will be, if any, from the Health Reform Law's quality initiatives;
- how successful ACOs, in which we anticipate participating, will be at coordinating care and reducing costs or whether they will decrease reimbursement;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs;
- whether the Company's revenues from UPL programs will be adversely affected, because there may be fewer indigent, non-Medicaid patients for whom the Company provides services pursuant to UPL programs; and
- reductions to Medicare payments CMS may impose for "excessive readmissions."

Because of the many variables involved, we are unable to predict the net effect on the Company of the expected increases in insured individuals using our facilities, the reductions in Medicare spending, reductions in Medicare and Medicaid DSH funding, and numerous other provisions in the Health Reform Law that may affect the Company. Further, it is unclear how efforts to repeal or revise the Health Reform Law and federal lawsuits challenging its constitutionality will be resolved or what the impact would be of any resulting changes to the law.

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 53.7% and 53.4% of our revenues for 2010 and 2009, respectively. Nongovernment payers, including managed care payers, continue to demand discounted fee structures, and the trend toward consolidation among nongovernment payers tends to increase their bargaining power over fee structures. As various provisions of the Health Reform Law are implemented, including the establishment of the Exchanges, nongovernment payers increasingly may demand reduced fees. Our future success will depend, in part, on our ability to retain and renew our managed care contracts and enter into new managed care contracts on terms favorable to us. Other health care providers may impact our ability to enter into managed care contracts or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. It is not clear what impact, if any, the increased obligations on managed care payers and other payers imposed by the Health Reform Law will have on our ability to negotiate reimbursement increases. If we are unable to retain and negotiate favorable contracts with managed care plans or experience reductions in payment increases or amounts received from nongovernment payers, our revenues may be reduced.

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

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

those physicians and their patients, they may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline.

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

Our operations are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians, as well as our physicians. We compete with other health care providers in recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our hospitals, including nurses and other nonphysician health care professionals. In some markets, the availability of nurses and other medical support personnel has been a significant operating issue to health care providers. We may be required to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary or contract personnel. As a result, our labor costs could increase. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Certain proposed changes in federal labor laws, including the Employee Free Choice Act, could increase the likelihood of employee unionization attempts. To the extent a significant portion of our employee base unionizes, it is possible our labor costs could increase materially. When negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur during the negotiation process, and our continued operation during any strikes could increase our labor costs. In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control labor costs, could have a material, adverse effect on our results of operations.

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

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

- billing and coding for services and properly handling overpayments;
- relationships with physicians and other referral sources;
- necessity and adequacy of medical care;
- quality of medical equipment and services;
- qualifications of medical and support personnel;
- confidentiality, maintenance, data breach, identity theft and security issues associated with health-related and personal information and medical records;
- screening, stabilization and transfer of individuals who have emergency medical conditions;
- licensure and certification;
- hospital rate or budget review;
- preparing and filing of cost reports;
- operating policies and procedures;
- activities regarding competitors; and
- addition of facilities and services.

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

Our financial relationships with referring physicians and their immediate family members must comply with the Stark Law by meeting an exception. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot provide assurance 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. See Item 1, "Business — Regulation and Other Factors."

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.

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, or amendment to, these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material, adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly. In addition, other legislation or regulations at the federal or state level may be adopted that adversely affect our business.

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

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

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

As required by statute, CMS has implemented the RAC program on a nationwide basis. Under the program, CMS contracts with RACs on a contingency fee basis to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The Health Reform Law expands the RAC program's scope to include managed Medicare plans and to include Medicaid claims. In addition, CMS employs MICs to perform post-payment audits of Medicaid claims and identify overpayments. The Health Reform Law increases federal funding for the MIC program for federal fiscal year 2011 and later years. In addition to RACs and MICs, the state Medicaid agencies and other contractors have increased their review activities.

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

Controls designed to reduce inpatient services may reduce our revenues.

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

Our overall business results may suffer from the economic downturn.

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

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

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

Effective July 1, 2011, the Health Reform Law will prohibit the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. Beginning in federal fiscal year 2015, the 25% of hospitals with the worst national risk-adjusted HAC rates in the previous year will receive a 1% reduction in their total inpatient operating Medicare payments. Hospitals with excessive readmissions for

conditions designated by HHS will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard.

The Health Reform Law also requires HHS to implement a value-based purchasing program for inpatient hospital services. The Health Reform Law requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1% in federal fiscal year 2013 and increasing by 0.25% each fiscal year up to 2% in federal fiscal year 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions. As proposed by CMS, the value-based purchasing program will initially calculate incentive payments based on hospitals' achievement of 17 clinical process of care measures and eight dimensions of a patient's experience of care using the HCAHPS survey and their improvement in meeting these standards compared to prior periods. For federal fiscal year 2013, CMS estimates the value-based purchasing program will redistribute $850 million among the nation's hospitals.

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

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

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

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

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

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

As required by the ARRA, the Secretary of HHS is in the process of developing and implementing an incentive payment program for eligible hospitals and health care professionals that adopt and meaningfully use certified EHR technology. HHS intends to use the Provider Enrollment, Chain and Ownership System ("PECOS") to verify Medicare enrollment prior to making EHR incentive program payments. During 2011, we anticipate receiving Medicare and Medicaid incentive payments for being a meaningful user of certified EHR technology. We anticipate a majority of 2011 incentive payments will be received and recognized as revenues during the fourth quarter of 2011. Medicare and Medicaid incentive payments for our eligible hospitals and professionals are estimated to range from $275 million to $325 million for 2011. Actual incentive payments could vary from these estimates due to certain

factors such as availability of federal funding for both Medicare and Medicaid incentive payments, timing of the approval of state Medicaid incentive payment plans by CMS and our ability to implement and demonstrate meaningful use of certified EHR technology.

We have incurred and will continue to incur both capital costs and operating expenses in order to implement our certified EHR technology and meet meaningful use requirements. These expenses are ongoing and are projected to continue over all stages of implementation of meaningful use. The timing of expenses will not correlate with the receipt of the incentive payments and the recognition of revenues. We estimate that operating expenses to implement our certified EHR technology and meet meaningful use will range from $125 million to $150 million for 2011. Actual operating expenses could vary from these estimates. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, including having an enrollment record in PECOS, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. Further, eligible providers that fail to demonstrate meaningful use of certified EHR technology will be subject to reduced payments from Medicare, beginning in federal fiscal year 2015 for eligible hospitals and calendar year 2015 for eligible professionals. Failure to implement certified EHR systems effectively and in a timely manner could have a material, adverse effect on our financial position and results of operations.

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

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

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

We operated 164 hospitals at December 31, 2010, and 74 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities' combined revenues represented approximately 52% of our consolidated revenues for the year ended December 31, 2010. 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, Texas and other areas across the Gulf Coast are located in hurricane-prone areas. In the recent past, hurricanes have had a disruptive effect on the operations of our hospitals in Florida, Texas and other coastal states, and the patient populations in those states. Our business activities could be harmed by a particularly active hurricane season or even a single storm, and the property insurance we obtain may not be adequate to cover losses from future hurricanes or other natural disasters.

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

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

Management believes HCA Holdings, Inc., its predecessors, subsidiaries and affiliates properly reported taxable income and paid taxes in accordance with applicable laws and agreements established with the IRS and final resolution of these disputes will not have a material, adverse effect on our results of operations or financial position.

However, if payments due upon final resolution of these issues exceed our recorded estimates, such resolutions could have a material, adverse effect on our results of operations or financial position.

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

We are subject to litigation relating to our business practices, including claims and legal actions by patients and others in the ordinary course of business alleging malpractice, product liability or other legal theories. 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 $734 million and $8 million, respectively, at December 31, 2010. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At December 31, 2010, we had a net unrealized gain of $10 million on the insurance subsidiary's investment securities.

We are exposed to market risk related to market illiquidity. Liquidity of the investments in debt and equity securities of our wholly-owned insurance subsidiary could be impaired by the inability to access the capital markets. Should the wholly-owned insurance subsidiary require significant amounts of cash in excess of normal cash requirements to pay claims and other expenses on short notice, we may have difficulty selling these investments in a timely manner or be forced to sell them at a price less than what we might otherwise have been able to in a normal market environment. At December 31, 2010, our wholly-owned insurance subsidiary had invested $250 million ($251 million par value) in tax-exempt student loan auction rate securities that continue to experience market illiquidity. It is uncertain if auction-related market liquidity will resume for these securities. We may be required to recognize other-than-temporary impairments on these long-term investments in future periods should issuers default on interest payments or should the fair market valuations of the securities deteriorate due to ratings downgrades or other issue specific factors.

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

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

As of December 31, 2010, the Investors indirectly owned approximately 96.8% 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 stockholders. 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.

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, 2010:

State	Hospitals	Beds
Alaska	1	250
California	5	1,637
Colorado	7	2,259
Florida	38	9,808
Georgia	11	1,946
Idaho	2	481
Indiana	1	278
Kansas	4	1,286
Kentucky	2	384
Louisiana	6	1,264
Mississippi	1	130
Missouri	6	1,055
Nevada	3	1,074
New Hampshire	2	295
Oklahoma	2	793
South Carolina	3	740
Tennessee	12	2,345
Texas	36	10,410
Utah	6	968
Virginia	10	3,089
International		
England	6	704
	164	41,196

In addition to the hospitals listed in the above table, we directly or indirectly operate 106 freestanding surgery centers. We also operate medical office buildings in conjunction with some of our hospitals. These office buildings are primarily occupied by physicians who practice at our hospitals. Fourteen of our general, acute care hospitals and three of our other properties have been mortgaged to support our obligations under our senior secured cash flow credit facility and the first lien secured notes we issued in 2009 and 2010. These three other properties are also subject to second mortgages to support our obligations under the second lien secured notes we issued in 2006 and 2009.

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

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

Item 3. ***Legal Proceedings***

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

Government Investigations, Claims and Litigation

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

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

New Hampshire Hospital Merger Litigation

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

General Liability and Other Claims

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

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

Item 4. ***(Removed and Reserved)***

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 1, 2011, there were 669 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 2008 or 2009.

On January 27, 2010, our Board of Directors declared a distribution to the Company's stockholders and holders of vested stock options. The distribution was $17.50 per share and vested stock option, or $1.751 billion in the aggregate. The distribution was paid on February 5, 2010 to holders of record on February 1, 2010. The distribution was funded using funds available under our existing senior secured credit facilities and approximately $100 million of cash on hand. Pursuant to the terms of our stock option plans, the holders of nonvested stock options received a $17.50 per share reduction to the exercise price of their share-based awards.

On May 5, 2010, our Board of Directors declared a distribution to the Company's stockholders and holders of vested stock options. The distribution was $5.00 per share and vested stock option, or $500 million in the aggregate. The distribution was paid on May 14, 2010 to holders of record on May 6, 2010. The distribution was funded using funds available under our existing senior secured credit facilities. Pursuant to the terms of our stock option plans, the holders of nonvested stock options received a $5.00 per share reduction to the exercise price of their share-based awards.

On November 23, 2010, our Board of Directors declared a distribution to the Company's stockholders and holders of stock options. The distribution was $20.00 per share and vested stock option, or approximately $2.1 billion in the aggregate. The distribution to stockholders and holders of vested options was paid on December 1, 2010 to holders of record on November 24, 2010. The distribution was funded using the proceeds from the November 2010 issuance of $1.525 billion aggregate principal amount of 7¾% senior notes due 2021, together with borrowings under our existing senior secured credit facilities. Pursuant to the terms of our stock option plans, the holders of nonvested options received $20.00 per share reductions (subject to certain tax limitations that resulted in deferred distributions for a portion of the declared distribution, which will be paid upon the vesting of the applicable stock options) to the exercise price of the share-based awards.

During the quarter ended December 31, 2010, we issued and sold 80,750 shares of common stock in connection with the cashless exercise of stock options for aggregate consideration of $1,029,563 resulting in 46,319 net settled shares. We also issued and sold 186,533 shares of common stock in connection with the cash exercise of stock options for aggregate consideration of $2,378,296. 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.

There were no repurchases of our common stock from October 1, 2010 through December 31, 2010.

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

HCA HOLDINGS, INC.
SELECTED FINANCIAL DATA
AS OF AND FOR THE YEARS ENDED DECEMBER 31
(Dollars in millions, except per share amounts)

	2010	2009	2008	2007	2006
Summary of Operations:					
Revenues	$ 30,683	$ 30,052	$ 28,374	$ 26,858	$ 25,477
Salaries and benefits	12,484	11,958	11,440	10,714	10,409
Supplies	4,961	4,868	4,620	4,395	4,322
Other operating expenses	5,004	4,724	4,554	4,233	4,056
Provision for doubtful accounts	2,648	3,276	3,409	3,130	2,660
Equity in earnings of affiliates	(282)	(246)	(223)	(206)	(197)
Gains on sales of investments	—	—	—	—	(243)
Depreciation and amortization	1,421	1,425	1,416	1,426	1,391
Interest expense	2,097	1,987	2,021	2,215	955
Losses (gains) on sales of facilities	(4)	15	(97)	(471)	(205)
Impairments of long-lived assets	123	43	64	24	24
Transaction costs	—	—	—	—	442
	28,452	28,050	27,204	25,460	23,614
Income before income taxes	2,231	2,002	1,170	1,398	1,863
Provision for income taxes	658	627	268	316	626
Net income	1,573	1,375	902	1,082	1,237
Net income attributable to noncontrolling interests	366	321	229	208	201
Net income attributable to HCA Holdings, Inc.	$ 1,207	$ 1,054	$ 673	$ 874	$ 1,036
Per common share data:					
Basic earnings per share	$ 12.75	$ 11.16	$ 7.16	$ 9.31	(a)
Diluted earnings per share	12.43	10.99	7.04	9.15	(a)
Cash dividends declared per share	42.50	—	—	—	(a)
Financial Position:					
Assets	$ 23,852	$ 24,131	$ 24,280	$ 24,025	$ 23,675
Working capital	2,650	2,264	2,391	2,356	2,502
Long-term debt, including amounts due within one year	28,225	25,670	26,989	27,308	28,408
Equity securities with contingent redemption rights	141	147	155	164	125
Noncontrolling interests	1,132	1,008	995	938	907
Stockholders' deficit	(10,794)	(7,978)	(9,260)	(9,600)	(10,467)
Cash Flow Data:					
Cash provided by operating activities	$ 3,085	$ 2,747	$ 1,990	$ 1,564	$ 1,988
Cash used in investing activities	(1,039)	(1,035)	(1,467)	(479)	(1,307)
Capital expenditures	(1,325)	(1,317)	(1,600)	(1,444)	(1,865)
Cash used in financing activities	(1,947)	(1,865)	(451)	(1,326)	(383)

	2010	2009	2008	2007	2006
Operating Data:					
Number of hospitals at end of period(b)	**156**	155	158	161	166
Number of freestanding outpatient surgical centers at end of period(c)	**97**	97	97	99	98
Number of licensed beds at end of period(d)	**38,827**	38,839	38,504	38,405	39,354
Weighted average licensed beds(e)	**38,655**	38,825	38,422	39,065	40,653
Admissions(f)	**1,554,400**	1,556,500	1,541,800	1,552,700	1,610,100
Equivalent admissions(g)	**2,468,400**	2,439,000	2,363,600	2,352,400	2,416,700
Average length of stay (days)(h)	**4.8**	4.8	4.9	4.9	4.9
Average daily census(i)	**20,523**	20,650	20,795	21,049	21,688
Occupancy(j)	**53%**	53%	54%	54%	53%
Emergency room visits(k)	**5,706,200**	5,593,500	5,246,400	5,116,100	5,213,500
Outpatient surgeries(l)	**783,600**	794,600	797,400	804,900	820,900
Inpatient surgeries(m)	**487,100**	494,500	493,100	516,500	533,100
Days revenues in accounts receivable(n)	**46**	45	49	53	53
Gross patient revenues(o)	**$ 125,640**	$ 115,682	$ 102,843	$ 92,429	$ 84,913
Outpatient revenues as a % of patient revenues(p)	**38%**	38%	37%	37%	36%

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HCA HOLDINGS, INC.

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

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

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

Forward-Looking Statements

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

2010 Operations Summary

Net income attributable to HCA Holdings, Inc. totaled $1.207 billion for 2010, compared to $1.054 billion for 2009. The 2010 results include net gains on sales of facilities of $4 million and impairments of long-lived assets of

2010 Operations Summary (Continued)

$123 million. The 2009 results include net losses on sales of facilities of $15 million and impairments of long-lived assets of $43 million.

Revenues increased to $30.683 billion for 2010 from $30.052 billion for 2009. Revenues increased 2.1% on both a consolidated basis and on a same facility basis for 2010, compared to 2009. The consolidated revenues increase can be attributed to the combined impact of a 0.9% increase in revenue per equivalent admission and a 1.2% increase in equivalent admissions. The same facility revenues increase resulted from a 0.6% increase in same facility revenue per equivalent admission and a 1.4% increase in same facility equivalent admissions.

During 2010, consolidated admissions declined 0.1% and same facility admissions increased 0.1%, compared to 2009. Inpatient surgical volumes declined 1.5% on a consolidated basis and declined 1.4% on a same facility basis during 2010, compared to 2009. Outpatient surgical volumes declined 1.4% on a consolidated basis and declined 1.2% on a same facility basis during 2010, compared to 2009. Emergency room visits increased 2.0% on a consolidated basis and increased 2.1% on a same facility basis during 2010, compared to 2009.

For 2010, the provision for doubtful accounts declined $628 million, to 8.6% of revenues from 10.9% of revenues for 2009. The combined self-pay revenue deductions for charity care and uninsured discounts increased $1.892 billion for 2010, compared to 2009. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of net revenues, uninsured discounts and charity care, was 25.6% for 2010, compared to 23.8% for 2009. Same facility uninsured admissions increased 5.4% and same facility uninsured emergency room visits increased 1.2% for 2010, compared to 2009.

Interest expense totaled $2.097 billion for 2010, compared to $1.987 billion for 2009. The $110 million increase in interest expense for 2010 was due primarily to an increase in the average effective interest rate.

Cash flows from operating activities increased $338 million, from $2.747 billion for 2009 to $3.085 billion for 2010. The increase related primarily to the net impact of improvements from a $198 million increase in net income and a $547 million reduction in income tax payments, offsetting a $384 million net decline from changes in working capital items and the provision for doubtful accounts.

Business Strategy

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

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

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

Business Strategy (Continued)

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

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

Continue to Leverage Our Scale and Market Positions to Enhance Profitability. We believe there is significant opportunity to continue to grow the profitability of our company by fully leveraging the scale and scope of our franchise. We are currently pursuing next generation performance improvement initiatives such as contracting for services on a multistate basis and expanding our support infrastructure for additional clinical and support functions, such as physician credentialing, medical transcription and electronic medical recordkeeping. We believe our centrally managed business processes and ability to leverage cost-saving practices across our extensive network will enable us to continue to manage costs effectively. We are in the process of creating a subsidiary that will leverage key components of our support infrastructure, including revenue cycle management, healthcare group purchasing, supply chain management and staffing functions, by offering these services to other hospital companies.

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

Critical Accounting Policies and Estimates

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

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

Revenues

Revenues are recorded during the period the health care services are provided, based upon the estimated amounts due from payers. Estimates of contractual allowances under managed care health plans are based upon the payment terms specified in the related contractual agreements. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The estimated reimbursement amounts are made on a payer-specific basis and are recorded based on the best information available regarding management's

Critical Accounting Policies and Estimates (Continued)

Revenues (Continued)

interpretation of the applicable laws, regulations and contract terms. Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals. We have invested significant resources to refine and improve our computerized billing systems and the information system data used to make contractual allowance estimates. We have developed standardized calculation processes and related training programs to improve the utility of our patient accounting systems.

The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires any hospital participating in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize the condition or make an appropriate transfer of the individual to a facility able to handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment. Federal and state laws and regulations, including but not limited to EMTALA, require, and our commitment to providing quality patient care encourages, the provision of services to patients who are financially unable to pay for the health care services they receive. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Health Reform Law"), requires health plans to reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place. Further, as enacted, the Health Reform Law contains provisions that seek to decrease the number of uninsured individuals, including requirements or incentives, which do not become effective until 2014, for individuals to obtain, and large employers to provide, insurance coverage. These mandates may reduce the financial impact of screening for and stabilizing emergency medical conditions. However, many factors are unknown regarding the impact of the Health Reform Law, including the outcome of court challenges to the constitutionality of the law and Congressional efforts to amend or repeal the law, how many previously uninsured individuals will obtain coverage as a result of the law or the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals and the payer mix.

We do not pursue collection of amounts related to patients who meet our guidelines to qualify as charity care; therefore, they are not reported in revenues. Patients treated at our hospitals for nonelective care, who have income at or below 200% of the federal poverty level, are eligible for charity care. The federal poverty level is established by the federal government and is based on income and family size. We provide discounts from our gross charges to uninsured patients who do not qualify for Medicaid or charity care. These discounts are similar to those provided to many local managed care plans. After the discounts are applied, we are still unable to collect a significant portion of uninsured patients' accounts, and we record significant provisions for doubtful accounts (based upon our historical collection experience) related to uninsured patients in the period the services are provided.

Due to the complexities involved in the classification and documentation of health care services authorized and provided, the estimation of revenues earned and the related reimbursement are often subject to interpretations that could result in payments that are different from our estimates. Adjustments to estimated Medicare and Medicaid reimbursement amounts and disproportionate-share funds, which resulted in net increases to revenues, related primarily to cost reports filed during the respective year were $52 million, $40 million and $32 million in 2010, 2009 and 2008, respectively. The adjustments to estimated reimbursement amounts, which resulted in net increases to revenues, related primarily to cost reports filed during previous years were $50 million, $60 million and $35 million in 2010, 2009 and 2008, respectively. We expect adjustments during the next 12 months related to Medicare and Medicaid cost report filings and settlements and disproportionate-share funds will result in increases to revenues within generally similar ranges.

HCA HOLDINGS, INC.

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

Critical Accounting Policies and Estimates (Continued)

Provision for Doubtful Accounts and the Allowance for Doubtful Accounts

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

The amount of the provision for doubtful accounts is based upon management's assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal, state, and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical writeoffs and recoveries at facilities that represent a majority of our revenues and accounts receivable (the "hindsight analysis") as a primary source of information in estimating the collectibility of our accounts receivable. We perform the hindsight analysis quarterly, utilizing rolling twelve-months accounts receivable collection and writeoff data. We believe our quarterly updates to the estimated allowance for doubtful accounts at each of our hospital facilities provide reasonable valuations of our accounts receivable. These routine, quarterly changes in estimates have not resulted in material adjustments to our allowance for doubtful accounts, provision for doubtful accounts or period-to-period comparisons of our results of operations. At December 31, 2010 and 2009, the allowance for doubtful accounts represented approximately 93% and 94%, respectively, of the $4.249 billion and $5.176 billion, respectively, patient due accounts receivable balance. The patient due accounts receivable balance represents the estimated uninsured portion of our accounts receivable. The estimated uninsured portion of Medicaid pending and uninsured discount pending accounts is included in our patient due accounts receivable balance.

The revenue deductions related to uninsured accounts (charity care and uninsured discounts) generally have the inverse effect on the provision for doubtful accounts. To quantify the total impact of and trends related to uninsured accounts, we believe it is beneficial to view these revenue deductions and provision for doubtful accounts in combination, rather than each separately. A summary of these amounts for the years ended December 31, follows (dollars in millions):

	2010	2009	2008
Provision for doubtful accounts	$ 2,648	$ 3,276	$ 3,409
Uninsured discounts	4,641	2,935	1,853
Charity care	2,337	2,151	1,747
Totals	$ 9,626	$ 8,362	$ 7,009

The provision for doubtful accounts, as a percentage of revenues, declined from 12.0% for 2008 to 10.9% for 2009 and declined to 8.6% for 2010. Our decision to increase uninsured discounts during the second half of 2009 has directly contributed to the decline in the provision for doubtful accounts. However, the sum of the provision for

HCA HOLDINGS, INC.

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

Critical Accounting Policies and Estimates (Continued)

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

doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of net revenues, uninsured discounts and charity care increased from 21.9% for 2008 to 23.8% for 2009 and to 25.6% for 2010.

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

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

	% of Accounts Receivable		
	Under 91 Days	91—180 Days	Over 180 Days
Accounts receivable aging at December 31, 2010:			
Medicare and Medicaid	14%	1%	1%
Managed care and other insurers	21	4	4
Uninsured	17	8	30
Total	52%	13%	35%
Accounts receivable aging at December 31, 2009:			
Medicare and Medicaid	12%	1%	1%
Managed care and other insurers	18	4	4
Uninsured	13	8	39
Total	43%	13%	44%

Our decisions, to increase uninsured discounts and to reduce the length of time accounts are left with our secondary collection agency, have contributed to improvements in our accounts receivable aging trends, particularly for our uninsured accounts receivable.

Professional Liability Claims

We, along with virtually all health care providers, operate in an environment with professional liability risks. Our facilities are insured by our wholly-owned insurance subsidiary for losses up to $50 million per occurrence, subject to a $5 million per occurrence self-insured retention. We purchase excess insurance on a claims-made basis for losses in excess of $50 million per occurrence. Our professional liability reserves, net of receivables under reinsurance contracts, do not include amounts for any estimated losses covered by our excess insurance coverage. Provisions for losses related to professional liability risks were $222 million, $211 million and $175 million for the years ended December 31, 2010, 2009 and 2008, respectively.

Reserves for professional liability risks represent the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The estimated ultimate cost includes estimates of direct expenses and fees paid to outside counsel and experts, but does not include the general overhead costs of our insurance subsidiary or corporate office. Individual case reserves are established based upon the particular circumstances of each reported claim and represent our estimates of the future costs that will be paid on

Critical Accounting Policies and Estimates (Continued)

Professional Liability Claims (Continued)

reported claims. Case reserves are reduced as claim payments are made and are adjusted upward or downward as our estimates regarding the amounts of future losses are revised. Once the case reserves for known claims are determined, information is stratified by loss layers and retentions, accident years, reported years, and geographic location of our hospitals. Several actuarial methods are employed to utilize this data to produce estimates of ultimate losses and reserves for incurred but not reported claims, including: paid and incurred extrapolation methods utilizing paid and incurred loss development to estimate ultimate losses; frequency and severity methods utilizing paid and incurred claims development to estimate ultimate average frequency (number of claims) and ultimate average severity (cost per claim); and Bornhuetter-Ferguson methods which add expected development to actual paid or incurred experience to estimate ultimate losses. These methods use our company-specific historical claims data and other information. Company-specific claim reporting and settlement data collected over an approximate 20-year period is used in our reserve estimation process. This company-specific data includes information regarding our business, including historical paid losses and loss adjustment expenses, historical and current case loss reserves, actual and projected hospital statistical data, professional liability retentions for each policy year, geographic information and other data.

Reserves and provisions for professional liability risks are based upon actuarially determined estimates. The estimated reserve ranges, net of amounts receivable under reinsurance contracts, were $1.067 billion to $1.276 billion at December 31, 2010 and $1.024 billion to $1.270 billion at December 31, 2009. Our estimated reserves for professional liability claims may change significantly if future claims differ from expected trends. We perform sensitivity analyses which model the volatility of key actuarial assumptions and monitor our reserves for adequacy relative to all our assumptions in the aggregate. Based on our analysis, we believe the estimated professional liability reserve ranges represent the reasonably likely outcomes for ultimate losses. We consider the number and severity of claims to be the most significant assumptions in estimating reserves for professional liabilities. A 2% change in the expected frequency trend could be reasonably likely and would increase the reserve estimate by $16 million or reduce the reserve estimate by $15 million. A 2% change in the expected claim severity trend could be reasonably likely and would increase the reserve estimate by $71 million or reduce the reserve estimate by $65 million. We believe adequate reserves have been recorded for our professional liability claims; however, due to the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes, our ultimate liability for professional liability claims could change by more than the estimated sensitivity amounts and could change materially from our current estimates.

The reserves for professional liability risks cover approximately 2,700 and 2,600 individual claims at December 31, 2010 and 2009, respectively, and estimates for unreported potential claims. The time period required to resolve these claims can vary depending upon the jurisdiction and whether the claim is settled or litigated. The average time period between the occurrence and payment of final settlement for our professional liability claims is approximately five years, although the facts and circumstances of each individual claim can result in an occurrence-to-settlement timeframe that varies from this average. The estimation of the timing of payments beyond a year can vary significantly.

Reserves for professional liability risks were $1.262 billion and $1.322 billion at December 31, 2010 and 2009, respectively. The current portion of these reserves, $268 million and $265 million at December 31, 2010 and 2009, respectively, is included in "other accrued expenses." Obligations covered by reinsurance contracts are included in the reserves for professional liability risks, as the insurance subsidiary remains liable to the extent reinsurers do not meet their obligations. Reserves for professional liability risks (net of $14 million and $53 million receivable under reinsurance contracts at December 31, 2010 and 2009, respectively) were $1.248 billion and $1.269 billion at December 31, 2010 and 2009, respectively. The estimated total net reserves for professional liability risks at

HCA HOLDINGS, INC.

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

Critical Accounting Policies and Estimates (Continued)

Professional Liability Claims (Continued)

December 31, 2010 and 2009 are comprised of $758 million and $680 million, respectively, of case reserves for known claims and $490 million and $589 million, respectively, of reserves for incurred but not reported claims.

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

	2010	2009	2008
Net reserves for professional liability claims, January 1	$ 1,269	$ 1,330	$ 1,469
Provision for current year claims	272	258	239
Favorable development related to prior years' claims	(50)	(47)	(64)
Total provision	222	211	175
Payments for current year claims	7	4	7
Payments for prior years' claims	236	268	307
Total claim payments	243	272	314
Net reserves for professional liability claims, December 31	$ 1,248	$ 1,269	$ 1,330

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

Income Taxes

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

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

Results of Operations

Revenue/Volume Trends

Our revenues depend upon inpatient occupancy levels, the ancillary services and therapy programs ordered by physicians and provided to patients, the volume of outpatient procedures and the charge and negotiated payment rates for such services. Gross charges typically do not reflect what our facilities are actually paid. Our facilities have entered into agreements with third-party payers, including government programs and managed care health plans, under which the facilities are paid based upon the cost of providing services, predetermined rates per diagnosis,

HCA HOLDINGS, INC.

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

Results of Operations (Continued)

Revenue/Volume Trends (Continued)

fixed per diem rates or discounts from gross charges. We do not pursue collection of amounts related to patients who meet our guidelines to qualify for charity care; therefore, they are not reported in revenues. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care that are similar to the discounts provided to many local managed care plans.

Revenues increased 2.1% to $30.683 billion for 2010 from $30.052 billion for 2009 and increased 5.9% for 2009 from $28.374 billion for 2008. The increase in revenues in 2010 can be primarily attributed to the combined impact of a 0.9% increase in revenue per equivalent admission and a 1.2% increase in equivalent admissions compared to the prior year. The increase in revenues in 2009 can be primarily attributed to the combined impact of a 2.6% increase in revenue per equivalent admission and a 3.2% increase in equivalent admissions compared to 2008. The decline in the rate of revenue growth from 5.9% for 2009 compared to 2008 to 2.1% for 2010 compared to 2009 is primarily due to a decline in the rate of volume growth (equivalent admission growth declined from 3.2% for 2009 compared to 2008 to 1.2% for 2010 compared to 2009) and a decline in uninsured revenues (uninsured revenues were $1.732 billion, $2.350 billion and $2.695 billion for the years ended December 31, 2010, 2009 and 2008, respectively) resulting from our increased uninsured discounts (uninsured discounts were $4.641 billion, $2.935 billion and $1.853 billion for the years ended December 31, 2010, 2009 and 2008, respectively).

Consolidated admissions declined 0.1% in 2010 compared to 2009 and increased 1.0% in 2009 compared to 2008. Consolidated inpatient surgeries declined 1.5% and consolidated outpatient surgeries declined 1.4% during 2010 compared to 2009. Consolidated inpatient surgeries increased 0.3% and consolidated outpatient surgeries declined 0.4% during 2009 compared to 2008. Consolidated emergency room visits increased 2.0% during 2010 compared to 2009 and increased 6.6% during 2009 compared to 2008.

Same facility revenues increased 2.1% for the year ended December 31, 2010 compared to the year ended December 31, 2009 and increased 6.1% for the year ended December 31, 2009 compared to the year ended December 31, 2008. The 2.1% increase for 2010 can be primarily attributed to the combined impact of a 0.6% increase in same facility revenue per equivalent admission and a 1.4% increase in same facility equivalent admissions. The 6.1% increase for 2009 can be primarily attributed to the combined impact of a 2.6% increase in same facility revenue per equivalent admission and a 3.4% increase in same facility equivalent admissions.

Same facility admissions increased 0.1% in 2010 compared to 2009 and increased 1.2% in 2009 compared to 2008. Same facility inpatient surgeries declined 1.4% and same facility outpatient surgeries declined 1.2% during 2010 compared to 2009. Same facility inpatient surgeries increased 0.5% and same facility outpatient surgeries declined 0.1% during 2009 compared to 2008. Same facility emergency room visits increased 2.1% during 2010 compared to 2009 and increased 7.0% during 2009 compared to 2008.

Same facility uninsured emergency room visits increased 1.2% and same facility uninsured admissions increased 5.4% during 2010 compared to 2009. Same facility uninsured emergency room visits increased 6.5% and same facility uninsured admissions increased 4.7% during 2009 compared to 2008.

HCA HOLDINGS, INC.

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

Results of Operations (Continued)

Revenue/Volume Trends (Continued)

The approximate percentages of our admissions related to Medicare, managed Medicare, Medicaid, managed Medicaid, managed care and other insurers and the uninsured for the years ended December 31, 2010, 2009 and 2008 are set forth below.

	Years Ended December 31,		
	2010	2009	2008
Medicare	34%	34%	35%
Managed Medicare	10	10	9
Medicaid	9	9	8
Managed Medicaid	8	7	7
Managed care and other insurers	32	34	35
Uninsured	7	6	6
	100%	100%	100%

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

	Years Ended December 31,		
	2010	2009	2008
Medicare	31%	31%	31%
Managed Medicare	9	8	8
Medicaid	9	8	7
Managed Medicaid	4	4	4
Managed care and other insurers	44	44	44
Uninsured(a)	3	5	6
	100%	100%	100%

(a) Increases in discounts to uninsured revenues have resulted in declines in the percentage of our inpatient revenues related to the uninsured, as the percentage of uninsured admissions compared to total admissions has increased slightly.

At December 31, 2010, we owned and operated 38 hospitals and 32 surgery centers in the state of Florida. Our Florida facilities' revenues totaled $7.490 billion, $7.343 billion and $7.009 billion for the years ended December 31, 2010, 2009 and 2008, respectively. At December 31, 2010, we owned and operated 36 hospitals and 23 surgery centers in the state of Texas. Our Texas facilities' revenues totaled $8.352 billion, $8.042 billion and $7.351 billion for the years ended December 31, 2010, 2009 and 2008, respectively. During 2010, 2009 and 2008, 57%, 57% and 55% of our admissions and 52%, 51% and 51%, respectively, of our revenues were generated by our Florida and Texas facilities. Uninsured admissions in Florida and Texas represented 63%, 64% and 63% of our uninsured admissions during 2010, 2009 and 2008, respectively.

We receive a significant portion of our revenues from government health programs, principally Medicare and Medicaid, which are highly regulated and subject to frequent and substantial changes. We have increased the indigent care services we provide in several communities in the state of Texas, in affiliation with other hospitals. The state of Texas has been involved in the effort to increase the indigent care provided by private hospitals. As a result of this additional indigent care provided by private hospitals, public hospital districts or counties in Texas

Results of Operations (Continued)

Revenue/Volume Trends (Continued)

have available funds that were previously devoted to indigent care. The public hospital districts or counties are under no contractual or legal obligation to provide such indigent care. The public hospital districts or counties have elected to transfer some portion of these available funds to the state's Medicaid program. Such action is at the sole discretion of the public hospital districts or counties. It is anticipated that these contributions to the state will be matched with federal Medicaid funds. The state then may make supplemental payments to hospitals in the state for Medicaid services rendered. Hospitals receiving Medicaid supplemental payments may include those that are providing additional indigent care services. Such payments must be within the federal UPL established by federal regulation. Our Texas Medicaid revenues included $657 million, $474 million and $262 million during 2010, 2009 and 2008, respectively, of Medicaid supplemental payments pursuant to UPL programs.

The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive payments beginning in 2011 for eligible hospitals and professionals that adopt and meaningfully use certified electronic health record ("EHR") technology. We estimate a majority of our eligible hospitals will attest to adopting, implementing, upgrading or demonstrating meaningful use of certified EHR technology during the fourth quarter of 2011, and we will not recognize any revenues related to the Medicare or Medicaid incentive payments until we are able to complete these attestations. We currently estimate that, during 2011 (primarily during our fourth quarter), the amount of Medicare or Medicaid incentive payments realizable (and revenues recognized) will be in the range of $275 million to $325 million. Actual incentive payments could vary from these estimates due to certain factors such as availability of federal funding for both Medicare and Medicaid incentive payments, timing of the approval of state Medicaid incentive payment plans by CMS and our ability to implement and demonstrate meaningful use of certified EHR technology. We have incurred and will continue to incur both capital costs and operating expenses in order to implement our certified EHR technology and meet meaningful use requirements. These expenses are ongoing and are projected to continue over all stages of implementation of meaningful use. The timing of recognizing the expenses will not correlate with the receipt of the incentive payments and the recognition of revenues. We estimate that operating expenses to implement our certified EHR technology and meet meaningful use will be in the range of $125 million to $150 million for 2011. Actual operating expenses could vary from these estimates. There can be no assurance that we will be able to demonstrate meaningful use of certified EHR technology, and the failure to do so could have a material, adverse effect on our results of operations.

HCA HOLDINGS, INC.

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

Results of Operations (Continued)

Operating Results Summary

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

	2010		2009		2008	
	Amount	Ratio	Amount	Ratio	Amount	Ratio
Revenues	$ 30,683	100.0	$ 30,052	100.0	$ 28,374	100.0
Salaries and benefits	12,484	40.7	11,958	39.8	11,440	40.3
Supplies	4,961	16.2	4,868	16.2	4,620	16.3
Other operating expenses	5,004	16.3	4,724	15.7	4,554	16.1
Provision for doubtful accounts	2,648	8.6	3,276	10.9	3,409	12.0
Equity in earnings of affiliates	(282)	(0.9)	(246)	(0.8)	(223)	(0.8)
Depreciation and amortization	1,421	4.6	1,425	4.8	1,416	5.0
Interest expense	2,097	6.8	1,987	6.6	2,021	7.1
Losses (gains) on sales of facilities	(4)	—	15	—	(97)	(0.3)
Impairments of long-lived assets	123	0.4	43	0.1	64	0.2
	28,452	92.7	28,050	93.3	27,204	95.9
Income before income taxes	2,231	7.3	2,002	6.7	1,170	4.1
Provision for income taxes	658	2.2	627	2.1	268	0.9
Net income	1,573	5.1	1,375	4.6	902	3.2
Net income attributable to noncontrolling interests	366	1.2	321	1.1	229	0.8
Net income attributable to HCA Holdings, Inc.	$ 1,207	3.9	$ 1,054	3.5	$ 673	2.4
% changes from prior year:						
Revenues	2.1%		5.9%		5.6%	
Income before income taxes	11.5		71.1		(16.3)	
Net income attributable to HCA Holdings, Inc.	14.5		56.7		(23.0)	
Admissions(a)	(0.1)		1.0		(0.7)	
Equivalent admissions(b)	1.2		3.2		0.5	
Revenue per equivalent admission	0.9		2.6		5.2	
Same facility % changes from prior year(c):						
Revenues	2.1		6.1		7.0	
Admissions(a)	0.1		1.2		0.9	
Equivalent admissions(b)	1.4		3.4		1.9	
Revenue per equivalent admission	0.6		2.6		5.1	

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

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

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

HCA HOLDINGS, INC.

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

Results of Operations (Continued)

Operating Results Summary (Continued)

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

The results of operations presented on a cash revenues basis for the years ended December 31, 2010, 2009 and 2008 (dollars in millions):

	2010			2009			2008		
	Amount	Non-GAAP % of Cash Revenues Ratios(b)	GAAP % of Revenues Ratios(b)	Amount	Non-GAAP % of Cash Revenues Ratios(b)	GAAP % of Revenues Ratios(b)	Amount	Non-GAAP % of Cash Revenues Ratios(b)	GAAP % of Revenues Ratios(b)
Revenues	$ 30,683		100.0%	$ 30,052		100.0%	$ 28,374		100.0%
Provision for doubtful accounts	2,648			3,276			3,409		
Cash revenues(a)	28,035	100.0%		26,776	100.0%		24,965	100.0%	
Salaries and benefits	12,484	44.5	40.7	11,958	44.7	39.8	11,440	45.8	40.3
Supplies	4,961	17.7	16.2	4,868	18.2	16.2	4,620	18.5	16.3
Other operating expenses	5,004	17.9	16.3	4,724	17.6	15.7	4,554	18.3	16.1
% changes from prior year:									
Revenues	2.1%			5.9%			5.6%		
Cash revenues	4.7			7.2			5.2		
Revenue per equivalent admission	0.9			2.6			5.2		
Cash revenue per equivalent admission	3.5			3.9			4.7		

(a) Cash revenues is defined as reported revenues less the provision for doubtful accounts. We use cash revenues as an analytical indicator for purposes of assessing the effect of uninsured patient volumes, adjusted for the effect of both the revenue deductions related to uninsured accounts (charity care and uninsured discounts) and the provision for doubtful accounts (which relates primarily to uninsured accounts), on our revenues and certain operating expenses, as a percentage of cash revenues. Variations in the revenue deductions related to uninsured accounts generally have the inverse effect on the provision for doubtful accounts. During 2010, uninsured discounts increased $1.706 billion and the provision for doubtful accounts declined $628 million, compared to 2009. During 2009, uninsured discounts increased $1.082 billion and the provision for doubtful accounts declined $133 million, compared to 2008. Cash revenues is commonly used as an analytical indicator within the health care industry. Cash revenues should not be considered as a measure of financial performance under generally accepted accounting principles. Because cash revenues is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, cash revenues, as presented, may not be comparable to other similarly titled measures of other health care companies.

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

HCA HOLDINGS, INC.

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

Results of Operations (Continued)

Years Ended December 31, 2010 and 2009

Net income attributable to HCA Holdings, Inc. totaled $1.207 billion for the year ended December 31, 2010 compared to $1.054 billion for the year ended December 31, 2009. Financial results for 2010 include net gains on sales of facilities of $4 million and asset impairment charges of $123 million. Financial results for 2009 include net losses on sales of facilities of $15 million and asset impairment charges of $43 million.

Revenues increased 2.1% to $30.683 billion for 2010 from $30.052 billion for 2009. The increase in revenues was due primarily to the combined impact of a 0.9% increase in revenue per equivalent admission and a 1.2% increase in equivalent admissions compared to 2009. Same facility revenues increased 2.1% due primarily to the combined impact of a 0.6% increase in same facility revenue per equivalent admission and a 1.4% increase in same facility equivalent admissions compared to 2009. Cash revenues (reported revenues less the provision for doubtful accounts) increased 4.7% for 2010, compared to 2009.

During 2010, consolidated admissions declined 0.1% and same facility admissions increased 0.1% for 2010, compared to 2009. Consolidated inpatient surgical volumes declined 1.5%, and same facility inpatient surgeries declined 1.4% during 2010 compared to 2009. Consolidated outpatient surgical volumes declined 1.4%, and same facility outpatient surgeries declined 1.2% during 2010 compared to 2009. Emergency room visits increased 2.0% on a consolidated basis and increased 2.1% on a same facility basis during 2010 compared to 2009.

Salaries and benefits, as a percentage of revenues, were 40.7% in 2010 and 39.8% in 2009. Salaries and benefits, as a percentage of cash revenues, were 44.5% in 2010 and 44.7% in 2009. Salaries and benefits per equivalent admission increased 3.2% in 2010 compared to 2009. Same facility labor rate increases averaged 2.7% for 2010 compared to 2009.

Supplies, as a percentage of revenues, were 16.2% in both 2010 and 2009. Supplies, as a percentage of cash revenues, were 17.7% in 2010 and 18.2% in 2009. Supply costs per equivalent admission increased 0.7% in 2010 compared to 2009. Supply costs per equivalent admission increased 2.4% for medical devices, 0.8% for blood products, and 2.9% for general medical and surgical items, and declined 0.7% for pharmacy supplies in 2010 compared to 2009.

Other operating expenses, as a percentage of revenues, increased to 16.3% in 2010 from 15.7% in 2009. Other operating expenses, as a percentage of cash revenues, increased to 17.9% in 2010 from 17.6% in 2009. Other operating expenses are primarily comprised of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and nonincome taxes. The major component of the increase in other operating expenses, as a percentage of revenues, was related to indigent care costs in certain Texas markets which increased to $354 million for 2010 from $248 million for 2009. Provisions for losses related to professional liability risks were $222 million and $211 million for 2010 and 2009, respectively.

Provision for doubtful accounts declined $628 million, from $3.276 billion in 2009 to $2.648 billion in 2010, and as a percentage of revenues, declined to 8.6% for 2010 from 10.9% in 2009. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts due directly from patients. The decline in the provision for doubtful accounts can be attributed to the $1.892 billion increase in the combined self-pay revenue deductions for charity care and uninsured discounts during 2010, compared to 2009. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of net revenues, uninsured discounts and charity care, was 25.6% for 2010, compared to 23.8% for 2009. At December 31, 2010, our allowance for doubtful accounts represented approximately 93% of the $4.249 billion total patient due accounts receivable balance, including accounts, net of estimated contractual discounts, related to patients for which eligibility for Medicaid coverage or uninsured discounts was being evaluated.

HCA HOLDINGS, INC.

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

Results of Operations (Continued)

Years Ended December 31, 2010 and 2009 (Continued)

Equity in earnings of affiliates increased from $246 million for 2009 to $282 million for 2010. Equity in earnings of affiliates relates primarily to our Denver, Colorado market joint venture.

Depreciation and amortization declined, as a percentage of revenues, to 4.6% in 2010 from 4.8% in 2009. Depreciation expense was $1.416 billion for 2010 and $1.419 billion for 2009.

Interest expense increased to $2.097 billion for 2010 from $1.987 billion for 2009. The increase in interest expense was due primarily to an increase in the average effective interest rate. Our average debt balance was $26.751 billion for 2010 compared to $26.267 billion for 2009. The average interest rate for our long-term debt increased from 7.6% for 2009 to 7.8% for 2010.

Net gains on sales of facilities were $4 million for 2010 and were related to sales of real estate and other health care entity investments. Net losses on sales of facilities were $15 million for 2009 and included $8 million of net losses on the sales of three hospital facilities and $7 million of net losses on sales of real estate and other health care entity investments.

Impairments of long-lived assets were $123 million for 2010 and included $74 million related to two hospital facilities and $49 million related to other health care entity investments, which includes $35 million for the writeoff of capitalized engineering and design costs related to certain building safety requirements (California earthquake standards) that have been revised. Impairments of long-lived assets were $43 million for 2009 and included $19 million related to goodwill and $24 million related to property and equipment.

The effective tax rate was 35.3% and 37.3% for 2010 and 2009, respectively. The effective tax rate computations exclude net income attributable to noncontrolling interests as it relates to consolidated partnerships. Our provisions for income taxes for 2010 and 2009 were reduced by $44 million and $12 million, respectively, related to reductions in interest expense related to taxing authority examinations. Excluding the effect of these adjustments, the effective tax rate for 2010 and 2009 would have been 37.6% and 38.0%, respectively.

Net income attributable to noncontrolling interests increased from $321 million for 2009 to $366 million for 2010. The increase in net income attributable to noncontrolling interests related primarily to growth in operating results of hospital joint ventures in two Texas markets.

Years Ended December 31, 2009 and 2008

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

Revenues increased 5.9% to $30.052 billion for 2009 from $28.374 billion for 2008. The increase in revenues was due primarily to the combined impact of a 2.6% increase in revenue per equivalent admission and a 3.2% increase in equivalent admissions compared to 2008. Same facility revenues increased 6.1% due primarily to the combined impact of a 2.6% increase in same facility revenue per equivalent admission and a 3.4% increase in same facility equivalent admissions compared to 2008. Cash revenues (reported revenues less the provision for doubtful accounts) increased 7.2% for 2009, compared to 2008.

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

Results of Operations (Continued)

Years Ended December 31, 2009 and 2008 (Continued)

facility outpatient surgeries declined 0.1% during 2009 compared to 2008. Emergency department visits increased 6.6% on a consolidated basis and increased 7.0% on a same facility basis during 2009 compared to 2008.

Salaries and benefits, as a percentage of revenues, were 39.8% in 2009 and 40.3% in 2008. Salaries and benefits, as a percentage of cash revenues, were 44.7% in 2009 and 45.8% in 2008. Salaries and benefits per equivalent admission increased 1.3% in 2009 compared to 2008. Same facility labor rate increases averaged 3.7% for 2009 compared to 2008.

Supplies, as a percentage of revenues, were 16.2% in 2009 and 16.3% in 2008. Supplies, as a percentage of cash revenues, were 18.2% in 2009 and 18.5% in 2008. Supply costs per equivalent admission increased 2.1% in 2009 compared to 2008. Same facility supply costs increased 5.9% for medical devices, 4.0% for pharmacy supplies, 7.1% for blood products and 7.0% for general medical and surgical items in 2009 compared to 2008.

Other operating expenses, as a percentage of revenues, declined to 15.7% in 2009 from 16.1% in 2008. Other operating expenses, as a percentage of cash revenues, declined to 17.6% in 2009 from 18.3% in 2008. Other operating expenses are primarily comprised of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and nonincome taxes. The overall decline in other operating expenses, as a percentage of revenues, is comprised of relatively small reductions in several areas, including utilities, employee recruitment and travel and entertainment. Other operating expenses include $248 million and $144 million of indigent care costs in certain Texas markets during 2009 and 2008, respectively. Provisions for losses related to professional liability risks were $211 million and $175 million for 2009 and 2008, respectively.

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

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

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

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

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

HCA HOLDINGS, INC.

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

Results of Operations (Continued)

Years Ended December 31, 2009 and 2008 (Continued)

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

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

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

Liquidity and Capital Resources

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

Cash provided by operating activities totaled $3.085 billion in 2010 compared to $2.747 billion in 2009 and $1.990 billion in 2008. Working capital totaled $2.650 billion at December 31, 2010 and $2.264 billion at December 31, 2009. The $338 million increase in cash provided by operating activities for 2010, compared to 2009, was primarily comprised of the net impact of the $198 million increase in net income, a $547 million improvement from lower income tax payments and a $384 million decline from changes in operating assets and liabilities and the provision for doubtful accounts. The $757 million increase in cash provided by operating activities for 2009, compared to 2008, related primarily to the $473 million increase in net income and $143 million improvement from changes in operating assets and liabilities and the provision for doubtful accounts. Cash payments for interest and income taxes declined $387 million for 2010 compared to 2009 and increased $203 million for 2009 compared to 2008.

Cash used in investing activities was $1.039 billion, $1.035 billion and $1.467 billion in 2010, 2009 and 2008, respectively. Excluding acquisitions, capital expenditures were $1.325 billion in 2010, $1.317 billion in 2009 and $1.600 billion in 2008. We expended $233 million, $61 million and $85 million for acquisitions of hospitals and health care entities during 2010, 2009 and 2008, respectively. Expenditures for acquisitions in 2010 included two hospital facilities, and in 2009 and 2008 were generally comprised of outpatient and ancillary services entities. Planned capital expenditures are expected to approximate $1.6 billion in 2011. At December 31, 2010, there were projects under construction which had an estimated additional cost to complete and equip over the next five years of $1.7 billion. We expect to finance capital expenditures with internally generated and borrowed funds.

During 2010, we received cash proceeds of $37 million from sales of other health care entities and real estate investments. We also received net cash proceeds of $472 million related to net changes in our investments. During 2009, we received cash proceeds of $41 million from dispositions of three hospitals and sales of other health care entities and real estate investments. We also received net cash proceeds of $303 million related to net changes in our investments. During 2008, we received cash proceeds of $143 million from dispositions of two hospitals and $50 million from sales of other health care entities and real estate investments.

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

Form 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2012

Or

☐ **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 Holdings, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**27-3865930**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One Park Plaza **Nashville, Tennessee**	**37203**
(Address of principal executive offices)	(Zip Code)

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

Not Applicable
(Former name, former address and former fiscal year, if changed since last report)

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 ☒ No ☐

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

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

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	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 ☐ No ☒

Indicate the number of shares outstanding of each of the issuer's classes of common stock as of the latest practicable date.

Class of Common Stock	*Outstanding at October 31, 2012*
Voting common stock, $.01 par value	441,493,600 shares

HCA HOLDINGS, INC.
Form 10-Q
September 30, 2012

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATED COMPREHENSIVE STATEMENTS OF OPERATIONS
FOR THE QUARTERS AND NINE MONTHS ENDED SEPTEMBER 30, 2012 AND 2011
Unaudited
(Dollars in millions, except per share amounts)

	Quarter		Nine Months	
	2012	2011	2012	2011
Revenues before provision for doubtful accounts	$ 8,893	$ 7,998	$ 27,245	$ 24,077
Provision for doubtful accounts	831	740	2,666	2,164
Revenues	8,062	7,258	24,579	21,913
Salaries and benefits	3,781	3,333	11,224	9,948
Supplies	1,375	1,263	4,216	3,833
Other operating expenses	1,510	1,369	4,496	4,017
Electronic health record incentive income	(131)	(51)	(256)	(90)
Equity in earnings of affiliates	(6)	(68)	(26)	(217)
Depreciation and amortization	417	362	1,254	1,078
Interest expense	446	519	1,336	1,572
Losses (gains) on sales of facilities	(7)	2	(4)	3
Losses on retirement of debt	—	406	—	481
Termination of management agreement	—	—	—	181
	7,385	7,135	22,240	20,806
Income before income taxes	677	123	2,339	1,107
Provision (benefit) for income taxes	222	(23)	760	307
Net income	455	146	1,579	800
Net income attributable to noncontrolling interests	95	85	288	270
Net income attributable to HCA Holdings, Inc.	$ 360	$ 61	$ 1,291	$ 530
Per share data:				
Basic earnings per share	$ 0.82	$ 0.12	$ 2.94	$ 1.08
Diluted earnings per share	$ 0.78	$ 0.11	$ 2.81	$ 1.04
Cash dividends declared per share	$ —	$ —	$ 2.00	$ —
Shares used in earnings per share calculations (in thousands):				
Basic	440,899	508,417	439,441	489,924
Diluted	459,515	527,515	458,822	509,583
Comprehensive income (loss) attributable to HCA Holdings, Inc.	$ 369	$ (24)	$ 1,291	$ 534

See accompanying notes.

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
Unaudited
(Dollars in millions)

	September 30, 2012	December 31, 2011
ASSETS		
Current assets:		
Cash and cash equivalents	$ 472	$ 373
Accounts receivable, less allowance for doubtful accounts of $4,475 and $4,106	4,598	4,533
Inventories	1,052	1,054
Deferred income taxes	322	594
Other	828	679
	7,272	7,233
Property and equipment, at cost	29,145	28,075
Accumulated depreciation	(16,185)	(15,241)
	12,960	12,834
Investments of insurance subsidiaries	473	548
Investments in and advances to affiliates	103	101
Goodwill and other intangible assets	5,460	5,251
Deferred loan costs	266	290
Other	768	641
	$ 27,302	$ 26,898
LIABILITIES AND STOCKHOLDERS' DEFICIT		
Current liabilities:		
Accounts payable	$ 1,585	$ 1,597
Accrued salaries	1,027	965
Other accrued expenses	1,498	1,585
Long-term debt due within one year	1,751	1,407
	5,861	5,554
Long-term debt	25,182	25,645
Professional liability risks	962	993
Income taxes and other liabilities	1,860	1,720
Stockholders' deficit:		
Common stock $0.01 par; authorized 1,800,000,000 shares; outstanding 441,383,000 shares in 2012 and 437,477,900 shares in 2011	4	4
Capital in excess of par value	1,680	1,601
Accumulated other comprehensive loss	(440)	(440)
Retained deficit	(9,103)	(9,423)
Stockholders' deficit attributable to HCA Holdings, Inc.	(7,859)	(8,258)
Noncontrolling interests	1,296	1,244
	(6,563)	(7,014)
	$ 27,302	$ 26,898

See accompanying notes.

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE NINE MONTHS ENDED SEPTEMBER 30, 2012 AND 2011
Unaudited
(Dollars in millions)

	2012	2011
Cash flows from operating activities:		
Net income	$ 1,579	$ 800
Adjustments to reconcile net income to net cash provided by operating activities:		
Changes in operating assets and liabilities	(2,923)	(2,336)
Provision for doubtful accounts	2,666	2,164
Depreciation and amortization	1,254	1,078
Income taxes	250	348
Losses (gains) on sales of facilities	(4)	3
Losses on retirement of debt	—	481
Amortization of deferred loan costs	44	56
Share-based compensation	39	24
Pay-in-kind interest	—	(78)
Other	7	6
Net cash provided by operating activities	2,912	2,546
Cash flows from investing activities:		
Purchase of property and equipment	(1,268)	(1,170)
Acquisition of hospitals and health care entities	(167)	(209)
Disposition of hospitals and health care entities	17	55
Change in investments	73	80
Other	5	4
Net cash used in investing activities	(1,340)	(1,240)
Cash flows from financing activities:		
Issuance of long-term debt	1,350	5,000
Net change in revolving credit facilities	(875)	(414)
Repayment of long-term debt	(689)	(6,583)
Distributions to noncontrolling interests	(303)	(281)
Payment of debt issuance costs	(20)	(84)
Issuance of common stock	—	2,506
Repurchase of common stock	—	(1,503)
Distributions to stockholders	(983)	(31)
Income tax benefits	82	54
Other	(35)	(22)
Net cash used in financing activities	(1,473)	(1,358)
Change in cash and cash equivalents	99	(52)
Cash and cash equivalents at beginning of period	373	411
Cash and cash equivalents at end of period	$ 472	$ 359
Interest payments	$ 1,404	$ 1,635
Income tax payments (refunds), net	$ 428	$ (95)

See accompanying notes.

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 — INTERIM CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

Reporting Entity

On November 17, 2006, HCA Inc. was acquired by a private investor group, including affiliates of, or funds sponsored by Bain Capital Partners, LLC, Kohlberg Kravis Roberts & Co., BAML Capital Partners and HCA founder, Dr. Thomas F. Frist Jr. (collectively, the "Investors") and by members of management and certain other investors. The transaction was accounted for as a recapitalization in our financial statements, with no adjustments to the historical basis of our assets and liabilities.

On November 22, 2010, HCA Inc. reorganized by creating a new holding company structure (the "Corporate Reorganization"). HCA Holdings, Inc. became the new parent company, and HCA Inc. became HCA Holdings, Inc.'s wholly-owned direct subsidiary. As part of the Corporate Reorganization, HCA Inc.'s outstanding shares of common stock were automatically converted, on a share for share basis, into identical shares of HCA Holdings, Inc.'s common stock. As a result of the Corporate Reorganization, HCA Holdings, Inc. was deemed the successor registrant to HCA Inc. under the Exchange Act.

During March 2011, we completed the initial public offering of 87,719,300 shares of our common stock at a price of $30.00 per share (before deducting underwriter discounts, commissions and other related offering expenses). Certain of our stockholders also sold 57,410,700 shares of our common stock in this offering. We did not receive any proceeds from the shares sold by the selling stockholders. Our common stock is traded on the New York Stock Exchange (symbol "HCA").

The Investors provided management and advisory services to the Company pursuant to a management agreement among HCA Inc. and the Investors executed in connection with the Investors' acquisition of HCA Inc. in November 2006. The management agreement was terminated pursuant to its terms upon completion of the initial public offering of our common stock during March 2011, and the Company paid the Investors a final fee of $181 million.

HCA Holdings, Inc. is a holding company whose affiliates own and operate hospitals and related health care entities. The term "affiliates" includes direct and indirect subsidiaries of HCA Holdings, Inc. and partnerships and joint ventures in which such subsidiaries are partners. At September 30, 2012, these affiliates owned and operated 162 hospitals, 112 freestanding surgery centers and provided extensive outpatient and ancillary services. HCA Holdings, Inc.'s facilities are located in 20 states and England. The terms "Company," "HCA," "we," "our" or "us," as used herein and unless otherwise stated or indicated by context, refer to HCA Inc. and its affiliates prior to the Corporate Reorganization and to HCA Holdings, Inc. and its affiliates after the Corporate Reorganization. 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.

Basis of Presentation

The accompanying unaudited condensed consolidated financial statements have been prepared in accordance with generally accepted accounting principles for interim financial information and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, they do not include all the information and footnotes required by generally accepted accounting principles for complete consolidated financial statements. In the opinion of management, all adjustments considered necessary for a fair presentation have been included and are of a normal and recurring nature.

The majority of our expenses are "costs of revenues" items. Costs that could be classified as general and administrative would include our corporate office costs, which were $62 million and $53 million for the quarters

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 — INTERIM CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (continued)

Basis of Presentation (continued)

ended September 30, 2012 and 2011, respectively, and $174 million and $162 million for the nine months ended September 30, 2012 and 2011, respectively. Operating results for the quarter and the nine months ended September 30, 2012 are not necessarily indicative of the results that may be expected for the year ending December 31, 2012. For further information, refer to the consolidated financial statements and footnotes thereto included in our annual report on Form 10-K for the year ended December 31, 2011.

Revenues are recorded during the period the health care services are provided, based upon the estimated amounts due from the patients and third-party payers. Third-party payers include federal and state agencies (under Medicare, Medicaid and other programs), managed care health plans, commercial insurance companies and employers. Estimates of contractual allowances under managed care health plans are based upon the payment terms specified in the related contractual agreements. Revenues related to uninsured patients and copayment and deductible amounts for patients who have health care coverage may have discounts applied (uninsured discounts and contractual discounts). We also record a provision for doubtful accounts related to uninsured accounts to record the net self pay accounts receivable at the estimated amounts we expect to collect. Our revenues from third-party payers, the uninsured and other revenues for the quarters and nine months ended September 30, 2012 and 2011 are summarized in the following tables (dollars in millions):

	Quarter			
	2012	Ratio	2011	Ratio
Medicare	$ 1,949	24.2%	$ 1,844	25.4%
Managed Medicare	720	8.9	610	8.4
Medicaid	378	4.7	453	6.2
Managed Medicaid	380	4.7	311	4.3
Managed care and other insurers	4,422	54.8	3,855	53.1
International (managed care and other insurers)	253	3.1	232	3.2
	8,102	100.4	7,305	100.6
Uninsured	576	7.1	508	7.0
Other	215	2.7	185	2.5
Revenues before provision for doubtful accounts	8,893	110.2	7,998	110.1
Provision for doubtful accounts	(831)	(10.2)	(740)	(10.1)
Revenues	$ 8,062	100.0%	$ 7,258	100.0%

	Nine Months			
	2012	Ratio	2011	Ratio
Medicare	$ 6,251	25.4%	$ 5,715	26.1%
Managed Medicare	2,199	8.9	1,806	8.2
Medicaid	1,188	4.8	1,440	6.6
Managed Medicaid	1,080	4.4	946	4.3
Managed care and other insurers	13,340	54.3	11,486	52.4
International (managed care and other insurers)	779	3.2	698	3.2
	24,837	101.0	22,091	100.8
Uninsured	1,757	7.1	1,390	6.3
Other	651	2.7	596	2.7
Revenues before provision for doubtful accounts	27,245	110.8	24,077	109.8
Provision for doubtful accounts	(2,666)	(10.8)	(2,164)	(9.8)
Revenues	$24,579	100.0%	$21,913	100.0%

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 1 — INTERIM CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (continued)

Basis of Presentation (continued)

The increase in revenues for the nine months ended September 30, 2012 compared to the nine months ended September 30, 2011 includes two adjustments (Rural Floor Provision Settlement and Supplemental Security Income ("SSI") ratios) related to Medicare revenues for prior periods. The net effect of the Medicare adjustments was an increase of $188 million to revenues. The Rural Floor Provision Settlement was signed on April 5, 2012. As a result of the agreement, we received additional Medicare payments of approximately $271 million during June 2012. This amount was recorded as an increase to Medicare revenues for the quarter ended March 31, 2012. During March 2012, the Centers for Medicare & Medicaid Services ("CMS") issued new SSI ratios used for calculating Medicare Disproportionate Share Hospital ("DSH") reimbursement for federal fiscal years ending September 30, 2006 through September 30, 2009. As a result, we recalculated our DSH reimbursement for all applicable periods. The cumulative impact of this retroactive adjustment was a reduction in Medicare revenues of approximately $83 million. This adjustment was recorded as a reduction to Medicare revenues during the quarter ended March 31, 2012. The net effect of these adjustments (and related expenses) added $170 million to income before income taxes, or $0.22 per diluted share, for the nine months ended September 30, 2012.

We previously reported $51 million and $90 million of Medicaid and Medicare electronic health record ("EHR") incentives for the quarter and nine months ended September 30, 2011, respectively, in the line item "Revenues" in our condensed consolidated income statements. These amounts have been reclassified and are now included in the line item "Electronic health record incentive income" in our condensed consolidated comprehensive statements of operations for the quarter and nine months ended September 30, 2011.

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

NOTE 2 — INCOME TAXES

At September 30, 2012, we were contesting certain claimed deficiencies and adjustments proposed by the IRS Examination Division in connection with its audit of HCA Inc.'s 2005 and 2006 federal income tax returns. The disputed items include the timing of recognition of certain patient service revenues, the deductibility of certain debt retirement costs and our method for calculating the tax allowance for doubtful accounts. The IRS Examination Division began an audit of HCA Inc.'s 2007, 2008 and 2009 federal income tax returns in 2010. During the quarter ended September 30, 2011, we finalized a settlement with the IRS Examination Division resolving all outstanding issues for our 1997 through 2001 tax years.

Our liability for unrecognized tax benefits was $519 million, including accrued interest of $47 million, as of September 30, 2012 ($494 million and $62 million, respectively, as of December 31, 2011). Unrecognized tax benefits of $158 million ($173 million as of December 31, 2011) would affect the effective rate, if recognized. The provision for income taxes reflects $1 million and $66 million (none and $42 million, respectively, net of tax) of interest expense and reductions in interest expense, respectively, related to taxing authority examinations for the quarters ended September 30, 2012 and 2011, respectively, and $20 million and $92 million ($13 million and $58 million, respectively, net of tax) of reductions in interest expense related to taxing authority examinations for the nine months ended September 30, 2012 and 2011, respectively.

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

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 3 — EARNINGS PER SHARE

We compute basic earnings per share using the weighted average number of common shares outstanding. We compute diluted earnings per share using the weighted average number of common shares outstanding, plus the dilutive effect of outstanding stock options, stock appreciation rights and restricted share units, computed using the treasury stock method. During September 2011, we repurchased 80.8 million shares of our common stock.

The following table sets forth the computation of basic and diluted earnings per share for the quarters and nine months ended September 30, 2012 and 2011 (dollars in millions, except per share amounts, and shares in thousands):

	Quarter		Nine Months	
	2012	2011	2012	2011
Net income attributable to HCA Holdings, Inc.	$ 360	$ 61	$ 1,291	$ 530
Weighted average common shares outstanding	440,899	508,417	439,441	489,924
Effect of dilutive securities	18,616	19,098	19,381	19,659
Shares used for diluted earnings per share	459,515	527,515	458,822	509,583
Earnings per share:				
Basic earnings per share	$ 0.82	$ 0.12	$ 2.94	$ 1.08
Diluted earnings per share	$ 0.78	$ 0.11	$ 2.81	$ 1.04

NOTE 4 — INVESTMENTS OF INSURANCE SUBSIDIARIES

A summary of our insurance subsidiaries' investments at September 30, 2012 and December 31, 2011 follows (dollars in millions):

	September 30, 2012			
	Amortized Cost	Unrealized Amounts		Fair Value
		Gains	Losses	
Debt securities:				
States and municipalities	$ 349	$ 24	$ —	$373
Auction rate securities	76	—	(5)	71
Asset-backed securities	15	—	—	15
Money market funds	67	—	—	67
	507	24	(5)	526
Equity securities	7	1	—	8
	$ 514	$ 25	$ (5)	534
Amounts classified as current assets				(61)
Investment carrying value				$473

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 4 — INVESTMENTS OF INSURANCE SUBSIDIARIES (continued)

	December 31, 2011			
	Amortized Cost	Unrealized Amounts		Fair Value
		Gains	Losses	
Debt securities:				
States and municipalities	$ 398	$ 19	$ —	$ 417
Auction rate securities	139	—	(8)	131
Asset-backed securities	20	—	—	20
Money market funds	53	—	—	53
	610	19	(8)	621
Equity securities	7	1	(1)	7
	$ 617	$ 20	$ (9)	628
Amounts classified as current assets				(80)
Investment carrying value				$ 548

At September 30, 2012 and December 31, 2011, the investments of our insurance subsidiaries were classified as "available-for-sale." Changes in temporary unrealized gains and losses are recorded as adjustments to other comprehensive income. At both September 30, 2012 and December 31, 2011, $19 million of our investments were subject to restrictions included in insurance bond collateralization and assumed reinsurance contracts.

Scheduled maturities of investments in debt securities at September 30, 2012 were as follows (dollars in millions):

	Amortized Cost	Fair Value
Due in one year or less	$ 72	$ 72
Due after one year through five years	140	149
Due after five years through ten years	111	119
Due after ten years	93	100
	416	440
Auction rate securities	76	71
Asset-backed securities	15	15
	$ 507	$ 526

The average expected maturity of the investments in debt securities at September 30, 2012 was 4.6 years, compared to the average scheduled maturity of 8.9 years. Expected and scheduled maturities may differ because the issuers of certain securities have the right to call, prepay or otherwise redeem such obligations prior to the scheduled maturity date. The average expected maturities for our auction rate and asset-backed securities were derived from valuation models of expected cash flows and involved management's judgment. At September 30, 2012, the average expected maturities for our auction rate and asset-backed securities were 5.2 years and 4.1 years, respectively, compared to average scheduled maturities of 24.4 years and 24.1 years, respectively.

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 5 — LONG-TERM DEBT

A summary of long-term debt at September 30, 2012 and December 31, 2011, including related interest rates at September 30, 2012, follows (dollars in millions):

	September 30, 2012	December 31, 2011
Senior secured asset-based revolving credit facility (effective interest rate of 1.7%)	$ 1,280	$ 2,155
Senior secured term loan facilities (effective interest rate of 5.0%)	7,183	7,425
Senior secured first lien notes (effective interest rate of 7.4%)	8,436	7,081
Other senior secured debt (effective interest rate of 6.8%)	394	350
First lien debt	17,293	17,011
Senior secured notes (effective interest rate of 11.0%)	197	197
Senior unsecured notes (effective interest rate of 7.3%)	9,443	9,844
Total debt (average life of 6.6 years, rates averaging 6.5%)	26,933	27,052
Less amounts due within one year	1,751	1,407
	$ 25,182	$ 25,645

During April 2012, we extended $75 million of our term loan A-1 facility with a final maturity of November 2012 and $651 million of our term loan B-1 facility with a final maturity of November 2013 to term loan A-3 with a final maturity of February 2016.

During February 2012, we issued $1.350 billion aggregate principal amount of 5.875% senior secured first lien notes due 2022. After the payment of related fees and expenses, we used the proceeds for general corporate purposes.

During August 2011, we issued $5.000 billion aggregate principal amount of notes, comprised of $3.000 billion of 6.50% senior secured first lien notes due 2020 and $2.000 billion of 7.50% senior unsecured notes due 2022. After the payment of related fees and expenses, we used the net proceeds from these debt issuances to redeem all of our outstanding $1.578 billion 9 5/8%/10 3/8% senior secured second lien toggle notes due 2016, at a redemption price of 106.783% of the principal amount, and all of our outstanding $3.200 billion 9 1/4% senior secured second lien notes due 2016, at a redemption price of 106.513% of the principal amount. The pretax loss on retirement of debt related to these redemptions was $406 million.

During June 2011, we redeemed all $1.000 billion aggregate principal amount of our 9 1/8% senior secured second lien notes due 2014, at a redemption price of 104.563% of the principal amount, and $108 million aggregate principal amount of our 9 7/8% senior secured second lien notes due 2017, at a redemption price of 109.875% of the principal amount. The pretax losses on retirement of debt related to these redemptions were $75 million.

NOTE 6 — FINANCIAL INSTRUMENTS

Interest Rate Swap Agreements

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

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 — FINANCIAL INSTRUMENTS (continued)

Interest Rate Swap Agreements (continued)

match the timing of the related liabilities. The notional amounts of the swap agreements represent amounts used to calculate the exchange of cash flows and are not our assets or liabilities. Our credit risk related to these agreements is considered low because the swap agreements are with creditworthy financial institutions.

The following table sets forth our interest rate swap agreements, which have been designated as cash flow hedges, at September 30, 2012 (dollars in millions):

	Notional Amount	Maturity Date	Fair Value
Pay-fixed interest rate swaps	$ 500	December 2014	$ (10)
Pay-fixed interest rate swaps	3,000	December 2016	(376)
Pay-fixed interest rate swaps	1,000	December 2017	(80)

During the next 12 months, we estimate $126 million will be reclassified from other comprehensive income ("OCI") to interest expense.

Cross Currency Swaps

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

Our cross currency swap is not designated as a hedge, and changes in fair value are recognized in results of operations. The following table sets forth our cross currency swap agreement at September 30, 2012 (amounts in millions):

	Notional Amount	Maturity Date	Fair Value
Euro — United States dollar currency swap	266 Euro	November 2013	$ (22)

Derivatives — Results of Operations

The following tables present the effect of our interest rate and cross currency swaps on our results of operations for the nine months ended September 30, 2012 (dollars in millions):

Derivatives in Cash Flow Hedging Relationships	Amount of Loss Recognized in OCI on Derivatives, Net of Tax	Location of Loss Reclassified from Accumulated OCI into Operations	Amount of Loss Reclassified from Accumulated OCI into Operations
Interest rate swaps	$ 100	Interest expense	$ 90

Derivatives Not Designated as Hedging Instruments	Location of Loss Recognized in Operations on Derivatives	Amount of Loss Recognized in Operations on Derivatives
Cross currency swap	Other operating expenses	$ 6

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 6 — FINANCIAL INSTRUMENTS (continued)

Credit-risk-related Contingent Features

We have agreements with each of our derivative counterparties that contain a provision where we could be declared in default on our derivative obligations if repayment of the underlying indebtedness is accelerated by the lender due to our default on the indebtedness. As of September 30, 2012, we have not been required to post any collateral related to these agreements. If we had breached these provisions at September 30, 2012, we would have been required to settle our obligations under the agreements at their aggregate, estimated termination value of $513 million.

NOTE 7 — ASSETS AND LIABILITIES MEASURED AT FAIR VALUE

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

ASC 820 emphasizes fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, ASC 820 establishes a fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumptions about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

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

Cash Traded Investments

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

Our wholly-owned insurance subsidiaries had investments in tax-exempt auction rate securities ("ARS"), which are backed by student loans substantially guaranteed by the federal government, of $71 million ($76 million par value) at September 30, 2012. We do not currently intend to attempt to sell the ARS as the

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 — ASSETS AND LIABILITIES MEASURED AT FAIR VALUE (continued)

Cash Traded Investments (continued)

liquidity needs of our insurance subsidiaries are expected to be met by other investments in their investment portfolios. During 2011 and the nine months ended September 30, 2012, certain issuers and their broker/dealers redeemed or repurchased $112 million and $63 million, respectively, of our ARS at par value. The valuation of these securities involved management's judgment, after consideration of market factors and the absence of market transparency, market liquidity and observable inputs. Our valuation models derived a fair market value compared to tax-equivalent yields of other student loan backed variable rate securities of similar credit worthiness and similar effective maturities.

Derivative Financial Instruments

We have entered into interest rate and cross currency swap agreements to manage our exposure to fluctuations in interest rates and foreign currency risks. The valuation of these instruments is determined using widely accepted valuation techniques, including discounted cash flow analysis on the expected cash flows of each derivative. This analysis reflects the contractual terms of the derivatives, including the period to maturity, and uses observable market-based inputs, including interest rate curves, foreign exchange rates and implied volatilities. To comply with the provisions of ASC 820 and ASU No. 2011-04, *Fair Value Measurement (Topic 820): Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRSs* ("ASU 2011-04"), we incorporate credit valuation adjustments to reflect both our own nonperformance risk and the respective counterparty's nonperformance risk in the fair value measurements. We have made the accounting policy election to use the exception under ASU 2011-04 (commonly referred to as the "portfolio exception") with respect to measuring counterparty credit risk for derivative instruments.

Although we determined the majority of the inputs used to value our derivatives fall within Level 2 of the fair value hierarchy, the credit valuation adjustments associated with our derivatives utilize Level 3 inputs, such as estimates of current credit spreads to evaluate the likelihood of default by us and our counterparties. We assessed the significance of the impact of the credit valuation adjustments on the overall valuation of our derivative positions, and at September 30, 2012 and December 31, 2011, we determined the credit valuation adjustments were not significant to the overall valuation of our derivatives.

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 — ASSETS AND LIABILITIES MEASURED AT FAIR VALUE (continued)

The following table summarizes our assets and liabilities measured at fair value on a recurring basis as of September 30, 2012 and December 31, 2011, aggregated by the level in the fair value hierarchy within which those measurements fall (dollars in millions):

	September 30, 2012			
		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
Investments of insurance subsidiaries:				
Debt securities:				
States and municipalities	$ 373	$ —	$ 373	$ —
Auction rate securities	71	—	—	71
Asset-backed securities	15	—	15	—
Money market funds	67	67	—	—
	526	67	388	71
Equity securities	8	2	5	1
Investments of insurance subsidiaries	534	69	393	72
Less amounts classified as current assets	(61)	(61)	—	—
	$ 473	$ 8	$ 393	$ 72
Liabilities:				
Cross currency swap (Income taxes and other liabilities)	$ 22	$ —	$ 22	$ —
Interest rate swaps (Income taxes and other liabilities)	466	—	466	—

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 7 — ASSETS AND LIABILITIES MEASURED AT FAIR VALUE (continued)

	December 31, 2011			
		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
Investments of insurance subsidiaries:				
Debt securities:				
States and municipalities	$ 417	$ —	$ 417	$ —
Auction rate securities	131	—	—	131
Asset-backed securities	20	—	20	—
Money market funds	53	53	—	—
	621	53	437	131
Equity securities	7	1	5	1
Investments of insurance subsidiaries	628	54	442	132
Less amounts classified as current assets	(80)	(54)	(26)	—
	$ 548	$ —	$ 416	$ 132
Liabilities:				
Cross currency swap (Income taxes and other liabilities)	$ 16	$ —	$ 16	$ —
Interest rate swaps (Income taxes and other liabilities)	399	—	399	—

The following table summarizes the activity related to the auction rate and equity securities investments of our insurance subsidiaries which have fair value measurements based on significant unobservable inputs (Level 3) during the nine months ended September 30, 2012 (dollars in millions):

Asset balances at December 31, 2011	$ 132
Unrealized gains included in other comprehensive income	3
Settlements	(63)
Asset balances at September 30, 2012	$ 72

The estimated fair value of our long-term debt was $28.706 billion and $27.199 billion at September 30, 2012 and December 31, 2011, respectively, compared to carrying amounts aggregating $26.933 billion and $27.052 billion, respectively. The estimates of fair value are generally based upon the quoted market prices or quoted market prices for similar issues of long-term debt with the same maturities.

NOTE 8 — CONTINGENCIES

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

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 8 — CONTINGENCIES (continued)

Health care companies are subject to numerous investigations by various governmental agencies. Under the Federal False Claims act ("FCA") private parties have the right to bring *qui tam*, or "whistleblower," suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions. Certain of our individual facilities have received government inquiries from federal and state agencies and our facilities may receive such inquiries in future periods. 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 results of operations or financial position.

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

As initially disclosed in 2010, the Civil Division of the Department of Justice ("DOJ") has contacted the Company in connection with its nationwide review of whether, in certain cases, hospital charges to the federal government relating to implantable cardio-defibrillators ("ICDs") met the CMS criteria. In connection with this nationwide review, the DOJ has indicated that it will be reviewing certain ICD billing and medical records at 95 HCA hospitals; the review covers the period from October 2003 to the present. In August 2012, HCA, along with non-HCA hospitals subject to the DOJ's review, received from the DOJ a proposed framework for resolving the DOJ's review of ICDs. The Company is cooperating in the review. The review could potentially give rise to claims against the Company under the federal FCA or other statutes, regulations or laws. At this time, we cannot predict what effect, if any, this review or any resulting claims could have on the Company.

In July 2012, the Civil Division of the U.S. Attorney's Office in Miami requested information on reviews assessing the medical necessity of interventional cardiology services provided at any Company facility (other than peer reviews). The Company is cooperating with the government's request and is currently producing medical records associated with particular reviews at eight hospitals, located primarily in Florida. At this time, we cannot predict what effect, if any, the request or any resulting claims, including any potential claims under the FCA, other statutes, regulations or laws, could have on the Company.

On October 28, 2011, a shareholder action was filed in the United States District Court for the Middle District of Tennessee. The case seeks to include, as a class, all persons who acquired the Company's stock pursuant or traceable to the Company's Registration Statement and Prospectus issued in connection with the March 9, 2011 initial public offering. The lawsuit asserts a claim under Section 11 of the Securities Act of 1933 against the Company, certain members of the board of directors, and certain underwriters in the offering. It further asserts a claim under Section 15 of the Securities Act of 1933 against the same members of the board of directors. The action alleged various deficiencies in the Company's disclosures in the Registration Statement. Subsequently, two additional class action complaints setting forth substantially similar claims were filed in the same federal court. All three cases were consolidated. On July 13, 2012, the lead plaintiff filed an amended complaint asserting claims under Sections 11 and 12(a)(2) of the Securities Act of 1933 against the Company, certain members of the board of directors, and certain underwriters in the offering. It further asserts a claim under Section 15 of the Securities Act of 1933 against the same members of the board of directors and Hercules Holdings II, LLC, a majority shareholder of the Company. The consolidated complaint alleges deficiencies in the Company's disclosures in the Registration Statement and Prospectus relating to: (1) the accounting for the Company's 2006 recapitalization and 2010 reorganization; (2) the Company's failure to maintain effective

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 8 — CONTINGENCIES (continued)

internal controls relating to its accounting for such transactions; and (3) the Company's Medicare and Medicaid revenue growth rates. The Company and other defendants moved to dismiss the amended complaint on September 11, 2012.

NOTE 9 — COMPREHENSIVE INCOME AND CAPITAL STRUCTURE

The components of comprehensive income, net of related taxes, for the quarters and nine months ended September 30, 2012 and 2011 are only attributable to HCA Holdings, Inc. and are as follows (dollars in millions):

	Quarter		Nine Months	
	2012	2011	2012	2011
Net income attributable to HCA Holdings, Inc.	$ 360	$ 61	$ 1,291	$ 530
Change in fair value of derivative instruments	(17)	(72)	(42)	(3)
Change in fair value of available-for-sale securities	2	1	5	—
Foreign currency translation adjustments	20	(18)	24	(4)
Defined benefit plans	4	4	13	11
Comprehensive income (loss)	$ 369	$ (24)	$ 1,291	$ 534

The components of accumulated other comprehensive loss, net of related taxes, are as follows (dollars in millions):

	September 30, 2012	December 31, 2011
Change in fair value of derivative instruments	$ (295)	$ (253)
Change in fair value of available-for-sale securities	12	7
Foreign currency translation adjustments	(1)	(25)
Defined benefit plans	(156)	(169)
Accumulated other comprehensive loss	$ (440)	$ (440)

The changes in stockholders' deficit, including changes in stockholders' deficit attributable to HCA Holdings, Inc. and changes in equity attributable to noncontrolling interests, are as follows (dollars in millions):

	Equity (Deficit) Attributable to HCA Holdings, Inc.					Equity Attributable to Noncontrolling Interests	Total
	Common Stock		Capital in Excess of Par Value	Accumulated Other Comprehensive Loss	Retained Deficit		
	Shares (000)	Par Value					
Balances, December 31, 2011	437,478	$ 4	$1,601	$ (440)	$(9,423)	$ 1,244	$ (7,014)
Net income	—	—	—	—	1,291	288	1,579
Other comprehensive loss	—	—	—	—	—	—	—
Distributions	—	—	—	—	(971)	(303)	(1,274)
Share-based benefit plans	3,905	—	83	—	—	—	83
Adjustment to the acquired controlling interest in equity investment	—	—	—	—	—	30	30
Other	—	—	(4)	—	—	37	33
Balances, September 30, 2012	441,383	$ 4	$1,680	$ (440)	$(9,103)	$ 1,296	$(6,563)

On February 3, 2012, our Board of Directors declared a distribution to the Company's stockholders and holders of vested stock awards. The distribution was $2.00 per share and vested stock award, or $971 million in the aggregate, and was paid on February 29, 2012 to holders of record on February 16, 2012. The distribution was funded using funds available under our senior secured credit facilities.

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 — SEGMENT AND GEOGRAPHIC INFORMATION

We operate in one line of business, which is operating hospitals and related health care entities. Our operations are structured into three geographically organized groups: the National, Southwest and Central Groups. At September 30, 2012, the National Group includes 63 hospitals located in Florida, South Carolina, southern Georgia, Alaska, California, Nevada, Utah and Idaho, the Southwest Group includes 47 hospitals located in Colorado, Texas, Oklahoma and the Wichita, Kansas market, and the Central Group includes 46 hospitals located in Louisiana, Indiana, Kentucky, Tennessee, Virginia, New Hampshire, northern Georgia and the Kansas City market. We also operate six hospitals in England, and these facilities are included in the Corporate and other group.

Adjusted segment EBITDA is defined as income before depreciation and amortization, interest expense, losses (gains) on sales of facilities, losses on retirement of debt, termination of management agreement, income taxes and net income attributable to noncontrolling interests. We use adjusted segment EBITDA as an analytical indicator for purposes of allocating resources to geographic areas and assessing their performance. Adjusted segment EBITDA is commonly used as an analytical indicator within the health care industry, and also serves as a measure of leverage capacity and debt service ability. Adjusted segment EBITDA should not be considered as a measure of financial performance under generally accepted accounting principles, and the items excluded from adjusted segment EBITDA are significant components in understanding and assessing financial performance. Because adjusted segment EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, adjusted segment EBITDA, as presented, may not be comparable to other similarly titled measures of other companies. The Southwest Group's increases in revenues, adjusted segment EBITDA and depreciation and amortization, and the declines in equity in earnings of affiliates, for the quarter and nine months ended September 30, 2012 compared to the quarter and nine months ended September 30, 2011 are primarily attributable to the financial consolidation of our 2011 acquisition of our partner's interest in the HCA-HealthONE LLC venture for periods subsequent to our acquisition of controlling interests during October 2011. The geographic distributions of our revenues, equity in earnings of affiliates, adjusted segment EBITDA and depreciation and amortization for the quarters and nine months ended September 30, 2012 and 2011 are summarized in the following table (dollars in millions):

	Quarter		Nine Months	
	2012	2011	2012	2011
Revenues:				
National Group	$ 3,108	$ 3,002	$ 9,539	$ 9,119
Southwest Group	2,864	2,239	8,618	6,724
Central Group	1,765	1,730	5,429	5,216
Corporate and other	325	287	993	854
	$ 8,062	$ 7,258	$ 24,579	$ 21,913
Equity in earnings of affiliates:				
National Group	$ 1	$ (3)	$ (6)	$ (5)
Southwest Group	(6)	(64)	(20)	(212)
Central Group	—	—	(1)	—
Corporate and other	(1)	(1)	1	—
	$ (6)	$ (68)	$ (26)	$ (217)
Adjusted segment EBITDA:				
National Group	$ 630	$ 587	$ 2,031	$ 1,835
Southwest Group	656	552	2,049	1,714
Central Group	323	298	1,052	949
Corporate and other	(76)	(25)	(207)	(76)
	$ 1,533	$ 1,412	$ 4,925	$ 4,422

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 10 — SEGMENT AND GEOGRAPHIC INFORMATION (continued)

	Quarter		Nine Months	
	2012	2011	2012	2011
Depreciation and amortization:				
National Group	$ 136	$ 129	$ 419	$ 381
Southwest Group	151	111	447	332
Central Group	90	86	265	263
Corporate and other	40	36	123	102
	$ 417	$ 362	$1,254	$ 1,078
Adjusted segment EBITDA	$1,533	$1,412	$4,925	$ 4,422
Depreciation and amortization	417	362	1,254	1,078
Interest expense	446	519	1,336	1,572
Losses (gains) on sales of facilities	(7)	2	(4)	3
Losses on retirement of debt	—	406	—	481
Termination of management agreement	—	—	—	181
Income before income taxes	$ 677	$ 123	$2,339	$ 1,107

NOTE 11 — ACQUISITIONS AND DISPOSITIONS

During the nine months ended September 30, 2012, we paid $58 million, assumed liabilities of $33 million and recorded goodwill of $53 million related to the acquisition of a hospital facility in the Southwest Group. During the nine months ended September 30, 2011, we paid $136 million to acquire a hospital in the National Group. During the nine months ended September 30, 2012 and 2011, we paid $109 million and $73 million, respectively, to acquire nonhospital health care entities. During the nine months ended September 30, 2012, we recorded final adjustments to the purchase price allocation related to our 2011 acquisition of our partner's interest in the HCA-HealthONE LLC joint venture. These adjustments resulted in a $30 million increase to noncontrolling interests, a $26 million reduction to property and equipment and a $56 million increase to goodwill.

During the nine months ended September 30, 2012, we received proceeds of $17 million and recognized a net pretax gain of $4 million related to sales of real estate investments. During the nine months ended September 30, 2011, we received proceeds of $55 million and recognized a net pretax loss of $3 million related to the sales of a hospital facility and our investment in a hospital joint venture.

NOTE 12 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

On November 22, 2010, HCA Inc. reorganized by creating a new holding company structure. HCA Holdings, Inc. became the new parent company, and HCA Inc. is now HCA Holdings, Inc.'s wholly-owned direct subsidiary. On November 23, 2010, HCA Holdings, Inc. issued $1.525 billion aggregate principal amount of 7 ¾% senior unsecured notes due 2021. These notes are senior unsecured obligations and are not guaranteed by any of our subsidiaries.

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

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION (continued)

Our summarized condensed consolidating comprehensive income statements for the quarters and nine months ended September 30, 2012 and 2011, condensed consolidating balance sheets at September 30, 2012 and December 31, 2011 and condensed consolidating statements of cash flows for the nine months ended September 30, 2012 and 2011, segregating HCA Holdings, Inc. issuer, HCA Inc. issuer, the subsidiary guarantors, the subsidiary non-guarantors and eliminations, follow:

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATING COMPREHENSIVE INCOME STATEMENT
FOR THE QUARTER ENDED SEPTEMBER 30, 2012
(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Revenues before provision for doubtful accounts	$ —	$ —	$ 4,672	$ 4,221	$ —	$ 8,893
Provision for doubtful accounts	—	—	484	347	—	831
Revenues	—	—	4,188	3,874	—	8,062
Salaries and benefits	—	—	1,995	1,786	—	3,781
Supplies	—	—	711	664	—	1,375
Other operating expenses	—	3	761	746	—	1,510
Electronic health record incentive income	—	—	(85)	(46)	—	(131)
Equity in earnings of affiliates	(379)	—	(1)	(5)	379	(6)
Depreciation and amortization	—	—	205	212	—	417
Interest expense	30	545	(98)	(31)	—	446
Gains on sales of facilities	—	—	—	(7)	—	(7)
Management fees	—	—	(170)	170	—	—
	(349)	548	3,318	3,489	379	7,385
Income (loss) before income taxes	349	(548)	870	385	(379)	677
Provision (benefit) for income taxes	(11)	(208)	325	116	—	222
Net income (loss)	360	(340)	545	269	(379)	455
Net income attributable to noncontrolling interests	—	—	18	77	—	95
Net income (loss) attributable to HCA Holdings, Inc.	$ 360	$ (340)	$ 527	$ 192	$ (379)	$ 360
Comprehensive income (loss) attributable to HCA Holdings, Inc.	$ 360	$ (357)	$ 531	$ 214	$ (379)	$ 369

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION (continued)

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATING COMPREHENSIVE STATEMENT OF OPERATIONS
FOR THE QUARTER ENDED SEPTEMBER 30, 2011
(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Revenues before provision for doubtful accounts	$ —	$ —	$ 4,530	$ 3,468	$ —	$ 7,998
Provision for doubtful accounts	—	—	424	316	—	740
Revenues	—	—	4,106	3,152	—	7,258
Salaries and benefits	—	—	1,901	1,432	—	3,333
Supplies	—	—	702	561	—	1,263
Other operating expenses	—	1	697	671	—	1,369
Electronic health record incentive income	—	—	(39)	(12)	—	(51)
Equity in earnings of affiliates	(77)	—	(24)	(44)	77	(68)
Depreciation and amortization	—	—	193	169	—	362
Interest expense	20	776	(245)	(32)	—	519
Losses on sales of facilities	—	—	2	—	—	2
Losses on retirement of debt	—	406	—	—	—	406
Management fees	—	—	(128)	128	—	—
	(57)	1,183	3,059	2,873	77	7,135
Income (loss) before income taxes	57	(1,183)	1,047	279	(77)	123
Provision (benefit) for income taxes	(4)	(357)	293	45	—	(23)
Net income (loss)	61	(826)	754	234	(77)	146
Net income attributable to noncontrolling interests	—	—	16	69	—	85
Net income (loss) attributable to HCA Holdings, Inc.	$ 61	$ (826)	$ 738	$ 165	$ (77)	$ 61
Comprehensive income (loss) attributable to HCA Holdings, Inc.	$ 61	$ (898)	$ 742	$ 148	$ (77)	$ (24)

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION (continued)

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATING COMPREHENSIVE INCOME STATEMENT
FOR THE NINE MONTHS ENDED SEPTEMBER 30, 2012
(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Revenues before provision for doubtful accounts	$ —	$ —	$ 14,328	$ 12,917	$ —	$ 27,245
Provision for doubtful accounts	—	—	1,505	1,161	—	2,666
Revenues	—	—	12,823	11,756	—	24,579
Salaries and benefits	—	—	5,928	5,296	—	11,224
Supplies	—	—	2,202	2,014	—	4,216
Other operating expenses	—	7	2,241	2,248	—	4,496
Electronic health record incentive income	—	—	(174)	(82)	—	(256)
Equity in earnings of affiliates	(1,348)	—	(4)	(22)	1,348	(26)
Depreciation and amortization	—	—	614	640	—	1,254
Interest expense	90	1,603	(274)	(83)	—	1,336
Losses (gains) on sales of facilities	—	—	3	(7)	—	(4)
Management fees	—	—	(498)	498	—	—
	(1,258)	1,610	10,038	10,502	1,348	22,240
Income (loss) before income taxes	1,258	(1,610)	2,785	1,254	(1,348)	2,339
Provision (benefit) for income taxes	(33)	(597)	1,014	376	—	760
Net income (loss)	1,291	(1,013)	1,771	878	(1,348)	1,579
Net income attributable to noncontrolling interests	—	—	51	237	—	288
Net income (loss) attributable to HCA Holdings, Inc.	$ 1,291	$ (1,013)	$ 1,720	$ 641	$ (1,348)	$ 1,291
Comprehensive income (loss) attributable to HCA Holdings, Inc.	$ 1,291	$(1,055)	$ 1,733	$ 670	$ (1,348)	$ 1,291

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION (continued)

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATING COMPREHENSIVE INCOME STATEMENT
FOR THE NINE MONTHS ENDED SEPTEMBER 30, 2011
(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Revenues before provision for doubtful accounts	$ —	$ —	$ 13,602	$ 10,475	$ —	$ 24,077
Provision for doubtful accounts	—	—	1,298	866	—	2,164
Revenues	—	—	12,304	9,609	—	21,913
Salaries and benefits	—	—	5,669	4,279	—	9,948
Supplies	—	—	2,133	1,700	—	3,833
Other operating expenses	—	5	2,064	1,948	—	4,017
Electronic health record incentive income	—	—	(60)	(30)	—	(90)
Equity in earnings of affiliates	(581)	—	(84)	(133)	581	(217)
Depreciation and amortization	—	—	582	496	—	1,078
Interest expense	80	2,208	(561)	(155)	—	1,572
Losses (gains) on sales of facilities	—	—	18	(15)	—	3
Losses on retirement of debt	—	481	—	—	—	481
Termination of management agreement	—	181	—	—	—	181
Management fees	—	—	(381)	381	—	—
	(501)	2,875	9,380	8,471	581	20,806
Income (loss) before income taxes	501	(2,875)	2,924	1,138	(581)	1,107
Provision (benefit) for income taxes	(29)	(1,055)	1,055	336	—	307
Net income (loss)	530	(1,820)	1,869	802	(581)	800
Net income attributable to noncontrolling interests	—	—	47	223	—	270
Net income (loss) attributable to HCA Holdings, Inc.	$ 530	$ (1,820)	$ 1,822	$ 579	$ (581)	$ 530
Comprehensive income (loss) attributable to HCA Holdings, Inc.	$ 530	$ (1,823)	$ 1,833	$ 575	$ (581)	$ 534

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION (continued)

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATING BALANCE SHEET
SEPTEMBER 30, 2012
(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
ASSETS						
Current assets:						
Cash and cash equivalents	$ —	$ —	$ 149	$ 323	$ —	$ 472
Accounts receivable, net	—	—	2,392	2,206	—	4,598
Inventories	—	—	602	450	—	1,052
Deferred income taxes	322	—	—	—	—	322
Other	14	—	368	446	—	828
	336	—	3,511	3,425	—	7,272
Property and equipment, net	—	—	7,226	5,734	—	12,960
Investments of insurance subsidiaries	—	—	—	473	—	473
Investments in and advances to affiliates	—	—	16	87	—	103
Goodwill and other intangible assets	—	—	1,666	3,794	—	5,460
Deferred loan costs	21	245	—	—	—	266
Investments in and advances to subsidiaries	18,173	—	—	—	(18,173)	—
Other	552	—	29	187	—	768
	$ 19,082	$ 245	$ 12,448	$ 13,700	$(18,173)	$ 27,302
LIABILITIES AND STOCKHOLDERS' (DEFICIT) EQUITY						
Current liabilities:						
Accounts payable	$ —	$ —	$ 1,019	$ 566	$ —	$ 1,585
Accrued salaries	—	—	588	439	—	1,027
Other accrued expenses	44	237	453	764	—	1,498
Long-term debt due within one year	—	1,686	34	31	—	1,751
	44	1,923	2,094	1,800	—	5,861
Long-term debt	1,525	22,989	151	517	—	25,182
Intercompany balances	24,805	(11,642)	(16,722)	3,559	—	—
Professional liability risks	—	—	—	962	—	962
Income taxes and other liabilities	567	489	568	236	—	1,860
	26,941	13,759	(13,909)	7,074	—	33,865
Stockholders' (deficit) equity attributable to HCA Holdings, Inc.	(7,859)	(13,514)	26,254	5,433	(18,173)	(7,859)
Noncontrolling interests	—	—	103	1,193	—	1,296
	(7,859)	(13,514)	26,357	6,626	(18,173)	(6,563)
	$ 19,082	$ 245	$ 12,448	$ 13,700	$(18,173)	$ 27,302

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION (continued)

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATING BALANCE SHEET
DECEMBER 31, 2011
(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
ASSETS						
Current assets:						
Cash and cash equivalents	$ —	$ —	$ 115	$ 258	$ —	$ 373
Accounts receivable, net	—	—	2,429	2,104	—	4,533
Inventories	—	—	602	452	—	1,054
Deferred income taxes	594	—	—	—	—	594
Other	50	—	184	445	—	679
	644	—	3,330	3,259	—	7,233
Property and equipment, net	—	—	7,088	5,746	—	12,834
Investments of insurance subsidiaries	—	—	—	548	—	548
Investments in and advances to affiliates	—	—	15	86	—	101
Goodwill and other intangible assets	—	—	1,605	3,646	—	5,251
Deferred loan costs	22	268	—	—	—	290
Investments in and advances to subsidiaries	16,825	—	—	—	(16,825)	—
Other	450	—	21	170	—	641
	$ 17,941	$ 268	$ 12,059	$13,455	$(16,825)	$26,898
LIABILITIES AND STOCKHOLDERS' (DEFICIT) EQUITY						
Current liabilities:						
Accounts payable	$ —	$ —	$ 899	$ 698	$ —	$ 1,597
Accrued salaries	—	—	568	397	—	965
Other accrued expenses	15	367	449	754	—	1,585
Long-term debt due within one year	—	1,347	28	32	—	1,407
	15	1,714	1,944	1,881	—	5,554
Long-term debt	1,525	23,454	110	556	—	25,645
Intercompany balances	24,121	(12,814)	(15,183)	3,876	—	—
Professional liability risks	—	—	—	993	—	993
Income taxes and other liabilities	538	415	556	211	—	1,720
	26,199	12,769	(12,573)	7,517	—	33,912
Stockholders' (deficit) equity attributable to HCA Holdings, Inc.	(8,258)	(12,501)	24,534	4,792	(16,825)	(8,258)
Noncontrolling interests	—	—	98	1,146	—	1,244
	(8,258)	(12,501)	24,632	5,938	(16,825)	(7,014)
	$ 17,941	$ 268	$ 12,059	$13,455	$(16,825)	$26,898

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION (continued)

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATING STATEMENT OF CASH FLOWS
FOR THE NINE MONTHS ENDED SEPTEMBER 30, 2012
(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities:						
Net income (loss)	$ 1,291	$ (1,013)	$ 1,771	$ 878	$ (1,348)	$ 1,579
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:						
Changes in operating assets and liabilities	30	(131)	(1,475)	(1,347)	—	(2,923)
Provision for doubtful accounts	—	—	1,505	1,161	—	2,666
Depreciation and amortization	—	—	614	640	—	1,254
Income taxes	250	—	—	—	—	250
Losses (gains) on sales of facilities	—	—	3	(7)	—	(4)
Amortization of deferred loan costs	1	43	—	—	—	44
Share-based compensation	39	—	—	—	—	39
Equity in earnings of affiliates	(1,348)	—	—	—	1,348	—
Other	—	11	—	(4)	—	7
Net cash provided by (used in) operating activities	263	(1,090)	2,418	1,321	—	2,912
Cash flows from investing activities:						
Purchase of property and equipment	—	—	(685)	(583)	—	(1,268)
Acquisition of hospitals and health care entities	—	—	(72)	(95)	—	(167)
Disposition of hospitals and health care entities	—	—	1	16	—	17
Change in investments	—	—	(9)	82	—	73
Other	—	—	(1)	6	—	5
Net cash used in investing activities	—	—	(766)	(574)	—	(1,340)
Cash flows from financing activities:						
Issuance of long-term debt	—	1,350	—	—	—	1,350
Net change in revolving bank credit facilities	—	(875)	—	—	—	(875)
Repayment of long-term debt	—	(604)	(16)	(69)	—	(689)
Distributions to noncontrolling interests	—	—	(46)	(257)	—	(303)
Payment of debt issuance costs	—	(20)	—	—	—	(20)
Distributions to stockholders	(983)	—	—	—	—	(983)
Changes in intercompany balances with affiliates, net	675	1,239	(1,556)	(358)	—	—
Income tax benefits	82	—	—	—	—	82
Other	(37)	—	—	2	—	(35)
Net cash (used in) provided by financing activities	(263)	1,090	(1,618)	(682)	—	(1,473)
Change in cash and cash equivalents	—	—	34	65	—	99
Cash and cash equivalents at beginning of period	—	—	115	258	—	373
Cash and cash equivalents at end of period	$ —	$ —	$ 149	$ 323	$ —	$ 472

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 12 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION (continued)

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATING STATEMENT OF CASH FLOWS
FOR THE NINE MONTHS ENDED SEPTEMBER 30, 2011
(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Cash flows from operating activities:						
Net income (loss)	$ 530	$ (1,820)	$ 1,869	$ 802	$ (581)	$ 800
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:						
Changes in operating assets and liabilities	34	(61)	(1,442)	(867)	—	(2,336)
Provision for doubtful accounts	—	—	1,298	866	—	2,164
Depreciation and amortization	—	—	582	496	—	1,078
Income taxes	348	—	—	—	—	348
Losses (gains) on sales of facilities	—	—	18	(15)	—	3
Losses on retirement of debt	—	481	—	—	—	481
Amortization of deferred loan costs	—	56	—	—	—	56
Share-based compensation	24	—	—	—	—	24
Pay-in-kind interest	—	(78)	—	—	—	(78)
Equity in earnings of affiliates	(581)	—	—	—	581	—
Other	—	7	—	(1)	—	6
Net cash provided by (used in) operating activities	355	(1,415)	2,325	1,281	—	2,546
Cash flows from investing activities:						
Purchase of property and equipment	—	—	(594)	(576)	—	(1,170)
Acquisition of hospitals and health care entities	—	—	(136)	(73)	—	(209)
Disposition of hospitals and health care entities	—	—	1	54	—	55
Change in investments	—	—	31	49	—	80
Other	—	—	—	4	—	4
Net cash used in investing activities	—	—	(698)	(542)	—	(1,240)
Cash flows from financing activities:						
Issuance of long-term debt	—	5,000	—	—	—	5,000
Net change in revolving bank credit facilities	—	(414)	—	—	—	(414)
Repayment of long-term debt	—	(6,529)	(8)	(46)	—	(6,583)
Distributions to noncontrolling interests	—	—	(55)	(226)	—	(281)
Changes in intercompany balances with affiliates, net	(1,358)	3,442	(1,625)	(459)	—	—
Payment of debt issuance costs	—	(84)	—	—	—	(84)
Issuances of common stock	2,506	—	—	—	—	2,506
Repurchase of common stock	(1,503)	—	—	—	—	(1,503)
Distributions to stockholders	(31)	—	—	—	—	(31)
Income tax benefits	54	—	—	—	—	54
Other	(29)	—	—	7	—	(22)
Net cash (used in) provided by financing activities	(361)	1,415	(1,688)	(724)	—	(1,358)
Change in cash and cash equivalents	(6)	—	(61)	15	—	(52)
Cash and cash equivalents at beginning of period	6	—	156	249	—	411
Cash and cash equivalents at end of period	$ —	$ —	$ 95	$ 264	$ —	$ 359

HCA HOLDINGS, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 13 — SUBSEQUENT EVENT

On October 23, 2012, our Board of Directors declared a distribution to the Company's stockholders and holders of certain vested stock awards. The distribution declared is $2.50 per share and vested stock award (subject to limitations for certain awards), or approximately $1.2 billion in the aggregate, including certain deferred distribution amounts. The distribution is expected to be paid on November 16, 2012 to holders of record on November 2, 2012. The distribution is expected to be funded using our existing senior secured credit facilities. Pursuant to the terms of our stock award plans, the holders of nonvested stock options and stock appreciation rights will receive a $2.50 per share reduction to the exercise price of their share-based awards (subject to certain limitations for certain stock awards that result in deferred distributions for a portion of the declared distribution, which will be paid upon the vesting of the applicable stock award). The holders of any nonvested restricted share units will be paid $2.50 per unit upon the vesting of the applicable restricted share units.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Forward-Looking Statements

This quarterly report on Form 10-Q includes certain disclosures which contain "forward-looking statements." Forward-looking statements include statements regarding estimated EHR incentive income and related EHR operating expenses, expected capital expenditures and expected net claim payments and all other statements that do not relate solely to historical or current facts, and can be identified by the use of words like "may," "believe," "will," "expect," "project," "estimate," "anticipate," "plan," "initiative" or "continue." These forward-looking statements are based on our current plans and expectations and are subject to a number of known and unknown uncertainties and risks, many of which are beyond our control, which could significantly affect current plans and expectations and our future financial position and results of operations. These factors include, but are not limited to, (1) the impact of our substantial indebtedness and the ability to refinance such indebtedness on acceptable terms, (2) the effects related to the enactment and implementation of the Budget Control Act of 2011 ("BCA") and the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (collectively, the "Health Reform Law"), the possible enactment of additional federal or state health care reforms and possible changes to the Health Reform Law and other federal, state or local laws or regulations affecting the health care industry, (3) increases in the amount and risk of collectibility of uninsured accounts and deductibles and copayment amounts for insured accounts, (4) the ability to achieve operating and financial targets, and attain expected levels of patient volumes and control the costs of providing services, (5) possible changes in the Medicare, Medicaid and other state programs, including Medicaid upper payment limit ("UPL") programs or waiver programs, that may impact reimbursements to health care providers and insurers, (6) the highly competitive nature of the health care business, (7) changes in service mix, revenue mix and surgical volumes, including potential declines in the population covered under managed care agreements, the ability to enter into and renew managed care provider agreements on acceptable terms and the impact of consumer driven health plans and physician utilization trends and practices, (8) the efforts of insurers, health care providers and others to contain health care costs, (9) the outcome of our continuing efforts to monitor, maintain and comply with appropriate laws, regulations, policies and procedures, (10) increases in wages and the ability to attract and retain qualified management and personnel, including affiliated physicians, nurses and medical and technical support personnel, (11) the availability and terms of capital to fund the expansion of our business and improvements to our existing facilities, (12) changes in accounting practices, (13) changes in general economic conditions nationally and regionally in our markets, (14) future divestitures which may result in charges and possible impairments of long-lived assets, (15) changes in business strategy or development plans, (16) delays in receiving payments for services provided, (17) the outcome of pending and any future tax audits, appeals and litigation associated with our tax positions, (18) potential adverse impact of known and unknown government investigations, litigation and other claims that may be made against us, (19) our ongoing ability to demonstrate meaningful use of certified electronic health record technology and recognize income for the related Medicare or Medicaid incentive payments, and (20) other risk factors described in our annual report on Form 10-K for the year ended December 31, 2011 and our other filings with the Securities and Exchange Commission. As a consequence, current plans, anticipated actions and future financial position and results of operations may differ from those expressed in any forward-looking statements made by or on behalf of HCA. You are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented in this report, which forward-looking statements reflect management's views only as of the date of this report. We undertake no obligation to revise or update any forward-looking statements, whether as a result of new information, future events or otherwise.

Health Care Reform

As enacted, the Health Reform Law will change how health care services are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced growth in Medicare program spending, reductions in Medicare and Medicaid Disproportionate Share Hospital ("DSH") payments, and the establishment of programs in which reimbursement is tied to quality and integration. In addition, the Health Reform Law

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Health Care Reform (continued)

reforms certain aspects of health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality, and contains provisions intended to strengthen fraud and abuse enforcement. Numerous lawsuits have challenged the constitutionality of the Health Reform Law. On June 28, 2012, the United States Supreme Court upheld the constitutionality of the individual mandate provisions of the Health Reform Law but struck down the provisions that would have allowed the Department of Health and Human Services ("HHS") to penalize states that do not implement the Medicaid expansion provisions with the loss of existing federal Medicaid funding. States that choose not to implement the Medicaid expansion will forego funding established by the Health Reform Law to cover most of the expansion costs. It is unclear how many states will decline to implement the Medicaid expansion. Further, repeal or modification of the Health Reform Law has become a theme in political campaigns during the 2012 election year. Due to these factors, we are unable to predict with any reasonable certainty or otherwise quantify the likely impact of the Health Reform Law on our business model, financial condition or result of operations.

Third Quarter 2012 Operations Summary

Revenues increased to $8.062 billion in the third quarter of 2012 from $7.258 billion in the third quarter of 2011. Net income attributable to HCA Holdings, Inc. totaled $360 million, or $0.78 per diluted share, for the quarter ended September 30, 2012, compared to $61 million, or $0.11 per diluted share, for the quarter ended September 30, 2011. Third quarter 2012 results include net gains on sales of facilities of $7 million, or $0.01 per diluted share. Third quarter 2011 results include losses on retirement of debt of $406 million, or $0.49 per diluted share. All "per diluted share" disclosures are based upon amounts net of the applicable income taxes. Shares used for diluted earnings per share were 459.5 million shares for the quarter ended September 30, 2012 and 527.5 million shares for the quarter ended September 30, 2011. During September 2011, we repurchased 80.8 million shares of our common stock.

Revenues increased 11.1% on a consolidated basis and increased 3.3% on a same facility basis for the quarter ended September 30, 2012, compared to the quarter ended September 30, 2011. The increase in consolidated revenues can be attributed primarily to the combined impact of a 2.5% increase in revenue per equivalent admission and a 8.3% increase in equivalent admissions. The same facility revenues increase resulted primarily from the combined net impact of a 0.7% increase in same facility revenue per equivalent admission and a 2.6% increase in same facility equivalent admissions. The increase in consolidated revenues (and consolidated volume metrics) for the third quarter of 2012 compared to the third quarter of 2011 is related primarily to the impact of the financial consolidation of the HCA-HealthONE LLC venture for periods subsequent to our acquisition of controlling interests during October 2011. The HealthONE venture's operating results and volume metrics are not included in our same facility amounts.

During the quarter ended September 30, 2012, consolidated admissions and same facility admissions increased 7.0% and 2.1%, respectively, compared to the quarter ended September 30, 2011. Inpatient surgeries increased 3.0% on a consolidated basis and declined 2.1% on a same facility basis during the quarter ended September 30, 2012, compared to the quarter ended September 30, 2011. Outpatient surgeries increased 9.3% on a consolidated basis and declined 0.8% on a same facility basis during the quarter ended September 30, 2012, compared to the quarter ended September 30, 2011. Emergency department visits increased 12.0% on a consolidated basis and 7.4% on a same facility basis during the quarter ended September 30, 2012, compared to the quarter ended September 30, 2011.

For the quarter ended September 30, 2012, the provision for doubtful accounts increased $91 million, compared to the quarter ended September 30, 2011. The self-pay revenue deductions for charity care and uninsured discounts increased $127 million and $448 million, respectively, during the third quarter of 2012,

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Third Quarter 2012 Operations Summary (continued)

compared to the third quarter of 2011. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of revenues, provision for doubtful accounts, uninsured discounts and charity care, was 30.5% for the third quarter of 2012, compared to 28.4% for the third quarter of 2011. Same facility uninsured admissions increased 7.3% and same facility uninsured emergency room visits increased 7.9% for the quarter ended September 30, 2012, compared to the quarter ended September 30, 2011.

Interest expense declined $73 million to $446 million for the quarter ended September 30, 2012 from $519 million for the quarter ended September 30, 2011. The decline in interest expense was due to a decline in the average effective interest rate.

Cash flows from operating activities declined $225 million from $880 million for the third quarter of 2011 to $655 million for the third quarter of 2012. The decline is primarily related to the combined impact of the decline from changes in working capital items of $145 million and the increase in income taxes of $107 million.

Results of Operations

Revenue/Volume Trends

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

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Revenue/Volume Trends (continued)

Revenues increased 11.1% from $7.258 billion in the third quarter of 2011 to $8.062 billion in the third quarter of 2012. Revenues are recorded during the period the health care services are provided, based upon the estimated amounts due from the patients and third-party payers. Third-party payers include federal and state agencies (under Medicare, Medicaid and other programs), managed care health plans, commercial insurance companies and employers. Estimates of contractual allowances under managed care health plans are based upon the payment terms specified in the related contractual agreements. Revenues related to uninsured patients and copayment and deductible amounts for patients who have health care coverage may have discounts applied (uninsured discounts and contractual discounts). We also record a provision for doubtful accounts related to uninsured accounts to record the net self pay accounts receivable at the estimated amounts we expect to collect. Our revenues from our third-party payers, the uninsured and other revenues for the quarters and nine months ended September 30, 2012 and 2011 are summarized in the following tables (dollars in millions):

	Quarter			
	2012	Ratio	2011	Ratio
Medicare	$ 1,949	24.2%	$ 1,844	25.4%
Managed Medicare	720	8.9	610	8.4
Medicaid	378	4.7	453	6.2
Managed Medicaid	380	4.7	311	4.3
Managed care and other insurers	4,422	54.8	3,855	53.1
International (managed care and other insurers)	253	3.1	232	3.2
	8,102	100.4	7,305	100.6
Uninsured	576	7.1	508	7.0
Other	215	2.7	185	2.5
Revenues before provision for doubtful accounts	8,893	110.2	7,998	110.1
Provision for doubtful accounts	(831)	(10.2)	(740)	(10.1)
Revenues	$ 8,062	100.0%	$ 7,258	100.0%

	Nine Months			
	2012	Ratio	2011	Ratio
Medicare	$ 6,251	25.4%	$ 5,715	26.1%
Managed Medicare	2,199	8.9	1,806	8.2
Medicaid	1,188	4.8	1,440	6.6
Managed Medicaid	1,080	4.4	946	4.3
Managed care and other insurers	13,340	54.3	11,486	52.4
International (managed care and other insurers)	779	3.2	698	3.2
	24,837	101.0	22,091	100.8
Uninsured	1,757	7.1	1,390	6.3
Other	651	2.7	596	2.7
Revenues before provision for doubtful accounts	27,245	110.8	24,077	109.8
Provision for doubtful accounts	(2,666)	(10.8)	(2,164)	(9.8)
Revenues	$24,579	100.0%	$21,913	100.0%

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Revenue/Volume Trends (continued)

The increase in revenues for the first nine months of 2012 compared to the first nine months of 2011 includes two adjustments (Rural Floor Provision Settlement and SSI ratios) related to Medicare revenues for prior periods. The net effect of the Medicare adjustments was an increase of $188 million to revenues. The Rural Floor Provision Settlement was signed on April 5, 2012. As a result of the agreement, we received additional Medicare payments of approximately $271 million during June 2012. This amount was recorded as an increase to Medicare revenues during the first quarter of 2012. During March 2012, the Centers for Medicare & Medicaid Services ("CMS") issued new SSI ratios used for calculating Medicare DSH reimbursement for federal fiscal years ending September 30, 2006 through September 30, 2009. As a result, we recalculated our DSH reimbursement for all applicable periods. The cumulative impact of this retroactive adjustment was a reduction in Medicare revenues of approximately $83 million. This adjustment was recorded as a reduction to Medicare revenues during the first quarter of 2012.

We previously reported $51 million and $90 million, respectively, of Medicaid and Medicare electronic health record ("EHR") incentives for the quarter and nine months ended September 30, 2011 in the line item "Revenues" in our condensed consolidated income statements. These amounts have been reclassified and are now included in the line item "Electronic health record incentive income" in our condensed consolidated comprehensive statements of operations for the quarter and nine months ended September 30, 2011.

Consolidated and same facility revenue per equivalent admission increased 2.5% and 0.7%, respectively, in the third quarter of 2012, compared to the third quarter of 2011. Consolidated and same facility equivalent admissions increased 8.3% and 2.6%, respectively, in the third quarter of 2012, compared to the third quarter of 2011. Consolidated and same facility admissions increased 7.0% and 2.1%, respectively, in the third quarter of 2012, compared to the third quarter of 2011. Consolidated and same facility outpatient surgeries increased 9.3% and declined 0.8%, respectively, in the third quarter of 2012, compared to the third quarter of 2011. Consolidated and same facility inpatient surgeries increased 3.0% and declined 2.1%, respectively, in the third quarter of 2012, compared to the third quarter of 2011. Consolidated and same facility emergency department visits increased 12.0% and 7.4%, respectively, in the third quarter of 2012, compared to the third quarter of 2011.

To quantify the total impact of and trends related to uninsured accounts, we believe it is beneficial to view the direct uninsured revenue deductions and provision for doubtful accounts in combination, rather than each separately. At September 30, 2012, our allowance for doubtful accounts represented approximately 92% of the $4.891 billion total patient due accounts receivable balance. The patient due accounts receivable balance represents the estimated uninsured portion of our accounts receivable. A summary of these adjustments to revenues amounts, related to uninsured accounts, for the quarters and nine months ended September 30, 2012 and 2011 follows (dollars in millions):

	Quarter				Nine Months			
	2012	Ratio	2011	Ratio	2012	Ratio	2011	Ratio
Charity care	$ 809	23%	$ 682	24%	$ 2,340	23%	$1,974	24%
Uninsured discounts	1,905	54	1,457	50	5,164	51	4,072	50
Provision for doubtful accounts	831	23	740	26	2,666	26	2,164	26
Totals	$3,545	100%	$2,879	100%	$10,170	100%	$8,210	100%

Same facility uninsured admissions increased by 2,263 admissions, or 7.3%, in the third quarter of 2012, compared to the third quarter of 2011. Same facility uninsured admissions in 2012, compared to 2011, increased

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Revenue/Volume Trends (continued)

8.9% in the second quarter of 2012 and increased 11.6% in the first quarter of 2012. Same facility uninsured admissions in 2011, compared to 2010, increased by 5.2% in the fourth quarter of 2011, 8.8% in the third quarter of 2011, 10.6% in the second quarter of 2011 and 4.7% in the first quarter of 2011.

The approximate percentages of our admissions related to Medicare, managed Medicare, Medicaid, managed Medicaid, managed care and other insurers and the uninsured for the quarters and nine months ended September 30, 2012 and 2011 are set forth in the following table.

	Quarter		Nine Months	
	2012	2011	2012	2011
Medicare	32%	33%	33%	34%
Managed Medicare	12	11	12	11
Medicaid	8	9	8	9
Managed Medicaid	9	8	9	8
Managed care and other insurers	31	31	30	31
Uninsured	8	8	8	7
	100%	100%	100%	100%

The approximate percentages of our inpatient revenues, before provision for doubtful accounts, related to Medicare, managed Medicare, Medicaid, managed Medicaid, managed care and other insurers and the uninsured for the quarters and nine months ended September 30, 2012 and 2011 are set forth in the following table.

	Quarter		Nine Months	
	2012	2011	2012	2011
Medicare	30%	31%	31%	31%
Managed Medicare	10	9	10	9
Medicaid	6	8	6	9
Managed Medicaid	4	4	4	4
Managed care and other insurers	46	45	45	44
Uninsured	4	3	4	3
	100%	100%	100%	100%

At September 30, 2012, we had 74 hospitals in the states of Texas and Florida. During the third quarter of 2012, 57% of our admissions and 47% of our revenues were generated by these hospitals. Uninsured admissions in Texas and Florida represented 61% of our uninsured admissions during the third quarter of 2012.

We receive a significant portion of our revenues from government health programs, principally Medicare and Medicaid, which are highly regulated and subject to frequent and substantial changes. We provide indigent care services in several communities in the state of Texas, in affiliation with other hospitals. The state of Texas has been involved in efforts to increase the indigent care provided by private hospitals. As a result of additional indigent care being provided by private hospitals, public hospital districts or counties in Texas have available funds that were previously devoted to indigent care. The public hospital districts or counties are under no contractual or legal obligation to provide such indigent care. The public hospital districts or counties have elected

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Revenue/Volume Trends (continued)

to transfer some portion of these available funds to the state's Medicaid program. Such action is at the sole discretion of the public hospital districts or counties. It is anticipated that these contributions to the state will be matched with federal Medicaid funds. The state then may make supplemental payments to hospitals in the state for Medicaid services rendered. Hospitals receiving Medicaid supplemental payments may include those that are providing additional indigent care services. Our Texas Medicaid revenues included $110 million and $123 million during the third quarters of 2012 and 2011, respectively, and $350 million and $424 million during the first nine months of 2012 and 2011, respectively, of Medicaid supplemental payments. In addition, we receive supplemental payments in several other states. We are aware these supplemental payment programs are currently being reviewed by certain state agencies and some states have made waiver requests to CMS to replace their existing supplemental payment programs. It is possible these reviews and waiver requests will result in the restructuring of such supplemental payment programs and could result in the payment programs being reduced or eliminated. In 2011, CMS approved a Medicaid waiver that allows Texas to continue receiving supplemental Medicaid reimbursement while expanding its Medicaid managed care program, thus Texas is operating pursuant to a waiver program. However, we cannot predict whether the Texas private supplemental Medicaid reimbursement program will continue or guarantee that revenues recognized for the program will not decline. Because deliberations about these programs are ongoing, we are unable to estimate the financial impact the program structure modifications, if any, may have on our results of operations.

Electronic Health Record Incentive Payments

The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive payments for eligible hospitals and professionals that adopt and meaningfully use certified EHR technology. We recognize income related to Medicare and Medicaid incentive payments using a gain contingency model that is based upon when our eligible hospitals have demonstrated meaningful use of certified EHR technology for the applicable period and the cost report information for the full cost report year that will determine the final calculation of the incentive payment is available.

Medicaid EHR incentive calculations and related payment amounts are based upon prior period cost report information available at the time our eligible hospitals adopt, implement or demonstrate meaningful use of certified EHR technology for the applicable period, and are not subject to revision for cost report data filed for a subsequent period. Thus, incentive income recognition occurs at the point our eligible hospitals adopt, implement or demonstrate meaningful use of certified EHR technology for the applicable period, as the cost report information for the full cost report year that will determine the final calculation of the incentive payment is known at that time.

Medicare EHR incentive calculations and related initial payment amounts are based upon the most current filed cost report information available at the time our eligible hospitals demonstrate meaningful use of certified EHR technology for the applicable period. However, unlike Medicaid, this initial payment amount will be adjusted based upon an updated calculation using the annual cost report information for the cost report period that began during the applicable payment year. Thus, incentive income recognition occurs at the point our eligible hospitals demonstrate meaningful use of certified EHR technology for the applicable period and the cost report information for the full cost report year that will determine the final calculation of the incentive payment is available.

We recognized $131 million ($52 million Medicare and $79 million Medicaid) of electronic health record incentive income during the third quarter of 2012, and we recognized $51 million ($17 million of Medicare and

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Electronic Health Record Incentive Payments (continued)

$34 million of Medicaid) of electronic health record incentive income during the third quarter of 2011. We recognized $256 million ($174 million Medicare and $82 million Medicaid) and $90 million ($17 million Medicare and $73 million Medicaid) of electronic health record incentive income during the first nine months of 2012 and 2011, respectively.

We have incurred and will continue to incur both capital costs and operating expenses in order to implement our certified EHR technology and meet meaningful use requirements. These expenses are ongoing and are projected to continue over all stages of implementation of meaningful use. The timing of recognition of the expenses may not correlate with the receipt of the incentive payments and the recognition of income. We incurred $24 million and $14 million during the third quarters of 2012 and 2011, respectively, and $61 million and $58 million during the first nine months of 2012 and 2011, respectively, of operating expenses to implement our certified EHR technology and meet meaningful use.

For 2012, we estimate EHR incentive income will be recognized in the range of $325 million to $350 million and that related EHR operating expenses will be in the range of $75 million to $100 million. Actual EHR incentive income and EHR operating expenses could vary from these estimates due to certain factors, including the availability of federal funding for both Medicare and Medicaid incentive payments and our ability to continue to demonstrate meaningful use of certified EHR technology. The failure of any of these factors to occur could have a material, adverse effect on our results of operations.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Operating Results Summary

The following is a comparative summary of results from operations for the quarters and nine months ended September 30, 2012 and 2011 (dollars in millions):

	Quarter			
	2012		2011	
	Amount	Ratio	Amount	Ratio
Revenues before provision for doubtful accounts	$ 8,893		$7,998	
Provision for doubtful accounts	831		740	
Revenues	8,062	100.0	7,258	100.0
Salaries and benefits	3,781	46.9	3,333	45.9
Supplies	1,375	17.1	1,263	17.4
Other operating expenses	1,510	18.7	1,369	18.8
Electronic health record incentive income	(131)	(1.6)	(51)	(0.7)
Equity in earnings of affiliates	(6)	(0.1)	(68)	(0.9)
Depreciation and amortization	417	5.2	362	5.0
Interest expense	446	5.5	519	7.2
Losses (gains) on sales of facilities	(7)	(0.1)	2	—
Losses on retirement of debt	—	—	406	5.6
	7,385	91.6	7,135	98.3
Income before income taxes	677	8.4	123	1.7
Provision (benefit) for income taxes	222	2.8	(23)	(0.3)
Net income	455	5.6	146	2.0
Net income attributable to noncontrolling interests	95	1.1	85	1.2
Net income attributable to HCA Holdings, Inc.	$ 360	4.5	$ 61	0.8
% changes from prior year:				
Revenues	11.1%		4.8%	
Income before income taxes	450.6		(73.7)	
Net income attributable to HCA Holdings, Inc.	493.2		(75.0)	
Admissions(a)	7.0		4.8	
Equivalent admissions(b)	8.3		5.4	
Revenue per equivalent admission	2.5		(0.5)	
Same facility % changes from prior year(c):				
Revenues	3.3		3.0	
Admissions(a)	2.1		3.2	
Equivalent admissions(b)	2.6		3.8	
Revenue per equivalent admission	0.7		(0.8)	

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Operating Results Summary (continued)

	Nine Months			
	2012		2011	
	Amount	Ratio	Amount	Ratio
Revenues before provision for doubtful accounts	$27,245		$ 24,077	
Provision for doubtful accounts	2,666		2,164	
Revenues	24,579	100.0	21,913	100.0
Salaries and benefits	11,224	45.7	9,948	45.4
Supplies	4,216	17.2	3,833	17.5
Other operating expenses	4,496	18.2	4,017	18.3
Electronic health record incentive income	(256)	(1.0)	(90)	(0.4)
Equity in earnings of affiliates	(26)	(0.1)	(217)	(1.0)
Depreciation and amortization	1,254	5.1	1,078	4.9
Interest expense	1,336	5.4	1,572	7.2
Losses (gains) on sales of facilities	(4)	—	3	—
Losses on retirement of debt	—	—	481	2.2
Termination of management agreement	—	—	181	0.8
	22,240	90.5	20,806	94.9
Income before income taxes	2,339	9.5	1,107	5.1
Provision for income taxes	760	3.1	307	1.5
Net income	1,579	6.4	800	3.6
Net income attributable to noncontrolling interests	288	1.1	270	1.2
Net income attributable to HCA Holdings, Inc.	$ 1,291	5.3	$ 530	2.4
% changes from prior year:				
Revenues	12.2%		5.0%	
Income before income taxes	111.3		(33.6)	
Net income attributable to HCA Holdings, Inc.	143.6		(42.6)	
Admissions(a)	7.9		3.3	
Equivalent admissions(b)	9.8		4.2	
Revenue per equivalent admission	2.2		0.8	
Same facility % changes from prior year(c):				
Revenues	4.1		3.6	
Admissions(a)	2.6		2.2	
Equivalent admissions(b)	3.8		3.0	
Revenue per equivalent admission	0.3		0.6	

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

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

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

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Quarters Ended September 30, 2012 and 2011

Net income attributable to HCA Holdings, Inc. totaled $360 million, or $0.78 per diluted share, for the third quarter of 2012 compared to $61 million, or $0.11 per diluted share, for the third quarter of 2011. Third quarter 2012 results include net gains on sales of facilities of $7 million, or $0.01 per diluted share. Third quarter 2011 results include losses on retirement of debt of $406 million, or $0.49 per diluted share. All "per diluted share" disclosures are based upon amounts net of the applicable income taxes. Shares used for diluted earnings per share were 459.5 million shares and 527.5 million shares for the quarters ended September 30, 2012 and 2011, respectively.

For the third quarter of 2012, consolidated and same facility admissions increased 7.0% and 2.1%, respectively, compared to the third quarter of 2011. Consolidated and same facility outpatient surgical volumes increased 9.3% and declined 0.8%, respectively, during the third quarter of 2012, compared to the third quarter of 2011. Consolidated and same facility inpatient surgeries increased 3.0% and declined 2.1%, respectively, in the third quarter of 2012, compared to the third quarter of 2011. Consolidated and same facility emergency department visits increased 12.0% and 7.4%, respectively, during the quarter ended September 30, 2012, compared to the quarter ended September 30, 2011.

Revenues before provision for doubtful accounts increased 11.2% for the third quarter of 2012 compared to the third quarter of 2011. Provision for doubtful accounts increased $91 million from $740 million in the third quarter of 2011 to $831 million in the third quarter of 2012. The provision for doubtful accounts relates primarily to uninsured amounts due directly from patients, including copayment and deductible amounts for patients who have health care coverage. The self-pay revenue deductions for charity care and uninsured discounts increased $127 million and $448 million, respectively, during the third quarter of 2012, compared to the third quarter of 2011. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of revenues, the provision for doubtful accounts, uninsured discounts and charity care, was 30.5% for the third quarter of 2012, compared to 28.4% for the third quarter of 2011. At September 30, 2012, our allowance for doubtful accounts represented approximately 92% of the $4.891 billion total patient due accounts receivable balance, including accounts, net of estimated contractual discounts, related to patients for which eligibility for Medicaid coverage or uninsured discounts was being evaluated.

Revenues increased 11.1% primarily due to the combined impact of revenue per equivalent admission growth of 2.5% and an increase of 8.3% in equivalent admissions for the third quarter of 2012 compared to the third quarter of 2011. Same facility revenues increased 3.3% due to the combined impact of a 0.7% increase in same facility revenue per equivalent admission and a 2.6% increase in same facility equivalent admissions for the third quarter of 2012 compared to the third quarter of 2011. The increase in revenues for the third quarter of 2012 compared to the third quarter of 2011 is related primarily to the financial consolidation of our 2011 acquisition of our partner's interest in the HCA-HealthONE LLC venture for periods subsequent to our acquisition of controlling interests during October 2011 (HealthONE revenues are not included in same facility amounts).

Salaries and benefits, as a percentage of revenues, were 46.9% in the third quarter of 2012 and 45.9% in the third quarter of 2011. Salaries and benefits per equivalent admission increased 4.7% in the third quarter of 2012 compared to the third quarter of 2011. Same facility labor rate increases averaged 1.6% for the third quarter of 2012 compared to the third quarter of 2011.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Quarters Ended September 30, 2012 and 2011 (continued)

Supplies, as a percentage of revenues, were 17.1% in the third quarter of 2012 and 17.4% in the third quarter of 2011. Supply cost per equivalent admission increased 0.6% in the third quarter of 2012 compared to the third quarter of 2011. Supply costs per equivalent admission increased 1.3% for medical devices and 0.7% for general medical and surgical items and declined 1.3% for pharmacy supplies and 8.5% for blood products in the third quarter of 2012 compared to the third quarter of 2011.

Other operating expenses, as a percentage of revenues, declined to 18.7% in the third quarter of 2012 from 18.8% in the third quarter of 2011. Other operating expenses is primarily comprised of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and nonincome taxes. Other operating expenses include $77 million and $78 million of indigent care costs in certain Texas markets during the third quarters of 2012 and 2011, respectively. Provisions for losses related to professional liability risks were $59 million and $62 million for the third quarters of 2012 and 2011, respectively.

We recognized $131 million ($52 million Medicare and $79 million Medicaid) and $51 million ($17 million Medicare and $34 million Medicaid) of electronic health record incentive income during the third quarters of 2012 and 2011, respectively. We recognize income related to Medicare and Medicaid incentive payments using a gain contingency model that is based upon when our eligible hospitals have demonstrated meaningful use of certified EHR technology for the applicable period and the cost report information for the full cost report year that will determine the final calculation of the incentive payment is available.

Equity in earnings of affiliates was $6 million and $68 million in the third quarters of 2012 and 2011, respectively. Equity in earnings of affiliates for the third quarter of 2011 relates primarily to our Denver, Colorado market (HealthONE) joint venture, which effective November 1, 2011, we began consolidating due to our acquisition of our partner's ownership interest.

Depreciation and amortization increased $55 million, from $362 million in the third quarter of 2011 to $417 million in the third quarter of 2012. The increase was primarily related to the consolidation of HealthONE.

Interest expense declined from $519 million in the third quarter of 2011 to $446 million in the third quarter of 2012 due to a decline in the average effective interest rate. Our average debt balance was $26.685 billion for the third quarter of 2012 compared to $25.600 billion for the third quarter of 2011. The average effective interest rate for our long term debt declined from 8.0% for the quarter ended September 30, 2011 to 6.6% for the quarter ended September 30, 2012 due primarily to debt refinancing transactions completed during 2011.

During the third quarter of 2012, we recorded net gains on sales of facilities of $7 million. During the third quarter of 2011, we recorded net losses on sales of facilities of $2 million.

During the third quarter of 2011, we recorded losses on retirement of debt of $406 million related to the redemptions of all of our outstanding $1.578 billion 9 5/8%/10 3/8% second lien toggle notes due 2016, at a redemption price of 106.783% and all of our outstanding $3.200 billion 9 1/4% second lien notes due 2016, at a redemption price of 106.513%.

The effective tax rates were a provision of 38.2% and a benefit of 60.0% for the third quarters of 2012 and 2011, respectively. The effective tax rate computations exclude net income attributable to noncontrolling interests as it relates to consolidated partnerships. Our provision for income taxes for the third quarter of 2011

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Quarters Ended September 30, 2012 and 2011 (continued)

was reduced by $42 million for reductions in interest expense related to taxing authority examinations and increased by $5 million related to certain state tax adjustments. Excluding the effect of these adjustments, the effective tax rate for the third quarter of 2011 would have been 36.7%.

Net income attributable to noncontrolling interests increased from $85 million for the third quarter of 2011 to $95 million for the third quarter of 2012.

Nine Months Ended September 30, 2012 and 2011

Net income attributable to HCA Holdings, Inc. totaled $1.291 billion, or $2.81 per diluted share, in the nine months ended September 30, 2012 compared to $530 million, or $1.04 per diluted share, in the nine months ended September 30, 2011. The first nine months of 2012 results include two Medicare adjustments (and related expenses) that added $170 million to income before income taxes, or $0.22 per diluted share. The first nine months of 2011 results include a charge of $181 million, or $0.29 per diluted share, related to the termination of the management agreement between HCA and the Investors upon the completion of our initial public offering and $481 million, or $0.60 per diluted share, of losses on retirement of debt. All "per diluted share" disclosures are based upon amounts net of the applicable income taxes. Shares used for diluted earnings per share were 458.8 million shares and 509.6 million shares for the nine months ended September 30, 2012 and 2011, respectively.

For the first nine months of 2012, consolidated and same facility admissions increased 7.9% and 2.6%, respectively, compared to the first nine months of 2011. Consolidated and same facility outpatient surgical volumes increased 10.8% and 0.6%, respectively, during the first nine months of 2012, compared to the first nine months of 2011. Consolidated and same facility inpatient surgeries increased 5.2% and declined 0.4%, respectively, in the first nine months of 2012, compared to the first nine months of 2011. Consolidated and same facility emergency department visits increased 12.0% and 7.2%, respectively, during the nine months ended September 30, 2012, compared to the nine months ended September 30, 2011.

Revenues before provision for doubtful accounts increased 13.2% for the first nine months of 2012 compared to the first nine months of 2011. Provision for doubtful accounts increased $502 million from $2.164 billion in the first nine months of 2011 to $2.666 billion in the first nine months of 2012. The provision for doubtful accounts relates primarily to uninsured amounts due directly from patients, including copayment and deductible amounts for patients who have health care coverage. The self-pay revenue deductions for charity care and uninsured discounts increased $366 million and $1.092 billion, respectively, during the first nine months of 2012, compared to the first nine months of 2011. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of revenues, the provision for doubtful accounts, uninsured discounts and charity care, was 29.3% for the first nine months of 2012, compared to 27.3% for the first nine months of 2011. At September 30, 2012, our allowance for doubtful accounts represented approximately 92% of the $4.891 billion total patient due accounts receivable balance, including accounts, net of estimated contractual discounts, related to patients for which eligibility for Medicaid coverage or uninsured discounts was being evaluated.

Revenues increased 12.2% primarily due to the combined impact of revenue per equivalent admission growth of 2.2% and an increase of 9.8% in equivalent admissions for the first nine months of 2012 compared to the first nine months of 2011. Same facility revenues increased 4.1% due to the combined impact of a 0.3%

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Nine Months Ended September 30, 2012 and 2011 (continued)

increase in same facility revenue per equivalent admission and a 3.8% increase in same facility equivalent admissions for the first nine months of 2012 compared to the first nine months of 2011. The increase in revenues for the first nine months of 2012 compared to the first nine months of 2011 is related primarily to the combined impact of the financial consolidation of our 2011 acquisition of our partner's interest in the HCA-HealthONE LLC venture for periods subsequent to our acquisition of controlling interests during October 2011 (HealthONE revenues are not included in same facility amounts) and two adjustments (Rural Floor Provision Settlement and SSI ratios) related to Medicare revenues for prior periods. The net effect of the Medicare adjustments was an increase of $188 million to revenues.

Salaries and benefits, as a percentage of revenues, were 45.7% in the first nine months of 2012 and 45.4% in the first nine months of 2011. Salaries and benefits per equivalent admission increased 2.8% in the first nine months of 2012 compared to the first nine months of 2011. Same facility labor rate increases averaged 1.6% for the first nine months of 2012 compared to the first nine months of 2011.

Supplies, as a percentage of revenues, were 17.2% in the first nine months of 2012 and 17.5% in the first nine months of 2011. Supply cost per equivalent admission increased 0.2% in the first nine months of 2012 compared to the first nine months of 2011. Supply costs per equivalent admission increased 1.1% for medical devices and 0.1% for general medical and surgical items and declined 1.5% for pharmacy supplies and 6.7% for blood products in the first nine months of 2012 compared to the first nine months of 2011.

Other operating expenses, as a percentage of revenues, declined to 18.2% in the first nine months of 2012 from 18.3% in the first nine months of 2011. Other operating expenses is primarily comprised of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and nonincome taxes. Other operating expenses include $228 million and $248 million of indigent care costs in certain Texas markets during the first nine months of 2012 and 2011, respectively. Provisions for losses related to professional liability risks were $230 million and $183 million for the first nine months of 2012 and 2011, respectively.

We recognized $256 million ($174 million Medicare and $82 million Medicaid) and $90 million ($17 million Medicare and $73 million Medicaid) of electronic health record incentive income during the first nine months of 2012 and 2011, respectively. We recognize income related to Medicare and Medicaid incentive payments using a gain contingency model that is based upon when our eligible hospitals have demonstrated meaningful use of certified EHR technology for the applicable period and the cost report information for the full cost report year that will determine the final calculation of the incentive payment is available.

Equity in earnings of affiliates was $26 million and $217 million in the first nine months of 2012 and 2011, respectively. Equity in earnings of affiliates for the first nine months of 2011 relates primarily to our Denver, Colorado market (HealthONE) joint venture, which effective November 1, 2011, we began consolidating due to our acquisition of our partner's ownership interest.

Depreciation and amortization increased $176 million, from $1.078 billion in the first nine months of 2011 to $1.254 billion in the first nine months of 2012. The consolidation of HealthONE for periods subsequent to November 1, 2011 represents $104 million of the increase in depreciation and amortization.

Interest expense declined from $1.572 billion in the first nine months of 2011 to $1.336 billion in the first nine months of 2012 due to a decline in the average effective interest rate. Our average debt balance was

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Results of Operations (continued)

Nine Months Ended September 30, 2012 and 2011 (continued)

$27.211 billion for the first nine months of 2012 compared to $26.289 billion for the first nine months of 2011. The average effective interest rate for our long term debt declined from 8.0% for the nine months ended September 30, 2011 to 6.6% for the nine months ended September 30, 2012 due primarily to debt refinancing transactions completed during 2011.

During the first nine months of 2012, we recorded net gains on sales of facilities of $4 million. During the first nine months of 2011, we recorded net losses on sales of facilities of $3 million.

During the first nine months of 2011, we recorded losses on retirement of debt of $481 million related to the redemptions of all $1.000 billion aggregate principal amount of our 9 1/8% senior secured notes due 2014, at a redemption price of 104.563% of the principal amount; $108 million aggregate principal amount of our 9 7/8% senior secured notes due 2017, at a redemption price of 109.875% of the principal amount; all of our outstanding $1.578 billion 9 5/8%/10 3/8% second lien toggle notes due 2016, at a redemption price of 106.783% and all of our outstanding $3.200 billion 9 1/4% second lien notes due 2016, at a redemption price of 106.513%. There were no losses on retirement of debt during the first nine months of 2012.

Our Investors provided management and advisory services to the Company, pursuant to a management agreement among HCA and the Investors executed in connection with the Investors' acquisition of HCA in November 2006. In March 2011, the management agreement was terminated pursuant to its terms upon completion of the initial public offering of our common stock, and the Investors were paid a final fee of $181 million.

The effective tax rates were 37.1% and 36.7% for the first nine months of 2012 and 2011, respectively. The effective tax rate computations exclude net income attributable to noncontrolling interests as it relates to consolidated partnerships.

Net income attributable to noncontrolling interests increased from $270 million for the first nine months of 2011 to $288 million for the first nine months of 2012.

Liquidity and Capital Resources

Cash provided by operating activities totaled $2.912 billion in the first nine months of 2012 compared to $2.546 billion in the first nine months of 2011. The $366 million increase in cash provided by operating activities in the first nine months of 2012 compared to the first nine months of 2011 related primarily to the combined impact of the increase in net income of $298 million, excluding the losses on retirement of debt of $481 million in the first nine months of 2011, an increase of $176 million from depreciation and amortization and a reduction of $98 million from income taxes. The combined interest payments and net tax payments (refunds) in the first nine months of 2012 and 2011 were $1.832 billion and $1.540 billion, respectively. Working capital totaled $1.411 billion at September 30, 2012 and $1.679 billion at December 31, 2011.

Cash used in investing activities was $1.340 billion in the first nine months of 2012 compared to $1.240 billion in the first nine months of 2011. Excluding acquisitions, capital expenditures were $1.268 billion in the first nine months of 2012 and $1.170 billion in the first nine months of 2011. We expended $58 million for the acquisition of a hospital facility and $109 million to acquire nonhospital health care facilities during the first nine months of 2012. We expended $136 million for the acquisition of a hospital facility and $73 million to acquire nonhospital health care facilities during the first nine months of 2011. Capital expenditures are expected

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Liquidity and Capital Resources (continued)

to approximate $1.83 billion in 2012. At September 30, 2012, there were projects under construction which had estimated additional costs to complete and equip over the next five years of approximately $1.44 billion. We expect to finance capital expenditures with internally generated and borrowed funds. We received $17 million and $55 million from sales of health care entities during the first nine months of 2012 and 2011, respectively. We received net cash flows from our investments of $73 million and $80 million in the first nine months of 2012 and 2011, respectively.

Cash used in financing activities totaled $1.473 billion during the first nine months of 2012 compared to $1.358 billion during the first nine months of 2011. During the first nine months of 2012, net cash flows used in financing activities included net debt repayments of $214 million, distributions to noncontrolling interests of $303 million, distributions to stockholders of $983 million, payments of debt issuance costs of $20 million and receipts of $82 million of income tax benefits for certain items (primarily distributions to holders of our stock options). During the first nine months of 2011, net cash flows used in financing activities included reductions in net borrowings of $1.997 billion, net proceeds of $2.506 billion related to the issuance of common stock in conjunction with our initial public offering, repurchase of common stock of $1.503 billion, distributions to noncontrolling interests of $281 million, distributions to stockholders of $31 million, payments of debt issuance costs of $84 million and receipts of $54 million of income tax benefits for certain items (primarily distributions to holders of our stock options).

We are a highly leveraged company with significant debt service requirements. Our debt totaled $26.933 billion at September 30, 2012. Our interest expense was $1.336 billion for the first nine months of 2012 and $1.572 billion for the first nine months of 2011. The decline in interest expense was related to a decline in the average effective interest rate.

In addition to cash flows from operations, available sources of capital include amounts available under our senior secured credit facilities ($3.155 billion and $4.255 billion available as of September 30, 2012 and October 31, 2012, respectively) and anticipated access to public and private debt markets.

During October 2012, our Board of Directors declared a distribution to the Company's stockholders and holders of certain vested stock awards. The distribution declared was $2.50 per share and vested stock award (subject to limitations for certain awards), or approximately $1.2 billion in the aggregate.

During October 2012, we issued $2.500 billion aggregate principal amount of notes, comprised of $1.250 billion of 4.75% senior secured first lien notes due 2023 and $1.250 billion of 5.875% senior unsecured notes due 2023. After the payment of related fees and expenses, we used the net proceeds for general corporate purposes, which included the repayment of an existing term loan due November 2013 and providing a financing source for the declared distribution to our stockholders.

During October 2012, we replaced our $2.000 billion senior secured revolving credit facility maturing on November 17, 2015, with a new facility on substantially the same terms other than foregoing a scheduled increase in interest rates and extending the maturity date to November 17, 2016.

During February 2012, our Board of Directors declared a distribution to the Company's stockholders and holders of vested stock awards. The distribution of $2.00 per share and vested stock award, or approximately $971 million in the aggregate, was paid during February 2012.

During February 2012, we issued $1.350 billion aggregate principal amount of 5.875% senior secured notes due 2022. After the payment of related fees and expenses, we used the proceeds for general corporate purposes.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Liquidity and Capital Resources (continued)

Investments of our insurance subsidiaries, to maintain statutory equity and pay claims, totaled $534 million and $628 million at September 30, 2012 and December 31, 2011, respectively. An insurance subsidiary maintained net reserves for professional liability risks of $361 million and $410 million at September 30, 2012 and December 31, 2011, respectively. Our facilities are insured by a wholly-owned insurance subsidiary for losses up to $50 million per occurrence; however, this coverage is subject to a $5 million per occurrence self-insured retention. Net reserves for the self-insured professional liability risks retained were $875 million and $842 million at September 30, 2012 and December 31, 2011, respectively. Claims payments, net of reinsurance recoveries, during the next 12 months are expected to approximate $290 million. We estimate that approximately $229 million of the expected net claim payments during the next 12 months will relate to claims subject to the self-insured retention.

Management believes that cash flows from operations, amounts available under our senior secured credit facilities and our anticipated access to public and private debt markets will be sufficient to meet expected liquidity needs during the next 12 months.

Market Risk

We are exposed to market risk related to changes in market values of securities. The investments in debt and equity securities of our wholly-owned insurance subsidiaries were $526 million and $8 million, respectively, at September 30, 2012. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At September 30, 2012, we had a net unrealized gain of $20 million on the insurance subsidiaries' investment securities.

We are exposed to market risk related to market illiquidity. Investments in debt and equity securities of our wholly-owned insurance subsidiaries could be impaired by the inability to access the capital markets. Should the wholly-owned insurance subsidiaries require significant amounts of cash in excess of normal cash requirements to pay claims and other expenses on short notice, we may have difficulty selling these investments in a timely manner or be forced to sell them at a price less than what we might otherwise have been able to in a normal market environment. At September 30, 2012, our wholly-owned insurance subsidiaries had invested $71 million ($76 million par value) in tax-exempt student loan auction rate securities that continue to experience market illiquidity. It is uncertain if auction-related market liquidity will resume for these securities. We may be required to recognize other-than-temporary impairments on these long-term investments in future periods should issuers default on interest payments or should the fair market valuations of the securities deteriorate due to ratings downgrades or other issue specific factors.

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

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Liquidity and Capital Resources (continued)

Market Risk (continued)

With respect to our interest-bearing liabilities, approximately $3.965 billion of long-term debt at September 30, 2012 was subject to variable rates of interest, while the remaining balance in long-term debt of $22.968 billion at September 30, 2012 was subject to fixed rates of interest. Both the general level of interest rates and, for the senior secured credit facilities, our leverage affect our variable interest rates. Our variable debt is comprised primarily of amounts outstanding under the senior secured credit facilities. Borrowings under the senior secured credit facilities bear interest at a rate equal to an applicable margin plus, at our option, either (a) a base rate determined by reference to the higher of (1) the federal funds rate plus 0.50% and (2) the prime rate of Bank of America, or (b) a LIBOR rate for the currency of such borrowing for the relevant interest period. The applicable margin for borrowings under the senior secured credit facilities may fluctuate according to a leverage ratio. The average effective interest rate for our long-term debt declined from 8.0% for the nine months ended September 30, 2011 to 6.6% for the nine months ended September 30, 2012.

The estimated fair value of our total long-term debt was $28.706 billion at September 30, 2012. The estimates of fair value are based upon the quoted market prices for the same or similar issues of long-term debt with the same maturities. Based on a hypothetical 1% increase in interest rates, the potential annualized reduction to future pretax earnings would be approximately $40 million. To mitigate the impact of fluctuations in interest rates, we generally target a portion of our debt portfolio to be maintained at fixed rates.

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

Pending IRS Disputes

We are contesting certain claimed deficiencies and adjustments proposed by the IRS Examination Division in connection with its audit of HCA Inc.'s 2005 and 2006 federal income tax returns. The disputed items include the timing of recognition of certain patient service revenues, the deductibility of certain debt retirement costs and our method for calculating the tax allowance for doubtful accounts. The IRS Examination Division began an audit of HCA Inc.'s 2007, 2008 and 2009 federal income tax returns in 2010.

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

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Operating Data

	2012	2011
Number of hospitals in operation at:		
March 31	**164**	156
June 30	**163**	157
September 30	**162**	157
December 31		163
Number of freestanding outpatient surgical centers in operation at:		
March 31	**109**	98
June 30	**110**	98
September 30	**112**	98
December 31		108
Licensed hospital beds at(a):		
March 31	**41,815**	39,075
June 30	**41,817**	39,472
September 30	**41,884**	39,526
December 31		41,594
Weighted average licensed beds(b):		
Quarter:		
First	**41,740**	39,061
Second	**41,789**	39,356
Third	**41,873**	39,509
Fourth		40,994
Year		39,735
Average daily census(c):		
Quarter:		
First	**23,284**	22,002
Second	**22,113**	20,764
Third	**22,122**	20,528
Fourth		21,213
Year		21,123
Admissions(d):		
Quarter:		
First	**443,300**	406,900
Second	**428,200**	397,500
Third	**430,500**	402,300
Fourth		413,700
Year		1,620,400
Equivalent admissions(e):		
Quarter:		
First	**711,100**	638,400
Second	**700,800**	638,900
Third	**705,200**	650,900
Fourth		667,700
Year		2,595,900

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Operating Data—(Continued)

	2012	2011
Average length of stay (days)(f):		
Quarter:		
First	**4.8**	4.9
Second	**4.7**	4.8
Third	**4.7**	4.7
Fourth		4.7
Year		4.8
Emergency room visits(g):		
Quarter:		
First	**1,688,400**	1,527,600
Second	**1,714,200**	1,512,000
Third	**1,724,000**	1,539,500
Fourth		1,564,400
Year		6,143,500
Outpatient surgeries(h):		
Quarter:		
First	**217,500**	193,000
Second	**219,800**	199,100
Third	**212,300**	194,300
Fourth		212,800
Year		799,200
Inpatient surgeries(i):		
Quarter:		
First	**128,300**	119,700
Second	**126,700**	120,200
Third	**124,700**	121,100
Fourth		123,500
Year		484,500
Days revenues in accounts receivable(j):		
Quarter:		
First	**53**	49
Second	**50**	50
Third	**52**	50
Fourth		52
Year		53
Gross patient revenues(k) (dollars in millions):		
Quarter:		
First	**$ 41,377**	$ 34,764
Second	**40,327**	34,242
Third	**40,125**	34,288
Fourth		38,222
Year		141,516
Outpatient revenues as a % of patient revenues(l):		
Quarter:		
First	**37%**	36%
Second	**39%**	37%
Third	**38%**	37%
Fourth		38%
Year		37%

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (continued)

Operating Data—(Continued)

BALANCE SHEET DATA

	% of Accounts Receivable		
	Under 91 Days	91 — 180 Days	Over 180 Days
Accounts receivable aging at September 30, 2012 (m):			
Medicare and Medicaid	13%	1%	1%
Managed care and other discounted	23	5	4
Uninsured	18	8	27
Total	54%	14%	32%

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

(b) Represents the average number of licensed beds, weighted based on periods owned.

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

(d) 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.

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

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

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

(h) 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.

(i) 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.

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

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

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

(m) Accounts receivable aging data is based upon consolidated gross accounts receivable of $9.073 billion (each 1% is equivalent to approximately $91 million of gross accounts receivable).

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The information called for by this item is provided under the caption "Market Risk" under Item 2, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

ITEM 4. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

HCA's chief executive officer and chief financial officer have reviewed and evaluated the effectiveness of HCA's disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) promulgated under the Securities Exchange Act of 1934 (the "Exchange Act")) as of the end of the period covered by this quarterly report. Based on that evaluation, the chief executive officer and chief financial officer have concluded HCA's disclosure controls and procedures were effective.

Changes in Internal Control Over Financial Reporting

During the period covered by this report, there have been no changes in our internal control over financial reporting that have materially affected or are reasonably likely to materially affect our internal control over financial reporting.

PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

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

Government Investigations, Claims and Litigation

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

As initially disclosed in 2010, the DOJ has contacted the Company in connection with its nationwide review of whether, in certain cases, hospital charges to the federal government relating to implantable cardio-defibrillators ("ICDs") met the CMS criteria. In connection with this nationwide review, the DOJ has indicated that it will be reviewing certain ICD billing and medical records at 95 HCA hospitals; the review covers the period from October 2003 to the present. In August 2012, HCA, along with non-HCA hospitals across the country subject to the DOJ's review, received from the DOJ a proposed framework for resolving the DOJ's review of ICDs. The Company is cooperating in the review. The review could potentially give rise to claims against the Company under the federal FCA or other statutes, regulations or laws. At this time, we cannot predict what effect, if any, this review or any resulting claims could have on the Company.

In July 2012, the Civil Division of the U.S. Attorney's Office in Miami requested information on reviews assessing the medical necessity of interventional cardiology services provided at any Company facility (other than peer reviews). The Company is cooperating with the government's request and is currently producing medical records associated with particular reviews at eight hospitals, located primarily in Florida. At this time,

we cannot predict what effect, if any, the request or any resulting claims, including any potential claims under the federal False Claims Act, other statutes, regulations or laws, could have on the Company.

New Hampshire Hospital Litigation

In 2006, the Foundation for Seacoast Health (the "Foundation") filed suit against HCA in state court in New Hampshire. The Foundation alleged that both the 2006 recapitalization transaction and a prior 1999 intra-corporate transaction violated a 1983 agreement that placed certain restrictions on transfers of the Portsmouth Regional Hospital. In May 2007, the trial court ruled against the Foundation on all its claims. On appeal, the New Hampshire Supreme Court affirmed the ruling on the 2006 recapitalization, but remanded to the trial court the claims based on the 1999 intra-corporate transaction. The trial court ruled in December 2009 that the 1999 intra-corporate transaction breached the transfer restriction provisions of the 1983 agreement. In September of 2011, the trial court issued its remedies phase decision and held that the only remedy to which the Foundation was entitled was rescission of the intra-corporate transfer that breached the transfer restriction (the Company has complied with the Court's order, and it is not expected that such compliance will have any material effect on our operations or financial position). The Court awarded the Foundation, under the terms of the Asset Purchase Agreement, a "fraction" of its attorney fees. The Foundation appealed the remedy phase ruling, and the Company cross-appealed the liability determination. On October 31, 2011, the New Hampshire Supreme Court, on its own, raised the question whether the appeal needed to await the trial court's further ruling on attorney fees. On November 21, 2011, after the parties briefed the issue, the New Hampshire Supreme Court dismissed the appeal as premature and remanded the case to the trial court. In February 2012, the trial court certified the case for a possible interlocutory appeal without addressing the attorney fees issue. The New Hampshire Supreme Court rejected the request for an interlocutory appeal. The parties subsequently reached a stipulation regarding the attorney fees. The trial court accepted the parties' stipulation regarding attorneys fees and entered final judgment on liability and remedies on May 4, 2012. Both sides filed appeals with the New Hampshire Supreme Court and briefing has been scheduled.

Securities Class Action Litigation

On October 28, 2011, a shareholder action, Schuh v. HCA Holdings, Inc. et al., was filed in the United States District Court for the Middle District of Tennessee seeking monetary relief. The case sought to include as a class all persons who acquired the Company's stock pursuant or traceable to the Company's Registration Statement issued in connection with the March 9, 2011 initial public offering. The lawsuit asserted a claim under Section 11 of the Securities Act of 1933 against the Company, certain members of the board of directors, and certain underwriters in the offering. It further asserted a claim under Section 15 of the Securities Act of 1933 against the same members of the board of directors. The action alleged various deficiencies in the Company's disclosures in the Registration Statement. Subsequently, two additional class action complaints, Kishtah v. HCA Holdings, Inc. et al. and Daniels v. HCA Holdings, Inc. et al., setting forth substantially similar claims against substantially the same defendants were filed in the same federal court on November 16, 2011 and December 12, 2011, respectively. All three of the cases were consolidated. On May 3, 2012, the court appointed New England Teamsters & Trucking Industry Pension Fund as Lead Plaintiff for the consolidated action. On July 13, 2012, the lead plaintiff filed an amended complaint asserting claims under Sections 11 and 12(a)(2) of the Securities Act of 1933 against the Company, certain members of the board of directors, and certain underwriters in the offering. It further asserts a claim under Section 15 of the Securities Act of 1933 against the same members of the board of directors and Hercules Holdings II, LLC, a majority shareholder of the Company. The consolidated complaint alleges deficiencies in the Company's disclosures in the Registration Statement and Prospectus relating to: (1) the accounting for the Company's 2006 recapitalization and 2010 reorganization; (2) the Company's failure to maintain effective internal controls relating to its accounting for such transactions; and (3) the Company's Medicare and Medicaid revenue growth rates. The Company and other defendants moved to dismiss the amended compliant on September 11, 2012.

In addition to the above described shareholder class actions, on December 8, 2011, a federal shareholder derivative action, Sutton v. Bracken, et al., putatively initiated in the name of the Company, was filed in the

United States District Court for the Middle District of Tennessee against certain officers and present and former directors of the Company seeking monetary relief. The action alleges breaches of fiduciary duties by the named officers and directors in connection with the accounting and earnings claims set forth in the shareholder class actions. Setting forth substantially similar claims against substantially the same defendants, an additional federal derivative action, Schroeder v. Bracken, et al., was filed in the United States District Court for the Middle District of Tennessee on December 16, 2011, and a state derivative action, Bagot v. Bracken, et al., was filed in Tennessee state court in the Davidson County Circuit Court on December 20, 2011. The federal derivative actions have been consolidated in the Middle District of Tennessee and the parties have agreed that those cases shall be stayed pending developments in the shareholder class actions. The state derivative action has also been stayed pending developments in the shareholder class actions.

General Liability and Other Claims

We are subject to claims for additional income taxes and related interest by the IRS Examination Division. For a description of those proceedings, see Part I, Item 2, "Management's Discussion and Analysis of Financial Condition and Results of Operations — Pending IRS Disputes" and Note 2 to our condensed consolidated financial statements.

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

ITEM 1A: RISK FACTORS

Reference is made to the factors set forth under the caption "Forward-Looking Statements" in Part I, Item 2 of this Form 10-Q and other risk factors described in our annual report on Form 10-K for the year ended December 31, 2011, which are incorporated herein by reference. There have not been any material changes to the risk factors previously disclosed in our annual report on Form 10-K for the year ended December 31, 2011 and our quarterly report on Form 10-Q for the quarter ended June 30, 2012.

ITEM 6. EXHIBITS

(a) List of Exhibits:

31.1	—	Certification of Chief Executive Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	—	Certification of Chief Financial Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32	—	Certification Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	—	The following financial information from our quarterly report on Form 10-Q for the quarters and nine months ended September 30, 2012 and 2011, filed with the SEC on November 6, 2012, formatted in Extensible Business Reporting Language (XBRL): (i) the condensed consolidated balance sheets at September 30, 2012 and December 31, 2011, (ii) the condensed consolidated comprehensive income statements for the quarters and nine months ended September 30, 2012 and 2011, (iii) the condensed consolidated statements of cash flows for the nine months ended September 30, 2012 and 2011 and (iv) the notes to condensed consolidated financial statements.(1)

(1) The XBRL related information in Exhibit 101 to this quarterly report on Form 10-Q shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, or otherwise subject to liability of that section and shall not be incorporated by reference into any filing or other document pursuant to the Securities Act of 1933, as amended, except as shall be expressly set forth by specific reference in such filing or document.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

HCA Holdings, Inc.

By: /S/ R. M ILTON JOHNSON
R. Milton Johnson
President and Chief Financial Officer

Date: November 6, 2012

EXHIBIT 31.1

CERTIFICATION

I, Richard M. Bracken, certify that:

1. I have reviewed this quarterly report on Form 10-Q of HCA Holdings, Inc.;

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

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

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

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

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

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

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

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

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

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

By: /S/ RICHARD M. B RACKEN
RICHARD M. BRACKEN
Chairman of the Board and Chief Executive Officer

Date: November 6, 2012

EXHIBIT 31.2

CERTIFICATION

I, R. Milton Johnson, certify that:

1. I have reviewed this quarterly report on Form 10-Q of HCA Holdings, Inc.;

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

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

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

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

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

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

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

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

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

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

By: /S/ R. MILTON JOHNSON
R. MILTON JOHNSON
President and Chief Financial Officer

Date: November 6, 2012

EXHIBIT 32

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

In connection with the Quarterly Report of HCA Holdings, Inc. (the "Company") on Form 10-Q for the quarter ended September 30, 2012, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned certifies, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

By: /S/ RICHARD M. B RACKEN
RICHARD M. BRACKEN
Chairman of the Board and Chief Executive Officer

November 6, 2012

By: /S/ R. MILTON JOHNSON
R. MILTON JOHNSON
President and Chief Financial Officer

November 6, 2012

EXHIBIT C2

SEC FILINGS

As a privately owned limited partnership, HealthTrust Purchasing Group does not file with the SEC.

EXHIBIT C3

CONFIDENTIAL- REDACTED

Financial Statements

Attached are audited financial statements for HealthTrust Purchasing Group for 2010 and 2011. These documents are filed with the Commission separately under seal of confidentiality pursuant to a Motion for Protective Order and are not to be disclosed or disseminated to the public without the Applicant's prior written consent.

BEFORE

THE PUBLIC UTILITIES COMMISSION OF OHIO

In the Matter of the Application of)
HealthTrust Purchasing Group, LP for) Case No. 11-1095-GA-AGG
Certification as a Competitive Retail)
Natural Gas Aggregator/Broker.)

ENTRY

The attorney examiner finds:

(1) On March 1, 2011, HealthTrust Purchasing Group, LP (HealthTrust or company) filed an application for certification as a competitive retail natural gas aggregator/broker. On that same day, HealthTrust filed a motion for a protective order, pursuant to Rule 4901-1-24(D), Ohio Administrative Code (O.A.C.), requesting that exhibits C-2, C-3, and C-5 of its application be kept under seal. These exhibits contain the company's financial information, including financial statements for 2008 and 2009.

(2) In support of its motion for a protective order, HealthTrust explains that exhibits C-2, C-3, and C-5 contain competitively sensitive and highly proprietary business financial information which is not generally known or available to the general public. Therefore, HealthTrust requests that the information found in exhibits C-2, C-3, and C-5 be treated as confidential.

(3) Section 4905.07, Revised Code, provides that all facts and information in the possession of the Commission shall be public, except as provided in Section 149.43, Revised Code, and as consistent with the purposes of Title 49 of the Revised Code. Section 149.43, Revised Code, specifies that the term "public records" excludes information which, under state or federal law, may not be released. The Ohio Supreme Court has clarified that the "state or federal law" exemption is intended to cover trade secrets. *State ex rel. Besser v. Ohio State* (2000), 89 Ohio St.3d 396, 399.

(4) Similarly, Rule 4901-1-24, O.A.C., allows an attorney examiner to issue an order to protect the confidentiality of information contained in a filed document, "to the extent that state or federal law prohibits release of the information, including

where the information is deemed . . . to constitute a trade secret under Ohio law, and where non-disclosure of the information is not inconsistent with the purposes of Title 49 of the Revised Code."

(5) Ohio law defines a trade secret as "information . . . that satisfies both of the following: (a) It derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use. (b) It is the subject of efforts that are reasonable under the circumstances to maintain its secrecy." Section 1333.61(D), Revised Code.

(6) The attorney examiner has examined the information covered by the motion for protective order filed by HealthTrust, as well as the assertions set forth in the supportive memorandum. Applying the requirements that the information have independent economic value and be the subject of reasonable efforts to maintain its secrecy pursuant to Section 1333.61(D), Revised Code, as well as the six-factor test set forth by the Ohio Supreme Court,[1] the attorney examiner finds that the information contained in exhibits C-2, C-3, and C-5 of HealthTrust's application constitutes trade secret information. Release of these documents is, therefore, prohibited under state law. The attorney examiner also finds that nondisclosure of this information is not inconsistent with the purposes of Title 49 of the Revised Code. Accordingly, the attorney examiner finds that HealthTrust's motion for protective order is reasonable with regard to exhibits C-2, C-3, and C-5 filed on March 1, 2011; therefore, the motion should be granted.

(7) Rule 4901-1-24(D)(4), O.A.C., provides for protective orders relating to gas marketers' certification renewal applications to expire after 24 months. The attorney examiner finds that the 24-month provision in Rule 4901-1-24(D)(4), O.A.C., is intended to synchronize the expiration of protective orders related to gas marketers' certification applications with the expiration of their certification and that the expiration dates should allow adequate time for consideration of any motion for extension.

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1 See *State ex rel. The Plain Dealer v. Ohio Dept. of Ins.*, (1997) 80 Ohio St.3d 513, 524-525.

Therefore, confidential treatment shall be afforded to exhibits C-2, C-3, and C-5 for a period ending 24 months from the effective date of the certificate issued to HealthTrust, or until April 1, 2013. Until that date, the docketing division should maintain, under seal, exhibits C-2, C-3, and C-5, which were filed under seal in this docket on March 1, 2011.

(8) Rule 4901-1-24(F), O.A.C., requires a party wishing to extend a protective order to file an appropriate motion at least 45 days in advance of the expiration date. If HealthTrust wishes to extend this confidential treatment, it should file an appropriate motion at least 45 days in advance of the expiration date. If no such motion to extend confidential treatment is filed, the Commission may release this information without prior notice to HealthTrust.

It is, therefore,

ORDERED, That the motion for protective order filed by HealthTrust be granted with regard to the information contained in exhibits C-2, C-3, and C-5 of HealthTrust's application. It is, further,

ORDERED, That the Commission's docketing division maintain, under seal, the unredacted exhibits C-2, C-3, and C-5, which were filed under seal in this docket on March 1, 2011, for a period of 24 months, ending on April 1, 2013. It is, further,

ORDERED, That a copy of this entry be served upon each party of record.

THE PUBLIC UTILITIES COMMISSION OF OHIO

Kerry K. Sheets

By: Kerry K. Sheets
Attorney Examiner

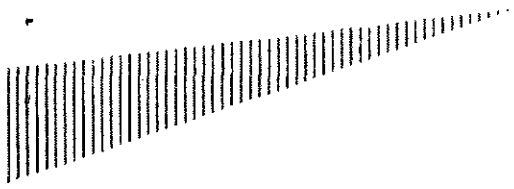
gap
/vrm

Entered in the Journal
APR 21 2011

Betty McCauley

Betty McCauley
Secretary

CONFIDENTIAL



ERNST & YOUNG

REDACTED

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Report of Independent Auditors

The Partners
HealthTrust Purchasing Group, LP

We have audited the accompanying balance sheet of HealthTrust Purchasing Group, LP (a Delaware limited partnership) (HPG or the Partnership) as of December 31, 2010, and the related statements of income, partners' capital, and cash flows for the year then ended. These financial statements are the responsibility of the Partnership's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Partnership's internal control over financial reporting. Our audit included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Partnership's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HealthTrust Purchasing Group, LP at December 31, 2010, and the results of its operations and its cash flows for the year then ended, in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

December 2, 2011

HealthTrust Purchasing Group, LP

Balance Sheet

December 31, 2010

Assets
Current assets:
- Cash
- Prepaid expenses
- Other receivables
- Administrative fees receivable

Property and equipment, at cost:
- Leasehold improvements
- Equipment

- Accumulated depreciation

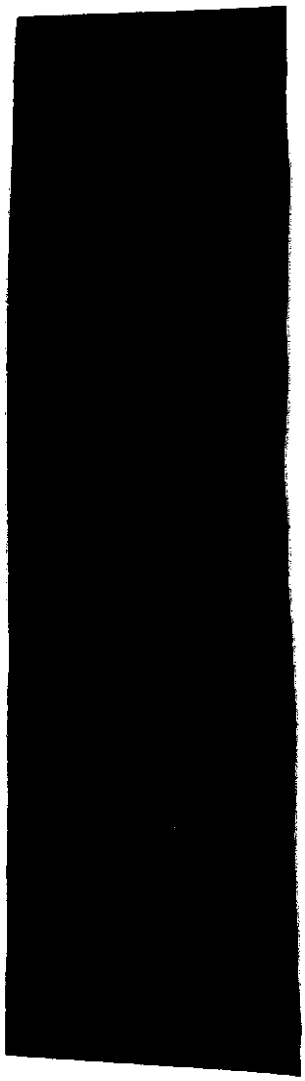
Deferred tax asset
Due from an HCA affiliate
Total assets

Liabilities and Partners' capital
Current liabilities:
- Accounts payable
- Net fees payable
- Taxes payable
- Accrued expenses and other current liabilities

Other liabilities

Partners' capital
Total liabilities and Partners' capital

See accompanying notes.



HealthTrust Purchasing Group, LP

Income Statement

Year Ended December 31, 2010

[redacted]

Revenues:
- Administrative fees, net
- Reimbursed costs

Other revenues

Operating expenses:
- Salaries and benefits
- Contract services
- Travel
- Rents and leases
- Other operating expenses
- Depreciation

Income before income taxes

Provision for income taxes

Net income

See accompanying notes.

HealthTrust Purchasing Group, LP

Statement of Partners' Capital

	Managing General Partner	Limited Partners	Total
Partners' capital at January 1, 2010	[redacted]		
Net income			
Distributions			
Reduction in managing partner's capital related to change in income taxes *(Note 2)*			
Partners' capital at December 31, 2010			

See accompanying notes.

HealthTrust Purchasing Group, LP

Statement of Cash Flows

Year Ended December 31, 2010

[redacted]

Operating activities
Net income
Adjustments to reconcile net income to net cash provided by operating activities:
  Depreciation
  Increase (decrease) in cash from operating assets and liabilities:
    Prepaid expenses and other current assets
    Administrative fees receivable
    Deferred tax asset
    Accounts payable
    Net fees payable
    Taxes payable
    Accrued expenses and other liabilities
Net cash provided by operating activities

Investing activities
Purchase of property and equipment

Financing activities
Net transfers to an HCA affiliate
Net distributions to partners
Net cash used in financing activities

Change in cash
Cash at January 1, 2010
Cash at December 31, 2010

See accompanying notes.

HealthTrust Purchasing Group, LP

Notes to Financial Statements

December 31, 2010

1. Organization

HealthTrust Purchasing Group, LP (a Delaware limited partnership) (HPG or the Partnership) is a Group Purchasing Organization (GPO) with both domestic and international office locations that negotiates contractual purchasing agreements with vendors to provide supplies, equipment and other services to member facilities. Members enter into participation agreements with HPG to obtain access to HPG's purchasing agreements with vendors. HPG's role is to provide comprehensive cost management solutions and certain administrative services to member facilities. HPG was originally organized as a wholly owned affiliate of HCA Holdings, Inc. (HCA). LifePoint Hospitals, Health Management Associates (HMA), Community Health Systems, Consorta, and Universal Health Services have joined as partners. The general partner and a limited partner of HPG are both subsidiaries of HCA and have a combined ownership interest in excess of 51%.

2. Accounting Policies

Revenues

Revenues consist of administrative fees generated under contracts with manufacturers and distributors for its members, various costs that are reimbursed by certain partners and other revenues.

Administrative Fee Revenues

Administrative fees are generated under contractual purchasing agreements with vendors of products and services. Vendors pay administrative fees to the Partnership in return for aggregated sales volumes from member facilities that purchase products qualified under HPG's contracts. The administrative fees paid to the Partnership represent a percentage of the purchases made by HPG's member facilities.

Revenues are recorded as products are delivered and services are performed. Administrative fees are fixed and determinable based on reported purchasing volume, and our customer (member) and vendor contracts substantiate persuasive evidence of an arrangement.

2. Accounting Policies (continued)

Administrative Fee Revenues (continued)

Certain partner and non-partner members receive revenue share payments (revenue share obligations). These obligations are recognized according to the customers' contractual agreements with HPG as the related administrative fee revenues are recognized. In accordance with Accounting Standards Codification (ASC) Topic 605-45, *Revenue Recognition, Principal Agent Considerations*, these obligations are netted against the related gross administrative fees, and are presented on the accompanying income statement as administrative fees, net.

Gross administrative fees include all administrative fees received pursuant to vendor contracts. Revenue share obligations represent the portion of the administrative fees which the Partnership is contractually obligated to share with certain partners and members. The following shows the components of net administrative fee revenues for the year ended December 31, 2010.

Gross administrative fees	[redacted]
Less revenue share obligations	
Administrative fees, net	

Revenues – Reimbursed Costs

HPG incurs out-of-pocket costs to perform contracting and implementation services for its partners and non-partner members. These costs are segregated into "reimbursed costs" and "non-reimbursed costs" using calculations outlined in the HPG partnership agreement. The amount of operating costs that is reimbursed prior to the computation of net administrative fees retained by the Partnership is presented as a component of revenues in the income statement when the related costs are incurred. Both reimbursed costs and non-reimbursed costs are recorded as expenses when incurred.

Other Revenues

Other revenues include approximately [redacted] related to the Partnership's annual conference. Revenues for conferences are recognized when the meetings are held and related obligations are performed.

2. Accounting Policies (continued)

Partnership Distributions

The partnership agreement requires net administrative fees received less the expenses incurred that are not reimbursed by the partners to be distributed to the partners on a monthly basis.

Vendor Rebates

The Partnership receives rebates pursuant to the provisions of certain vendor agreements. The rebates are earned by members based on the amounts of their purchases. The Partnership collects, processes, and pays the rebates as a service to its members. Vendor rebates are excluded from revenues. The vendor rebates are recorded for active members when the Partnership receives cash payments from vendors.

Administrative Fees Receivable

The Partnership usually receives administrative fees a month or a quarter in arrears of actual member activity. HPG records administrative fees receivable based on member purchasing data provided by vendors and projections based on member purchase history.

The recorded amount of administrative fees receivable is based upon management's assessment of historical and expected net collections, business and economic conditions, and other collection indicators. Management relies on the results of detailed reviews of historical collections as a primary source of information to utilize in estimating the administrative fees receivable. Adverse changes in general economic conditions or vendor operations could affect the Partnership's collection of administrative fees receivable, cash flows and results of operations.

Leasehold Improvements and Equipment

Leasehold improvements and equipment are stated at cost. Depreciation expense is computed using the straight-line method. Leasehold improvements are depreciated over the shorter of the economic life or the lease term. Estimated useful lives of equipment vary generally from four to 10 years.

2. Accounting Policies (continued)

Due From an HCA Affiliate

Due from an HCA affiliate, in part, represents the net excess of funds transferred to a cash management account of an HCA affiliate over funds transferred to, or paid on behalf of, HPG.

Generally, this balance is decreased by automatic cash transfers from the account to reimburse HPG's bank accounts for operating expenses; and fees and services provided by HCA affiliates, including information systems services, internal audit services, certain shared services, and other operating expenses (such as payroll, interest, and insurance). Generally, the balance is increased through daily transfers of cash by HPG to the account.

Information systems services fees represent an allocation of mainframe and other systems processing costs as well as the costs of related support services. The cost of these information systems services for the year ended December 31, 2010, was approximately $8,933,000 and is included in the accompanying income statement as a component of contract services.

Internal audit services represent an allocation of costs incurred by HCA to perform audits of the Partnership vendor contracts. The cost of these services for the year ended December 31, 2010, was approximately [redacted] and is included in the accompanying income statement as a component of contract services.

To facilitate payroll administration, all personnel assigned to perform duties for the Partnership are employed by an HCA affiliate. The Partnership reimburses the HCA affiliate for the direct cost (i.e., salaries and related benefits) associated with such personnel. Such reimbursements are included in the accompanying income statement as a component of salaries and benefits.

Costs for certain services performed for the Partnership by an HCA affiliate are not charged to HPG and therefore are not included in HPG's income statement. These services include but are not limited to accounts payable, treasury, and design and construction functions.

For amounts due from an HCA affiliate, the Partnership receives interest income monthly based on the outstanding undistributed balances at a monthly average interest rate that the HCA affiliate earns on all of its investment accounts. Interest income under these arrangements of approximately [redacted] is included in the accompanying income statement as a component of other revenues.

2. Accounting Policies (continued)

Income Taxes

No provision for federal income taxes is made in the accounts of the Partnership since such taxes are liabilities of the partners and depend upon their respective tax situations.

Since inception in 1999, the Partnership has been subject to the Tennessee Excise Tax (a tax based on net income). HCA affiliates own more than 50% of the Partnership; as a result and pursuant to a specific state ruling, HPG must be included in HCA's combined Tennessee franchise/excise tax return. Due to net operating losses of the combined group, no Tennessee Excise Tax has been paid by the combined group from 1999-2010. Although no tax has been paid, current and deferred taxes are reported in the Partnership's financial statements in accordance with ASC Topic 740, *Income Taxes*, as if the Partnership had filed a separate return with the taxing authority. Prior to 2010, certain deferred state tax benefits were recorded for administrative fee accruals and the related deemed tax payments were reflected as adjustments to the general partner's capital account. During 2010, the partnership agreement was changed to specifically define administrative fee revenues applicable to the Partnership and the partners, and the deferred state tax benefits for administrative fee accruals and the related previous adjustments to the general partner's capital account were reversed. No tax sharing agreement currently exists between HCA and HPG.

The Partnership's tax returns and the amounts reflected as distributable Partnership income or loss are subject to examination by the federal and state taxing authorities. In the event of an examination of the Partnership's tax return, the tax liability of the partners could be changed if any adjustment to the Partnership income or loss is ultimately sustained by the taxing authorities.

Business Receipts Tax

A gross business receipts tax may be levied against gross receipts of administration fees. Currently, management is in negotiations with a state taxation authority to obtain an exemption for certain of these fees from the business receipts tax and expects a resolution in 2011. As of December 31, 2010, approximately [redacted] was accrued for the business receipts tax and represents management's estimate of fees to be paid.

2. Accounting Policies (continued)

Insurance Programs

An HCA affiliate maintains an occurrence-based insurance policy with a commercial insurer for workers compensation claims incurred by HCA affiliates, including the Partnership. The cost of this policy is allocated to all participating HCA affiliates based, in part, on actual claims experience. The cost for the year ended December 31, 2010, was approximately [redacted] and is included as a component of salaries and benefits in the accompanying income statement.

Use of Estimates

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

Financial Instruments

The carrying amounts reported in the balance sheet for administrative fees receivable, accounts payable, net fees payable, other receivables, accrued expenses and other current liabilities approximate fair values due to the short maturities of the financial instruments.

Concentration of Credit Risk

The Partnership's credit risks primarily relate to administrative fees receivable. Administrative fees receivable consist primarily of amounts due from vendors. The Partnership routinely performs evaluations of the amounts receivable and collections from vendors to determine that administrative fees receivable are stated at fair value.

3. Retirement Plans

The Partnership participates in retire[redacted]ans and a deferred compensation benefit plan of HCA. A liability of approximately [redacted] for the deferred compensation benefit plan is included in accrued expenses on the accompanying balance sheet at December 31, 2010. Liabilities associated with other retirement plans are maintained by an HCA affiliate, and the expense of these plans is allocated to the Partnership and included as a component of salaries and benefits in the accompanying income statement. Total benefits expense was approximately [redacted]n 2010.

4. Leases

Operating lease rental expense, relating primarily to the rental of office space and equipment, was approximately [redacted] or the year ended December 31, 2010, and is included in the accompanying income statement as rents and leases.

Future minimum rental commitments under noncancelable operating leases (with an initial or remaining term in excess of one year) at December 31, 2010, are as follows:

2011
2012
2013
2014
2015
Thereafter
Total minimum rental commitments [redacted]

Future minimum sublease rental commitments under noncancelable operating leases (with an initial or remaining term in excess of one year) at December 31, 2010 are [redacted]

5. Commitments and Contingencies

The Partnership is subject to claims and suits arising in the ordinary course of business. In certain of these actions, the claimants may seek punitive damages against the Partnership, which are usually not covered by insurance. In the opinion of management, the ultimate resolution of such pending claims and legal proceedings will not have a material, adverse effect on the Partnership's results of operations or financial position.

The Partnership is party to an agreement whereby one of its partners could be paid [redacted] upon an adverse change in control as strictly defined within the partnership agreement. However, as management controls if, and when, any such change in control would happen, and no such change is anticipated, no accrual is recorded as of December 31, 2010.

The Partnership has entered into and may continue to enter into agreements with various members guaranteeing a certain level of savings provided the applicable members agree to use the Partnership as their GPO. A penalty would be assessed against the Partnership, in some cases, if the savings levels are not realized. The savings levels guaranteed were met or exceeded prior to December 31, 2010 for the majority of the contracts. Currently, there is no loss estimated

5. Commitments and Contingencies (continued)

on the contracts that were not fulfilled by December 31, 2010 as management projects that such guarantees will be met within the terms set by the contracts. No estimate of the maximum potential payout can currently be made as the calculation of any payout requires a certain purchasing threshold to be reached by the member, which is not known until the end of the guarantee measurement period.

6. Related-Party Transactions

The Partnership is allocated costs and interest income from HCA affiliates for various services including information systems fees, internal audit services, certain shared services and other operating expenses (such as payroll, interest and insurance) as described in Note 2 under "Due From an HCA Affiliate."

Expenses for certain GPO-related services, including information systems fees and clinical and implementation services, are paid by the Partnership to Consorta and HMA pursuant to the provisions of their agreements with HPG. The costs for the year ended December 31, 2010, were approximately [redacted] for Consorta and [redacted] HMA. These costs are included in the accompanying income statement as components of contract services.

Expenses for maintenance and systems development costs are paid to Global Healthcare Exchange, a related party of an HCA affiliate. The cost for the year ended December 31, 2010, was approximately [redacted] and is included in the accompanying income statement as a component of contract services.

7. Income Taxes

The provision for income taxes is comprised of:

	[redacted]
Current:	
State	
Foreign	
Deferred:	
State	
Provision for income taxes	

7. Income Taxes (continued)

Deferred income tax assets of approximately [redacted] at December 31, 2010, primarily related to the timing of depreciation, are included in long-term assets. Future realization of the Partnership's deferred tax assets is based upon sufficient taxable income.

8. Subsequent Events

The Partnership has evaluated subsequent events through December 2, 2011, the date the financial statements were available for issuance.

Ernst & Young LLP

Assurance | Tax | Transactions | Advisory

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