HCA INC/TN
Form 424B3
September 26, 2007
Table of Contents

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Registration No. 333-145054

PROSPECTUS

HCA Inc.

Offers to Exchange

$1,000,000,000 aggregate principal amount of its 9 1/8% Senior Secured Notes due 2014, $3,200,000,000 aggregate principal amount of its 9 1/4% Senior Secured Notes due 2016 and $1,500,000,000 aggregate principal amount of its 9 5/8%/10 3/8% Senior Secured Toggle Notes due 2016 (collectively, the exchange notes), each of which have been registered under the Securities Act of 1933, as amended (the Securities Act), for any and all of its outstanding 9 1/8% Senior Secured Notes due 2014, 9 1/4% Senior Secured Notes due 2016 and 9 5/8%/10 3/8% Senior Secured Toggle Notes due 2016 (collectively, the outstanding notes), respectively (such transactions, collectively, the exchange offers).

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

The Exchange Offers

We will exchange all outstanding notes that are validly tendered and not validly withdrawn for an equal principal amount of exchange notes that are freely tradable.

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

The exchange offers expire at 11:59 p.m., New York City time, on October 24, 2007, unless extended. We do not currently intend to extend the expiration date.

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

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

Results of the Exchange Offers

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

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

See Risk Factors beginning on page 27 for a discussion of certain risks that you should consider before participating in the exchange offers.

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

The date of this prospectus is September 26, 2007.

Table of Contents

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

TABLE OF CONTENTS

MARKET, RANKING AND OTHER INDUSTRY DATA

The data included in this prospectus regarding markets and ranking, including the size of certain markets and our position and the position of our competitors within these markets, are based on reports of government agencies or published industry sources and estimates based on HCA Inc. (HCA) management s knowledge and experience in the markets in which HCA operates. These estimates have been based on information obtained from our trade and business organizations and other contacts in the markets in which we operate. HCA believes these estimates to be accurate as of the date of this prospectus. However, this information may prove to be inaccurate because of the method by which HCA obtained some of the data for the estimates or because this information cannot always be verified with complete certainty due to the limits on the availability and reliability of raw data, the voluntary nature of the data gathering process and other limitations and uncertainties. As a result, you should be aware that market, ranking and other similar industry data included in this prospectus, and estimates and beliefs based on that data, may not be reliable. HCA cannot guarantee the accuracy or completeness of any such information contained in this prospectus.

Table of Contents

PROSPECTUS SUMMARY

This summary highlights information appearing elsewhere in this prospectus. This summary is not complete and does not contain all of the information that you should consider before investing in the notes. You should carefully read the entire prospectus, including the financial data and related notes and the section entitled Risk Factors. On July 24, 2006, Hercules Acquisition Corporation (Hercules Acquisition) and Hercules Holding II, LLC (Hercules Holding), a limited liability company currently owned by investment funds associated with Bain Capital Partners, Kohlberg Kravis Roberts & Co. and Merrill Lynch Global Private Equity (collectively, the Sponsors), entered into an Agreement and Plan of Merger (the Merger Agreement) with HCA Inc. (HCA) pursuant to which Hercules Acquisition merged with and into HCA, with HCA continuing as the surviving corporation (the Merger). Immediately following consummation of the Merger on November 17, 2006, investment funds associated with or designated by the Sponsors, certain entities affiliated with HCA founder and director Dr. Thomas F. Frist, Jr. (the Frist Entities), certain other co-investors and certain members of HCA s management directly or indirectly own HCA.

Unless the context otherwise requires or as otherwise indicated, references in this prospectus to HCA, the Issuer, we, our, us and the Company refer to HCA Inc. and its consolidated subsidiaries. Financial information identified in this prospectus as pro forma gives effect to the closing of the Merger and the related Recapitalization of HCA described in this prospectus.

Our Company

We are the largest and most diversified investor-owned health care services provider in the United States. As of June 30, 2007, we operated 172 hospitals and 107 freestanding surgery centers in 20 states, England and Switzerland (including eight nonconsolidated hospitals and nine nonconsolidated surgery centers managed under joint ventures) and had approximately 183,000 employees and 35,000 affiliated physicians. For the year ended December 31, 2006, we generated revenues of $25.477 billion and net income of $1.036 billion, and for the six months ended June 30, 2007, we generated revenues of $13.406 billion and net income of $296 million.

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.

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

Our Industry

The U.S. health care industry is large and growing. According to the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare and Medicaid programs, U.S. health expenditures increased from 9.1% of gross domestic product (GDP), or $254 billion, in 1980 to 15.9%, or $1.9 trillion, in 2004. Additionally, CMS estimates that hospital spending, which has a 25-year track record of

Table of Contents

growth, currently represents more than 30% of total health care spending and is expected to grow at a 7.2% compounded annual growth rate from 2005 through 2015, reaching $1.2 trillion by 2015.

We believe that we are well positioned to benefit from the expected growth in hospital spending as well as the following hospital industry fundamentals:

Demographics. An aging population and longer life expectancies are expected to increase the demand for health care services in the United States. There are approximately 36 million Americans aged 65 or older, according to the U.S. Census Bureau s 2004 interim projections. This age group is expected to increase to approximately 40 million by 2010 and approximately 47 million by 2015, significantly increasing the number of eligible Medicare beneficiaries. According to CMS, Americans aged 65 or older spend 300% more per capita on hospital care as compared to the remainder of the U.S. population. The hospital industry is expected to benefit from these trends as a result of the corresponding increase in the demand for health care services.

Stable Reimbursement Environment. The acute care hospital sector is characterized by a stable Medicare reimbursement and commercial pricing environment. In the United States, general acute care hospitals are instrumental to the delivery of quality health care and represent a critical element of the overall health care infrastructure. Approximately 85% of these hospitals are owned and managed by not-for-profit or government entities that, according to the American Hospital Association (AHA), tend to have lower operating margins than investor-owned hospitals. We believe that Medicare, which accounts for approximately 30% of total hospital spending, will continue to provide appropriate pricing increases that will enable hospitals to provide high quality clinical care. For fiscal 2007, Medicare has budgeted a total payment increase of $3.4 billion for acute care inpatient services, which we believe is consistent with recent historical experience. CMS forecasts Medicare hospital spending to nearly double over the next 10 years.

Commercial pricing has also been stable for hospital providers, and we believe commercial payors typically offer rate increases that exceed those offered by Medicare. With respect to commercial reimbursement, based on our experience, well-positioned hospital companies generally have been successful at receiving mid to high single-digit private pay increases over the past few years, and we expect this trend to continue.

Stable Industry Operating Margins. Over the past twenty years, the hospital industry has demonstrated an ability to manage its cost structure in response to changes in the reimbursement environment. Similarly, the hospital industry has managed unexpected cost increases due to exogenous factors, such as labor shortages or medical technology advances, by achieving increased levels of reimbursement from government and commercial payors. As a result, industry-wide margins historically have been stable. According to AHA, industry-wide operating margins increased approximately 200 basis points from 1990 to 2004, and while there were periods of modest margin expansion and contraction, in no five-year period did margins decline more than two percentage points.

Our Strengths

Largest Provider with a Diversified Revenue Base. We are the largest and most diversified investor-owned health care services provider in the United States. We maintain a diverse portfolio of assets with no single facility contributing more than 2.3% of revenue and no single metropolitan statistical area contributing more than 7.5% of revenue for the year ended December 31, 2006. In addition, we maintain a diversified payor base, including approximately 2,600 managed care contracts, with no one commercial payor representing more than 7% of revenue in the year ended December 31, 2006. We believe that our broad geographic footprint and diverse revenue base limit exposure to any single local market. We also provide a diverse array of medical and surgical

Table of Contents

services across different settings ranging from large hospitals to ambulatory surgery centers (ASCs), which, we believe, limits our exposure to changes in reimbursement policies targeting specific services or care settings.

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

Strong Presence in High Growth Markets. We have a leading market share in 13 of the 20 fastest growing markets in the United States with a population of greater than one million, including a significant presence in Florida and Texas, both of which are expected to grow in population at a rate higher than the national average. We believe that the majority of the high growth markets in which we have a presence will experience more rapid growth among the population aged 65 or older than the national average. We believe we will benefit from our presence in these key markets due to an expected increase in hospital spending.

Well-Capitalized Portfolio of High-Quality Assets. We have invested over $8.5 billion in our facilities over the past five years to expand the range, and improve the quality, of services provided at our facilities. As a result of our disciplined and strategic deployment of capital, we believe our hospitals enjoy a competitive advantage to attract high-quality physicians, maximize cost efficiencies and address the health care needs of our local communities.

Leading Provider of Outpatient Services. We are one of the largest providers of outpatient services in the United States, and these outpatient services accounted for approximately 36% of our revenues in 2006. The scope of our outpatient services reflects a recent trend toward the provision of an increasing number of services on an outpatient basis. An important component of our strategy is to achieve a fully integrated delivery model through the development of market-leading outpatient services, both to address outpatient migration and to provide higher growth, higher margin services.

Reputation for Quality. Since our founding, we have maintained an unwavering focus on patients and clinical outcomes, which has earned us a leading reputation with the physicians, employees and communities that are our constituents. We have invested extensively in quality over the past 10 years, with an emphasis on implementing information technology and adopting industry-wide best practices and clinical protocols. As a result of these efforts, settled professional liability claims, based on actuarial projections per 1,000 beds, have dropped from 14.5 in 1997 to 10.0 in 2006. We also previously participated in the CMS National Voluntary Hospital Reporting Initiative and now participate in its successor, the Hospital Quality Alliance (HQA), which currently requires hospitals to report on their compliance with 21 measures of quality for four conditions affecting hospital inpatients in order to receive a full Medicare market basket payment increase. We believe quality measures increasingly will influence physician and patient choices about health care delivery and maximize our reimbursement as payors put more emphasis on performance. Our reputation and focus on providing high-quality patient care continue to make us the provider of choice for thousands of individual healthcare consumers, physicians and payors.

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

Leveraging Our Purchasing Power. We have established a captive group purchasing organization (GPO) to partner with other health care services providers to take advantage of our combined purchasing power. Our GPO generated $87 million, $101 million and $86 million of administrative

Table of Contents

fees from suppliers in 2004, 2005 and 2006, respectively, for performing GPO services and significantly lowered our supply costs. Because of our scale, our GPO has a per-unit cost advantage over competitors that we believe ranges from 5% to 15%.

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

Reducing Financial Impact of Uninsured Admissions. Beginning in 2004, we instituted at a small group of our hospitals a pilot program called the Qualified Medical Practitioner Program (QMP). The QMP is designed to reduce crowding at emergency rooms experiencing high volumes of low-intensity patients by informing patients of the most appropriate setting from which they may obtain treatment. Under the QMP, patients who meet certain criteria under federal guidelines are clinically examined to determine if their cases are emergencies or if treatment in a physician s office or clinic would be more appropriate.

Demonstrated Strong and Stable Cash Flows. Our leading market positions, diversified revenues, focus on operational efficiency and high-quality portfolio of assets have enabled us to generate strong and stable operating cash flows over the past several years. We generated EBITDA of $3.786 billion in 2004, $4.178 billion in 2005 and $4.007 billion in 2006 and cash flows from operating activities of $2.954 billion in 2004, $2.971 billion in 2005 and $1.845 billion in 2006. We believe that expected demand for hospital and outpatient services, together with our diversified payor base, geographic locations and service offerings, will allow us to continue to generate strong cash flows. We provide a reconciliation of EBITDA to net income and cash flows from operating activities in Summary Historical and Pro Forma Financial and Other Data.

Experienced Management Team with Significant Equity Investment. Members of our management team are widely considered leaders in the hospital industry. Chairman and Chief Executive Officer Jack Bovender, Jr. has been with us for over 28 years and has been CEO for the past five years. In addition, Mr. Bovender was a hospital administrator during our 1989 buyout. President and Chief Operating Officer Richard Bracken began his career with us approximately 25 years ago and has held various executive positions with the Company. Executive Vice President and Chief Financial Officer R. Milton Johnson joined us over 24 years ago and has held various positions in financial operations at the Company. In addition, we benefit from our team of world-class operators who have the experience and talent necessary to run a complex healthcare business.

In connection with the Recapitalization, several of our senior executive officers and other employees rolled over stock options or shares of our company or made additional cash investments in an aggregate amount of $125 million. We also implemented a stock incentive plan under which approximately 1,500 employees (including executive officers) are eligible to receive options covering up to 10% of our fully diluted equity immediately after consummation of the Recapitalization. In addition, on January 30, 2007, we completed an offering of 781,960 shares of our common stock to approximately 570 of our employees for an aggregate purchase price of $40 million.

Strategy

We are committed to providing high quality, cost-effective health care while complying fully with our ethics policy, governmental regulations and guidelines and industry standards. The principal elements of our strategy are as follows:

Leverage Our Leading Local Market Positions. We strive to maintain and enhance the leading positions that we enjoy in the majority of our markets. We believe that the broad geographic presence of our facilities across a

range of markets, in combination with the breadth and quality of services provided by our facilities, increases our attractiveness to patients and large employers and positions us to negotiate more favorable terms from commercial payors and increase the number of payors with whom we contract. We also intend to strategically enhance our outpatient presence in our communities and increase our local marketing efforts to attract more patients to our facilities.

Expand Our Presence in Key Markets. We seek to grow our business in key markets, focusing on large, high growth urban and suburban communities, primarily in the southern and western regions of the United States. We seek to strategically invest in new and expanded services at our existing hospitals and surgery centers to increase our revenues at those facilities and provide the benefits of medical technology advances to our communities. For example, we intend to continue to expand high volume and high margin specialty services, such as cardiology and orthopedic services, and increase the capacity, scope and convenience of our outpatient facilities. To complement this organic growth, we intend to continue to opportunistically develop and acquire new hospitals and outpatient facilities. We believe these initiatives will enable us to grow our volumes, increase our acuity mix and enhance our operating margins, while simultaneously satisfying unmet demand in our existing markets.

Continue to Leverage Our Scale. We will continue to obtain price efficiencies through our GPO and to build on the cost savings and efficiencies in billing, collection and other processes we have achieved through our regional service centers. We are increasingly taking advantage of our national scale by contracting for services on a multistate basis. We will explore the feasibility of replicating our successful shared services model for additional clinical and support functions, such as physician credentialing, medical transcription and electronic medical recordkeeping, across multiple markets. We continuously seek new ways to leverage our scale to generate operating efficiencies and increase cash flow.

Continue to Develop Enduring Physician Relationships. We depend on the quality and dedication of the physicians who serve at our facilities, and we aggressively recruit both primary care physicians and key specialists to meet community needs and improve our market position. We strategically recruit physicians, often assisting them in establishing a practice or joining an existing practice where there is a community need and providing support to build their practices in compliance with regulatory standards. We intend to improve both service levels and revenues in our markets by:

- expanding the number of high quality specialty services, such as cardiology, orthopedics, oncology and neonatology;
- continuing to use joint ventures with physicians to further develop our outpatient business, particularly through ambulatory surgery centers and outpatient diagnostic centers;
- developing medical office buildings to provide convenient facilities for physicians to locate their practices and serve their patients; and
- continuing our focus on improving hospital quality and performance and implementing advanced technologies in our facilities to attract physicians to our facilities.

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

Table of Contents

next generation of hospital leadership. We believe that our continued investment in the training and retention of employees improves the quality of care, enhances operational efficiency and fosters employee loyalty.

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

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

Recent Development

On July 20, 2007, we completed the sale of our two Switzerland hospitals for $394 million. These were the only hospitals we owned or operated in Switzerland, and we expect to recognize a pretax gain of approximately $310 million on the sale. Proceeds from the sale were used to reduce the outstanding balance under our European term loan.

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

Table of Contents

The Recapitalization

On July 24, 2006, HCA entered into the Merger Agreement with Hercules Holding and Hercules Acquisition, pursuant to which the parties agreed to the Merger, subject to the terms and conditions therein. The investment funds associated with the Sponsors and their respective affiliates and/or assignees, along with the Frist Entities and their respective assignees, are collectively referred to herein as the Investors.

At the effective time of the Merger on November 17, 2006, each share of HCA common stock outstanding immediately prior to the Merger (other than shares held by HCA as treasury stock or otherwise owned by Hercules Holding immediately prior to the effective time of the Merger, shares held by subsidiaries of Hercules Holding or HCA, or shares held by holders who properly demanded and perfected their appraisal rights) was cancelled, ceased to exist and was converted into the right to receive $51.00 in cash, without interest and less any applicable withholding taxes.

In connection with the Recapitalization (as defined below), seven senior executive officers of HCA, who are referred to in this prospectus as the Senior Management Participants, invested, through cash investments, rollovers of HCA employee stock options and/or rollovers of HCA common stock, an aggregate of $47 million. In connection with the Recapitalization, certain of our managers also participated in the equity of HCA through cash investments, rollovers of HCA employee stock options and/or rollovers of HCA common stock. Together, these managers and the Senior Management Participants are referred to in this prospectus as the Management Participants, and the aggregate value of their equity participation was $125 million. In connection with the consummation of the Recapitalization, we implemented a stock incentive plan under which approximately 1,500 employees (including executive officers) are eligible to receive options covering up to 10% of our fully diluted equity immediately after consummation of the Recapitalization. In addition, on January 30, 2007, we completed an offering of 781,960 shares of our common stock to approximately 570 of our employees for an aggregate purchase price of $40 million.

Investment funds associated with the Sponsors, or their respective assignees, indirectly invested $3.776 billion in our company as part of the Recapitalization. Of the $3.776 billion invested in our company, Citigroup Inc. (the parent of Citigroup Global Markets Inc.) and Banc of America Securities LLC contributed $150 million and $50 million, respectively, to Hercules Holding in connection with the Merger. The Frist Entities contributed 17,343,193 shares of HCA common stock to Hercules Holding or to one or more other parent companies in return for an ownership interest in such entities. Based on the merger consideration per share of HCA common stock, the commitments of the Frist Entities had an aggregate value of $885 million. The Frist Entities invested an additional $65 million, which increased the aggregate investment of the Frist Entities to $950 million.

The acquisition of HCA by the Investors was financed by borrowings under our senior secured credit facilities, the notes offered in the Recapitalization, the equity investments by the Investors, participation of the Management Participants described above, rollover of existing indebtedness and cash on hand. The offering of the notes, the borrowings under our senior secured credit facilities, the equity investments by the Investors and participation by the Management Participants, the Merger, the refinancing transactions described herein and other related transactions are collectively referred to in this prospectus as the Recapitalization. For a more complete description of the Recapitalization, see Ownership and Corporate Structure, The Merger and Description of Other Indebtedness.

In connection with the Recapitalization, we repaid an aggregate of $3.109 billion of HCA s then existing indebtedness and incurred indebtedness-related costs of approximately $73 million.

Table of Contents

Ownership and Corporate Structure

Approximately 97.5% of our outstanding shares of capital stock is held indirectly by the Investors, and the remaining approximately 2.5% is held directly by the Management Participants. This structure was achieved through a series of equity contributions which occurred in connection with the Merger. For purposes of this prospectus, the calculations of percentages of our capital stock held by the Investors and the Management Participants exclude shares underlying options covering approximately 14% of our fully diluted equity which have been and may be granted to certain of our employees. See The Merger , Executive Compensation and Security Ownership of Certain Beneficial Owners. The equity and indebtedness figures in the diagram below are as of June 30, 2007.

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(1) Includes (i) approximately $3.776 billion of cash equity invested by investment funds associated with or designated by the Sponsors and their respective assignees and (ii) approximately $950 million invested by the Frist Entities and their respective assignees, of which $885 million was in the form of a rollover of the Frist Entities equity interests in HCA and $65 million was a cash equity investment. Investment funds associated with each of the Sponsors indirectly own 24.8% of our company, and their assignees, Citigroup and Banc of America Securities, collectively indirectly own 4.2% of our Company. The Frist Entities and their assignees indirectly own 18.9% of our Company following the consummation of the Recapitalization.

(2) Represents $125 million invested by the Management Participants in the form of a rollover of their previously existing equity interests in HCA to equity interests in HCA following the Merger and through cash investments. Additionally, on January 30, 2007, we completed an offering of 781,960 shares of our common stock to approximately 570 of our employees for an aggregate purchase price of $40 million.

(3) Upon the closing of the Recapitalization, we entered into (i) a $2.000 billion asset-based revolving credit facility with a six-year maturity ($1.660 billion outstanding at June 30, 2007); (ii) a $2.000 billion senior secured revolving credit facility with a six-year maturity ($0 outstanding at June 30, 2007); (iii) a $2.750 billion senior secured term loan A facility with a six-year maturity ($2.694 billion outstanding at June 30, 2007); (iv) an $8.800 billion senior secured term loan B facility with a seven-year maturity ($8.756 billion

Table of Contents

outstanding at June 30, 2007); and (v) a 1.0 billion, or $1.279 billion-equivalent (as of the closing of the Recapitalization) (995 million, or $1.341 billion-equivalent, at June 30, 2007), senior secured European term loan facility with a seven-year maturity, collectively referred to herein as the senior secured credit facilities, unless the context otherwise requires.

(4) As of June 30, 2007, consists of (i) an aggregate principal amount of $367 million medium-term notes with maturities ranging from 2010 to 2025 and a weighted average interest rate of 8.42%; (ii) an aggregate principal amount of $886 million debentures with maturities ranging from 2015 to 2095 and a weighted average interest rate of 7.55%; (iii) an aggregate principal amount of $5.987 billion senior notes with maturities ranging from 2007 to 2033 and a weighted average interest rate of 6.91%; (iv) £150 million ($301 million-equivalent at June 30, 2007) aggregate principal amount of 8.75% senior notes due 2010; (v) $422 million of secured debt, which represents capital leases and other secured debt with a weighted average interest rate of 6.80%; and (vi) $18 million of unamortized debt discounts that reduce the existing indebtedness. For more information regarding our unsecured and other indebtedness, see Description of Other Indebtedness Other Indebtedness.

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

In connection with the Recapitalization, the notes and guarantees were secured by second-priority liens on substantially all the capital stock of HealthTrust, Inc. The Hospital Company and the first-tier subsidiaries of the subsidiary guarantors (but limited to 65% of the voting stock of any such first-tier subsidiary that is a foreign subsidiary), subject to certain exceptions.

In connection with the consummation of the Recapitalization, we implemented a stock incentive plan under which approximately 1,500 employees (including executive officers) are eligible to receive options to acquire our stock. The new plan permits the granting of options covering up to 10% of our fully diluted equity immediately after consummation of the Recapitalization. Substantially all of the available equity awards under the plan were granted at or soon after the closing of the Recapitalization.

Table of Contents

Sources and Uses

The sources and uses of the funds for the Recapitalization are shown in the table below.

Sources of funds:	(Dollars in millions)	Uses of funds:	
Senior secured credit facilities(1):		Equity purchase price(7)	$ 20,284
Asset-based revolving credit facility	$ 1,535	Rollover equity(5)	1,010
Revolving credit facility		Repayment of existing indebtedness(8)	3,182
Term loan A facility	2,750	Retained existing secured indebtedness(2)	230
Term loan B facility	8,800	Retained existing unsecured indebtedness(3)	7,519
European term loan facility	1,279	Transaction costs(9)	745
Outstanding notes	5,700		
Retained existing secured indebtedness(2)	230		
Retained existing unsecured indebtedness(3)	7,519		
Equity contribution(4)(5)	3,782		
Rollover equity(5)	1,010		
HCI dividend(6)	365		
Total sources of funds	$ 32,970	Total uses of funds	$ 32,970

(1) Upon the closing of the Recapitalization, we entered into senior secured credit facilities consisting of (i) a $2,000 million asset-based revolving credit facility with a six-year maturity and a borrowing base of 85% of eligible accounts receivable with customary reserves and eligibility criteria; (ii) a $2,000 million senior secured revolving credit facility with a six-year maturity; (iii) a $2,750 million senior secured term loan A facility with a six-year maturity; (iv) an $8,800 million senior secured term loan B facility with a seven-year maturity; and (v) a $1,279 million-equivalent (as of the closing of the Recapitalization) (1.0 billion) senior secured European term loan facility with a seven-year maturity.

(2) Consisted of, as of the closing of the Recapitalization, $230 million of secured debt, which primarily represented capital leases.

(3) Consisted of, as of the closing of the Recapitalization, (i) an aggregate principal amount of $377 million medium-term notes with maturities ranging from 2007 to 2025 and a weighted average interest rate of 8.42%; (ii) an aggregate principal amount of $886 million debentures with maturities ranging from 2015 to 2095 and a weighted average interest rate of 7.55%; (iii) an aggregate principal amount of $5,993 million senior notes with maturities ranging from 2007 to 2033 and a weighted average interest rate of 6.91%; (iv) £150 million ($283 million-equivalent as of the closing of the Recapitalization) aggregate principal amount of 8.75% senior notes due 2010; and (v) $20 million of unamortized debt discounts which reduced the existing indebtedness. For more information regarding our existing indebtedness, see Description of Other Indebtedness Other Indebtedness.

(4) Represents the cash equity contributed, as of the closing of the Recapitalization, by (i) investment funds associated with or designated by the Sponsors or their respective assignees and (ii) the Frist Entities. See (5) below. On January 30, 2007, we completed an offering of 781,960 shares of our common stock to approximately 570 of our employees for an aggregate purchase price of $40 million. As a result of that offering, the delayed cash equity contributed by investment funds associated with or designated by the Sponsors on March 30, 2007 was reduced to $60 million.

(5) Includes approximately (i) $885 million contributed by the Frist Entities or their respective assignees in the form of a rollover of their existing equity interests in HCA; and (ii) $125 million invested by the

Table of Contents

Management Participants in the form of a rollover of their existing equity interests in HCA to equity interests in HCA following the Merger and through cash investments.

(6) In connection with the Recapitalization, our insurance subsidiary, HealthCare Indemnity, Inc. (HCI) declared a $365 million dividend, which was used to pay down existing indebtedness. The proceeds of this dividend represented a portion of the excess capital of HCI. For additional information about our insurance practices generally, see Business Insurance.

(7) The holders of outstanding shares of our common stock received $51.00 in cash per share in connection with the Recapitalization. This represents approximately 412.0 million shares outstanding plus net option value of approximately $283 million, which is calculated based on approximately 24.9 million options outstanding with an average exercise price of $39.74 per share, and excludes approximately $1,010 million, on a pre-tax basis, of rollover equity and participations of the Management Participants and the Frist Entities.

(8) Consisted of, as of the closing of the Recapitalization, (i) an aggregate of $3,109 million of HCA s existing indebtedness, consisting of $1,319 million in aggregate principal amount of notes redeemed pursuant to tender offers conducted in connection with the Recapitalization; $715 million borrowed under a $1,750 million five-year revolving credit facility; and $1,075 million of senior term loans; and (ii) indebtedness-related costs comprising of approximately $36 million of accrued interest, $28 million of pay floating interest rate swap agreements and $9 million of tender premiums.

(9) Fees and expenses associated with the Recapitalization, including placement and other financing fees, advisory fees, transaction fees paid to affiliates of the Sponsors, and other transaction costs and professional fees. See Certain Relationships and Related Party Transactions.

Table of Contents

The Sponsors

Bain Capital Partners

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

Kohlberg Kravis Roberts & Co.

KKR, founded in 1976, is one of the world s oldest and most experienced private equity firms specializing in management buyouts. KKR s investment approach is focused on acquiring attractive business franchises and working closely with management over the long term to design and implement value-creating strategies. KKR has offices in New York, Menlo Park, London, Paris, Hong Kong and Tokyo.

Merrill Lynch Global Private Equity

Merrill Lynch Global Private Equity is the private equity arm of Merrill Lynch & Co., Inc. MLGPE invests in leading companies across industries and takes a partnership approach with management to create long-term shareholder value. MLGPE has offices in New York, London, São Paulo, Tokyo, Sydney, Bangkok and Hong Kong.

Table of Contents

The Exchange Offers

On November 17, 2006, HCA Inc. issued in a private offering $1,000,000,000 aggregate principal amount of 9 1/8% Senior Secured Notes due 2014 (the outstanding 2014 cash pay notes), $3,200,000,000 aggregate principal amount of 9 1/4% Senior Secured Notes due 2016 (the outstanding 2016 cash pay notes and, together with the outstanding 2014 cash pay notes, the outstanding cash pay notes) and $1,500,000,000 aggregate principal amount of 9 5/8%/10 3/8% Senior Secured Toggle Notes due 2016 (the toggle notes and, together with the outstanding cash pay notes, the outstanding notes). The term exchange 2014 cash pay notes refers to the 9 1/8% Senior Secured Notes due 2014, the term exchange 2016 cash pay notes refers to the 9 1/ 4% Senior Secured Notes due 2016 and the term exchange toggle notes refers to the 9 5/8%/10 3/8% Senior Secured Toggle Notes due 2016, each as registered under the Securities Act of 1933, as amended (the Securities Act), and all of which collectively are referred to as the exchange notes. The term notes collectively refers to the outstanding notes and the exchange notes.

General

In connection with the private offering, HCA Inc. and the guarantors of the outstanding notes entered into a registration rights agreement with the initial purchasers pursuant to which they agreed, among other things, to deliver this prospectus to you and to complete the exchange offers within 360 days after the date of original issuance of the outstanding notes. You are entitled to exchange in the exchange offers your outstanding notes for exchange notes which are identical in all material respects to the outstanding notes except:

- the exchange notes have been registered under the Securities Act;
- the exchange notes are not entitled to any registration rights which are applicable to the outstanding notes under the registration rights agreement; and
- the liquidated damages provisions of the registration rights agreement are not applicable.

The Exchange Offers

HCA Inc. is offering to exchange :

- $1,000,000,000 aggregate principal amount of 9 1/8% Senior Secured Notes due 2014 which have been registered under the Securities Act for any and all of its existing 9 1/8% Senior Secured Notes due 2014;
- $3,200,000,000 aggregate principal amount of 9 1/4% Senior Secured Notes due 2016 which have been registered under the Securities Act for any and all of its existing 9 1/4% Senior Secured Notes due 2016; and
- $1,500,000,000 9 5/8%/10 3/8% aggregate principal amount of Senior Secured Toggle Notes due 2016 which have been registered under the Securities Act for any and all of its existing 9 5/8%/10 3/8% Senior Secured Toggle Notes due 2016.

You may only exchange outstanding notes in minimum denominations of $2,000 and integral multiples of $1,000 in excess of $2,000.

13

Table of Contents

Resale	Based on an interpretation by the staff of the Securities and Exchange Commission (the SEC) set forth in no-action letters issued to third parties, we believe that the exchange notes issued pursuant to the exchange offers in exchange for the outstanding notes may be offered for resale, resold and otherwise transferred by you (unless you are our affiliate within the meaning of Rule 405 under the Securities Act) without compliance with the registration and prospectus delivery provisions of the Securities Act, provided that:

- you are acquiring the exchange notes in the ordinary course of your business; and
- you have not engaged in, do not intend to engage in, and have no arrangement or understanding with any person to participate in, a distribution of the exchange notes.

If you are a broker-dealer and receive exchange notes for your own account in exchange for outstanding notes that you acquired as a result of market-making activities or other trading activities, you must acknowledge that you will deliver this prospectus in connection with any resale of the exchange notes. See Plan of Distribution.

Any holder of outstanding notes who:

- is our affiliate;
- does not acquire exchange notes in the ordinary course of its business; or
- tenders its outstanding notes in the exchange offers with the intention to participate, or for the purpose of participating, in a distribution of exchange notes

cannot rely on the position of the staff of the SEC enunciated in *Morgan Stanley & Co. Incorporated* (available June 5, 1991) and *Exxon Capital Holdings Corporation* (available May 13, 1988), as interpreted in *Shearman & Sterling* (available July 2, 1993), or similar no-action letters and, in the absence of an exemption therefrom, must comply with the registration and prospectus delivery requirements of the Securities Act in connection with any resale of the exchange notes.

Expiration Date	The exchange offers will expire at 11:59 p.m., New York City time, on October 24, 2007, unless extended by HCA Inc. HCA Inc. currently does not intend to extend the expiration date.
Withdrawal	You may withdraw the tender of your outstanding notes at any time prior to the expiration of the exchange offers. HCA Inc. will return to you any of your outstanding notes that are not accepted for any reason for exchange, without expense to you, promptly after the expiration or termination of the exchange offers.

Table of Contents

Conditions to the Exchange Offers	Each exchange offer is subject to customary conditions, which HCA Inc. may waive. See The Exchange Offers Conditions to the Exchange Offers.
Procedures for Tendering Outstanding Notes	If you wish to participate in any of the exchange offers, you must complete, sign and date the applicable accompanying letter of transmittal, or a facsimile of such letter of transmittal, according to the instructions contained in this prospectus and the letter of transmittal. You must then mail or otherwise deliver the letter of transmittal, or a facsimile of such letter of transmittal, together with your outstanding notes and any other required documents, to the exchange agent at the address set forth on the cover page of the letter of transmittal.

If you hold outstanding notes through The Depository Trust Company (DTC) and wish to participate in the exchange offers, you must comply with the Automated Tender Offer Program procedures of DTC by which you will agree to be bound by the letter of transmittal. By signing, or agreeing to be bound by, the letter of transmittal, you will represent to us that, among other things:

- you are not our affiliate within the meaning of Rule 405 under the Securities Act;
- you do not have an arrangement or understanding with any person or entity to participate in the distribution of the exchange notes;
- you are acquiring the exchange notes in the ordinary course of your business; and
- if you are a broker-dealer that will receive exchange notes for your own account in exchange for outstanding notes that were acquired as a result of market-making activities, you will deliver a prospectus, as required by law, in connection with any resale of such exchange notes.

Special Procedures for Beneficial Owners	If you are a beneficial owner of outstanding notes that are registered in the name of a broker, dealer, commercial bank, trust company or other nominee, and you wish to tender those outstanding notes in the exchange offer, you should contact the registered holder promptly and instruct the registered holder to tender those outstanding notes on your behalf. If you wish to tender on your own behalf, you must, prior to completing and executing the letter of transmittal and delivering your outstanding notes, either make appropriate arrangements to register ownership of the outstanding notes in your name or obtain a properly completed bond power from the registered holder. The transfer of registered ownership may take considerable time and may not be able to be completed prior to the expiration date.

Table of Contents

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

Table of Contents

The Exchange Notes

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

Issuer	HCA Inc.
Securities Offered	$1,000,000,000 aggregate principal amount of 9 1/8% senior secured notes due 2014. $3,200,000,000 aggregate principal amount of 9 1/4% senior secured notes due 2016. $1,500,000,000 aggregate principal amount of 9 5/8%/10 3/8% senior secured toggle notes due 2016.
Maturity Date	The exchange 2014 cash pay notes will mature on November 15, 2014. The exchange 2016 cash pay notes and the exchange toggle notes each will mature on November 15, 2016.
Interest Rate	Interest on the exchange 2014 cash pay notes will be payable in cash and will accrue at a rate of 9 1/8% per annum. Interest on the exchange 2016 cash pay notes will be payable in cash and will accrue at a rate of 9 1/4% per annum. Cash interest on the exchange toggle notes will accrue at a rate of 9 5/8% per annum, and PIK interest (as defined below) will accrue at a rate of 10 3/8% per annum. For any interest period thereafter through November 15, 2011, we may elect to pay interest on the exchange toggle notes (i) in cash, (ii) by increasing the principal amount of the exchange toggle notes or issuing new toggle notes (PIK interest) for the entire amount of the interest payment or (iii) by paying interest on half of the principal amount of the exchange toggle notes in cash interest and half in PIK interest. After November 15, 2011, all interest on the exchange toggle notes will be payable in cash. If we elect to pay PIK interest, we will increase the principal amount of the exchange toggle notes or issue new exchange toggle notes in an amount equal to the amount of PIK interest for the applicable interest payment period (rounded up to the nearest $1,000) to holders of the exchange toggle notes on the relevant record date.
Interest Payment Dates	We will pay interest on the exchange notes on May 15 and November 15. Interest began to accrue from the issue date of the notes.
Ranking	The exchange notes will be our senior secured obligations and will: rank senior in right of payment to any future subordinated indebtedness;

Table of Contents

- rank equally in right of payment with all of our existing and future senior indebtedness;
- be effectively subordinated in right of payment to indebtedness under our asset-based revolving credit facility to the extent of the collateral securing such indebtedness on a first-priority basis and to indebtedness under our other senior secured credit facilities to the extent of the collateral securing such indebtedness on a first- and second-priority basis; and
- be effectively subordinated in right of payment to all existing and future indebtedness and other liabilities of our non-guarantor subsidiaries (other than indebtedness and liabilities owed to us or one of our guarantor subsidiaries).

As of June 30, 2007, (1) the outstanding notes and related guarantees ranked effectively junior to approximately $14.451 billion of senior secured indebtedness under our senior secured credit facilities and $422 million of capital leases and other secured debt and includes approximately $168 million of obligations of our non-guarantor subsidiaries, and (2) we had an additional $1.858 billion of unutilized capacity under our senior secured revolving credit facility and $245 million of unutilized capacity under our asset-based revolving credit facility, subject to borrowing base limitations.

Guarantees

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

- rank senior in right of payment to all existing and future subordinated indebtedness of the guarantor subsidiary;
- rank equally in right of payment with all existing and future senior indebtedness of the guarantor subsidiary;
- be effectively subordinated in right of payment to indebtedness under our asset-based revolving credit facility to the extent of the collateral securing such indebtedness on a first-priority basis and to indebtedness under our other senior secured credit facilities to the extent of the collateral securing such indebtedness on a first- and second-priority basis; and
- be effectively subordinated in right of payment to all existing and future indebtedness and other liabilities of any subsidiary of a guarantor that is not also a guarantor of the notes.

Any guarantee of the exchange notes will be released in the event such guarantee is released under the senior secured credit facilities.

Table of Contents

	Our non-guarantor subsidiaries accounted for $10.564 billion, or 41.5%, of our total revenues for the year ended December 31, 2006, and $10.508 billion, or 44.3%, of our total assets, and $9.841 billion, or 28.6%, of our total liabilities, in each case as of June 30, 2007.
Security	The exchange notes and guarantees of the exchange notes will be secured by second-priority liens, subject to permitted liens, on certain of the assets of HCA Inc. and the subsidiary guarantors that secure our senior secured credit facilities on a first-priority basis, which assets include: substantially all the capital stock of any material first-tier subsidiary of HCA Inc. or of any first-tier subsidiary of any subsidiary guarantor of the notes (but limited to 65% of the voting stock of any such first-tier subsidiary that is a foreign subsidiary), subject to certain exceptions; and substantially all tangible and intangible assets of our company and each subsidiary guarantor, other than (1) properties defined as principal properties under our indenture dated as of December 16, 1993, so long as any indebtedness secured by those properties on a first-priority basis remains outstanding, (2) other properties that will not secure our senior secured facilities, (3) deposit accounts, other bank or securities accounts and cash and (4) leaseholds and motor vehicles, subject to certain exceptions. See Description of Notes Security. See Risk Factors Risks Related to the Notes There are circumstances other than repayment or discharge of the notes under which the collateral securing the notes and guarantees will be released automatically, without your consent or the consent of the trustee for an explanation of one of the important exceptions to the obligation to pledge the capital stock of first-tier subsidiaries of any subsidiary guarantors. The exchange notes and guarantees of the exchange notes also will be secured by third-priority liens, subject to permitted liens, on the accounts receivable and certain related assets of HCA Inc. and certain of the subsidiary guarantors, and the proceeds thereof, to the extent permitted by law and contract, which assets will secure our asset-based revolving credit facility on a first-priority basis and our other senior secured credit facilities on a second-priority basis.
Optional Redemption	We may redeem the exchange notes, in whole or in part, at any time prior to November 15, 2010, with respect to the exchange 2014 cash pay notes, and November 15, 2011, with respect to the exchange 2016 cash pay notes and the exchange toggle notes, at a price equal to 100% of the principal amount of the exchange notes redeemed plus accrued and unpaid interest to the redemption date and a make-whole premium, as described under Description of Notes Optional Redemption.

Table of Contents

We may redeem the exchange notes, in whole or in part, on or after November 15, 2010, with respect to the exchange 2014 cash pay notes, and November 15, 2011, with respect to the exchange 2016 cash pay notes and the exchange toggle notes, at the prices set forth under Description of Notes Optional Redemption.

Additionally, from time to time before November 15, 2009, we may choose to redeem up to 35% of the principal amount of each of the exchange cash pay notes and the exchange toggle notes at a redemption price equal to 109.125% of the face amount thereof, with respect to the exchange 2014 cash pay notes, 109.250% of the face amount thereof, with respect to the exchange 2016 cash pay notes, and 109.625% of the face amount thereof, with respect to the exchange toggle notes, in each case with the net cash proceeds that we raise in one or more equity offerings, so long as at least 50% of the aggregate principal amount of each of the exchange cash pay notes and the exchange toggle notes remains outstanding afterwards.

Mandatory Principal Redemption

If the exchange toggle notes would otherwise constitute applicable high yield discount obligations within the meaning of Section 163(i)(1) of the Internal Revenue Code of 1986, as amended (the Code), at the end of the first accrual period ending after the fifth anniversary of the outstanding toggle notes issuance (the AHYDO redemption date), we will be required to redeem for cash a portion of each exchange toggle note then outstanding equal to the Mandatory Principal Redemption Amount (such redemption, a Mandatory Principal Redemption). The redemption price for the portion of each exchange toggle note redeemed pursuant to a Mandatory Principal Redemption will be 100% of the principal amount of such portion plus any accrued interest thereon on the date of redemption. The Mandatory Principal Redemption Amount means the portion of an exchange toggle note required to be redeemed to prevent such exchange toggle note from being treated as an applicable high yield discount obligation within the meaning of Section 163(i)(1) of the Code. No partial redemption or repurchase of the exchange toggle notes prior to the AHYDO redemption date pursuant to any other provision of the indenture will alter our obligation to make the Mandatory Principal Redemption with respect to any exchange toggle notes that remain outstanding on the AHYDO redemption date.

Change of Control Offer

Upon the occurrence of a change of control, you will have the right, as holders of the exchange notes, to require us to repurchase some or all of your exchange notes at 101% of their face amount, plus accrued and unpaid interest to the repurchase date. See Description of Notes Repurchase at the Option of Holders Change of Control.

We may not be able to pay you the required price for exchange notes you present to us at the time of a change of control, because:

- we may not have enough funds at that time; or
- the terms of our indebtedness under our senior secured credit facilities may prevent us from making such payment.

Table of Contents

Your right to require us to repurchase the exchange notes upon the occurrence of a change of control will cease to apply to a series of exchange notes at all times after such exchange notes have investment grade ratings from both Moody s Investors Service, Inc. and Standard & Poor s.

Certain Covenants	The indenture governing the exchange notes contains covenants limiting our ability and the ability of our restricted subsidiaries to:

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

These covenants are subject to a number of important limitations and exceptions. See Description of Notes. Many of these covenants will cease to apply to a series of exchange notes at all times after such exchange notes have investment grade ratings from both Moody s Investors Service, Inc. and Standard & Poor s.

Original Issue Discount	We have the option to pay interest on the exchange toggle notes in cash interest or PIK interest for any interest payment period prior to November 15, 2011. For U.S. federal income tax purposes, the existence of this option means that none of the interest payments on the exchange toggle notes will be qualified stated interest even if we never exercise the option to pay PIK interest. Consequently, the exchange toggle notes will be treated as issued with original issue discount, and U.S. holders will be required to include the original issue discount in gross income for U.S. federal income tax purposes on a constant yield to maturity basis, regardless of whether interest is paid currently in cash. For more information, see Certain United States Federal Tax Consequences.
No Prior Market	The exchange notes will be freely transferable but will be new securities for which there will not initially be a market. Accordingly, we cannot assure you whether a market for the exchange notes will develop or as to the liquidity of any such market that may develop. The initial

purchasers in the private offering of the outstanding notes have informed us that they currently intend to make a market in the exchange notes; however, they are not obligated to do so, and they may discontinue any such market-making activities at any time without notice.

Table of Contents

Risk Factors

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

Table of Contents

SUMMARY HISTORICAL AND PRO FORMA FINANCIAL AND OTHER DATA

The following table sets forth our summary historical consolidated financial data and summary unaudited pro forma consolidated income statement data, at the dates and for the periods indicated. The summary historical consolidated financial data as of and for the six months ended June 30, 2006 and 2007 have been derived from our unaudited consolidated financial statements and related notes appearing elsewhere in this prospectus. The historical financial data as of December 31, 2005 and 2006 and for the fiscal years ended December 31, 2004, 2005 and 2006 have been derived from our historical consolidated financial statements included elsewhere in this prospectus, which have been audited by Ernst & Young LLP. The historical financial data as of December 31, 2004 have been derived from our consolidated financial statements audited by Ernst & Young LLP that are not included in this prospectus. The results of operations for any interim period are not necessarily indicative of the results to be expected for the full year or any future period.

The summary unaudited pro forma consolidated income statement data for the year ended December 31, 2006 have been prepared to give effect to the Recapitalization in the manner described under Unaudited Pro Forma Consolidated Income Statement and the notes thereto as if it had occurred on January 1, 2006. The pro forma adjustments are based upon available information and certain assumptions that we believe are reasonable. The summary unaudited pro forma income statement data are for informational purposes only and do not purport to represent what our results of operations actually would have been if the Recapitalization had occurred at any date, and do not purport to project the results of operations for any future period.

The summary historical and unaudited pro forma consolidated financial and other data should be read in conjunction with Unaudited Pro Forma Consolidated Income Statement, Selected Historical Consolidated Financial Information, Management s Discussion and Analysis of Financial Condition and Results of Operations and our audited consolidated financial statements and related notes appearing elsewhere in this prospectus.

Table of Contents

	Historical					Pro Forma
	Year Ended December 31,			Six Months Ended June 30,		Year Ended December 31,
	2004	2005	2006	2006	2007	2006
				(Unaudited)		(Unaudited)
	(Dollars in millions)					
Income Statement Data:						
Revenues	$ 23,502	$ 24,455	$ 25,477	$ 12,775	$ 13,406	$ 25,477
Salaries and benefits	9,419	9,928	10,409	5,216	5,301	10,409
Supplies	3,901	4,126	4,322	2,205	2,199	4,322
Other operating expenses	3,797	4,039	4,057	2,009	2,118	4,090
Provision for doubtful accounts	2,669	2,358	2,660	1,273	1,444	2,660
Gains on investments	(56)	(53)	(243)	(100)	(7)	(243)
Equity in earnings of affiliates	(194)	(221)	(197)	(108)	(105)	(197)
Depreciation and amortization	1,250	1,374	1,391	697	716	1,391
Interest expense	563	655	955	382	1,114	2,293
Gains on sales of facilities		(78)	(205)	(5)	(16)	(205)
Transaction costs			442			
Impairment of long-lived assets	12		24		24	24
	21,361	22,128	23,615	11,569	12,788	24,544
Income before minority interests and income taxes	2,141	2,327	1,862	1,206	618	933
Minority interests in earnings of consolidated entities	168	178	201	101	116	201
Income before income taxes	1,973	2,149	1,661	1,105	502	732
Provision for income taxes	727	725	625	431	206	272
Net income	$ 1,246	$ 1,424	$ 1,036	$ 674	$ 296	$ 460
Statement of Cash Flows Data:						
Cash flows provided by operating activities	$ 2,954	$ 2,971	$ 1,845	$ 732	$ 406	
Cash flows used in investing activities	(1,688)	(1,681)	(1,307)	(795)	(418)	
Cash flows provided by (used in) financing activities	(1,347)	(1,212)	(240)	463	(268)	
Other Financial Data:						
EBITDA(1)	$ 3,786	$ 4,178	$ 4,007	$ 2,184	$ 2,332	$ 4,416
Capital expenditures	1,513	1,592	1,865	820	675	
Operating Data(2):						
Number of hospitals at end of period(3)	182	175	166	176	164	
Number of freestanding outpatient surgical centers at end of period(4)	84	87	98	92	98	
Number of licensed beds at end of period(5)	41,852	41,265	39,354	41,300	39,175	
Weighted average licensed beds(6)	41,997	41,902	40,653	41,259	39,245	
Admissions(7)	1,659,200	1,647,800	1,610,100	823,900	787,000	
Equivalent admissions(8)	2,454,000	2,476,600	2,416,700	1,235,900	1,183,700	
Average length of stay (days)(9)	5.0	4.9	4.9	4.9	5.0	
Average daily census(10)	22,493	22,225	21,688	22,451	21,663	
Occupancy(11)	54%	53%	53%	54%	55%	
Emergency room visits(12)	5,219,500	5,415,200	5,213,500	2,658,100	2,553,900	
Outpatient surgeries(13)	834,800	836,600	820,900	423,600	408,400	

Inpatient surgeries(14)	541,000	541,400	533,100	269,300	261,700
Days revenues in accounts receivable(15)	48	50	53	48	51
Gross patient revenues(16)	$ 71,279	$ 78,662	$ 84,913	$ 42,438	$ 45,664
Outpatient revenues as a percentage of patient revenues(17)	37%	36%	36%	36%	36%

Table of Contents

	Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
			(Dollars in millions)	(Unaudited)	
Balance Sheet Data:					
Working capital(18)	$ 1,509	$ 1,320	$ 2,502	$ 1,874	$ 2,593
Property, plant and equipment, net	11,396	11,379	11,669	11,578	11,544
Cash and cash equivalents	258	336	634	736	354
Total assets	21,840	22,225	23,675	23,120	23,704
Total debt	10,530	10,475	28,408	11,664	28,096
Minority interests in equity of consolidated entities	809	828	907	901	891
Equity securities with contingent redemption rights			125		165
Total stockholders equity (deficit)	4,407	4,863	(11,374)	4,826	(10,905)

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

The table below presents a reconciliation of historical and pro forma EBITDA to net income and a reconciliation of historical EBITDA to cash flows from operating activities:

	Historical					Pro Forma
	Year Ended December 31,			Six Months Ended June 30,		Year Ended December 31,
	2004	2005	2006	2006	2007	2006
			(Dollars in millions)	(Unaudited)		(Unaudited)
Net income	$ 1,246	$ 1,424	$ 1,036	$ 674	$ 296	$ 460
Provision for income taxes	727	725	625	431	206	272
Interest expense	563	655	955	382	1,114	2,293
Depreciation and amortization	1,250	1,374	1,391	697	716	1,391
EBITDA	3,786	4,178	4,007	2,184	2,332	$ 4,416
Interest payments	(533)	(624)	(893)	(351)	(1,092)	
Income tax payments, net of refunds	(394)	(563)	(1,087)	(810)	(227)	
Increase (decrease) in cash from operating assets and liabilities and the provision for doubtful accounts	(1)	80	(280)	(324)	(656)	
Other	96	(100)	98	33	49	
Cash flows from operating activities	$ 2,954	$ 2,971	$ 1,845	$ 732	$ 406	

25

Table of Contents

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

(3) Excludes facilities that are not consolidated (but are accounted for using the equity method) for financial reporting purposes.

(4) Excludes facilities that are not consolidated (but are accounted for using the equity method) for financial reporting purposes.

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

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

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

(8) Equivalent admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Equivalent admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient 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.

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

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

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

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

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

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

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

(16)

Gross patient revenues are based upon our standard charge listing. Gross charges/revenues 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.

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

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

Table of Contents

RISK FACTORS

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

Risks Related to the Exchange Offers

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

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

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

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

We are offering the exchange notes to the holders of the outstanding notes. The outstanding notes were offered and sold in November 2006 to institutional investors and are eligible for trading in the PORTAL market.

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

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

Based on interpretations of the staff of the SEC contained in *Exxon Capital Holdings Corp.*, SEC no-action letter (April 13, 1988), *Morgan Stanley & Co. Inc.*, SEC no-action letter (June 5, 1991) and *Shearman & Sterling*,

Table of Contents

SEC no-action letter (July 2, 1983), we believe that you may offer for resale, resell or otherwise transfer the exchange notes without compliance with the registration and prospectus delivery requirements of the Securities Act. However, in some instances described in this prospectus under Plan of Distribution, certain holders of exchange notes will remain obligated to comply with the registration and prospectus delivery requirements of the Securities Act to transfer the exchange notes. If such a holder transfers any exchange notes without delivering a prospectus meeting the requirements of the Securities Act or without an applicable exemption from registration under the Securities Act, such a holder may incur liability under the Securities Act. We do not and will not assume, or indemnify such a holder against, this liability.

Risks Related to Our Indebtedness

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

We are highly leveraged. The following chart shows our level of indebtedness and certain other information as of June 30, 2007.

	As of June 30, 2007 (Unaudited) (Dollars in millions)
Senior secured credit facilities(1):	
Asset-based revolving credit facility	$ 1,660
Revolving credit facility	
Term loan A facility	2,694
Term loan B facility	8,756
European term loan facility	1,341
The notes	5,700
Other secured indebtedness(2)	422
Unsecured indebtedness(3)	7,523
Total indebtedness	$ 28,096

(1) Upon the closing of the Recapitalization, we entered into (i) a $2,000 million asset-based revolving credit facility with a six-year maturity, (ii) a $2,000 million senior secured revolving credit facility with a six-year maturity, (iii) a $2,750 million senior secured term loan A facility with a six-year maturity; (iv) a $8,800 million senior secured term loan B facility with a seven-year maturity; and (v) a 1.0 billion, or $1,279 million-equivalent (as of the closing of the Recapitalization) (995 million, or $1,341 million-equivalent, at June 30, 2007), senior secured European term loan facility with a seven-year maturity.

(2) Consists of capital leases and other secured debt with a weighted average interest rate of 6.80%.

(3) Consists of (i) an aggregate principal amount of $367 million medium-term notes with maturities ranging from 2010 to 2025 and a weighted average interest rate of 8.42%; (ii) an aggregate principal amount of $886 million debentures with maturities ranging from 2015 to 2095 and a weighted average interest rate of 7.55%; (iii) an aggregate principal amount of $5,987 million senior notes with maturities ranging from 2007 to 2033 and a weighted average interest rate of 6.91%; (iv) £150 million ($301 million-equivalent at June 30, 2007) aggregate principal amount of 8.75% senior notes due 2010; and (v) $18 million of unamortized debt discounts, which reduce the existing indebtedness. For more information regarding our unsecured and other indebtedness, see Description of Other Indebtedness Other Indebtedness.

We also had an additional $245 million available for borrowing under our asset-based revolving credit facility at June 30, 2007, subject to borrowing base limitations, and $1.858 billion available for borrowing under our senior secured revolving credit facility at that date after considering outstanding letters of credit of approximately $142 million.

28

Table of Contents

Our high degree of leverage could have important consequences for you, including:

- making it more difficult for us to make payments on the notes;
- increasing our vulnerability to general economic and industry conditions;
- 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 borrowings, including the unhedged portion of our borrowings under our senior secured credit facilities, are at variable rates of interest;
- limiting our ability to make strategic acquisitions or causing us to make non-strategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, product 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 may be able to incur substantial additional indebtedness in the future, subject to the restrictions contained in our senior secured credit facilities and the indenture governing the notes. If new indebtedness is added to our current debt levels, the related risks that we now face could intensify.

Our pro forma cash interest expense for the year ended December 31, 2006 would have been $2.213 billion. At June 30, 2007, we had $14.451 billion of debt under our senior secured credit facilities, all of which are based on a floating rate index, offset by fixed-pay interest rate swap agreements that apply to $8.000 billion of this amount. A 1% increase in these floating rates would increase annual interest expense by approximately $65 million.

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

Our senior secured credit facilities and the indenture governing the notes contain various covenants that limit our ability to engage in specified types of transactions. These covenants limit our and our restricted 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) availability is less than a specified percentage of the borrowing base 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.

Table of Contents

In addition, under our senior secured credit facilities we are required to satisfy and maintain specified financial ratios and other financial condition tests. Our ability to meet those financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will meet those ratios and tests. A breach of any of these covenants could result in a default under each of our senior secured credit facilities. Upon the occurrence of an event of default under our senior secured credit facilities, our lenders could elect to declare all amounts outstanding under our senior secured credit facilities to be immediately due and payable and terminate all commitments to extend further credit. If we were unable to repay those amounts, the lenders under our senior secured credit facilities could proceed against the collateral granted to them to secure each such indebtedness. We have pledged a significant portion of our assets as collateral under our senior secured credit facilities and our existing senior notes. If any of the lenders under our senior secured credit facilities accelerate the repayment of borrowings, we cannot assure you that we will have sufficient assets to repay our senior secured credit facilities and the notes.

Risks Related to Our Business

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

The health care business is highly competitive, and competition among hospitals and other health care providers for patients has intensified in recent years. Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. In 2005, CMS began making public performance data related to ten quality measures that hospitals submit in connection with their Medicare reimbursement. On February 8, 2006, the federal Deficit Reduction Act of 2005 (DRA 2005) was enacted by Congress to expand and provide for the future expansion of the number of quality measures that must be reported. CMS has expanded the number of quality measures as required by DRA 2005, and we expect that CMS will continue to expand the number of quality measures in the future, including adding measures relating to outpatient care. Additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures, 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 hospitals that compete with our hospitals are owned by governmental agencies or not-for-profit corporations supported by endowments, charitable contributions and/or tax revenues and can finance capital expenditures and operations on a tax-exempt basis. Our hospitals are facing increasing competition from physician-owned specialty hospitals and from both our own and unaffiliated freestanding surgery centers for market share in high margin services and for quality physicians and personnel. Also, we anticipate that the number of physician-owned specialty hospitals may increase as HHS has ended a moratorium on the enrollment of such hospitals in Medicare. 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. Further, if our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than our hospitals and ambulatory surgery centers, we may experience an overall decline in patient volume. See Business Competition.

The growth of uninsured and patient due accounts and a deterioration in the collectability 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.

Table of Contents

The amount of the provision for doubtful accounts is based upon management s assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal and state governmental and private employer health care coverage, the rate of growth in uninsured patient admissions and other collection indicators. At June 30, 2007, our allowance for doubtful accounts represented approximately 87% of the $4.244 billion patient due accounts receivable balance, including accounts, net of estimated contractual discounts, related to patients for which eligibility for Medicaid coverage was being evaluated (pending Medicaid accounts). For the year ended December 31, 2006, the provision for doubtful accounts increased to 10.4% of revenues compared to 9.6% of revenues in 2005. Adjusting for the effect of the uninsured discount policy implemented January 1, 2005, the provision for doubtful accounts was 14.1% and 12.4% of revenues for the years ended December 31, 2006 and 2005, respectively.

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 collectability of these accounts will adversely affect our collection of accounts receivable, cash flows and results of operations.

Changes in governmental interpretations may negatively impact our ability to obtain reimbursement of Medicare bad debts.

The Medicare program will reimburse 70% of bad debts related to deductibles and coinsurance for patients with Medicare coverage, after the provider has made a reasonable effort to collect these amounts. On March 30, 2006, the United States District Court for the Western District of Michigan entered a final order in *Battle Creek Health System v. Thompson*, which provided that reasonable collection efforts have not been satisfied as long as the Medicare accounts remained with an external collection agency. The case was appealed to the United States Court of Appeals for the Sixth Circuit. A decision adverse to Battle Creek was issued on August 14, 2007. We utilize extensive in-house and external collection efforts for our accounts receivable, including deductible and coinsurance amounts owed by patients with Medicare coverage. However, we utilize a secondary collection agency after in-house and primary collection agency efforts have been unsuccessful. We are currently modifying our accounts receivable collection processes to provide us with reasonable collection results and comply with CMS s interpretation of reasonable collection efforts. Possible future changes in judicial and administrative interpretations of laws and regulations governing Medicare could disrupt our collections processes, increase our costs or otherwise adversely affect our business and results of operations.

Changes in governmental programs may reduce our revenues or profitability.

A significant portion of our patient volumes is derived from government health care programs, principally Medicare and Medicaid, which are highly regulated and subject to frequent and substantial changes. We derived approximately 58% of our admissions from the Medicare and Medicaid programs in 2006. In recent years, legislative and regulatory changes have resulted in limitations on and, in some cases, reductions in levels of payments to health care providers for certain services under these government programs. Possible future changes in the Medicare, Medicaid, and other state programs, including Medicaid supplemental payments pursuant to upper payment limit (UPL) programs, may impact reimbursements to health care providers and insurers. Such changes may also increase our operating costs, which could reduce our profitability.

Effective January 1, 2007, as a result of DRA 2005, reimbursements for ASC overhead costs are limited to no more than the overhead costs paid to hospital outpatient departments under the Medicare hospital outpatient prospective payment system for the same procedure. On August 2, 2007, CMS issued final regulations that change payment for procedures performed in an ASC, effective January 1, 2008. Under this rule, ASC payment groups will increase from the current nine clinically disparate payment groups to the 221 Ambulatory Procedure Classification groups (APCs) used under the outpatient prospective payment system for these surgical services. CMS estimates that the rates for procedures performed in an ASC setting will equal 65% of the corresponding rates paid for the same procedures performed in an outpatient hospital setting. Moreover, if CMS determines that

Table of Contents

a procedure is commonly performed in a physician s office, the ASC reimbursement for that procedure will be limited to the reimbursement allowable under the Medicare Part B Physician Fee Schedule. In addition, all surgical procedures, other than those that pose a significant safety risk or generally require an overnight stay, will be payable as ASC procedures. This will expand the number of procedures that Medicare will pay for if performed in an ASC. Because the new payment system will have a significant impact on payments for certain procedures, the final rule establishes a four-year transition period for implementing the revised payment rates. More Medicare procedures that are now performed in hospitals, such as ours, may be moved to ASCs, reducing surgical volume in our hospitals. Also, more Medicare procedures that are now performed in ASCs, such as ours, may be moved to physicians offices. Commercial third-party payers may adopt similar policies.

On August 1, 2007, CMS announced a final rule for federal fiscal year 2008 for the hospital inpatient prospective payment system. This rule adopts a two-year implementation of Medicare Severity Diagnosis-Related Groups (MS-DRGs), a severity-adjusted diagnosis-related group system. This change represents a refinement to the existing diagnosis-related group (DRG) system, making its impact on revenue difficult to predict. Realignments in the DRG system could impact the margins we receive for certain services. This rule provides for a 3.3% market basket update for hospitals that submit certain quality patient care indicators and a 1.3% update for hospitals that do not submit this data. While we will endeavor to comply with all data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals. Medicare payments to hospitals in federal fiscal year 2008 will be reduced by 1.2% to eliminate what CMS estimates will be the effect of coding or classification changes as a result of hospitals implementing the MS-DRG system. CMS estimates that this so-called documentation and coding adjustment will increase to 1.8% for both federal fiscal years 2009 and 2010. Additionally, Medicare payments to hospitals are subject to a number of other adjustments, and the actual impact on payments to specific hospitals may vary. In some cases, commercial third-party payers rely on all or portions of the Medicare DRG system to determine payment rates. The change from traditional Medicare DRGs to MS-DRGs could adversely impact those rates if commercial third-party payers adopt MS-DRGs.

Hospital operating margins have been, and may continue to be, under pressure because of deterioration in pricing flexibility and payer mix, and growth in operating expenses in excess of the increase in prospective payment system payments under the Medicare program.

Since most states must operate with balanced budgets and since the Medicaid program is often among the state s largest programs, states can be expected to adopt or consider adopting legislation designed to reduce their Medicaid expenditures. DRA 2005 includes Medicaid cuts of approximately $4.8 billion over five years. On May 29, 2007, CMS published a final rule entitled Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership. A moratorium was placed on this rule, delaying its implementation until 2008. However, when the moratorium expires next year, this final rule could significantly impact state Medicaid programs. In its proposed form, this rule was expected to reduce federal Medicaid funding by $12.2 billion over five years. As a result of the moratorium on implementing the final rule, the impact of the final rule has not been quantified. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems. Future legislation or other changes in the administration or interpretation of government health programs could have a material, adverse effect on our financial position and results of operations.

Demands of nongovernment payers may adversely affect our growth in revenues.

Our ability to negotiate favorable contracts with nongovernment payers, including managed care plans, significantly affects the revenues and operating results of most of our hospitals. Admissions derived from managed care and other insurers accounted for approximately 36% of our admissions in 2006. Nongovernment payers, including managed care payers, increasingly are demanding discounted fee structures, and the trend toward consolidation among nongovernment payers tends to increase their bargaining power over fee structures. Reductions in price increases or the amounts received from managed care, commercial insurance or other payers could have a material adverse effect on our financial position and results of operations.

Table of Contents

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

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

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

Our operations are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians, as well as our physicians. We compete with other health care providers in recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our hospitals, including nurses and other nonphysician health care professionals. In some markets, the availability of nurses and other medical support personnel has become a significant operating issue to health care providers. This shortage may require us to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. In addition, to the extent that a significant portion of our employee base unionizes, or attempts to unionize, our labor costs could increase. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control labor costs, could have a material adverse effect on our results of operations.

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

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

- billing for services;
- relationships with physicians and other referral sources;
- adequacy of medical care;
- quality of medical equipment and services;
- qualifications of medical and support personnel;
- confidentiality, maintenance and security issues associated with health-related information and medical records;
- the screening, stabilization and transfer of individuals who have emergency medical conditions;

licensure;

hospital rate or budget review;

operating policies and procedures; and

addition of facilities and services.

Table of Contents

Among these laws are the Anti-kickback Statute, the Stark Law and the False Claims Act and similar state laws. These laws impact the relationships that we may have with physicians and other referral sources. We have a variety of financial relationships with physicians and others who either refer or influence the referral of patients to our hospitals and other health care facilities, including employment contracts, leases and professional service agreements. We also have similar relationships with physicians and facilities to which patients are referred from our facilities from time to time. We also provide financial incentives, including minimum revenue guarantees, to recruit physicians into the communities served by our hospitals. The Office of Inspector General at HHS (OIG) has enacted safe harbor regulations that outline practices that are deemed protected from prosecution under the Anti-kickback Statute. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements, including joint ventures and financial relationships with physicians and other referral sources and persons and entities to which we refer patients, do not qualify for safe harbor protection. Failure to qualify for a safe harbor does not mean that the arrangement necessarily violates the Anti-kickback Statute but may subject the arrangement to greater scrutiny; however, we cannot assure you that practices that are outside of a safe harbor will not be found to violate the Anti-kickback Statute. Allegations of violations of the Anti-kickback Statute may also be brought under the federal Civil Monetary Penalty Law, which requires a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute.

Our financial relationships with referring physicians and their immediate family members must comply with the Stark Law by meeting an exception. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot assure you 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 False Claims Act, either under a suit brought by the government or by a private person under a *qui tam*, or whistleblower, suit.

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

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

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

Commencing in 1997, we became aware that we were the subject of governmental investigations and litigation relating to our business practices. The investigations were concluded through a series of agreements executed in 2000 and 2003. In January 2001, we entered into an eight-year Corporate Integrity Agreement (CIA) with the OIG. Under the CIA, we have numerous affirmative obligations, including the requirement that we report potential violations of applicable federal health care laws and regulations and have, pursuant to this obligation, reported a number of potential violations of the Stark Law, the Anti-kickback Statute, the Emergency

Table of Contents

Medical Treatment and Active Labor Act (EMTALA) and other laws, most of which we consider to be nonviolations or technical violations. The government could determine that our reporting and/or our resolution of reported issues have been inadequate. If we are found to be in violation of the CIA or any applicable health care laws or regulations, we could be subject to repayment requirements, substantial monetary fines, civil penalties, exclusion from participation in the Medicare and Medicaid and other federal and state health care programs, and, for violations of certain laws and regulations, criminal penalties. Any such sanctions or expenses could have a material adverse effect on our financial position, results of operations or liquidity.

In 2005, we and certain of our executive officers and directors were named in various federal securities law class actions and several shareholders have filed derivative lawsuits purportedly on behalf of the Company. Additionally, a former employee filed a complaint against certain of our executive officers pursuant to the Employee Retirement Income Security Act, and we have been served with a shareholder demand letter addressed to our Board of Directors. We have reached an agreement in principle for the settlement of the derivative lawsuits, subject to court approval. We have also reached an agreement with the lead plaintiffs in the federal securities law class actions for the settlement of those actions, subject to approval of the court and the putative class members.

On July 24, 2006, we announced that we had entered into the Merger Agreement. In connection with the Merger, we are aware of eight asserted class action lawsuits related to the Merger filed against us, certain of our executive officers, our directors and the Sponsors, and one lawsuit filed against us and one of our affiliates seeking enforcement of contractual obligations allegedly arising from the Merger. Certain of these lawsuits, though not all, are the subject of an agreement in principle to settle, which is subject to court approval. We believe the settlements, once approved, will have the effect of resolving the remaining suits. These proceedings are described in greater detail under Business Legal Proceedings.

Health care companies are subject to numerous investigations by various governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring *qui tam*, or whistleblower, suits against companies that submit false claims for payments to the government. Some states have adopted similar state whistleblower and false claims provisions. From time to time, companies doing business under federal health care programs may be contacted by various governmental agencies in connection with a government investigation either brought by the government or by a private person under a qui tam action. Because of the confidential nature of some government investigations or a confidential seal under the federal False Claims Act, we do not always know the particulars of the allegations or concerns at the time the government notifies us that an investigation is proceeding. Certain of our individual facilities have received, and other facilities from time to time may receive, government inquiries from federal and state agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on our financial position, results of operations and liquidity.

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

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare, Managed Medicare and 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

Table of Contents

review and by payer pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material adverse effect on our business, financial position and results of operations.

Our 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 revenue. Even though we have implemented network security measures, our servers are vulnerable to computer viruses, break-ins and similar disruptions from unauthorized tampering. The occurrence of any of these events could result in interruptions, delays, the loss or corruption of data, or cessations in the availability of systems, all of which could have a material adverse effect on our financial position and results of operations and harm our business reputation.

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

- accounting and financial reporting;
- billing and collecting accounts;
- coding and compliance;
- clinical systems;
- medical records and document storage;
- inventory management; and
- negotiating, pricing and administering managed care contracts and supply contracts.

State efforts to regulate the construction or expansion of hospitals 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 certificate of need, 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 hospitals in a number of states with certificate of need laws. The failure to obtain any requested certificate of need could impair our ability to operate or expand operations. Any such failure could, in turn, adversely affect our ability to attract patients to our hospitals 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 changes in those states.

We operated 172 hospitals at June 30, 2007, and 73 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities combined revenues represented approximately 51% of our consolidated revenues for the year ended December 31, 2006. This concentration makes us particularly sensitive to regulatory, economic, environmental and competition 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.

Table of Contents

In addition, our hospitals in Florida and Texas and other areas across the Gulf Coast are located in hurricane-prone areas. In the recent past, hurricanes have had a disruptive effect on the operations of our hospitals in Florida, Texas and other coastal states, and the patient populations in those states. Our business activities could be harmed by a particularly active hurricane season or even a single storm. In addition, the premiums to renew our property insurance policy for 2006 and 2007 increased significantly over premiums incurred in 2005. We were not able to obtain coverage in the amounts we have had under our policies prior to 2006. As a result of such increases in premiums, we expect that our cash flows and profitability will be adversely affected. In addition, the property insurance we obtain may not be adequate to cover losses from future hurricanes or other natural disasters.

We may be subject to liabilities from claims by the IRS.

We are currently contesting before the Appeals Division of the Internal Revenue Service (the IRS) certain claimed deficiencies and adjustments proposed in connection with the IRS examination of the 2001 and 2002 federal income tax returns for HCA and certain affiliates that are treated as partnerships for federal income tax purposes (affiliated partnerships). During 2006, the IRS began an examination of the 2003 and 2004 federal income tax returns for HCA and 19 affiliated partnerships. The disputed items pending before the IRS Appeals Division or proposed by the IRS Examination Division through September 14, 2007 include the deductibility of a portion of the 2001 and 2003 government settlement payments, the timing of recognition of certain patient service revenues in 2001 through 2004, the method for calculating the tax allowance for doubtful accounts in 2002 through 2004, and the amount of insurance expense deducted in 2001 and 2002. See Management s Discussion and Analysis of Financial Condition and Results of Operations Pending IRS Disputes.

Through September 14, 2007, the IRS is seeking an additional $1.4 billion ($655 million at June 30, 2007) in federal income taxes, interest and penalties with respect to these issues. These amounts are net of a refundable deposit of $215 million that we made in 2006. The additional adjustments by the IRS subsequent to June 30, 2007 relate primarily to our method for calculating the tax allowance for doubtful accounts in 2003 and 2004. The IRS has not determined the final amount of additional income tax, interest and penalties that it may claim upon completion of the 2003 and 2004 examinations. We expect the IRS will complete its examination of the 2003 and 2004 federal income tax returns and begin an examination of our 2005 and 2006 federal income tax returns within the next twelve months.

We believe that HCA and the affiliated partnerships properly reported taxable income in accordance with applicable laws and agreements established with the IRS and that adequate provisions have been recorded to satisfy final resolution of the disputed issues. However, if payments due upon final resolution of these issues exceed our recorded estimates, our results of operations and financial position could be adversely affected.

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

We are subject to litigation relating to our business practices, including claims and legal actions by patients and others in the ordinary course of business alleging malpractice, product liability or other legal theories. See Business Legal Proceedings. Some of these actions involve large claims and significant defense costs. We self-insure a substantial portion of our professional liability risks. Management believes our self-insured reserves and insurance coverage are sufficient to cover claims arising out of the operation of our facilities. If payments for claims exceed actuarially determined estimates, are not covered by insurance or reinsurers fail to meet their obligations, our results of operations and financial position could be adversely affected.

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.

Table of Contents

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

We are exposed to market risk related to changes in market values of securities. The investments in debt and equity securities of our wholly-owned insurance subsidiary were $1.897 billion and $46 million, respectively, at June 30, 2007. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At June 30, 2007, we had a net unrealized gain of $4 million on the insurance subsidiary s investment securities. The fair value of investments is generally based on quoted market prices. If the insurance subsidiary were to experience significant declines in the fair value of its investments, this could require additional investment by us to allow the insurance subsidiary to satisfy its minimum capital requirements.

We are also exposed to market risk related to changes in interest rates and periodically enter into interest rate swap agreements to manage our exposure to these fluctuations. Our interest rate swap agreements involve the exchange of fixed and variable rate interest payments between two parties, based on common notional principal amounts and maturity dates. The net interest payments based on the notional amounts in these agreements generally match the timing of the cash flows of the related liabilities. The notional amounts of the swap agreements represent balances used to calculate the exchange of cash flows and are not assets or liabilities of HCA. Any market risk or opportunity associated with these swap agreements is offset by the opposite market impact on the related debt. See Management s Discussion and Analysis of Financial Condition and Results of Operations Quantitative and Qualitative Disclosures About Market Risk.

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

The Investors indirectly own approximately 97.5% of our outstanding shares of capital stock following the Recapitalization. As a result, the Investors have control over our decisions to enter into any corporate transaction and have the ability to prevent any transaction that requires the approval of shareholders regardless of whether noteholders believe that any such transactions are in their own best interests. For example, the Investors could cause us to make acquisitions that increase the amount of our indebtedness or sell assets, either of which may impair our ability to make payments under the notes.

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

Risks Related to the Notes

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

We may not be able to generate sufficient cash to service all of our indebtedness, including the notes, and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

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

Table of Contents

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital or restructure or refinance our indebtedness, including the notes. 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 to obtain the proceeds that we could realize from them, and these proceeds may not be adequate to meet any debt service obligations then due. Additionally, our senior secured credit facilities and the indenture governing the notes limit the use of the proceeds from any disposition; as a result, we may not be allowed, under these documents, to use proceeds from such dispositions to satisfy all current debt service obligations.

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

Certain of our senior secured credit facilities are collateralized by a first-priority lien, subject to permitted liens, in, among other things, the capital stock of our company, the capital stock of any material wholly owned first-tier subsidiary of our company or of any U.S. subsidiary guarantor and substantially all of our and the U.S. subsidiary guarantors other tangible and intangible assets, subject to exceptions. In addition, our asset-based revolving credit facility has a first-priority lien in the accounts receivable of our company and certain of our subsidiaries, and our other senior secured credit facilities, other than the European term loan facility, have a second-priority lien in those receivables. The indenture also permits us to incur additional indebtedness secured on a first-priority basis by such assets in the future. The first- and second-priority liens in the collateral securing indebtedness under our senior secured credit facilities, as the case may be, and any such future indebtedness are higher in priority as to such collateral than the security interests securing the notes and the guarantees. The notes and the related guarantees are secured, subject to permitted liens, by a second-priority lien or a third-priority lien, as the case may be, in the assets that secure our senior secured credit facilities on a first-priority or second-priority basis, as the case may be. Holders of the indebtedness under our senior secured credit facilities and any other indebtedness collateralized by a higher-priority lien in such collateral are entitled to receive proceeds from the realization of value of such collateral to repay such indebtedness in full before the holders of the notes are entitled to any recovery from such collateral. As a result, holders of the notes are only entitled to receive proceeds from the realization of value of assets securing our senior secured credit facilities on a higher-priority basis after all indebtedness and other obligations under our senior secured credit facilities and any other obligations secured by higher-priority liens on such assets are repaid in full. The notes are effectively junior in right of payment to indebtedness under our senior secured credit facilities and any other indebtedness collateralized by a higher-priority lien in our assets, to the extent of the realizable value of such collateral. In addition, the indenture permits us to incur additional indebtedness secured by a lien that ranks equally with the notes. Any such indebtedness may further limit the recovery from the realization of the value of such collateral available to satisfy holders of the notes.

As of June 30, 2007, we had $20.151 billion of senior secured indebtedness. We also had an additional $1.858 billion available for borrowing under our senior secured revolving credit facility after considering the outstanding letters of credit of approximately $142 million and $245 million available for borrowing under our asset-based revolving credit facility, subject to borrowing base limitations, at that date.

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

The notes are not guaranteed by any of our non-U.S. subsidiaries, our less than wholly-owned U.S. subsidiaries or certain other U.S. subsidiaries. Accordingly, claims of holders of the notes are structurally subordinate to the claims of creditors of these non-guarantor subsidiaries, including trade creditors. All obligations of our non-guarantor subsidiaries will have to be satisfied before any of the assets of such subsidiaries would be available for distribution, upon a liquidation or otherwise, to us or a guarantor of the notes.

Table of Contents

Our non-guarantor subsidiaries accounted for $10.564 billion, or 41.5%, of our total revenues for the year ended December 31, 2006. Our non-guarantor subsidiaries accounted for $10.508 billion, or 44.3%, of our total assets, and $9.841 billion, or 28.6%, of our total liabilities, in each case as of June 30, 2007.

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

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

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

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

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

The collateral that secures the notes and guarantees on a lower-priority basis is also subject to any and all exceptions, defects, encumbrances, liens and other imperfections as were or may in the future be accepted by the lenders under our senior secured credit facilities and other creditors that have the benefit of higher-priority liens

Table of Contents

on such collateral from time to time. The existence of any such exceptions, defects, encumbrances, liens and other imperfections could adversely affect the value of the collateral securing the notes as well as the ability of the collateral agent to realize or foreclose on such collateral.

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

No appraisal of the value of the collateral has been made in connection with the exchange offer, nor was such an appraisal made in connection with the issuance of the outstanding notes, and the fair market value of the collateral is subject to fluctuations based on factors that include, among others, general economic conditions and similar factors. The amount to be received upon a sale of the collateral would be dependent on numerous factors, including, but not limited to, the actual fair market value of the collateral at such time, the timing and the manner of the sale and the availability of buyers. By its nature, portions of the collateral may be illiquid and may have no readily ascertainable market value. In the event of a foreclosure, liquidation, bankruptcy or similar proceeding, the collateral may not be sold in a timely or orderly manner and the proceeds from any sale or liquidation of this collateral may not be sufficient to pay our obligations under the notes.

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

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

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

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

In addition, we will not be required to comply with all or any portion of Section 314(d) of the Trust Indenture Act of 1939 (the Trust Indenture Act) if we determine, in good faith based on advice of counsel, that, under the terms of that Section and/or any interpretation or guidance as to the meaning thereof of the SEC and its staff, including no action letters or exemptive orders, all or such portion of Section 314(d) of the Trust Indenture Act is inapplicable to the released collateral. For example, so long as no default or event of default under the indenture would result therefrom and such transaction would not violate the Trust Indenture Act, we may, among other things, without any release or consent by the indenture trustee, conduct ordinary course activities with respect to collateral, such as selling, factoring, abandoning or otherwise disposing of collateral and making ordinary course cash payments (including repayments of indebtedness). See Description of Notes.

Table of Contents

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

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

- a sale, transfer or other disposal of such collateral in a transaction not prohibited under the indenture;
- with respect to collateral held by a guarantor, upon the release of such guarantor from its guarantee;
- with respect to collateral that is capital stock, upon the dissolution of the issuer of such capital stock in accordance with the indenture; and
- with respect to any collateral in which the notes have a second-priority or third-priority lien, upon any release by the lenders under our senior secured credit facilities of their first-priority or second-priority security interest in such collateral unless such release occurs in connection with a discharge in full in cash of first lien obligations, which discharge is not in connection with a foreclosure of, or other exercise of remedies with respect to, non-receivables collateral by the first lien secured parties (such discharge not in connection with any such foreclosure or exercise of remedies, a Payment Discharge); *provided* that, in the case of a Payment Discharge, the lien on any non-receivables collateral disposed of in satisfaction in whole or in part of first lien obligations shall be automatically released but any proceeds thereof not used for purposes of the discharge of first lien obligations in full in cash or otherwise in accordance with the indenture governing the notes shall be subject to lien in favor of the collateral agent for the noteholders.

In addition, the guarantee of a subsidiary guarantor will be automatically released in connection with a sale of such subsidiary guarantor in a transaction not prohibited by the indenture, or in the event the lenders under the senior credit facilities release such guarantor from its obligations under such facilities.

The indenture permits us to designate one or more of our restricted subsidiaries that is a guarantor of the notes as an unrestricted subsidiary. If we designate a subsidiary guarantor as an unrestricted subsidiary for purposes of the indenture governing the notes, all of the liens on any collateral owned by such subsidiary or any of its subsidiaries and any guarantees of the notes by such subsidiary or any of its subsidiaries will be released under the indenture but not necessarily under our senior secured credit facilities. Designation of an unrestricted subsidiary will reduce the aggregate value of the collateral securing the notes to the extent that liens on the assets of the unrestricted subsidiary and its subsidiaries are released. In addition, the creditors of the unrestricted subsidiary and its subsidiaries will have a senior claim on the assets of such unrestricted subsidiary and its subsidiaries. See Description of Notes.

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

The indenture permits liens in favor of third parties to secure additional debt, including purchase money indebtedness and capital lease obligations, and any assets subject to such liens are automatically excluded from the collateral securing the notes and the guarantees. Our ability to incur purchase money indebtedness and capital lease obligations is subject to the limitations as described in Description of Notes. In addition, certain categories of assets are excluded from the collateral securing the notes and the guarantees. Excluded assets include certain principal properties as defined under our indenture dated December 16, 1993 (our wholly-owned acute care hospitals providing general medical and surgical services), the assets of our non-guarantor subsidiaries and equity investees, certain capital stock and other securities of our subsidiaries and equity investees and the proceeds from any of the foregoing. See Description of Notes. If an event of default occurs and the notes are accelerated, the notes and the guarantees will rank equally with the holders of other unsubordinated and unsecured indebtedness of the relevant entity with respect to such excluded property.

Table of Contents

Our non-guarantor subsidiaries accounted for $10.508 billion, or 44.3%, of our total assets as of June 30, 2007.

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

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

As a result, holders of the notes could lose a portion or all of their security interest in the capital stock or other securities of those subsidiaries during such period. It may be more difficult, costly and time-consuming for holders of the notes to foreclose on the assets of a subsidiary than to foreclose on its capital stock or other securities, so the proceeds realized upon any such foreclosure could be significantly less than those that would have been received upon any sale of the capital stock or other securities of such subsidiary. See Description of Notes Security.

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

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

The collateral is subject to casualty risks.

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

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

Upon the occurrence of specific kinds of change of control events, we will be required to offer to repurchase all outstanding notes at 101% of their principal amount plus accrued and unpaid interest. The source of funds for any such purchase of the notes will be our available cash or cash generated from our subsidiaries operations or other sources, including borrowings, sales of assets or sales of equity. We may not be able to repurchase the

Table of Contents

notes upon a change of control because we may not have sufficient financial resources to purchase all of the notes that are tendered upon a change of control. Further, we will be contractually restricted under the terms of our senior secured credit facilities from repurchasing all of the notes tendered by holders upon a change of control. Accordingly, we may not be able to satisfy our obligations to purchase the notes unless we are able to refinance or obtain waivers under the instruments governing that indebtedness. Our failure to repurchase the notes upon a change of control would cause a default under the indenture and a cross-default under the instruments governing our senior secured credit facilities. The instruments governing our senior secured credit facilities also provide that a change of control will be a default that permits lenders to accelerate the maturity of borrowings thereunder. Any of our future debt agreements may contain similar provisions.

The lenders under our senior secured credit facilities have the discretion to release the guarantors under the instruments governing that indebtedness in a variety of circumstances, which cause those guarantors to be released from their guarantees of the notes.

While any obligations under our senior secured credit facilities remain outstanding, any guarantee of the notes may be released without action by, or consent of, any holder of the notes or the trustee under the indenture governing the notes, at the discretion of lenders under our senior secured credit facilities, if the related guarantor is no longer a guarantor of obligations under that indebtedness or any other indebtedness. See Description of Notes. The lenders under our senior secured credit facilities have the discretion to release the guarantees under the senior secured credit facilities in a variety of circumstances. You will not have a claim as a creditor against any subsidiary that is no longer a guarantor of the notes, and the indebtedness and other liabilities, including trade payables, whether secured or unsecured, of those subsidiaries will effectively be senior to claims of noteholders.

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

The ability of holders of the notes to realize upon the collateral will be subject to certain bankruptcy law limitations in the event of our bankruptcy. Under applicable U.S. federal bankruptcy laws, secured creditors are prohibited from repossessing their security from a debtor in a bankruptcy case without bankruptcy court approval and may be prohibited from disposing of security repossessed from such a debtor without bankruptcy court approval. Moreover, applicable federal bankruptcy laws generally permit the debtor to continue to retain collateral, including cash collateral, even though the debtor is in default under the applicable debt instruments, provided that the secured creditor is given adequate protection.

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

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

Table of Contents

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

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

- we or any of the guarantors, as applicable, were insolvent or rendered insolvent by reason of the issuance of the notes or the incurrence of the guarantees;
- the issuance of the notes or the incurrence of the guarantees left us or any of the guarantors, as applicable, with an unreasonably small amount of capital to carry on the business;
- we or any of the guarantors intended to, or believed that we or such guarantor would, incur debts beyond our or such guarantor s ability to pay as they mature; or
- we or any of the guarantors was a defendant in an action for money damages, or had a judgment for money damages docketed against us or such guarantor if, in either case, after final judgment, the judgment is unsatisfied.

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

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

We cannot be certain as to the standards a court would use to determine whether or not we or the guarantors were solvent at the relevant time or, regardless of the standard that a court uses, that the issuance of the guarantees would not be further subordinated to our or any of our guarantors other debt. Generally, however, an entity would be considered insolvent if, at the time it incurred indebtedness:

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

You will be required to pay U.S. federal income tax on the toggle notes even if we do not pay cash interest.

None of the interest payments on the toggle notes will be qualified stated interest for U.S. federal income tax purposes, even if we never exercise the option to pay PIK interest, because the toggle notes provide us with the option to pay cash interest or PIK interest for any interest payment period after the initial interest payment and prior to November 15, 2011. Consequently, the toggle notes will be treated as issued with original issue discount for U.S. federal income tax purposes, and U.S. holders will be required to include the original issue discount in gross income on a constant yield to maturity basis, regardless of whether interest is paid currently in cash. See Certain United States Federal Tax Consequences.

Table of Contents

FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements within the meaning of the federal securities laws, which involve risks and uncertainties. You can identify forward-looking statements because they contain words such as believes, expects, may, will, should, seeks, approxima intends, plans, estimates, projects or anticipates or similar expressions that concern our strategy, plans or intentions. All statements we make relating to estimated and projected earnings, margins, costs, expenditures, cash flows, growth rates and financial results are forward-looking statements. In addition, we, through our management, from time to time make forward-looking public statements concerning our expected future operations and performance and other developments. All of these forward-looking statements are subject to risks and uncertainties that may change at any time, and, therefore, our actual results may differ materially from those we expected. We derive most of our forward-looking statements from our operating budgets and forecasts, which are based upon many detailed assumptions. While we believe that our assumptions are reasonable, we caution that it is very difficult to predict the impact of known factors, and, of course, it is impossible for us to anticipate all factors that could affect our actual results.

Some of the important factors that could cause actual results to differ materially from our expectations are disclosed under Risk Factors and elsewhere in this prospectus, including, without limitation, in conjunction with the forward-looking statements included in this prospectus. All subsequent written and oral forward-looking statements attributable to us, or persons acting on our behalf, are expressly qualified in their entirety by these cautionary statements.

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

Table of Contents

THE MERGER

On July 24, 2006, HCA entered into the Merger Agreement with Hercules Holding and Hercules Acquisition, pursuant to which the parties agreed to the Merger, subject to the terms and conditions therein. The investment funds associated with the Sponsors and their respective affiliates and/or assignees, along with the Frist Entities and their respective assignees, are collectively referred to herein as the Investors.

At the effective time of the Merger on November 17, 2006, each share of HCA common stock outstanding immediately prior to the Merger (other than shares held by HCA as treasury stock or otherwise owned by Hercules Holding immediately prior to the effective time of the Merger, shares held by subsidiaries of Hercules Holding or HCA, or shares held by holders who properly demanded and perfected their appraisal rights) was cancelled, ceased to exist and was converted into the right to receive $51.00 in cash, without interest and less any applicable withholding taxes.

In connection with the Recapitalization (as defined below), seven senior executive officers of HCA, who are referred to in this prospectus as the Senior Management Participants, invested, through cash investments, rollovers of HCA employee stock options and/or rollovers of HCA common stock, an aggregate of $47 million. In connection with the Recapitalization, certain of our managers also participated in the equity of HCA through cash investments, rollovers of HCA employee stock options and/or rollovers of HCA common stock. Together, these managers and the Senior Management Participants are referred to in this prospectus as the Management Participants, and the aggregate value of their equity participation was $125 million. In connection with the consummation of the Recapitalization, we implemented a stock incentive plan under which approximately 1,500 employees (including executive officers) are eligible to receive options covering up to 10% of our fully diluted equity immediately after consummation of the Recapitalization. In addition, on January 30, 2007, we completed an offering of 781,960 shares of our common stock to approximately 570 of our employees for an aggregate purchase price of $40 million.

Investment funds associated with the Sponsors, or their respective assignees, indirectly invested $3.776 billion in our company as part of the Recapitalization. Of the $3.776 billion invested in our company, Citigroup Inc. (the parent of Citigroup Global Markets Inc.) and Banc of America Securities LLC contributed $150 million and $50 million, respectively, to Hercules Holding in connection with the Merger. The Frist Entities contributed 17,343,193 shares of HCA common stock to Hercules Holding or to one or more other parent companies in return for an ownership interest in such entities. Based on the merger consideration per share of HCA common stock, the commitments of the Frist Entities had an aggregate value of approximately $885 million. The Frist Entities invested an additional $65 million, which increased the aggregate investment of the Frist Entities to $950 million.

Approximately 97.5% of our outstanding shares of capital stock is held indirectly by the Investors, and the remaining 2.5% is held directly by the Management Participants. This structure was achieved through a series of equity contributions which occurred in connection with the Merger. For purposes of this prospectus, the calculations of percentages of our capital stock held by the Investors and the Management Participants exclude shares underlying options covering approximately 14% of our fully diluted equity which have been and may be granted to certain of our employees. See Executive Compensation and Security Ownership of Certain Beneficial Owners. The equity and indebtedness figures in the diagram below are as of June 30, 2007.

Table of Contents

(1) Includes (i) approximately $3.776 billion of cash equity invested by investment funds associated with or designated by the Sponsors and their respective assignees and (ii) approximately $950 million invested by the Frist Entities and their respective assignees, of which approximately $885 million was in the form of a rollover of the Frist Entities equity interests in HCA and approximately $65 million was a cash equity investment. Investment funds associated with each of the Sponsors indirectly own 24.8% of our company, and their assignees, Citigroup and Banc of America Securities, collectively indirectly own 4.2% of our Company. The Frist Entities and other assignees indirectly own 18.9% of our Company following the consummation of the Recapitalization.

(2) Represents $125 million invested by the Management Participants in the form of a rollover of their previously existing equity interests in HCA to equity interests in HCA following the Merger and through cash investments. Additionally, on January 30, 2007, we completed an offering of 781,960 shares of our common stock to approximately 570 of our employees for an aggregate purchase price of $40 million.

(3) Upon the closing of the Recapitalization, we entered into (i) a $2.000 billion asset-based revolving credit facility with a six-year maturity ($1.660 billion outstanding at June 30, 2007); (ii) a $2.000 billion senior secured revolving credit facility with a six-year maturity ($0 outstanding at June 30, 2007); (iii) a $2.750 billion senior secured term loan A facility with a six-year maturity ($2.694 billion outstanding at June 30, 2007); (iv) a $8.800 billion senior secured term loan B facility with a seven-year maturity ($8.756 billion outstanding at June 30, 2007); and (v) a 1.0 billion, or $1.279 billion-equivalent (as of the closing of the Recapitalization) (995 million, or $1.341 billion-equivalent, at June 30, 2007), senior secured European term loan facility with a seven-year maturity, collectively referred to herein as the senior secured credit facilities, unless the context otherwise requires.

(4) As of June 30, 2007, consists of (i) an aggregate principal amount of $367 million medium-term notes with maturities ranging from 2010 to 2025 and a weighted average interest rate of 8.42%; (ii) an aggregate principal amount of $886 million debentures with maturities ranging from 2015 to 2095 and a weighted average interest rate of 7.55%; (iii) an aggregate principal amount of $5.987 billion senior notes with maturities ranging from 2007 to 2033 and a weighted average interest rate of 6.91%; (iv) £150 million ($301 million-equivalent at June 30, 2007) aggregate principal amount of 8.75% senior notes due 2010; (v) $422 million of secured debt, which primarily represents capital leases and other secured debt with a weighted average interest rate of 6.80%; and (vi) $18 million of unamortized debt discounts that reduce the existing indebtedness. For more information regarding our unsecured and other indebtedness, see Description of Other Indebtedness Other Indebtedness.

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

Table of Contents

In connection with the Recapitalization, the notes and guarantees were secured by second-priority liens on substantially all the capital stock of HealthTrust, Inc. The Hospital Company and the first-tier subsidiaries of the subsidiary guarantors (but limited to 65% of the voting stock of any such first-tier subsidiary that is a foreign subsidiary), subject to certain exceptions.

The Merger Agreement contains various covenants, customary seller representations and warranties of HCA, customary buyer representations and warranties of Hercules Holding and Hercules Acquisition, and customary covenants and other agreements between Hercules Holding and Hercules Acquisition, on the one hand, and HCA, on the other hand. The representations and warranties terminated at the closing of the Merger, and a majority of the covenants were satisfied in connection with the closing of the Merger. However, certain obligations remain in effect.

The Merger Agreement requires HCA to indemnify and hold harmless (i) the present and former officers and directors of HCA against any and all losses (including reasonable attorney s fees and expenses) arising out of, relating to, or in connection with any acts or claims occurring or alleged to have occurred prior to the effective time of the Merger and (ii) such persons against any and all damages arising out of actions or omissions in connection with such persons serving as an officer, director or other fiduciary in any entity if such service was at the request or for the benefit of HCA. In addition, HCA is required to maintain a tail policy to the policy of directors and officers insurance liability that was maintained by HCA on the date of the Merger Agreement for the period from the closing date of the Merger through and including the date six years after the closing date of the Merger.

In addition, the Merger Agreement sets forth various ongoing obligations of HCA with respect to its employees. In particular, until the first anniversary of the closing date of the Merger, HCA is required to provide each employee of HCA or any of its subsidiaries as of the effective time of the Merger with compensation (excluding equity-based compensation) and employee benefits that are no less favorable in the aggregate than those provided immediately prior to the effective time of the Merger.

Upon consummation of the Merger, except as otherwise agreed by the holder and Hercules Holding, all outstanding options for common stock of HCA under HCA s then existing equity incentive plans became fully vested and immediately exercisable. All such options not exercised prior to the Merger (other than certain options identified by HCA as being held by Management Participants which were not exercised by the holders thereof and, as a result of elections by Management Participants, automatically converted into options for shares of HCA following the Merger (the Rollover Options)) were cancelled and converted into the right to receive a cash payment equal to the number of shares of HCA common stock underlying the option multiplied by the amount by which $51.00 exceeded the exercise price of each share of HCA common stock underlying the options, without interest and less any withholding taxes.

In addition to the Rollover Options, in connection with the Recapitalization, we established the HCA Inc. 2006 Stock Incentive Plan for Key Employees of HCA Inc. and its Affiliates (the 2006 Plan). The 2006 Plan permits the granting of awards covering 10% of our fully diluted equity immediately after consummation of the Recapitalization. During the six months ended June 30, 2007, we granted 8,924,500 options under the 2006 Plan. As of June 30, 2007, no options granted under the 2006 Plan have vested, and there were 1,875,100 shares available for future grants under the 2006 Plan. See Note 2 to our unaudited consolidated financial statements included in this prospectus.

In connection with the Recapitalization, we entered into senior secured credit facilities consisting of (i) a $2.000 billion asset-based revolving credit facility with a six-year maturity and a borrowing base of 85% of eligible accounts receivable with customary reserves and eligibility criteria; (ii) a $2.000 billion senior secured revolving credit facility with a six-year maturity; (iii) a $2.750 billion senior secured term loan A facility with a six-year maturity; (iv) a $8.800 billion senior secured term loan B facility with a seven-year maturity; and (v) a 1.0 billion, or $1.279 billion-equivalent (as of the closing of the Recapitalization) (995 million, or $1,341 million-equivalent, at June 30, 2007), senior secured European term loan facility with a seven-year maturity; and we issued $5.700 billion aggregate principal amount of the outstanding notes. The amount drawn on the asset-based revolving credit facility on the closing date was $1.535 billion.

Table of Contents

USE OF PROCEEDS

We will not receive any cash proceeds from the issuance of the exchange notes pursuant to the exchange offers. In consideration for issuing the exchange notes as contemplated in this prospectus, we will receive in exchange a like principal amount of outstanding notes, the terms of which are identical in all material respects to the exchange notes. The outstanding notes surrendered in exchange for the exchange notes will be retired and cancelled and cannot be reissued. Accordingly, the issuance of the exchange notes will not result in any change in our capitalization.

CAPITALIZATION

The following table sets forth our capitalization as of June 30, 2007. The information in this table should be read in conjunction with The Merger, Selected Historical Consolidated Financial Data, Management s Discussion and Analysis of Financial Condition and Results of Operations and the financial statements included elsewhere in this prospectus.

	As of June 30, 2007 (Unaudited) (Dollars in millions)
Cash and cash equivalents	$ 354
Senior secured credit facilities(1):	
Asset-based revolving credit facility	$ 1,660
Revolving credit facility	
Term loan A facility	2,694
Term loan B facility	8,756
European term loan facility	1,341
The notes	5,700
Other secured indebtedness(2)	422
Total senior secured indebtedness	20,573
Unsecured indebtedness(3)	7,523
Total indebtedness	28,096
Total stockholders deficit	(10,740)
Total capitalization	$ 17,356

(1) Upon the closing of the Recapitalization, we entered into (i) a $2,000 million asset-based revolving credit facility with a six-year maturity, (ii) a $2,000 million senior secured revolving credit facility with a six-year maturity, (iii) a $2,750 million senior secured term loan A facility with a six-year maturity; (iv) an $8,800 million senior secured term loan B facility with a seven-year maturity; and (v) a 1.0 billion, or $1,279 million-equivalent (as of the closing of the Recapitalization) (995 million, or $1.341 billion-equivalent at June 30, 2007), senior secured European term loan facility with a seven-year maturity.

(2) Consists of capital leases and other secured debt with a weighted average interest rate of 6.80%.

(3) Consists of (i) an aggregate principal amount of $367 million medium-term notes with maturities ranging from 2010 to 2025 and a weighted average interest rate of 8.42%; (ii) an aggregate principal amount of $886 million debentures with maturities ranging from 2015 to 2095 and a weighted average interest rate of 7.55%; (iii) an aggregate principal amount of $5,987 million senior notes with maturities ranging from 2007 to 2033 and a weighted average interest rate of 6.91%; (iv) £150 million ($301 million-equivalent at June 30, 2007) aggregate principal amount of 8.75% senior notes due 2010; and (v) $18 million of unamortized debt discounts which reduce the existing indebtedness. For more information regarding our unsecured and other indebtedness, see Description of Other Indebtedness Other Indebtedness.

50

Table of Contents

UNAUDITED PRO FORMA CONSOLIDATED INCOME STATEMENT

The following unaudited pro forma consolidated income statement for the year ended December 31, 2006 has been developed by applying pro forma adjustments to the historical audited consolidated income statement of HCA Inc. appearing elsewhere in this prospectus. The unaudited pro forma consolidated income statement gives effect to the Recapitalization as if it had occurred on January 1, 2006. Assumptions underlying the pro forma adjustments are described in the accompanying notes, which should be read in conjunction with this unaudited pro forma consolidated income statement.

The unaudited pro forma adjustments are based upon available information and certain assumptions that we believe are reasonable under the circumstances. The unaudited pro forma consolidated income statement does not purport to represent what our results of operations would have been had the Recapitalization actually occurred on the date indicated, and they do not purport to project our results of operations for any future period. All pro forma adjustments and their underlying assumptions are described more fully in the notes to unaudited pro forma consolidated income statement.

You should read the unaudited pro forma consolidated income statement and the related notes in conjunction with the information contained in The Merger, Capitalization, Selected Historical Consolidated Financial Information, Management s Discussion and Analysis of Financial Condition and Results of Operations and the consolidated financial statements and related notes thereto appearing elsewhere in this prospectus.

Table of Contents

UNAUDITED PRO FORMA CONSOLIDATED INCOME STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2006

(Dollars in millions)

	Historical HCA	Pro Forma Adjustments	Pro Forma HCA
Revenues	$ 25,477	$	$ 25,477
Salaries and benefits	10,409		10,409
Supplies	4,322		4,322
Other operating expenses	4,057	33(1)	4,090
Provision for doubtful accounts	2,660		2,660
Gains on investments	(243)		(243)
Equity in earnings of affiliates	(197)		(197)
Depreciation and amortization	1,391		1,391
Interest expense	955	1,338(2)	2,293
Gains on sales of facilities	(205)		(205)
Transaction costs	442	(442)(3)	
Impairment of long-lived assets	24		24
	23,615	929	24,544
Income before minority interests and income taxes	1,862	(929)	933
Minority interests in earnings of consolidated entities	201		201
Income before income taxes	1,661	(929)	732
Provision for income taxes	625	(353)(4)	272
Net income	$ 1,036	$ (576)	$ 460

See Accompanying Notes to Unaudited Pro Forma Consolidated Income Statement

Table of Contents

NOTES TO UNAUDITED PRO FORMA CONSOLIDATED INCOME STATEMENT

(1) Reflects $13 million for the period prior to the Recapitalization related to the $15 million annual fee to affiliates of our Sponsors in accordance with the management agreement entered into at closing, and the loss of investment income of $20 million, assuming an investment yield of 6.25%, for the period prior to the Recapitalization, related to the payment of the $365 million dividend from our insurance subsidiary concurrently with the closing of the Recapitalization.

(2) Reflects the pro forma adjustment to interest expense resulting from our new capital structure, which is calculated as follows (dollars in millions):

	Year Ended December 31, 2006
Cash interest on new borrowings(i)	$ 2,213
Amortization of deferred financing costs(ii)	80
Total pro forma interest expense	2,293
Less: Historical interest expense	955
Adjustment to interest expense	$ 1,338

(i) Pro forma interest expense for the twelve months following the Recapitalization assumes: (1) an estimated average outstanding balance of $1,736 million on our $2,000 million asset-based revolving credit facility using an assumed interest rate equal to the average three-month LIBOR for 2006 of 5.20% plus a margin of 1.75%, (2) an estimated average outstanding balance of $0 on our $2,000 million revolving credit facility, (3) borrowings of $2,750 million under our term loan A facility and $8,800 million under our term loan B facility using an assumed interest rate equal to the average three-month LIBOR for 2006 of 5.20% plus a margin of 2.50% and 2.75%, respectively, net of the impact of our $4,000 million pay-fixed 4.910% and $4,000 million pay-fixed 4.782% interest rate swap agreements, (4) borrowings of $1,256 million-equivalent (at December 31, 2006) (1.0 billion) under our European term loan facility using an assumed interest rate equal to the average three-month Euro LIBOR for 2006 of 3.08% plus a margin 2.50%, (5) borrowings of $8,100 million under existing senior notes, debentures and medium term notes that were not repaid in the Recapitalization using stated interest rates varying between 5.75% and 9.00%, (6) cash interest on the $4,200 million of cash-pay notes and the $1,500 million of toggle notes subject to the exchange offers, and (7) commitment fees of 0.38% and 0.50% on the estimated unused portion of our asset-based revolving credit facility and revolving credit facility, respectively. To the extent we elect to pay PIK interest on the toggle notes, our cash interest expense would decrease accordingly, but our long-term obligations to pay principal would be increased. A 0.125% variance in assumed interest rates would amount to a change in total pro forma interest expense of $8 million after taking into consideration the $8,000 million pay-fixed interest rate swap agreements.

(ii) Represents annual amortization expense on approximately $614 million of deferred financing costs, using a weighted average maturity of 7.7 years.

(3) Reflects the elimination of the following nonrecurring charges related to the Recapitalization that were included our historical results of operations for the year ended December 31, 2006 (dollars in millions):

	Year Ended December 31, 2006
Compensation expense related to accelerated vesting of stock options and restricted stock and other employee benefits	$ 258

Consulting, legal, accounting and other transaction costs		131
Loss on extinguishment of debt		53
Total	$	442

(4) Represents an estimated statutory tax rate of 38% applied to the pro forma adjustments described above.

Table of Contents

SELECTED HISTORICAL CONSOLIDATED FINANCIAL INFORMATION

The following table sets forth selected historical consolidated financial data of HCA Inc. as of the dates and for the periods indicated. The selected historical consolidated financial data as of and for the six months ended June 30, 2006 and 2007 have been derived from our unaudited consolidated financial statements and related notes appearing elsewhere in this prospectus. The selected historical consolidated financial data as of December 31, 2005 and 2006 and for each of the three years in the period ended December 31, 2006 have been derived from our audited consolidated financial statements and related notes appearing elsewhere in this prospectus, which have been audited by Ernst & Young LLP. The selected historical consolidated financial data as of December 31, 2002, 2003 and 2004 and for the two years in the period ended December 31, 2003 presented in this table have been derived from audited consolidated financial statements audited by Ernst & Young LLP that are not included in this prospectus. The results of operations for any interim period are not necessarily indicative of the results to be expected for the full year or any future period.

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

	Year Ended December 31,					Six Months Ended June 30,	
	2002	2003	2004	2005	2006	2006	2007
				(Dollars in millions)		(Unaudited)	
Income Statement Data:							
Revenues	$ 19,729	$ 21,808	$ 23,502	$ 24,455	$ 25,477	$ 12,775	$ 13,406
Salaries and benefits	7,952	8,682	9,419	9,928	10,409	5,216	5,301
Supplies	3,158	3,522	3,901	4,126	4,322	2,205	2,199
Other operating expenses	3,341	3,676	3,797	4,039	4,057	2,009	2,118
Provision for doubtful accounts	1,581	2,207	2,669	2,358	2,660	1,273	1,444
(Gains) losses on investments	2	(1)	(56)	(53)	(243)	(100)	(7)
Equity in earnings of affiliates	(206)	(199)	(194)	(221)	(197)	(108)	(105)
Depreciation and amortization	1,010	1,112	1,250	1,374	1,391	697	716
Interest expense	446	491	563	655	955	382	1,114
Gains on sales of facilities	(6)	(85)		(78)	(205)	(5)	(16)
Transaction costs					442		
Impairment of long-lived assets	19	130	12		24		24
Government settlement and investigation related costs	661	(33)					
Impairment of investment securities	168						
	18,126	19,502	21,361	22,128	23,615	11,569	12,788
Income before minority interests and income taxes	1,603	2,306	2,141	2,327	1,862	1,206	618
Minority interests in earnings of consolidated entities	148	150	168	178	201	101	116
Income before income taxes	1,455	2,156	1,973	2,149	1,661	1,105	502
Provision for income taxes	622	824	727	725	625	431	206
Net income	$ 833	$ 1,332	$ 1,246	$ 1,424	$ 1,036	$ 674	$ 296

Table of Contents

	Year Ended December 31,					Six Months Ended June 30,	
	2002	2003	2004	2005	2006	2006	2007
				(Dollars in millions)		(Unaudited)	
Statement of Cash Flows Data:							
Cash flows provided by operating activities	$ 2,648	$ 2,292	$ 2,954	$ 2,971	$ 1,845	$ 732	$ 406
Cash flows used in investing activities	(1,740)	(2,862)	(1,688)	(1,681)	(1,307)	(795)	(418)
Cash flows provided by (used in) financing activities	(934)	650	(1,347)	(1,212)	(240)	463	(268)
Other Financial Data:							
EBITDA(1)	$ 2,911	$ 3,759	$ 3,786	$ 4,178	$ 4,007	$ 2,184	$ 2,332
Capital expenditures	1,718	1,838	1,513	1,592	1,865	820	675
Ratio of earnings to fixed charges(2)	3.63	4.42	3.96	3.84	2.61	3.32	1.40
Balance Sheet Data:							
Working capital(3)	$ 766	$ 1,654	$ 1,509	$ 1,320	$ 2,502	$ 1,874	$ 2,593
Property, plant and equipment (net)	9,721	11,065	11,396	11,379	11,669	11,578	11,544
Cash and cash equivalents	259	339	258	336	634	736	354
Total assets	19,059	21,400	21,840	22,225	23,675	23,120	23,704
Total debt (including debt due within one year)	6,943	8,707	10,530	10,475	28,408	11,664	28,096
Minority interests in equity of consolidated entities	611	680	809	828	907	901	891
Equity securities with contingent redemption rights					125		165
Total stockholders (deficit) equity	5,702	6,209	4,407	4,863	(11,374)	4,826	(10,905)

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

Table of Contents

Historical EBITDA is calculated as follows:

	Year Ended December 31					Six Months Ended June 30,	
	2002	2003	2004	2005	2006	2006	2007
						(unaudited)	
	(Dollars in millions)						
Net income	$ 833	$ 1,332	$ 1,246	$ 1,424	$ 1,036	$ 674	$ 296
Provision for income taxes	622	824	727	725	625	431	206
Interest expense	446	491	563	655	955	382	1,114
Depreciation and amortization	1,010	1,112	1,250	1,374	1,391	697	716
EBITDA	$ 2,911	$ 3,759	$ 3,786	$ 4,178	$ 4,007	$ 2,184	$ 2,332

(2) For purposes of calculating the ratio of earnings to fixed charges, earnings consist of income before minority interests in earnings of consolidated entities and income taxes plus fixed charges, exclusive of capitalized interest. Fixed charges include cash and noncash interest expense, whether expensed or capitalized, amortization of debt issuance cost, and the portion of rented expense representative of the interest factor.

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

Table of Contents

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

The following discussion and analysis of our financial condition and results of operations covers periods prior to and following the closing of the Recapitalization. The discussion and analysis of historical periods prior to the closing of the Recapitalization does not reflect the significant impact that the Recapitalization has had and will have on us, including significantly increased leverage and liquidity requirements. You should read the following discussion of our results of operations and financial condition with the Unaudited Pro Forma Consolidated Income Statement, Selected Historical Consolidated Financial Data and the audited and unaudited historical consolidated financial statements and related notes included elsewhere in this prospectus. This discussion contains forward-looking statements and involves numerous risks and uncertainties, including, but not limited to, those described in the Risk Factors section of this prospectus. Actual results may differ materially from those contained in any forward-looking statements.

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

Overview

We are the largest and most diversified investor-owned health care services provider in the United States. As of June 30, 2007, we operated 172 hospitals and 107 freestanding surgery centers in 20 states, England and Switzerland (including eight nonconsolidated hospitals and nine nonconsolidated surgery centers managed under joint ventures) and had approximately 183,000 employees and 35,000 affiliated physicians. For the year ended December 31, 2006, we generated revenues of $25.477 billion and net income of $1.036 billion, and for the six months ended June 30, 2007, we generated revenues of $13.406 billion and net income of $296 million.

On November 17, 2006, we consummated the Merger with Merger Sub, a wholly owned subsidiary of Hercules Holding, pursuant to which Hercules Holding acquired all of our outstanding shares of common stock for $51.00 per share in cash. The Merger, the financing transactions related to the Merger and other related transactions had a transaction value of approximately $33.0 billion and are collectively referred to in this discussion as the Recapitalization. As a result of the Recapitalization, our outstanding common stock is owned by Hercules Holding, certain members of management and other key employees, and certain other entities. Our common stock is no longer registered with the SEC and is no longer traded on a national securities exchange.

Six Months Ended June 30, 2007 Operations Summary

Net income totaled $296 million for the six months ended June 30, 2007, compared to $674 million for the six months ended June 30, 2006. Revenues increased to $13.406 billion in the six months ended June 30, 2007 from $12.775 billion for the six months ended June 30, 2006. For the six months ended June 30, 2007 and 2006, the provision for doubtful accounts was 10.8% and 10.0% of revenues, respectively. The results for the six months ended June 30, 2007 include interest expense of $1.114 billion, compared to $382 million in the six months ended June 30, 2006. The $732 million increase in interest expense is primarily due to the increased debt related to the Recapitalization. Gains on sales of investments of $7 million were realized during the six months ended June 30, 2007 and the financial results for the six months ended June 30, 2006 include gains on sales of investments of $100 million related to securities held by our wholly-owned insurance subsidiary.

During the six months ended June 30, 2007, same facility admissions decreased 1.6% and same facility equivalent admissions decreased 1.4% compared to the six months ended June 30, 2006. Same facility inpatient surgeries decreased 0.7% and same facility outpatient surgeries decreased 1.4% during the six months ended June 30, 2007 compared to the six months ended June 30, 2006. Same facility revenue per equivalent admission increased 9.1% in the six months ended June 30, 2007 compared to the six months ended June 30, 2006.

Table of Contents

2006 Operations Summary

Net income totaled $1.036 billion for the year ended December 31, 2006 compared to $1.424 billion for the year ended December 31, 2005. The 2006 results include reductions to estimated professional liability reserves of $136 million, gains on investments of $243 million, gains on sales of facilities of $205 million, transaction costs related to the Recapitalization of $442 million and an impairment of long-lived assets of $24 million. The 2005 results include reductions to estimated professional liability reserves of $83 million, expenses associated with hurricanes of $60 million, gains on investments of $53 million, gains on sales of facilities of $78 million, a favorable tax settlement of $48 million and a tax benefit of $24 million related to the repatriation of foreign earnings.

Revenues increased 4.2% on a consolidated basis and 6.2% on a same facility basis for the year ended December 31, 2006 compared to the year ended December 31, 2005. The consolidated revenues increase can be attributed to a 6.8% increase in revenue per equivalent admission, offsetting a 2.4% decline in equivalent admissions. The same facility revenues increase resulted from flat same facility equivalent admissions and a 6.2% increase in same facility revenue per equivalent admission.

During the year ended December 31, 2006, same facility admissions increased 0.2% compared to the year ended December 31, 2005. Same facility inpatient surgeries increased 0.7% and same facility outpatient surgeries decreased 1.2% during the year ended December 31, 2006 compared to the year ended December 31, 2005.

For the year ended December 31, 2006, the provision for doubtful accounts increased to 10.4% of revenues from 9.6% of revenues for the year ended December 31, 2005. Same facility uninsured admissions increased 10.9% and same facility uninsured emergency room visits increased 6.2% for the year ended December 31, 2006 compared to the year ended December 31, 2005.

Interest expense totaled $955 million for the year ended December 31, 2006 compared to $655 million for the year ended December 31, 2005. Interest expense for the fourth quarter of 2006 was $373 million and represented an increase of $207 million compared to the fourth quarter of 2005, due primarily to the increased debt related to the Recapitalization.

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

Revenues

Revenues are recorded during the period the health care services are provided, based upon the estimated amounts due from payers. Estimates of contractual allowances under managed care health plans are based upon the payment terms specified in the related contractual agreements. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The estimated reimbursement amounts are made on a payer-specific basis and are recorded based on the best information available regarding management s interpretation of the applicable laws, regulations and contract terms. Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms that result from contract renegotiations and renewals. We have

Table of Contents

invested significant resources to refine and improve our computerized billing system 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.

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. Federal and state laws and regulations, including but not limited to EMTALA, require, and our commitment to providing quality patient care encourages, the provision of services to patients who are financially unable to pay for the health care services they receive.

We do not pursue collection of amounts related to patients who meet our guidelines to qualify as charity care; therefore, they are not reported in revenues. The revenues associated with uninsured patients who do not meet our guidelines to qualify as charity care have generally been reported in revenues at gross charges. 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. On January 1, 2005, we modified our policies to 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.

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. A hypothetical 1% change in net receivables that are subject to contractual discounts at December 31, 2006 would result in an impact on pretax earnings of approximately $32 million.

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. We consider the return of an account from the primary external collection agency to be the culmination of our reasonable collection efforts and the timing basis for writing off the account balance. Writeoffs are based upon specific identification and the writeoff process requires a writeoff adjustment entry to the patient accounting system. We do not pursue collection of amounts related to patients that meet our guidelines to qualify as charity care. Charity care is not reported in revenues and does not have an impact on the provision for doubtful accounts.

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

Table of Contents

receivable collection and writeoff data. At December 31, 2006, the allowance for doubtful accounts represented approximately 86% of the $3.972 billion patient due accounts receivable balance, including accounts, net of the related estimated contractual discounts, related to patients for which eligibility for Medicaid assistance or charity was being evaluated (pending Medicaid accounts). At December 31, 2005, the allowance for doubtful accounts represented approximately 85% of the $3.404 billion patient due accounts receivable balance, including pending Medicaid accounts, net of the related estimated contractual discounts. The provision for doubtful accounts was 10.4% of revenues in 2006, 9.6% of revenues in 2005 and 11.4% of revenues in 2004. Our uninsured discount policy, which became effective January 1, 2005, resulted in $1.095 billion and $769 million in discounts to the uninsured being recorded during 2006 and 2005, respectively. Adjusting for the effect of the uninsured discounts, the provision for doubtful accounts was 14.1% and 12.4% of revenues for the years ended December 31, 2006 and 2005, respectively. See Supplemental Non-GAAP Disclosures, Operating Measures Adjusted for the Impact of Discounts for the Uninsured. Days revenues in accounts receivable were 53 days, 50 days and 48 days at December 31, 2006, 2005 and 2004, 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, 2006 and 2005 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, 2006:			
Medicare and Medicaid.	13%	1%	2%
Managed care and other insurers	21	4	4
Uninsured	20	11	24
Total	54%	16%	30%
Accounts receivable aging at December 31, 2005:			
Medicare and Medicaid	13%	2%	2%
Managed care and other insurers	21	4	4
Uninsured	21	11	22
Total	55%	17%	28%

Professional Liability Claims

We, along with virtually all health care providers, operate in an environment with professional liability risks. Prior to 2007, a substantial portion of our professional liability risks was insured through a wholly-owned insurance subsidiary. Reserves for professional liability risks were $1.584 billion and $1.621 billion at December 31, 2006 and December 31, 2005, respectively. The current portion of these reserves, $275 million and $285 million at December 31, 2006 and 2005, 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 $42 million and $43 million receivable under reinsurance contracts at December 31, 2006 and 2005, respectively) were $1.542 billion and $1.578 billion at December 31, 2006 and 2005, respectively. Reserves and provisions for professional liability risks are based upon actuarially determined estimates. The independent actuaries estimated reserve ranges, net of amounts receivable under reinsurance contracts, were $1.321 billion to $1.545 billion at December 31, 2006 and $1.373 billion to $1.589 billion at December 31, 2005. Reserves for

Table of Contents

professional liability risks represent the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known.

The reserves for professional liability risks cover approximately 3,000 and 3,300 individual claims at December 31, 2006 and 2005, 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 estimation of the timing of payments beyond a year can vary significantly. Changes to the estimated reserve amounts are included in current operating results. Due to the considerable variability that is inherent in such estimates, there can be no assurance that the ultimate liability will not exceed management s estimates.

Provisions for losses related to professional liability risks were $217 million, $298 million and $291 million for the years ended December 31, 2006, 2005 and 2004, respectively. We recognized reductions in our estimated professional liability insurance reserves of $136 million, $83 million and $59 million during 2006, 2005 and 2004, respectively. These reductions reflect the recognition by the external actuaries of our improving frequency and severity claim trends. This improving frequency and moderating severity can be primarily attributed to tort reforms enacted in key states, particularly Texas, and our risk management and patient safety initiatives, particularly in the areas of obstetrics and emergency services.

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 that we have properly reported taxable income and paid taxes in accordance with applicable laws, federal and state taxing authorities may challenge our tax positions upon audit. To reflect the possibility that our positions may not ultimately be sustained, we have established, and when appropriate adjust, provisions for potential adverse tax outcomes, based on our evaluation of the underlying facts and circumstances. Final audit results may vary from our estimates.

Results of Operations

Revenue/Volume Trends for the Six Months Ended June 30, 2007

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

Revenues increased 4.9% from $12.775 billion in the six months ended June 30, 2006 to $13.406 billion for the six months ended June 30, 2007. The increase in revenues can be attributed to the net impact of a 9.6% increase in revenue per equivalent admission and a 4.2% decrease in equivalent admissions for the six months ended June 30, 2007 compared to the six months ended June 30, 2006.

Table of Contents

Consolidated admissions decreased 4.5% and same facility admissions decreased 1.4% compared to the six months ended June 30, 2006. Consolidated inpatient surgeries decreased 2.8% and same facility inpatient surgeries decreased 0.7% in the six months ended June 30, 2007 compared to the six months ended June 30, 2006. Consolidated outpatient surgeries decreased 3.6% and same facility outpatient surgeries decreased 1.4% in the six months ended June 30, 2007 compared to the six months ended June 30, 2006.

Admissions related to Medicare, managed Medicare, Medicaid, managed Medicaid, managed care and other insurers and the uninsured for the six months ended June 30, 2007 and 2006 are set forth in the following table.

	Six Months Ended June 30,	
	2007	**2006**
Medicare	**36%**	38%
Managed Medicare	**7**	6
Medicaid	**8**	9
Managed Medicaid	**7**	6
Managed care and other insurers	**36**	36
Uninsured	**6**	5
	100%	100%

Same facility uninsured admissions increased by 4,634 admissions, or 11.2% (a 12.4% increase in first quarter of 2007 and a 9.9% increase in second quarter of 2007), in the six months ended June 30, 2007 compared to the six months ended June 30, 2006. The quarterly trend of same facility uninsured admissions growth during 2006, compared to 2005, was 13.1% during the first quarter, 10.5% during the second quarter, 10.1% during the third quarter and 8.7% during the fourth quarter.

At June 30, 2007, we had 73 hospitals in the states of Texas and Florida. During the six months ended June 30, 2007, 55% of our admissions and 51% of our revenues were generated by these hospitals. Uninsured admissions in Texas and Florida represent 61% of our uninsured admissions for the six months ended June 30, 2007.

The approximate percentages of our inpatient revenues related to Medicare, managed Medicare, Medicaid, managed Medicaid, managed care and other insurers and the uninsured for the six months ended June 30, 2007 and 2006 are set forth in the following table.

	Six Months Ended June 30,	
	2007	**2006**
Medicare	**33%**	36%
Managed Medicare	**7**	6
Medicaid	**7**	6
Managed Medicaid	**3**	3
Managed care and other insurers	**44**	44
Uninsured	**6**	5
	100%	100%

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. Our Medicaid revenues increased by $178 million during the six months ended June 30, 2007 compared to the six months ended June 30, 2006 due to expected increases in supplemental payments pursuant to upper payment limit (UPL) programs in certain Texas markets. There are ongoing discussions with the Centers for Medicare and Medicaid Services (CMS) about the structure of such programs. The outcome of such discussions might affect the federal portion of these supplemental payments, which is a significant component of the total supplemental payments.

62

Table of Contents

Revenue/Volume Trends 2006

Revenues increased 4.2% to $25.477 billion for the year ended December 31, 2006 from $24.455 billion for the year ended December 31, 2005 and increased 4.1% for the year ended December 31, 2005 from $23.502 billion for the year ended December 31, 2004. The increase in revenues in 2006 can be primarily attributed to a 6.8% increase in revenue per equivalent admission offsetting a 2.4% decline in equivalent admissions compared to the prior year. Our uninsured discount policy, which became effective January 1, 2005, resulted in $1.095 billion and $769 million in discounts to the uninsured being recorded during 2006 and 2005, respectively. Adjusting for the effect of the uninsured discounts, revenue per equivalent admission increased 8.0% in the year ended December 31, 2006 compared to the year ended December 31, 2005. See Supplemental Non-GAAP Disclosures, Operating Measures Adjusted for the Impact of Discounts for the Uninsured. The increase in revenues in 2005 can be primarily attributed to a 0.9% increase in equivalent admissions and a 3.1% increase in revenue per equivalent admission compared to the prior year.

Same facility admissions increased 0.2% in 2006 compared to 2005 and increased 0.1% in 2005 compared to 2004. Same facility inpatient surgeries increased 0.7% and same facility outpatient surgeries decreased 1.2% during 2006 compared to 2005. Same facility inpatient surgeries increased 0.9% and same facility outpatient surgeries increased 0.3% during 2005 compared to 2004. Same facility emergency room visits decreased 0.8% during 2006 compared to 2005 and increased 4.8% during 2005 compared to 2004.

Admissions related to Medicare, managed Medicare, Medicaid, managed Medicaid, managed care and other insurers and the uninsured for the years ended December 31, 2006, 2005 and 2004 are set forth below.

	Years ended December 31,		
	2006	**2005**	**2004**
Medicare	**37%**	38%	39%
Managed Medicare	**6**	(a)	(a)
Medicaid	**9**	10	10
Managed Medicaid	**6**	5	4
Managed care and other insurers(a)	**36**	42	42
Uninsured	**6**	5	5
	100%	100%	100%

(a) Prior to 2006, managed Medicare admissions were classified as managed care.

Same facility uninsured emergency room visits increased 6.2% and same facility uninsured admissions increased 10.9% during 2006 compared to 2005. Same facility uninsured emergency room visits increased 11.0% and same facility uninsured admissions increased 9.5% during 2005 compared to 2004. Management cannot predict whether the current trends in same facility emergency room visits and same facility uninsured admissions will continue.

Several factors negatively affected patient volumes in 2006 and 2005. Unit closures and changes in Medicare admission guidelines led to reductions in rehabilitation and skilled nursing admissions. Cardiac admissions have been affected by competition from physician-owned heart hospitals and credentialing decisions made at some of our Florida hospitals. More stringent enforcement of case management guidelines led to certain patient services being classified as outpatient observation visits instead of one-day admissions. To increase patient volumes, we plan to increase physician recruitment, increase available medical office building space on or near our campuses, and continue capital spending devoted to both maintenance of technology and facilities and growth and expansion programs.

Table of Contents

At December 31, 2006, we owned and operated 38 hospitals and 33 surgery centers in the state of Florida. Our Florida facilities revenues totaled $6.563 billion and $6.276 billion for the years ended December 31, 2006 and 2005, respectively. At December 31, 2006, we owned and operated 35 hospitals and 22 surgery centers in the state of Texas. Our Texas facilities revenues totaled $6.316 billion and $5.900 billion for the years ended December 31, 2006 and 2005, respectively.

We provided $1.296 billion, $1.138 billion and $926 million of charity care during the years ended December 31, 2006, 2005 and 2004, respectively. On January 1, 2005, we modified our policies to provide a discount to uninsured patients who do not qualify for Medicaid or charity care. These discounts are similar to those provided to many local managed care plans and totaled $1.095 billion and $769 million for the years ended December 31, 2006 and 2005, 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. Legislative changes have resulted in limitations and even reductions in levels of payments to health care providers for certain services under these government programs.

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, 2006, 2005 and 2004 are set forth below.

	Years ended December 31,		
	2006	**2005**	**2004**
Medicare	**34%**	36%	37%
Managed Medicare	**6**	(a)	(a)
Medicaid	**6**	7	6
Managed Medicaid	**3**	3	3
Managed care and other insurers(a)	**46**	49	48
Uninsured(b)	**5**	5	6
	100%	100%	100%

(a) Prior to 2006, managed Medicare revenues were classified managed care.

(b) Uninsured revenues for the years ended December 31, 2006 and 2005 were reduced due to discounts to the uninsured, related to the uninsured discount program implemented January 1, 2005.

Table of Contents

Operating Results Summary for the Six Months Ended June 30, 2007

The following are comparative summaries of results from operations for the quarters ended June 30, 2007 and 2006 (dollars in millions):

	Six Months Ended June 30,			
	2007		2006	
	Amount	Ratio	Amount	Ratio
Revenues	**$ 13,406**	**100.0**	$ 12,775	100.0
Salaries and benefits	**5,301**	**39.5**	5,216	40.8
Supplies	**2,199**	**16.4**	2,205	17.3
Other operating expenses	**2,118**	**15.8**	2,009	15.7
Provision for doubtful accounts	**1,444**	**10.8**	1,273	10.0
Gains on investments	**(7)**		(100)	(0.8)
Equity in earnings of affiliates	**(105)**	**(0.8)**	(108)	(0.8)
Depreciation and amortization	**716**	**5.3**	697	5.4
Interest expense	**1,114**	**8.3**	382	3.0
Gains on sales of facilities	**(16)**	**(0.1)**	(5)	
Impairment of long-lived assets	**24**	**0.2**		
	12,788	**95.4**	11,569	90.6
Income before minority interests and income taxes	**618**	**4.6**	1,206	9.4
Minority interests in earnings of consolidated entities	**116**	**0.9**	101	0.8
Income before income taxes	**502**	**3.7**	1,105	8.6
Provision for income taxes	**206**	**1.5**	431	3.3
Net income	**$ 296**	**2.2**	$ 674	5.3
% changes from prior year:				
Revenues	**4.9%**		4.3%	
Income before income taxes	**(54.5)**		(10.3)	
Net income	**(56.0)**		(17.7)	
Admissions(a)	**(4.5)**		(1.9)	
Equivalent admissions(b)	**(4.2)**		(1.6)	
Revenue per equivalent admission	**9.6**		6.0	
Same facility % changes from prior year(c):				
Revenues	**7.5**		5.5	
Admissions(a)	**(1.6)**		(0.1)	
Equivalent admissions(b)	**(1.4)**		0.1	
Revenue per equivalent admission	**9.1**		5.4	

(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 which were either acquired or divested during the current and prior period.

Table of Contents

Six Months Ended June 30, 2007 and 2006

Net income totaled $296 million in the six months ended June 30, 2007 compared to $674 million in the six months ended June 30, 2006. Revenues increased 4.9% due to favorable pricing trends, evidenced by net revenue per equivalent admission growth of 9.6%, and weak volume trends that resulted in a decline in equivalent admissions of 4.2%. The $378 million decline in net income was primarily due to the net impact of the $732 million increase in interest expense and the $225 million reduction in the provision for income taxes.

For the first six months of 2007, admissions decreased 4.5% and same facility admissions decreased 1.6% compared to the first six months of 2006. Inpatient surgical volumes decreased 2.8% on a consolidated basis and decreased 0.7% on a same facility basis during the first six months of 2007, compared to the first six months of 2006. Outpatient surgical volumes decreased 3.6% on a consolidated basis and decreased 1.4% on a same facility basis compared to the first six months of 2006.

Salaries and benefits, as a percentage of revenues, were 39.5% in the first six months of 2007 and 40.8% in the first six months of 2006. Salaries and benefits per equivalent admission increased 6.1% compared to the first six months of 2006. Labor rate increases averaged 5.6% for the first six months of 2007 compared to the first six months of 2006.

Supplies, as a percentage of revenues, were 16.4% in the first six months of 2007 compared to 17.3% in the first six months of 2006. Supply cost per equivalent admission increased 4.1% in the first six months of 2007. Same facility supply costs increased 5.5% for medical devices (cardiology and orthopedic) in the first six months of 2007 compared to the first six months of 2006.

Other operating expenses, as a percentage of revenues, were 15.8% in the first six months of 2007 compared to 15.7% in the first six months of 2006. 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. We recorded $131 million of indigent care costs related to upper payment limit programs during the first six months of 2007. Adjusting for the impact of these costs and the related revenues, other operating expenses would have decreased to 15.0% of revenues. Provisions for losses related to professional liability risks were $97 million for each of the six months ended June 30, 2007 and 2006. We recorded reductions to our estimated professional liability reserves of $85 million and $36 million during the six months ended June 30, 2006 and 2005, respectively, to reflect the recognition by our external actuaries of improving frequency and severity claim trends at our facilities. We expect the favorable professional liability trends experienced during 2006 and 2005 to continue during 2007 and have considered those favorable trends in our 2007 estimated professional liability expense accruals.

Provision for doubtful accounts, as a percentage of revenues, was 10.8% in the first six months of 2007 compared to 10.0% in the first six months of 2006. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts due directly from patients. At June 30, 2007, our allowance for doubtful accounts represented approximately 87% of the $4.244 billion total patient due accounts receivable balance.

Gains on investments of $7 million and $100 million in the first six months of 2007 and 2006, respectively, relate to sales of investment securities by our wholly-owned insurance subsidiary. We converted the majority of our equity investments to investments in debt securities during the fourth quarter of 2006 and do not expect to realize gains on investments during 2007 at amounts comparable to those realized during 2006.

Equity in earnings of affiliates decreased from $108 million in the first six months of 2006 to $105 million in the first six months of 2007. These amounts related primarily to the operations of our Denver market joint venture, which is accounted for under the equity method of accounting.

Table of Contents

Depreciation and amortization increased by $19 million, from $697 million in the first six months of 2006 to $716 million in the first six months of 2007.

Interest expense increased from $382 million in the first six months of 2006 to $1.114 billion in the first six months of 2007 due to the increased debt related to the Recapitalization. Our average debt balance was $28.004 billion for first six months of 2007 compared to $11.213 billion for the first six months of 2006. The average interest rate for our long term debt increased from 7.0% at June 30, 2006 to 7.7% at June 30, 2007.

During the first six months of 2007, we recognized gains of $16 million related to sales of real estate investments. Gains on sales of facilities were $5 million for the first six months of 2006 and included the gain on the sale of a hospital in North Carolina.

We recorded a pretax charge of $24 million to adjust the value of a building to estimated fair value during the first six months of 2007.

Minority interests in earnings of consolidated entities increased from $101 million for the first six months of 2006 to $116 million for the first six months of 2007 due primarily to improved operations in two Texas market partnerships.

Our effective tax rate was 41.0% for the first six months of 2007 and 39.0% for the first six months of 2006.

Table of Contents

Operating Results Summary 2006

The following are comparative summaries of operating results for the years ended December 31, 2006, 2005 and 2004 (dollars in millions):

	2006		2005		2004	
	Amount	**Ratio**	**Amount**	**Ratio**	**Amount**	**Ratio**
Revenues	**$ 25,477**	**100.0**	$ 24,455	100.0	$ 23,502	100.0
Salaries and benefits	**10,409**	**40.9**	9,928	40.6	9,419	40.1
Supplies	**4,322**	**17.0**	4,126	16.9	3,901	16.6
Other operating expenses	**4,057**	**16.0**	4,039	16.5	3,797	16.0
Provision for doubtful accounts	**2,660**	**10.4**	2,358	9.6	2,669	11.4
Gains on investments	**(243)**	**(1.0)**	(53)	(0.2)	(56)	(0.2)
Equity in earnings of affiliates	**(197)**	**(0.8)**	(221)	(0.9)	(194)	(0.8)
Depreciation and amortization	**1,391**	**5.5**	1,374	5.6	1,250	5.3
Interest expense	**955**	**3.7**	655	2.7	563	2.4
Gains on sales of facilities	**(205)**	**(0.8)**	(78)	(0.3)		
Transaction costs	**442**	**1.7**				
Impairment of long-lived assets	**24**	**0.1**			12	0.1
	23,615	**92.7**	22,128	90.5	21,361	90.9
Income before minority interests and income taxes	**1,862**	**7.3**	2,327	9.5	2,141	9.1
Minority interests in earnings of consolidated entities	**201**	**0.8**	178	0.7	168	0.7
Income before income taxes	**1,661**	**6.5**	2,149	8.8	1,973	8.4
Provisions for income taxes	**625**	**2.4**	725	3.0	727	3.1
Net income	**$ 1,036**	**4.1**	$ 1,424	5.8	$ 1,246	5.3
% changes from prior year:						
Revenues	**4.2%**		4.1%		7.8%	
Income before income taxes	**(22.7)**		9.0		(8.5)	
Net income	**(27.2)**		14.2		(6.5)	
Admissions(a)	**(2.3)**		(0.7)		1.5	
Equivalent admissions(b)	**(2.4)**		0.9		2.0	
Revenue per equivalent admission	**6.8**		3.1		5.6	
Same facility % changes from prior year: (c)						
Revenues	**6.2**		4.7		7.3	
Admissions(a)	**0.2**		0.1		0.7	
Equivalent admissions(b)			1.4		1.3	
Revenue per equivalent admission	**6.2**		3.2		6.0	

(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.

The results of operations for the years ended December 31, 2006 and 2005, adjusted for the impact of our uninsured discount policy, are presented in the following table. Revenues, the provision for doubtful accounts, certain operating expense categories as a percentage of revenues and revenue per equivalent admission have been

Table of Contents

adjusted to exclude the discounts under our uninsured discount policy (non-GAAP financial measures). We believe these non-GAAP financial measures are useful to investors and provide disclosures of our results of operations on the same basis as that used by management. Management finds this information to be useful to enable the evaluation of revenue and certain expense category trends that are influenced by patient volumes and are generally analyzed as a percentage of revenues.

Supplemental Non-GAAP Disclosures

Operating Measures Adjusted for the Impact of Discounts for the Uninsured

(Dollars in millions, except revenue per equivalent admission)

The results of operations for the year ended December 31, 2006, adjusted for the impact of our uninsured discount policy, are presented below:

	Year Ended December 31, 2006						
	Reported GAAP(a) Amounts	Uninsured Discounts Adjustment(b)	Non-GAAP Adjusted Amounts(c)	GAAP % of Revenues		Non-GAAP % of Adjusted Revenues	
				2006	2005	2006	2005
Revenues	$ 25,477	$ 1,095	$ 26,572	100.0%	100.0%	100.0%	100.0%
Salaries and benefits	10,409		10,409	40.9	40.6	39.2	39.4
Supplies	4,322		4,322	17.0	16.9	16.3	16.4
Other operating expenses	4,057		4,057	16.0	16.5	15.2	15.9
Provision for doubtful accounts	2,660	1,095	3,755	10.4	9.6	14.1	12.4
Admissions	1,610,100		1,610,100				
Equivalent admissions	2,416,700		2,416,700				
Revenue per equivalent admission	$ 10,542		$ 10,995				
% change from prior year	6.8%		8.0%				
Same Facility(d):							
Revenues	$ 24,448	$ 1,063	$ 25,511				
Admissions	1,557,700		1,557,700				
Equivalent admissions	2,322,500		2,322,500				
Revenue per equivalent admission	$ 10,527		$ 10,984				
% change from prior year	6.2%		7.3%				

(a) Generally accepted accounting principles (GAAP).

(b) Represents the impact of the discounts for the uninsured for the period. On January 1, 2005, we modified our policies to 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. In implementing the discount policy, we first attempt to qualify uninsured patients for Medicaid, other federal or state assistance or charity care. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

(c) Revenues, the provision for doubtful accounts, certain operating expense categories as a percentage of revenues and revenue per equivalent admission have been adjusted to exclude the discounts under our uninsured discount policy (non-GAAP financial measures). We believe these non-GAAP financial measures are useful to investors and provide disclosures of our results of operations on the same basis as that used by management. Management finds this information to be useful to enable the evaluation of revenue and certain expense category trends that are influenced by patient volumes and are generally analyzed as a percentage of revenues. These non-GAAP financial measures should not be considered an alternative 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.

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

Table of Contents

Years Ended December 31, 2006 and 2005

Net income totaled $1.036 billion for the year ended December 31, 2006 compared to $1.424 billion for the year ended December 31, 2005. Financial results for 2006 include gains on investments of $243 million, gains on sales of facilities of $205 million, reductions to estimated professional liability reserves of $136 million, expenses related to the Recapitalization of $442 million and an asset impairment charge of $24 million. Financial results for 2005 include gains on investments of $53 million, gains on sales of facilities of $78 million, reductions to estimated professional liability reserves of $83 million, an adverse financial impact from hurricanes of $60 million, a tax benefit of $24 million related to the repatriation of foreign earnings, and a favorable tax settlement of $48 million related to the divestitures in 1998 and 2001 of certain noncore business units.

Revenues increased 4.2% to $25.477 billion for the year ended December 31, 2006 from $24.455 billion for the year ended December 31, 2005. The increase in revenues was due primarily to a 6.8% increase in revenue per equivalent admission offsetting a 2.4% decline in equivalent admissions compared to the prior year. Same facility revenues increased 6.2% due to a 6.2% increase in same facility revenue per equivalent admission and flat same facility equivalent admissions for the year ended December 31, 2006 compared to the year ended December 31, 2005.

During the year ended December 31, 2006, same facility admissions increased 0.2%, compared to the year ended December 31, 2005. Same facility inpatient surgeries increased 0.7% and same facility outpatient surgeries decreased 1.2% during the year ended December 31, 2006 compared to the year ended December 31, 2005.

Salaries and benefits, as a percentage of revenues, were 40.9% in 2006 and 40.6% in 2005. Salaries and benefits per equivalent admission increased 7.4% in 2006 compared to 2005. Labor rate increases averaged approximately 5.4% for the year ended December 31, 2006 compared to 2005.

Supplies, as a percentage of revenues, were 17.0% in 2006 and 16.9% in 2005. Supply costs per equivalent admission increased 7.4% in 2006 compared to 2005. Same facility supply costs increased 11.0% for medical devices (cardiology and orthopedic) and 2.6% for pharmacy products.

Other operating expenses, as a percentage of revenues, decreased to 16.0% in 2006 from 16.5% in 2005. Other operating expenses in 2006 reflect reductions to our estimated professional liability reserves of $136 million, compared to $83 million in reductions recorded in 2005. 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.

Provision for doubtful accounts, as a percentage of revenues, increased to 10.4% for the year ended December 31, 2006 from 9.6% in the year ended December 31, 2005. Adjusting for the effect of the discount policy for the uninsured, the provision for doubtful accounts, as a percentage of revenues, was 14.1% in 2006 compared to 12.4% in 2005. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts due directly from patients. The increase in the provision for doubtful accounts, as a percentage of revenues, can be attributed to an increasing amount of patient financial responsibility under certain managed care plans and same facility increases in uninsured emergency room visits of 6.2% and uninsured admissions of 10.9% in 2006 compared to 2005. At December 31, 2006, our allowance for doubtful accounts represented approximately 86% of the $3.972 billion total patient due accounts receivable balance, including accounts, net of estimated contractual discounts, related to patients for which eligibility for Medicaid coverage was being evaluated.

Gains on investments for the year ended December 31, 2006 of $243 million relate to sales of investment securities by our wholly-owned insurance subsidiary. Gains on investments for the year ended December 31, 2005 were $53 million. Net unrealized gains on investment securities declined from $184 million at December 31, 2005 to $25 million at December 31, 2006. The increase in realized gains and the decline in unrealized gains were primarily due to the decision to liquidate our equity investment portfolio and reinvest in debt and interest-bearing investments.

Table of Contents

Equity in earnings of affiliates decreased from $221 million for the year ended December 31, 2005 to $197 million for the year ended December 31, 2006. The decrease was primarily due to decreases in profits at the Denver, Colorado market joint venture.

Depreciation and amortization decreased, as a percentage of revenue, to 5.5% in the year ended December 31, 2006 from 5.6% in the year ended December 31, 2005. During 2005, we incurred additional depreciation expense of approximately $44 million to correct accumulated depreciation of certain facilities and assure a consistent application of our accounting policy relative to certain short-lived medical equipment.

Interest expense increased to $955 million for the year ended December 31, 2006 from $655 million for the year ended December 31, 2005. While interest expense increased $300 million for the year ended December 31, 2006 compared to 2005, $207 million of the increase occurred during the fourth quarter of 2006 due to the increased debt related to the Recapitalization. Our average debt balance was $13.811 billion for the year ended December 31, 2006 compared to $9.828 billion for the year ended December 31, 2005. The average interest rate for our long-term debt increased from 7.0% at December 31, 2005 to 7.9% at December 31, 2006.

Gains on sales of facilities were $205 million for the year ended December 31, 2006 and included a $92 million gain on the sale of four hospitals in West Virginia and Virginia and a $93 million gain on the sale of two hospitals in Florida. Gains on sales were facilities were $78 million for the year ended December 31, 2005 and included a $29 million gain related to the recognition of previously deferred gain on the sale of a group of medical office buildings.

Minority interests in earnings of consolidated entities increased from $178 million for the year ended December 31, 2005 to $201 million for the year ended December 31, 2006. The increase relates primarily to the operations of surgery centers and other outpatient services entities.

The effective tax rate was 37.6% for the year ended December 31, 2006 and 33.8% for the year ended December 31, 2005. During 2005, the effective tax rate was reduced due to a favorable tax settlement of $48 million related to the divestiture of certain noncore business units and a tax benefit of $24 million from the repatriation of foreign earnings. Excluding the effect of the combined $72 million tax benefit, the effective tax rate for the year ended December 31, 2005 would have been 37.1%.

Years Ended December 31, 2005 and 2004

Net income increased 14.2%, from $1.246 billion for the year ended December 31, 2004 to $1.424 billion for the year ended December 31, 2005. Financial results for 2005 include gains on investments of $53 million, gains on sales of facilities of $78 million, reductions to estimated professional liability reserves of $83 million, an adverse financial impact from hurricanes of $60 million, a tax benefit of $24 million related to the repatriation of foreign earnings, and a favorable tax settlement of $48 million related to the divestures in 1998 and 2001 of certain noncore business units. The 2004 results include gains on investments of $56 million, a favorable change in the estimated provision for doubtful accounts totaling $46 million based upon refinements to our allowance for doubtful accounts estimation process, a $59 million reduction to estimated professional liability reserves, an adverse financial impact from hurricanes of $40 million, and an impairment of long-lived assets of $12 million.

Revenues increased 4.1% to $24.455 billion for the year ended December 31, 2005 compared to $23.502 billion for the year ended December 31, 2004. The increase in revenues was due to a 0.9% increase in equivalent admissions and 3.1% increase in revenue per equivalent admission. Adjusting for the effect of the uninsured discount policy, revenues increased 7.3% for the year ended December 31, 2005 compared to 2004. For the year ended December 31, 2005, admissions decreased 0.7% and same facility admissions increased by 0.1% compared to 2004. Outpatient surgical volumes increased 0.2% and increased 0.3% on a same facility basis in 2005 compared to 2004.

Table of Contents

Salaries and benefits, as a percentage of revenues, were 40.6% in 2005 and 40.1% in 2004. Adjusting for the effect of the uninsured discount policy, salaries and benefits were 39.4% of revenues for the year ended December 31, 2005. Labor rate increases averaged approximately 4.2% for the year ended December 31, 2005.

Supply costs increased, as a percentage of revenues, to 16.9% for the year ended December 31, 2005 from 16.6% for the year ended December 31, 2004. Adjusting for the effect of the uninsured discount policy, supplies were 16.4% of revenues for the year ended December 31, 2005. During 2005, general supply cost trends included a more stable pricing environment for medical devices and pharmacy items and a stabilization in usage rates for drug-eluting stents.

Other operating expenses (primarily consisting of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance and nonincome taxes), as a percentage of revenues, increased to 16.5% in 2005 from 16.0% in 2004. Adjusting for the effect of the uninsured discount policy, other operating expenses were 15.9% of revenues for the year ended December 31, 2005.

The provision for doubtful accounts, as a percentage of revenues, declined to 9.6% for the year ended December 31, 2005 from 11.4% for the year ended December 31, 2004. Adjusting for the effect of the uninsured discount policy, the provision for doubtful accounts was 12.4% of revenues in the year ended December 31, 2005. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to uninsured amounts due directly from patients. The increase in the provision for doubtful accounts (adjusted for uninsured discounts), as a percentage of revenues, related to an increasing amount of patient financial responsibility under certain managed care plans, increases in uninsured emergency room visits of 9.9% and increases in uninsured admissions of 8.9% in 2005 compared to 2004. At December 31, 2005, the allowance for doubtful accounts represented approximately 85% of the $3.404 billion total patient due accounts receivable balance, including accounts, net of estimated contractual discounts, related to patients for which eligibility for Medicaid coverage was being evaluated.

Gains on investments for the year ended December 31, 2005 of $53 million consist primarily of net gains on investment securities held by our wholly-owned insurance subsidiary. Gains on investments for the year ended December 31, 2004 were $56 million. At December 31, 2005, we had net unrealized gains of $184 million on the insurance subsidiary s investment securities.

Equity in earnings of affiliates increased to $221 million for the year ended December 31, 2005 compared to $194 million for the year ended December 31, 2004. The increase was primarily due to an increase in profits at the Denver, Colorado market joint venture.

Depreciation and amortization increased, as a percentage of revenues, to 5.6% in the year ended December 31, 2005 from 5.3% in the year ended December 31, 2004. A portion of the increase is the result of additional depreciation expense of approximately $44 million recorded during 2005 to correct accumulated depreciation at certain facilities and assure a consistent application of our accounting policy relative to certain short-lived medical equipment.

Interest expense increased to $655 million for the year ended December 31, 2005 from $563 million for the year ended December 31, 2004. The average debt balance was $9.828 billion for the year ended December 31, 2005 compared to $8.853 billion for the year ended December 31, 2004. The average interest rate for our long-term debt increased from 6.5% at December 31, 2004 to 7.0% at December 31, 2005.

During 2004, we closed San Jose Medical Center in San Jose, California, resulting in a pretax asset impairment charge of $12 million ($8 million after-tax).

Minority interests in earnings of consolidated entities increased to $178 million for the year ended December 31, 2005 compared to $168 million for the year ended December 31, 2004.

Table of Contents

The effective tax rate was 33.8% for the year ended December 31, 2005 and 36.8% for the year ended December 31, 2004. During 2005, the effective tax rate was reduced due to a favorable tax settlement of $48 million related to the divestures of certain noncore business units in 1998 and 2001 and a tax benefit of $24 million related to the repatriation of foreign earnings. Excluding the effect of the combined $72 million of tax benefits, the effective tax rate for the year ended December 31, 2005 would have been 37.1%.

Liquidity and Capital Resources for the Six Months Ended June 30, 2007

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

Cash provided by operating activities totaled $406 million in the first six months of 2007 compared to $732 million in the first six months of 2006. Net income was $378 million lower in the first six months of 2007 compared to the first six months of 2006. In the first six months of 2007, our combined payments for interest and taxes were $1.319 billion, which represented a $158 million increase compared to the first six months of 2006. Working capital totaled $2.593 billion at June 30, 2007 and $2.502 billion at December 31, 2006.

Cash used in investing activities was $418 million in the first six months of 2007 compared to $795 million in the first six months of 2006. Excluding acquisitions, capital expenditures were $675 million in the first six months of 2007 and $820 million in the first six months of 2006. Capital expenditures are expected to approximate $1.7 billion in 2007 and $1.6 billion in 2008. At June 30, 2007, there were projects under construction which had estimated additional costs to complete and equip over the next five years of approximately $1.9 billion. We expect to finance capital expenditures with internally generated and borrowed funds. During the first six months of 2007 and 2006, we received cash proceeds of $65 million and $291 million, respectively, from dispositions of hospitals and health care entities. We received cash flows from our investments of $192 million for the first six months of 2007 and expended $150 million to increase investments for the first six months of 2006. Effective January 1, 2007, our facilities are generally self-insured for the first $5 million of per occurrence losses, and we are not required to maintain investments to fund the liabilities for claims that occurred after December 31, 2006. See Business Insurance.

Cash used in financing activities totaled $268 million during the first six months of 2007 compared to cash provided by financing activities of $463 million during the first six months of 2006. During the first six months of 2007, we decreased net borrowings by $356 million, issued 1,965,000 shares of common stock and received proceeds of $100 million. During the first six months of 2006, we increased net borrowings by $1.183 billion and repurchased 13.0 million shares of common stock for $653 million.

In addition to cash flows from operations, available sources of capital include amounts available under the senior secured credit facilities ($2.286 billion as of July 31, 2007) and anticipated access to public and private debt markets.

Investments of our professional liability insurance subsidiary to maintain statutory equity and pay claims (primarily claims that occurred prior to January 1, 2007) totaled $1.943 billion at June 30, 2007 and $2.143 billion at December 31, 2006, respectively. Claims payments, net of reinsurance recoveries, during the next twelve months are expected to approximate $250 million. Our wholly-owned insurance subsidiary has entered into certain reinsurance contracts, and the obligations covered by the reinsurance contracts are included in the 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. To minimize our exposure to losses from reinsurer insolvencies, we routinely monitor the financial condition of our reinsurers. The amounts receivable related to the reinsurance contracts were $45 million and $42 million at June 30, 2007 and December 31, 2006, respectively.

Table of Contents

Financing Activities

Due to the Recapitalization, we are highly leveraged and have significant debt service requirements. Our debt totaled $28.096 billion at June 30, 2007, which represents a $16.432 billion increase from the total debt of $11.664 billion at June 30, 2006. Interest expense increased from $196 million in the second quarter of 2006 to $557 million in the second quarter of 2007. Interest expense for the six months ended June 30, 2007 and 2006 was $1.114 billion and $382 million, respectively. We expect our interest expense to increase from $955 million for the year ended December 31, 2006 to approximately $2.3 billion in 2007.

In connection with the Recapitalization, we entered into (i) a $2.000 billion senior secured asset-based revolving credit facility with a borrowing base of 85% of eligible accounts receivable, subject to customary reserves and eligibility criteria ($245 million available at June 30, 2007) (the ABL credit facility) and (ii) a senior secured credit agreement (the cash flow credit facility and, together with the ABL credit facility, the senior secured credit facilities), consisting of a $2.000 billion revolving credit facility ($1.858 billion available at June 30, 2007 after giving effect to certain outstanding letters of credit), a $2.750 billion term loan A ($2.694 billion outstanding at June 30, 2007), a $8.800 billion term loan B ($8.756 billion outstanding at June 30, 2007) and a 1.000 billion European term loan (995 million or $1.341 billion outstanding at June 30, 2007). Obligations under the cash flow credit facility are guaranteed by substantially all material, wholly-owned U.S. subsidiaries, except those restricted under our 1993 Indenture. In addition, borrowings under the European term loan are guaranteed by all material, wholly-owned European subsidiaries.

Also in connection with the Recapitalization, we issued $4.200 billion of senior secured notes (comprised of $1.000 billion of 9 1/8% notes due 2014 and $3.200 billion of 9 1/4% notes due 2016) and $1.500 billion of 9 5/8% senior secured toggle notes (which allow us, at our option, to pay interest in kind during the first five years) due 2016, which are subject to certain standard covenants. The notes are guaranteed by certain of our subsidiaries.

In 2006, we issued $1.000 billion of 6.5% notes due 2016. Proceeds of $625 million were used to refinance the amounts outstanding under our 2005 term loan, and the remaining proceeds were used to pay down amounts advanced under our bank revolving credit facility.

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

Liquidity and Capital Resources for 2006

Cash provided by operating activities totaled $1.845 billion in 2006 compared to $2.971 billion in 2005 and $2.954 billion in 2004. Working capital totaled $2.502 billion at December 31, 2006 and $1.320 billion at December 31, 2005. Cash flows provided by operating activities include income tax benefits related to the exercise of employee stock awards of $163 million and $50 million for the years ended December 31, 2005 and 2004, respectively. For the year ended December 31, 2006, income tax benefits related to the exercise of employee stock awards of $97 million were included in financing activities. The lower cash provided by operating activities in 2006 when compared to both 2005 and 2004 relates, primarily, to increases in income tax payments, net of refunds, of $524 million for 2006 compared to 2005 and $693 million for 2006 compared to 2004, and increases in accounts receivable, net of the provision for doubtful accounts, of $92 million for 2006 compared to 2005 and $404 million for 2006 compared to 2004.

Cash used in investing activities was $1.307 billion, $1.681 billion and $1.688 billion in 2006, 2005 and 2004, respectively. Excluding acquisitions, capital expenditures were $1.865 billion in 2006, $1.592 billion in 2005 and $1.513 billion in 2004. We expended $112 million, $126 million and $44 million for acquisitions of hospitals and health care entities during 2006, 2005 and 2004, respectively. During 2006, acquisitions included

three hospitals and outpatient and ancillary services entities. During 2005 and 2004, the acquisitions were generally comprised of outpatient and ancillary services entities. Capital expenditures in all three years were funded by a combination of cash flows from operations and the issuance of debt.

The sales of nine hospitals were completed during 2006, and we received cash proceeds of $560 million. We also received proceeds of $91 million on the sales of real estate investments and our equity investment in a hospital joint venture. The sales of five hospitals were completed during 2005 and we received cash proceeds of $260 million.

Cash used in financing activities totaled $240 million in 2006, $1.212 billion in 2005 and $1.347 billion in 2004. The Recapitalization included the issuance of $19.964 billion of long-term debt, the receipt of $3.782 billion of equity contributions, the repurchase of $20.364 billion of common stock, the payment of $745 million related to Recapitalization related fees and expenses, and the retirement of $3.182 billion of existing long-term debt.

During 2006, we repurchased 13.1 million shares (excluding the Recapitalization) of our common stock for a total of $653 million. During 2005, we repurchased 36.7 million shares of our common stock for a total cost of $1.856 billion. During 2004, we repurchased 77.4 million shares of our common stock for a total cost of $3.109 billion. During 2005, we received cash inflows of $943 million related to the exercise of employee stock options.

In addition to cash flows from operations, available sources of capital include amounts available under our senior secured credit facilities ($1.8 billion as of December 31, 2006 and $2.5 billion as of February 28, 2007) and anticipated access to public and private debt markets.

Investments of our professional liability insurance subsidiary, to maintain statutory equity and pay claims, totaled $2.143 billion and $2.384 billion at December 31, 2006 and 2005, respectively. The amounts receivable related to reinsurance contracts were $42 million and $43 million at December 31, 2006 and 2005, respectively.

Financing Activities

Our debt totaled $28.408 billion at December 31, 2006 and represented a $17.933 billion increase from the total debt of $10.475 billion at December 31, 2005.

Proceeds from the senior secured credit facilities and the senior secured notes described under Liquidity and Capital Resources for Six Months Ended June 30, 2007 Financing Activities were used in connection with the closing of the Recapitalization and to repay the amounts owed under our previous bank credit agreements. In connection with the Recapitalization, we also tendered for all amounts outstanding under the 8.85% notes due 2007, the 7.00% notes due 2007, the 7.25% notes due 2008, the 5.25% notes due 2008 and the 5.50% notes due 2009 (collectively, the Short-term Notes). Approximately 97% of the $1.365 billion total outstanding amount under the Short-term Notes was repurchased pursuant to the tender.

In 2005, in connection with our modified Dutch auction tender offer, we entered into the 2005 term loan with several banks, which had a maturity of May 2006. Under this agreement, we borrowed $800 million. Proceeds from the 2005 term loan were used to partially fund the repurchase of our common stock. The proceeds of $175 million from the sales of hospitals in 2005 were used to repay a portion of the amounts outstanding under the 2005 term loan.

Table of Contents

Contractual Obligations and Off-Balance Sheet Arrangements

As of December 31, 2006, maturities of contractual obligations and other commercial commitments are presented in the table below (dollars in millions):

		Payment due by Period			
Contractual Obligations(a)	**Total**	**Current**	**2-3 Years**	**4-5 Years**	**After 5 Years**
Long-term debt including interest, excluding the senior secured credit facilities(b)	$ 25,272	$ 1,197	$ 2,370	$ 3,745	$ 17,960
Loans outstanding under the senior secured credit facilities, including interest(b)	22,535	1,390	2,892	3,235	15,018
Operating leases(c)	1,287	236	348	199	504
Purchase and other obligations(c)	27	17	5	5	
Total contractual obligations	$ 49,121	$ 2,840	$ 5,615	$ 7,184	$ 33,482

		Commitment Expiration by Period			
Other Commercial Commitments					
Not Recorded on the Consolidated Balance Sheet	**Total**	**Current**	**2-3 Years**	**4-5 Years**	**After 5 Years**
Letters of credit(d)	$ 134	$ 46	$	$	$ 88
Surety bonds(e)	131	126	5		
Physician commitments(f)	37	34	2	1	
Guarantees(g)	2				2
Total commercial commitments	$ 304	$ 206	$ 7	$ 1	$ 90

(a) We have not included obligations to pay estimated professional liability claims ($1.584 billion at December 31, 2006) in this table. The estimated professional liability claims are expected to be funded by the designated investment securities that are restricted for this purpose ($2.143 billion at December 31, 2006).

(b) Estimate of interest payments assumes that interest rates, borrowing spreads and foreign currency exchange rates at December 31, 2006, remain constant during the period presented.

(c) Future operating lease obligations and purchase obligations are not recorded in our consolidated balance sheet.

(d) Amounts relate primarily to instances in which we have letters of credit outstanding with insurance companies that issued workers compensation insurance policies to us in prior years. The letters of credit serve as security to the insurance companies for payment obligations we retained.

(e) Amounts relate primarily to instances in which we have agreed to indemnify various commercial insurers who have provided surety bonds to cover damages for malpractice cases which were awarded to plaintiffs by the courts. These cases are currently under appeal and the bonds will not be released by the courts until the cases are closed.

(f)

In consideration for physicians relocating to the communities in which our hospitals are located and agreeing to engage in private practice for the benefit of the respective communities, we make advances to physicians, normally over a period of one year, to assist in establishing the physicians practices. The actual amount of these commitments to be advanced often depends upon the financial results of the physicians private practices during the recruitment agreement payment period. The physician commitments reflected were based on our maximum exposure on effective agreements at December 31, 2006.

(g) We have entered into guarantee agreements related to certain leases.

Table of Contents

Indebtedness

Senior Secured Credit Facilities

Overview

On November 17, 2006 in connection with the Recapitalization, we entered into the senior secured credit facilities with Banc of America Securities LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and bookrunners, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A. and Citicorp North America, Inc., as co-syndication agents and Merrill Lynch Capital Corporation, as documentation agent.

The senior secured credit facilities provide senior secured financing of $16.800 billion, consisting of:

- $12.800 billion-equivalent in term loan facilities, comprised of a $2.750 billion senior secured term loan A facility with a term of six years, a $8.800 billion senior secured term loan B facility with a term of seven years and a 1.000 billion senior secured European term loan facility ($1.320 billion at December 31, 2006 and $1.341 billion at June 30, 2007) with a term of seven years; and

- $4.000 billion in revolving credit facilities, comprised of a $2.000 billion senior secured asset-based revolving credit facility with a term of six years and a $2.000 billion senior secured revolving credit facility available in dollars, euros and pounds sterling with a term of six years. Availability under the asset-based revolving credit facility is subject to a borrowing base of 85% of eligible accounts receivable less customary reserves and to certain eligibility criteria.

HCA Inc. is the primary borrower under the senior secured credit facilities, except that a U.K. subsidiary is the borrower under the European term loan facility. The revolving credit facilities include borrowing capacity available for letters of credit and for borrowings on same-day notice, referred to as the swingline loans. A portion of the letter of credit availability under the cash-flow revolving credit facility is available in euros, dollars and pounds sterling. The asset-based revolving credit facility is documented in a separate loan agreement from the other senior secured credit facilities.

Interest Rate and Fees

Borrowings under the senior secured credit facilities bear interest at a rate equal to, at our option, either (a) LIBOR for deposits in the applicable currency for the relevant interest period plus an applicable margin or (b) the higher of (1) the prime rate of Bank of America, N.A. and (2) the federal funds effective rate plus 0.50%, plus an applicable margin. The applicable margin for borrowing under the senior secured credit facilities, with the exception of the term loan B (where the margin is static), may be reduced subject to our attaining certain leverage ratios.

In addition to paying interest on outstanding principal under the senior secured credit facilities, we pay a commitment fee to the lenders under the revolving credit facilities in respect of the unutilized commitments thereunder. The initial commitment fee rate is 0.50% per annum for the revolving credit facility and 0.375% for the asset-based revolving credit facility. Each of these commitment fee rates may be reduced subject to our attaining certain leverage ratios. We must also pay customary letter of credit fees.

Prepayments

The senior secured credit facilities (other than the asset-based revolving credit facility) require us to prepay outstanding term loans, subject to certain exceptions, with:

- 50% (which percentage will be reduced to 25% if our total leverage ratio is 5.50x or less and to 0% if our total leverage ratio is 5.00x or less) of our annual excess cash flow;

Table of Contents

100% of the net cash proceeds of all nonordinary course asset sales or other dispositions of property, other than the Receivables Collateral, as defined below, if we do not (1) reinvest or commit to reinvest those proceeds in assets to be used in our business or to make certain other permitted investments within 15 months as long as such reinvestment is completed within 180 days or (2) apply such proceeds within 15 months to repay debt of HCA Inc. that was outstanding on the effective date of the Merger scheduled to mature prior to the earliest final maturity of the senior secured credit facilities then outstanding; and

100% of the net cash proceeds of any incurrence of debt, other than proceeds from the receivables facilities and other debt permitted under the senior secured credit facilities.

The foregoing mandatory prepayments are applied among the term loan facilities (1) during the first three years after the effective date of the Merger, pro rata to such facilities based on the respective aggregate amounts of unpaid principal installments thereof due during such period, with amounts allocated to each facility being applied to the remaining installments thereof in direct order of maturity and (2) thereafter, pro rata to such facilities, with amounts allocated to each facility being applied, in the case of the term loan A facility, pro rata to the remaining installments thereof and, in the case of the term loan B facility or the European term loan facility, to the next eight unpaid scheduled installments of principal of such facility and then pro rata to the remaining amortization payments under such facility. Notwithstanding the foregoing, (i) proceeds of asset sales by foreign subsidiaries are applied solely to prepay European term loans until such term loans have been repaid in full and (ii) we are not required to prepay loans under the term loan A facility or the term loan B facility with net cash proceeds of asset sales or with excess cash flow, in each case attributable to foreign subsidiaries, to the extent that the repatriation of such amounts is prohibited or delayed by applicable local law or would result in material adverse tax consequences.

The asset-based revolving credit facility requires us to prepay outstanding loans if borrowings exceed the borrowing base.

We may voluntarily repay outstanding loans under the senior secured credit facilities at any time without premium or penalty, other than customary breakage costs with respect to LIBOR loans.

Amortization

We are required to repay the loans under the term loan facilities as follows:

the term loan A facility amortizes in quarterly installments such that the aggregate amount of the original funded principal amount of such facility repaid pursuant to such amortization payments in each year, commencing with the year ending December 31, 2007, is equal to $112.5 million in years 1 and 2, $225 million in years 3 and 4, $450 million in year 5 and $1.625 billion in year 6; and

each of the term loan B facility and the European term loan facility amortizes in equal quarterly installments commencing March 31, 2007 in aggregate annual amounts equal to 1% of the original funded principal amount of such facility, with the balance being payable on the final maturity date of such term loans.

Principal amounts outstanding under the revolving credit facilities are due and payable in full at maturity, six years from the date of the closing of the senior secured credit facilities.

Guarantee and Security

All obligations under the senior secured credit facilities are unconditionally guaranteed by substantially all existing and future, direct and indirect, wholly-owned material domestic subsidiaries that are Unrestricted Subsidiaries under the 1993 Indenture (except for certain special purpose subsidiaries that only guarantee and pledge their assets under the asset-based revolving credit facility), and the obligations under the European term

Table of Contents

loan facility are also unconditionally guaranteed by HCA Inc. and each of our existing and future wholly owned material subsidiaries formed under the laws of England and Wales, subject, in each of the foregoing cases, to any applicable legal, regulatory or contractual constraints and to the requirement that such guarantee does not cause adverse tax consequences.

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

All obligations under the senior secured credit facilities (other than the asset-based revolving credit facility), and the guarantees of such obligations, are secured, subject to permitted liens and other exceptions, by:

- a first-priority lien on the capital stock owned by HCA Inc. or by any U.S. guarantor in each of their respective first-tier subsidiaries (limited, in the case of foreign subsidiaries, to 65% of the voting stock of such subsidiaries);
- a first-priority lien on substantially all present and future assets of HCA Inc. and of each U.S. guarantor other than (i) Principal Properties (as defined in the 1993 Indenture) except for certain Principal Properties not to exceed 10% of Consolidated Net Tangible Assets (as defined under the 1993 Indenture), (ii) certain other real properties and (iii) deposit accounts, other bank or securities accounts, cash, leaseholds, motor-vehicles and certain other exceptions (such collateral under this and the preceding bullet, the Non-Receivables Collateral); and
- a second-priority lien on certain of the Receivables Collateral (such portion of the Receivables Collateral, the Shared Receivables Collateral ; the Receivables Collateral which does not secure such senior secured credit facilities on a second-priority basis is referred to as the Separate Receivables Collateral).

The obligations of the borrowers and the guarantors under the European term loan facility are also secured by substantially all present and future assets of such borrowers and each such guarantor (the European Collateral), subject to permitted liens and other exceptions (including, without limitation, exceptions for deposit accounts, other bank or securities accounts, cash, leaseholds, motor-vehicles and certain other exceptions) and subject to such security interests otherwise being permitted by applicable law and contract and not resulting in adverse tax consequences.

Certain Covenants and Events of Default

The senior secured credit facilities contain a number of covenants that, among other things, restrict, subject to certain exceptions, our ability to:

- incur additional indebtedness;
- create liens;
- enter into sale and leaseback transactions;
- engage in mergers or consolidations;
- sell or transfer assets;

pay dividends and distributions or repurchase our capital stock;

make investments, loans or advances;

prepay certain subordinated indebtedness (including the notes and certain other indebtedness existing on the effective date of the Merger (Retained Indebtedness)), subject to exceptions for repayments of Retained Indebtedness maturing prior to the senior secured credit facilities and, in certain cases, to satisfaction of a maximum first-lien leverage condition;

make certain acquisitions;

Table of Contents

engage in certain transactions with affiliates;

amend material agreements governing certain subordinated indebtedness (including the notes); and

change our lines of business.

In addition, the senior secured credit facilities will require us to maintain the following financial covenants:

in the case of the asset-based revolving credit facility, a minimum interest coverage ratio (applicable only when availability under such facility is less than 10% of the borrowing base thereunder); and

in the case of the other senior secured credit facilities, a maximum total leverage ratio.

The senior secured credit facilities will also contain certain customary affirmative covenants and events of default, including a change of control.

The Notes

As described above, on November 17, 2006, in connection with the Recapitalization, we issued $4.200 billion of senior secured notes (comprised of $1.000 billion of 9 1/8% notes due 2014 and $3.200 billion of 9¼% notes due 2016) and $1.500 billion of 9 5/8% senior secured toggle notes due 2016. These notes are guaranteed by certain of our subsidiaries. The notes contain covenants that limit our and our restricted subsidiaries ability to, among other things, incur additional indebtedness or issue certain preferred shares, make restricted payments, 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.

Other Indebtedness

Senior Notes, Debentures and Medium Term Notes

As of June 30, 2007, we have outstanding an aggregate principal amount of $6.873 billion and £150 million of senior notes and debentures issued under our 1993 Indenture, consisting of the following series:

$7,196,000 aggregate principal amount of 7.00% Senior Notes due 2007;

$16,035,000 aggregate principal amount of 7.25% Senior Notes due 2008;

$2,097,000 aggregate principal amount of 5.25% Senior Notes due 2008;

$3,488,000 aggregate principal amount of 5.50% Senior Notes due 2009;

$691,170,000 aggregate principal amount of 8.75% Senior Notes due 2010;

£150,000,000 aggregate principal amount of 8.75% Senior Notes due 2010;

$475,820,000 aggregate principal amount of 7.875% Senior Notes due 2011;

$500,000,000 aggregate principal amount of 6.95% Senior Notes due 2012;

$500,000,000 aggregate principal amount of 6.30% Senior Notes due 2012;

$500,000,000 aggregate principal amount of 6.25% Senior Notes due 2013;

$500,000,000 aggregate principal amount of 6.75% Senior Notes due 2013;

$500,000,000 aggregate principal amount of 5.75% Senior Notes due 2014;

$750,000,000 aggregate principal amount of 6.375% Senior Notes due 2015;

$1,000,000,000 aggregate principal amount of 6.50% Senior Notes due 2016;

$291,436,000 aggregate principal amount of 7.69% Senior Notes due 2025;

Table of Contents

$250,000,000 aggregate principal amount of 7.50% Senior Notes due 2033;

$150,000,000 aggregate principal amount of 7.19% Debentures due 2015;

$135,645,000 aggregate principal amount of 7.5% Debentures due 2023;

$150,000,000 aggregate principal amount of 8.36% Debentures due 2024;

$150,000,000 aggregate principal amount of 7.05% Debentures due 2027;

$100,000,000 aggregate principal amount of 7.75% Debentures due 2036; and

$200,000,000 aggregate principal amount of 7.50% Debentures due 2095.

We also have outstanding $121,180,000 aggregate principal amount of our 8.70% Medium Term Notes due 2010; $121,110,000 aggregate principal amount of our 9.00% Medium Term Notes due 2014; and $125,000,000 aggregate principal amount of our 7.58% Medium Term Notes due 2025.

All of our outstanding series of senior notes, debentures and medium term notes were issued under the 1993 Indenture. The terms of the 1993 Indenture governing the existing senior notes, debentures and medium term notes provide that in addition to customary events of default, the aggregate amount of all other indebtedness of HCA secured by mortgages on Principal Properties (as such term is defined in the indenture) together with the aggregate principal amount of all indebtedness of restricted subsidiaries (as such term is defined in the 1993 Indenture) may not exceed 15% of the consolidated net tangible assets of HCA and its consolidated subsidiaries.

Other Secured Indebtedness

We had outstanding approximately $422 million of capital leases and other secured debt as of June 30, 2007.

Under our lease with HRT of Roanoke, Inc., effective December 20, 2005, we make annual payments for rent and additional expenses for the use of premises in Roanoke and Salem, Virginia. The rent payments will increase each year beginning January 1, 2007 by the lesser of 3% or the change in the Consumer Price Index. The lease is for a fixed-term of 12 years with the option to extend the lease for another ten years.

Under our lease with Medical City Dallas Limited, effective March 18, 2004, we make annual payments for rent for the use of premises that are a part of a complex known as Medical City Dallas located in Dallas, Texas. The rent payment is adjusted yearly based on the fair market value of the premises and a capitalization rate. The initial term is 240 months with the option to extend for two more terms of 240 months each.

Covenant Compliance

Under our senior secured credit facilities, we are required to satisfy and maintain specified financial ratios. Our continued ability to meet these ratios can be affected by events beyond our control, and we cannot assure you that we will meet these ratios. A breach of any of the covenants under our senior secured credit facilities could result in a default under those facilities. Upon the occurrence of an event of default under the senior secured credit facilities, the lenders 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. Any such acceleration would also result in a default under the indenture governing the notes. Additionally, incurrence-based financial ratios under certain provisions of the indenture governing the notes may limit our ability to engage in activities such as incurring additional indebtedness, making investments and paying dividends. See Risk Factors Risks Related to Our Indebtedness.

81

Table of Contents

Quantitative and Qualitative Disclosure about Market Risk

We are exposed to market risk related to changes in market values of securities. The investments in debt and equity securities of our wholly-owned insurance subsidiary were $1.897 billion and $46 million, respectively, at June 30, 2007. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. The fair value of investments is generally based on quoted market prices. At June 30, 2007, we had a net unrealized gain of $4 million on the insurance subsidiary s investment securities. If the insurance subsidiary were to experience significant declines in the fair value of its investments, this could require additional investment by us to allow the insurance subsidiary to satisfy its minimum capital requirements.

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

With respect to our interest-bearing liabilities, approximately $6.456 billion of long-term debt at June 30, 2007 is subject to variable rates of interest, while the remaining balance in long-term debt of $21.640 billion at June 30, 2007 is subject to fixed rates of interest. Both the general level of interest rates and, for the senior secured credit facilities, our leverage affect our variable interest rates. Our variable 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, as determined by the type of borrowing, either (a) a base rate determined by reference to the higher of (1) the federal funds rate plus 1/2 of 1% 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, plus, in each case, an applicable margin. The applicable margin for borrowings under the senior secured credit facilities, with the exception of term loan B where the margin is static, may be reduced subject to attaining certain leverage ratios. On February 16, 2007, we amended the cash flow credit facility to reduce the applicable margins with respect to the term loan borrowings thereunder. On June 20, 2007, we amended the ABL credit facility to reduce the applicable margin with respect to borrowings thereunder.

Due primarily to the lowering of our credit ratings in connection with the Recapitalization, the average rate for our long-term debt increased from 7.0% at June 30, 2006 to 7.7% at June 30, 2007. The estimated fair value of our total long-term debt was $28.366 billion at June 30, 2007. 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 $65 million. To mitigate the impact of fluctuations in interest rates, we generally target a portion of our debt portfolio to be maintained at fixed rates.

Our international operations and the European term loan expose us to market risks associated with foreign currencies. In order to mitigate the currency exposure related to debt service obligations through December 31, 2011 under the European term loan, we have entered into cross currency swap agreements. A cross currency swap is an agreement between two parties to exchange a stream of principal and interest payments in one currency for a stream of principal and interest payments in another currency over a specified period.

Financial Instruments

Derivative financial instruments are employed to manage risks, including foreign currency and interest rate exposures, and are not used for trading or speculative purposes. We recognize derivative instruments, such as

Table of Contents

interest rate swap agreements and foreign exchange contracts, in the consolidated balance sheets at fair value. Changes in the fair value of derivatives are recognized periodically either in earnings or in stockholders equity, as a component of other comprehensive income, depending on whether the derivative financial instrument qualifies for hedge accounting, and if so, whether it qualifies as a fair value hedge or a cash flow hedge. Gains and losses on derivatives designated as cash flow hedges, to the extent they are effective, are recorded in other comprehensive income, and subsequently reclassified to earnings to offset the impact of the hedged items when they occur.

Changes in the value of financial instruments denominated in foreign currencies used as hedges of the net investment in foreign operations are reported in other comprehensive income. Changes in the fair value of derivatives not qualifying as hedges, and for any portion of a hedge that is ineffective, are reported in earnings.

The net interest paid or received on interest rate swaps is recognized as interest expense. Gains and losses resulting from the early termination of interest rate swap agreements are deferred and amortized as adjustments to expense over the remaining period of the debt originally covered by the terminated swap.

Effects of Inflation and Changing Prices

Various federal, state and local laws have been enacted that, in certain cases, limit our ability to increase prices. Revenues for general, acute care hospital services rendered to Medicare patients are established under the federal government s prospective payment system. Total Medicare revenues approximated 26% in 2006, 27% in 2005 and 28% in 2004 of our total patient revenues.

Management believes that hospital industry operating margins have been, and may continue to be, under significant pressure because of changes in payer mix and growth in operating expenses in excess of the increase in prospective payments under the Medicare program. In addition, as a result of increasing regulatory and competitive pressures, our ability to maintain operating margins through price increases to non-Medicare patients is limited.

Pending IRS Disputes

We are currently contesting before the Appeals Division of the Internal Revenue Service (the IRS) certain claimed deficiencies and adjustments proposed by the IRS in connection with its examination of the 2001 and 2002 federal income tax returns for HCA and certain affiliates that are treated as partnerships for federal income tax purposes (affiliated partnerships). During 2006, the IRS began an examination of the 2003 and 2004 federal income tax returns for HCA and 19 affiliated partnerships. The IRS has not determined the final amount of additional income tax, interest and penalties that it may claim upon completion of these examinations. The disputed items pending before the IRS Appeal Division or proposed by the IRS Examination Division through June 30, 2007 include the deductibility of a portion of the 2001 government settlement payment, the timing of recognition of certain patient service revenues in 2001 through 2004, the method for calculating the tax allowance for doubtful accounts in 2002, and the amount of insurance expense deducted in 2001 and 2002. Through June 30, 2007, the IRS is seeking an additional $655 million in income taxes (this amount has increased as discussed in Risk Factors Risk Related to Our Business We may be subject to liabilities from claims by the IRS.), interest and penalties with respect to these issues. This amount is net of a refundable deposit of $215 million that we made during 2006. We expect the IRS will complete its examination of the 2003 and 2004 federal income tax returns and begin an examination of our 2005 and 2006 federal income tax returns within the next twelve months.

During the first quarter of 2007, we reached a settlement with the IRS Appeals Division regarding the timing of recognition of certain patient service revenue in 2000 and the amount of insurance expense deducted during 1999 and 2000. As a result of the settlement, we paid $10 million of additional income tax and interest in April 2007, which did not materially affect our results of operations.

Table of Contents

During 2003, the United States Court of Appeals for the Sixth Circuit affirmed a United States Tax Court (Tax Court) decision received in 1996 related to the IRS examination of Hospital Corporation of America s 1987 through 1988 federal income tax returns, in which the IRS contested the method that Hospital Corporation of America used to calculate its tax allowance for doubtful accounts. Due to the volume and complexity of calculating the tax allowance for doubtful accounts, the IRS has not determined the amount of additional tax and interest that it may claim for taxable years after 1988. Thirty-one federal taxable periods for HCA, its predecessors and subsidiaries from 1987 through 1996 are affected by the Tax Court decision. These taxable periods are pending before the IRS Examination Division, the Tax Court and the United States Court of Federal Claims. In 2004, we made a payment of $109 million for additional federal tax and interest, based on our estimate of amounts due for taxable periods through 1996. As of June 30, 2007, we and the IRS had reached agreement with respect to the tax and interest computations for two of the 31 federal taxable periods.

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

Table of Contents

BUSINESS

Our Company

We are the largest and most diversified investor-owned health care services provider in the United States. As of June 30, 2007, we operated 172 hospitals and 107 freestanding surgery centers in 20 states, England and Switzerland (including eight nonconsolidated hospitals and nine nonconsolidated surgery centers managed under joint ventures) and had approximately 183,000 employees and 35,000 affiliated physicians. For the year ended December 31, 2006, we generated revenues of $25.477 billion and net income of $1.036 billion, and for the six months ended June 30, 2007, we generated revenues of $13.406 billion and net income of $296 million.

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.

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

Our Industry

The U.S. health care industry is large and growing. According to the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare and Medicaid programs, U.S. health expenditures increased from 9.1% of gross domestic product (GDP), or $254 billion, in 1980 to 15.9%, or $1.9 trillion, in 2004. Additionally, CMS estimates that hospital spending, which has a 25-year track record of growth, currently represents more than 30% of total health care spending and is expected to grow at a 7.2% compounded annual growth rate from 2005 through 2015, reaching $1.2 trillion by 2015.

We believe that we are well positioned to benefit from the expected growth in hospital spending as well as the following hospital industry fundamentals:

Demographics. An aging population and longer life expectancies are expected to increase the demand for health care services in the United States. There are approximately 36 million Americans aged 65 or older, according to the U.S. Census Bureau s 2004 interim projections. This age group is expected to increase to approximately 40 million by 2010 and approximately 47 million by 2015, significantly increasing the number of eligible Medicare beneficiaries. According to CMS, Americans aged 65 or older spend 300% more per capita on hospital care as compared to the remainder of the U.S. population. The hospital industry is expected to benefit from these trends as a result of the corresponding increase in the demand for health care services.

Stable Reimbursement Environment. The acute care hospital sector is characterized by a stable Medicare reimbursement and commercial pricing environment. In the United States, general acute care hospitals are instrumental to the delivery of quality health care and represent a critical element of the overall health care infrastructure. Approximately 85% of these hospitals are owned and managed by not-for-profit or government entities that, according to the American Hospital Association (AHA), tend to have lower operating margins than investor-owned hospitals. We believe that Medicare, which accounts for approximately 30% of total hospital spending, will continue to provide appropriate pricing increases that will enable hospitals to provide high quality clinical care. For fiscal 2007, Medicare has budgeted a total payment increase of $3.4 billion for acute care inpatient services, which we believe is consistent with recent historical experience. CMS forecasts Medicare hospital spending to nearly double over the next 10 years.

Table of Contents

Commercial pricing has also been stable for hospital providers, and we believe commercial payors typically offer rate increases that exceed those offered by Medicare. With respect to commercial reimbursement, based on our experience, well-positioned hospital companies generally have been successful at receiving mid to high single-digit private pay increases over the past few years, and we expect this trend to continue.

Stable Industry Operating Margins. Over the past twenty years, the hospital industry has demonstrated an ability to manage its cost structure in response to changes in the reimbursement environment. Similarly, the hospital industry has managed unexpected cost increases due to exogenous factors, such as labor shortages or medical technology advances, by achieving increased levels of reimbursement from government and commercial payors. As a result, industry-wide margins historically have been stable. According to AHA, industry-wide operating margins increased approximately 200 basis points from 1990 to 2004, and while there were periods of modest margin expansion and contraction, in no five-year period did margins decline more than two percentage points.

Our Strengths

Largest Provider with a Diversified Revenue Base. We are the largest and most diversified investor-owned health care services provider in the United States. We maintain a diverse portfolio of assets with no single facility contributing more than 2.3% of revenue and no single metropolitan statistical area contributing more than 7.5% of revenue for the year ended December 31, 2006. In addition, we maintain a diversified payor base, including approximately 2,600 managed care contracts, with no one commercial payor representing more than 7% of revenue in the year ended December 31, 2006. We believe that our broad geographic footprint and diverse revenue base limit exposure to any single local market. We also provide a diverse array of medical and surgical services across different settings ranging from large hospitals to ambulatory surgery centers (ASCs), which, we believe, limits our exposure to changes in reimbursement policies targeting specific services or care settings.

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

Strong Presence in High Growth Markets. We have a leading market share in 13 of the 20 fastest growing markets in the United States with a population of greater than one million, including a significant presence in Florida and Texas, both of which are expected to grow in population at a rate higher than the national average. We believe that the majority of the high growth markets in which we have a presence will experience more rapid growth among the population aged 65 or older than the national average. We believe we will benefit from our presence in these key markets due to an expected increase in hospital spending.

Well-Capitalized Portfolio of High-Quality Assets. We have invested over $8.5 billion in our facilities over the past five years to expand the range, and improve the quality, of services provided at our facilities. As a result of our disciplined and strategic deployment of capital, we believe our hospitals enjoy a competitive advantage to attract high-quality physicians, maximize cost efficiencies and address the health care needs of our local communities.

Leading Provider of Outpatient Services. We are one of the largest providers of outpatient services in the United States, and these outpatient services accounted for approximately 36% of our revenues in 2006. The scope of our outpatient services reflects a recent trend toward the provision of an increasing number of services on an outpatient basis. An important component of our strategy is to achieve a fully integrated delivery model through the development of market-leading outpatient services, both to address outpatient migration and to provide higher growth, higher margin services.

Table of Contents

Reputation for Quality. Since our founding, we have maintained an unwavering focus on patients and clinical outcomes, which has earned us a leading reputation with the physicians, employees and communities that are our constituents. We have invested extensively in quality over the past 10 years, with an emphasis on implementing information technology and adopting industry-wide best practices and clinical protocols. As a result of these efforts, settled professional liability claims, based on actuarial projections per 1,000 beds, have dropped from 14.5 in 1997 to 10.0 in 2006. We also previously participated in the CMS National Voluntary Hospital Reporting Initiative and now participate in its successor, the Hospital Quality Alliance (HQA), which currently requires hospitals to report on their compliance with 21 measures of quality for four conditions affecting hospital inpatients in order to receive a full Medicare market basket payment increase. We believe quality measures increasingly will influence physician and patient choices about health care delivery and maximize our reimbursement as payors put more emphasis on performance. Our reputation and focus on providing high-quality patient care continue to make us the provider of choice for thousands of individual healthcare consumers, physicians and payors.

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

Leveraging Our Purchasing Power. We have established a captive group purchasing organization (GPO) to partner with other health care services providers to take advantage of our combined purchasing power. Our GPO generated $87 million, $101 million and $86 million of administrative fees from suppliers in 2004, 2005 and 2006, respectively, for performing GPO services and significantly lowered our supply costs. Because of our scale, our GPO has a per-unit cost advantage over competitors that we believe ranges from 5% to 15%.

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

Reducing Financial Impact of Uninsured Admissions. Beginning in 2004, we instituted at a small group of our hospitals a pilot program called the Qualified Medical Practitioner Program (QMP). The QMP is designed to reduce crowding at emergency rooms experiencing high volumes of low-intensity patients by informing patients of the most appropriate setting from which they may obtain treatment. Under the QMP, patients who meet certain criteria under federal guidelines are clinically examined to determine if their cases are emergencies or if treatment in a physician s office or clinic would be more appropriate.

Demonstrated Strong and Stable Cash Flows. Our leading market positions, diversified revenues, focus on operational efficiency and high-quality portfolio of assets have enabled us to generate strong and stable operating cash flows over the past several years. We generated EBITDA of $3.786 billion in 2004, $4.178 billion in 2005 and $4.007 billion in 2006 and cash flows from operating activities of $2.954 billion in 2004, $2.971 billion in 2005 and $1.845 billion in 2006. We believe that expected demand for hospital and outpatient services, together with our diversified payor base, geographic locations and service offerings, will allow us to continue to generate strong cash flows.

Experienced Management Team with Significant Equity Investment. Members of our management team are widely considered leaders in the hospital industry. Chairman and Chief Executive Officer Jack Bovender, Jr. has been with us for over 28 years and has been CEO for the past five years. In addition, Mr. Bovender was a hospital administrator during our 1989 buyout. President and Chief Operating Officer Richard Bracken began his career with us approximately 25 years ago and has held various executive positions with the Company. Executive Vice President and Chief Financial Officer R. Milton Johnson joined us over 24 years ago and has held various positions in financial operations at the Company. In addition, we benefit from our team of world-class operators who have the experience and talent necessary to run a complex business.

Table of Contents

In connection with the Recapitalization, several of our senior executive officers and other employees rolled over stock options or shares of our company or made additional cash investments in an aggregate amount of $125 million. We also implemented a stock incentive plan under which approximately 1,500 employees (including executive officers) are eligible to receive options covering up to 10% of our fully diluted equity immediately after consummation of the Recapitalization. In addition, on January 30, 2007, we completed an offering of 781,960 shares of our common stock to approximately 570 of our employees for an aggregate purchase price of $40 million.

Our Strategy

We are committed to providing high quality, cost-effective health care while complying fully with our ethics policy, governmental regulations and guidelines and industry standards. The principal elements of our strategy are as follows:

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

Expand Our Presence in Key Markets. We seek to grow our business in key markets, focusing on large, high growth urban and suburban communities, primarily in the southern and western regions of the United States. We seek to strategically invest in new and expanded services at our existing hospitals and surgery centers to increase our revenues at those facilities and provide the benefits of medical technology advances to our communities. For example, we intend to continue to expand high volume and high margin specialty services, such as cardiology and orthopedic services, and increase the capacity, scope and convenience of our outpatient facilities. To complement this organic growth, we intend to continue to opportunistically develop and acquire new hospitals and outpatient facilities. We believe these initiatives will enable us to grow our volumes, increase our acuity mix and enhance our operating margins, while simultaneously satisfying unmet demand in our existing markets.

Continue to Leverage Our Scale. We will continue to obtain price efficiencies through our GPO and to build on the cost savings and efficiencies in billing, collection and other processes we have achieved through our regional service centers. We are increasingly taking advantage of our national scale by contracting for services on a multistate basis. We will explore the feasibility of replicating our successful shared services model for additional clinical and support functions, such as physician credentialing, medical transcription and electronic medical recordkeeping, across multiple markets. We continuously seek new ways to leverage our scale to generate operating efficiencies and increase cash flow.

Continue to Develop Enduring Physician Relationships. We depend on the quality and dedication of the physicians who serve at our facilities, and we aggressively recruit both primary care physicians and key specialists to meet community needs and improve our market position. We strategically recruit physicians, often assisting them in establishing a practice or joining an existing practice where there is a community need and providing support to build their practices in compliance with regulatory standards. We intend to improve both service levels and revenues in our markets by:

- expanding the number of high quality specialty services, such as cardiology, orthopedics, oncology and neonatology;

- continuing to use joint ventures with physicians to further develop our outpatient business, particularly through ambulatory surgery centers and outpatient diagnostic centers;

Table of Contents

developing medical office buildings to provide convenient facilities for physicians to locate their practices and serve their patients; and

continuing our focus on improving hospital quality and performance and implementing advanced technologies in our facilities to attract physicians to our facilities.

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

Maintain Our Dedication to the Care and Improvement of Human Life. Our business is built on putting patients first and providing high quality health care services in the communities we serve. Our dedicated professionals oversee our Quality Review System, which measures clinical outcomes, satisfaction and regulatory compliance to improve hospital quality and performance. In addition, we continue to implement advanced health information technology to improve the quality and convenience of services to our communities. We are building on our advanced electronic medication administration record, which uses bar coding technology to ensure that each patient receives the right medication, toward a fully electronic health record that provides convenient access, electronic order entry and decision support for physicians. These technologies improve patient safety, quality and efficiency. Above all, we remain committed to a corporate culture that places a high value on compassion, honesty, integrity, fairness, loyalty, respect and kindness.

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

Business Drivers and Measures

Our Financial Policies and Objectives

We seek to optimize our financial and operating performance by implementing the business strategy set forth under Our Strategy. Our success in implementing this strategy depends, in turn, on our ability to fulfill our financial policies and objectives, which include the following:

Operations: We plan to focus on our core operations the provision of high quality, cost-effective health care in large, high growth urban and suburban communities, primarily in the southern and western regions of the United States. Our specific policies designed to maintain this focus include:

use physician recruitment and investments in new and expanded services to drive use of our facilities;

seek rate increases from managed care payors commensurate with increases in our underlying costs to provide high quality services;

manage operating expenses by, among other methods, leveraging our scale;

seek cost savings from reductions in our workforce, staffing reconfigurations and reductions in variable marketing and advertising expenses; and consider divesting non-core assets, where appropriate.

89

Table of Contents

Leverage: We expect to have significant indebtedness for the foreseeable future. However, we expect to:

- manage our floating interest rate exposure, including through the fixed-pay interest rate swap agreements for which we are the counterparty on $8.0 billion of our senior secured credit facility debt; and
- endeavor to improve our credit quality over time.

Capital Expenditures: We plan to maintain a disciplined capital expenditure approach by:

- targeting new investments with potentially high returns;
- deploying capital strategically to improve our competitive position and market share and to enhance our operations; and
- manage discretionary capital expenditures based on the strength of our cash flow.

Operational Factors

In pursuing our business and our financial policies and objectives, we pay close attention to a number of performance measures and operational factors.

Our revenues depend upon inpatient occupancy levels, the ancillary services and therapy programs ordered by physicians and provided to patients, the volume of outpatient procedures and the charges and negotiated payment rates for such services. Our expenses depend upon the levels of salaries and benefits to our employees, the cost of supplies and other operating expenses. To monitor these variables, we use a variety of metrics, including those described below.

Volume Measures:

- admissions, which is the total number of patients admitted to our hospitals and which we use as a measure of inpatient volume;
- equivalent admissions, which is a measure of patient volume that also takes into account outpatient volume;
- the payor mix of our admissions, i.e., the percentage of our admissions related to Medicare, Medicaid, managed Medicare, managed Medicaid, managed care and other insurers, and uninsured patients;
- emergency room visits;
- inpatient and outpatient surgeries; and

the average daily census of patients in our hospital beds.

Pricing Measures:

revenue per equivalent admission; and

revenue, minus our provision for doubtful accounts, per equivalent admission.

Expense Measures:

salaries and benefits expense per equivalent admission;

supplies expense per equivalent admission;

other operating expenses (including contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance and nonincome taxes) per equivalent admission; and

operating expenses, minus our provision for doubtful accounts, per equivalent admission.

Table of Contents

We set forth the volume measures described above, except for payor mix, for the years ended December 31, 2004, 2005 and 2006 under the heading Operating Data in Summary Summary Historical and Pro Forma Financial and Other Data. We give details about the payor mix for these periods in Results of Operations Revenue/Volume Trends.

The pricing and expense measures described above can be derived by dividing (1) the amounts from the applicable line items in our income statement (minus our provision for doubtful accounts, where indicated) by (2) equivalent admissions, which are set forth under the heading Operating Data in Summary Summary Historical and Pro Forma Financial and Other Data.

Addressing Uninsured and Self-Pay Patients

An increase in self-pay accounts receivable in our industry has led many hospital companies, including our company, to increase their write-offs of accounts receivable and increase their provisions for doubtful accounts.

A high percentage of our uninsured patients are initially admitted through our emergency rooms. For the year ended December 31, 2006, approximately 76% of our admissions of uninsured patients occurred through our emergency rooms. EMTALA requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital s emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the individual to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual s ability to pay for treatment.

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

- screening all patients, including the uninsured, through our developing QMP program, 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. Our up-front collections have increased from $185 million in 2004 to $258 million in 2005 to $269 million in 2006.

Business Segments

On January 1, 2006, we reorganized our company into the following three geographically organized groups:

- *Western Group*. The Western Group is comprised of the markets in Alaska, California, Colorado, Idaho, Kansas, Nevada, Oklahoma, Texas and Utah. Samuel Hazen, who has held various positions with HCA for 24 years, is the Western Group s President. As of December 31, 2006, there were 54 consolidating hospitals within the Western Group. In many of our Western Group markets, we maintain the number one or two inpatient market position, based on inpatient admissions. The Western Group includes all seven of our non-consolidated hospitals, with respect to which major strategic and operating decisions are shared equally with non-HCA partners. For the year ended December 31, 2006, the Western Group generated revenues of $10.495 billion.
- *Central Group*. The Central Group is comprised of the markets in Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, New Hampshire, Tennessee and Virginia. Paul Rutledge, who has held various positions with HCA for 20 years, is the Central Group s President. As of December 31, 2006, there were 51 consolidating hospitals within the Central Group. For the year ended December 31, 2006, the Central Group generated revenues of $5.514 billion.

Table of Contents

Eastern Group. The Eastern Group is comprised of the markets in Florida, Georgia and South Carolina. Charles Hall, who has held various positions with HCA for 20 years, is the Eastern Group s President. As of December 31, 2006, there were 53 consolidating hospitals within the Eastern Group. For the year ended December 31, 2006, the Eastern Group generated revenues of $8.609 billion.

We also owned and operated eight hospitals in England and Switzerland as of December 31, 2006, which are included in our Corporate and Other Segment. These international facilities generated revenues of $743 million for the year ended December 31, 2006.

On July 20, 2007, we completed the sale of our two Switzerland hospitals for $394 million. These were the only hospitals we owned or operated in Switzerland, and we expect to recognize a pretax gain of approximately $310 million on the sale. Proceeds from the sale were used to reduce the outstanding balance under our European term loan.

The reorganization created smaller groups and correspondingly smaller division and market structures. This change was designed to augment our market-based strategy by encouraging hospitals in a market to work together as a system to provide integrated services to their respective community. This new structure allows our management to focus on more manageable groupings of hospitals and provide them with more direct support.

Note 13 to our audited consolidated financial statements and Note 8 to our unaudited condensed consolidated financial statements contain information by segment on our revenues, equity in earnings of affiliates, adjusted segment EBITDA, depreciation and amortization, assets and goodwill for the years ended December 31, 2004, 2005 and 2006 and the quarters and six months ended June 30, 2006 and 2007, respectively.

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, 2006, we owned and operated 160 general, acute care hospitals with 38,754 licensed beds, and an additional six general, acute care hospitals with 2,127 licensed beds are operated through joint ventures that 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, 2006, we operated six psychiatric hospitals with 600 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.

Outpatient health care facilities operated by us include freestanding surgery centers, diagnostic and imaging centers, comprehensive outpatient rehabilitation and physical therapy centers, outpatient radiation and oncology therapy centers and various other facilities. These outpatient services are an integral component of our strategy to develop comprehensive health care networks in select communities. Several of our surgery centers are operated through partnerships, with majority ownership of each partnership typically held by a general partner that is an affiliate of HCA.

The operating agreements governing our hospital joint ventures and our surgery center partnerships allocate profits and losses to the partners in proportion to their respective membership interests in a given joint venture or

Table of Contents

partnership. These agreements also generally prohibit the partners from operating competing businesses within a stated distance of, or geographic area around, the hospital or surgery center operated by the joint venture or partnership, as the case may be, and restrict transfers of membership interests primarily through rights of first refusal in favor of the other partners and/or the joint venture itself.

As part of our ongoing business strategy, we enter into agreements to acquire or divest various facilities, including, but not limited to, hospitals, surgery centers and medical offices. To the extent we are divesting facilities, most of the agreements subject us to non-competition clauses for a stated period following the closing of the divestiture. In each case, the non-competition clause is limited geographically to the particular county of, or a stated distance around, the divested facility. These agreements also provide that we indemnify the buyers for certain liabilities that relate to the period during which we owned the facilities and breaches of the representations and warranties contained in the agreements. The agreements often provide certain limitations and procedural obligations relative to the buyers rights to indemnification, including a limitation that certain indemnity claims cannot exceed the purchase price. In connection with acquisitions of facilities, many of the agreements require us to undertake, for a stated period, certain capital expenditures and other obligations, such as agreements not to close any acquired facility and to provide the same level of charitable and indigent care as was provided prior to our acquisition of the facility.

Certain of our affiliates provide capital resources and 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.

Hospital Utilization

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

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

	Years Ended December 31,				
	2002	2003	2004	2005	2006
Number of hospitals at end of period(a)	173	184	182	175	166
Number of freestanding outpatient surgery centers at end of period(b)	74	79	84	87	98
Number of licensed beds at end of period(c)	39,932	42,108	41,852	41,265	39,354
Weighted average licensed beds(d)	39,985	41,568	41,997	41,902	40,653
Admissions(e)	1,582,800	1,635,200	1,659,200	1,647,800	1,610,100
Equivalent admissions(f)	2,339,400	2,405,400	2,454,000	2,476,600	2,416,700
Average length of stay (days)(g)	5.0	5.0	5.0	4.9	4.9
Average daily census(h)	21,509	22,234	22,493	22,225	21,688
Occupancy rate(i)	54%	54%	54%	53%	53%
Emergency room visits(j)	4,802,800	5,160,200	5,219,500	5,415,200	5,213,500
Outpatient surgeries(k)	809,900	814,300	834,800	836,600	820,900
Inpatient surgeries(l)	518,100	528,600	541,000	541,400	533,100

Table of Contents

(a) Excludes seven facilities in 2003, 2004, 2005 and 2006, and six facilities in 2002 that are not consolidated (but were accounted for using the equity method) for financial reporting purposes.

(b) Excludes nine facilities in 2006, seven facilities in 2005, eight facilities in 2004 and four facilities in 2003 and 2002 that are not consolidated (but were accounted for using the equity method) for financial reporting purposes.

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

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

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

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

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

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

(i) Represents the percentage of hospital licensed beds occupied by patients. Both the average daily census and the 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.

Government Health Programs and Our Business

We receive payment for patient services from the federal government primarily under the Medicare program, state governments under their respective Medicaid or similar programs, managed care plans, private insurers and directly from patients. Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal 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. 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 has been increasing each year. Collection of amounts due from

Table of Contents

individuals is typically more difficult than from governmental or third-party payers. On January 1, 2005, we modified our policies to provide a discount 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. In implementing the discount policy, we attempt to qualify uninsured patients for Medicaid, other federal or state assistance or charity care. If an uninsured patient does not qualify for these programs, the uninsured discount is applied. See Management s Discussion and Analysis of Financial Condition and Results of Operations Results of Operations Revenue/Volume Trends.

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 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. See also Business Drivers and Measures.

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 patient revenues from such sources for the years ended December 31, 2004, 2005 and 2006 were as follows:

	Year Ended December 31,		
	2004	**2005**	**2006**
Medicare	28%	27%	26%
Managed Medicare	(a)	(a)	5
Medicaid	5	5	5
Managed Medicaid	3	3	3
Managed care and other insurers(a)	54	57	53
Uninsured(b)	10	8	8
	100%	100%	100%

(a) Prior to 2006, managed Medicare revenues were classified as managed care.

(b) Uninsured revenues for the years ended December 31, 2006 and 2005 were reduced by $1.095 billion and $769 million, respectively, of discounts to the uninsured, related to the uninsured discount program implemented January 1, 2005.

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 hospital inpatient PPS, fixed payment amounts per inpatient discharge are established based on the patient s assigned diagnosis related group (DRG). DRGs classify treatments for illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. DRG weights represent the average resources for a given DRG relative to the average resources for all DRGs. When the cost to treat certain patients falls well outside the normal distribution, providers typically receive additional outlier payments. DRG payments do not consider a specific hospital s cost but are adjusted for area wage differentials. Hospitals, other than those defined as new, receive PPS reimbursement for inpatient capital costs based on DRG weights multiplied by a geographically adjusted federal rate.

Table of Contents

DRG rates are updated and DRG weights are recalibrated each federal fiscal year (which begins October 1). The index used to update the 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. However, for several years, the percentage increases to the DRG rates have been lower than the percentage increases in the costs of goods and services purchased by hospitals. In federal fiscal year 2006, the DRG rate increase was a market basket of 3.7%. For federal fiscal year 2007, the Centers for Medicare and Medicaid Services (CMS) set the DRG rate increase at the full market basket of 3.4%. For federal fiscal year 2008, the market basket rate of increase is 3.3%. Medicare payments to hospitals in fiscal 2008 will be reduced by 1.2% to eliminate what CMS estimates will be the effect of coding or classification changes as a result of hospitals implementing the MS-DRG system described in the next paragraph. This so-called documentation and coding adjustment will increase to 1.8% for both fiscal 2009 and 2010. Additionally, Medicare payments to hospitals are subject to a number of other adjustments, and the actual impact on payments to specific hospitals may vary. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provided for DRG rate increases for certain federal fiscal years at the full market basket, if data for ten patient care quality indicators were submitted to the Secretary of the Department of Health and Human Services (HHS). On February 8, 2006, the federal Deficit Reduction Act of 2005 (DRA 2005) was enacted by Congress to expand and provide for the future expansion of the number of quality measures that must be reported. CMS has expanded the number of quality measures as required by DRA 2005, and we expect that CMS will continue to expand the number of quality measures in the future, including adding measures relating to outpatient care. Failure to submit the required quality indicators will result in a two percentage point reduction to the market basket update. All of our hospitals paid under Medicare inpatient DRG PPS are participating in the quality initiative by the Secretary of HHS by submitting the quality data requested. 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.

In August 2006, CMS changed the methodology used to recalibrate the DRG weights from charge-based weights to cost relative weights under a three-year transition period beginning in federal fiscal year 2007. The adoption of the cost relative weights is not anticipated to have a material financial impact on us. On August 22, 2007, CMS issued a final rule which adopts a two-year implementation of Medicare Severity Diagnostic-Related Groups (MS-DRGs), a severity-adjusted diagnosis-related group system. This change represents a refinement to the existing DRG system, making its impact on revenue difficult to quantify. Realignments in the DRG system could impact the margins we receive for certain services.

Future realignments in the DRG system could also reduce the margins we receive for certain specialties, including cardiology and orthopedics. The greater proliferation of specialty hospitals in recent years has caused CMS to focus on payment levels for such specialties. Changes in the payments received for specialty services could have an adverse effect on our revenues.

Historically, the Medicare program has set aside 5.1% of Medicare inpatient payments to pay for outlier cases. CMS estimates that outlier payments were 3.96% and 4.65% of total operating DRG payments for federal fiscal years 2005 and 2006, respectively. For federal fiscal year 2007, CMS has established an outlier threshold of $24,485, which resulted in outlier payments of 4.6% as estimated by CMS. For federal fiscal year 2008, CMS has established an outlier threshold of $22,635. We do not anticipate that the change to the outlier threshold for federal fiscal year 2008 will have a material impact on our revenues.

We recorded $124 million, $148 million and $162 million of revenues related to Medicare operating outlier cases for 2004, 2005 and 2006, respectively. These amounts represent 1.9%, 2.2% and 2.5% of our Medicare revenues and 0.5%, 0.6% and 0.6% of our total revenues for 2004, 2005 and 2006, respectively.

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. Medicare Part A services include hospital, skilled

nursing facility and hospice services. Medicare Part B services include physician services and other outpatient services. CMS has continued to use existing 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 and independent diagnostic testing facilities are reimbursed on a fee schedule.

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 2005 and 2006 by market basket of 3.3% and 3.7%, respectively. However, as a result of the expiration of additional payments for drugs that were being paid in calendar year 2005, for calendar year 2006 there was an effective 2.25% reduction to the market basket of 3.7%, resulting in a net market basket of 1.45%. For calendar year 2007, MMA provided for a full market basket update of 3.4%. CMS has announced that it will require hospitals to submit quality data relating to outpatient care in order to receive the full market basket increase under the outpatient PPS beginning in calendar year 2009. CMS has proposed 10 quality measures related to outpatient care that hospitals must report in order to receive the full market basket update in 2009. Hospitals that fail to submit such data will receive the market basket update minus two percentage points for the outpatient PPS.

Rehabilitation

CMS reimburses inpatient rehabilitation facilities (IRFs) on a PPS basis. Under IRF PPS, patients are classified into case mix groups based upon impairment, age, comorbidities (additional diseases or disorders from which the patient suffers) and functional capability. IRFs are paid a predetermined amount per discharge that reflects the patient s case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. For federal fiscal years 2006 and 2007, CMS updated the PPS rate for rehabilitation hospitals and units by market basket of 3.6% and 3.3%, respectively. However, CMS also applied reductions to the standard payment amount of 1.9% and 2.6% for federal fiscal years 2006 and 2007, respectively, to account for coding changes that do not reflect real changes in case mix. For federal fiscal year 2008, CMS updated the PPS rate for IRFs by a market basket of 3.2%. As of December 31, 2006, we had one rehabilitation hospital, which is operated through a joint venture, and 49 hospital rehabilitation units.

On May 7, 2004, CMS published a final rule to change the criteria for being classified as an IRF, commonly known as the 75 percent rule. CMS revised the medical conditions for patients served by rehabilitation facilities from ten medical conditions to 13 conditions. Pursuant to this final rule, a specified percentage of a facility s inpatients over a given year must be treated for one of these conditions. The final rule, as amended by DRA 2005, provides for a transition period during which the percentage threshold would increase. For cost reporting periods that began on or after July 1, 2004 and before July 1, 2005, the compliance threshold was set at 50% of the IRF s total patient population. For cost reporting periods beginning on or after July 1, 2005 and before July 1, 2007, the compliance threshold was set at 60% of the IRF s total patient population. For cost reporting periods beginning on or after July 1, 2007, and before July 1, 2008, the compliance threshold is set at 65%. The compliance threshold will be set at 75% for cost reporting periods beginning on or after July 1, 2008. Implementation of the 75 percent rule has started to reduce our IRF admissions and can be expected to continue to significantly restrict the treatment of patients whose medical conditions do not meet any of the 13 approved conditions.

Medicare fiscal intermediaries have been given the authority to develop and implement Local Coverage Determinations (LCD) to determine the medical necessity of care rendered to Medicare patients where there is no national coverage determination. Some intermediaries have finalized their LCDs for rehabilitation services. A restrictive rehabilitation LCD has the potential to significantly impact Medicare rehabilitation payments. Some fiscal intermediaries have implemented LCDs that are more stringent than the 75 percent rule or have retroactively denied coverage based on new LCDs. The financial impact on us of the implementation of final rehabilitation LCDs throughout our markets is uncertain.

Table of Contents

Psychiatric

Payments to PPS-exempt psychiatric hospitals and units are based upon reasonable cost, subject to a cost-per-discharge target (the TEFRA limits) which are updated annually by a market basket index. The target amount for federal fiscal year 2006 was subject to a market basket update of 3.8% for psychiatric hospitals and units that are being paid under the three-year transition to the inpatient psychiatric PPS.

On November 15, 2004, CMS published a final regulation to implement a PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units of general, acute care hospitals and critical access hospitals (IPF PPS). The new prospective payment system replaces the cost-based system for reporting periods beginning on or after January 1, 2005. IPF PPS is a per diem prospective payment system, 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. IPF PPS is being implemented over a three-year transition period with full payment under IPF PPS to begin in the fourth year. Also, CMS has included a stop-loss provision to ensure that hospitals avoid significant losses during the transition. CMS has established the IPF PPS payment rate in a manner intended to be budget neutral and has adopted a July 1 update cycle. Thus, the initial IPF PPS per diem payment rate was effective for the 18-month period January 1, 2005 through June 30, 2006. CMS updated payments under the IPF PPS for rate year 2007 (July 1, 2006 to June 30, 2007) by 4.5% (reflecting the blend of the 4.6% update for IPF TEFRA and the 4.3% update for IPF PPS payments). The market basket update for rate year 2007 accounted for moving from a calendar year to a rate year (the annual market basket was estimated to be 3.4%). CMS has updated payments under IPF PPS for rate year 2008 (July 1, 2007 to June 30, 2008) by 3.1% (reflecting the blend of the update for IPF TEFRA and the IPF PPS system).

As of December 31, 2006, we had six psychiatric hospitals and 36 hospital psychiatric units.

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. For federal fiscal year 2006, CMS applied an occupational mix adjustment factor to the wage index amounts for the first time but limited the adjustment to 10% of the wage index. CMS increased the occupational mix adjustment to 100% for inpatient PPS effective for federal fiscal year 2007 and subsequent years.

MMA lowered the labor share for inpatient PPS payments for hospitals with wage indices less than or equal to 1.0 from 71.1% to 62.0%, effective October 1, 2004, unless the lower percentage would result in lower payments to the hospital. This change, in effect, increases payments for all hospitals whose wage index is less than or equal to 1.0. For all other hospitals, CMS lowered the 71.1% labor share to 69.7%, effective October 1, 2005. Also, effective October 1, 2005, IRF PPS adopted the Core-Based Statistical Area (CBSA) definition of labor market geographic areas but has not adopted an occupational mix adjustment. For federal fiscal year 2006, IRFs received a blended (50/50) wage index based on the old and new wage geographic definitions.

The occupational mix adjustment has not been applied to IPF PPS at this time. However, in the final rule published on May 9, 2006, CMS adopted the CBSA definition of labor market geographic areas for IPF PPS effective July 1, 2006.

The adoption of the wage indices based upon the new wage definitions and the adoption of the occupational mix adjustment for inpatient PPS, while slightly negative in the aggregate, are not anticipated to have a material financial impact for 2007.

CMS has a significant initiative underway that could affect the administration of the Medicare program and impact how hospitals bill and receive payment for covered Medicare services. In accordance with MMA, CMS has initiated the implementation of contractor reform whereby CMS will competitively bid the Medicare fiscal

Table of Contents

intermediary and Medicare carrier functions to Medicare Administrative Contractors (MACs). Hospital companies will have the option to work with the selected MAC in the jurisdiction where a given hospital is located or to use the MAC in the jurisdiction where the hospital company s home office is located. CMS has awarded MAC contracts in Jurisdictions 3, 4, and 5 to Noridian Administrative Services, Trailblazer Health Enterprises, and Wisconsin Physicians Service Health Insurance Corporation, respectively. HCA currently operates 63 hospitals in these three jurisdictions combined, and Mutual of Omaha continues to serve as their fiscal intermediary in each of these three jurisdictions. An additional five jurisdictions are expected to be awarded in 2007, and the remaining seven jurisdictions are expected to be awarded in September 2008. All of these changes could impact claims processing functions and the resulting cash flow. We cannot predict the impact that these changes could have on our cash flow.

Effective January 1, 2007, as a result of DRA 2005, reimbursements for ASC overhead costs are limited to no more than the overhead costs paid to hospital outpatient departments under the Medicare hospital outpatient prospective payment system for the same procedure. On August 2, 2007, CMS issued final regulations that change payment for procedures performed in an ASC, effective January 1, 2008. Under this rule, ASC payment groups will increase from the current nine clinically disparate payment groups to the 221 APCs used under the outpatient prospective payment system for these surgical services. CMS estimates that the rates for procedures performed in an ASC setting will equal 65% of the corresponding rates paid for the same procedures performed in an outpatient hospital setting. Moreover, if CMS determines that a procedure is commonly performed in a physician s office, the ASC reimbursement for that procedure will be limited to the reimbursement allowable under the Medicare Part B Physician Fee Schedule. In addition, all surgical procedures, other than those that pose a significant safety risk or generally require an overnight stay, will be payable as ASC procedures. This will expand the number of procedures that Medicare will pay for if performed in an ASC. Because the new payment system will have a significant impact on payments for certain procedures, the final rule establishes a four-year transition period for implementing the revised payment rates. More Medicare procedures that are now performed in hospitals, such as ours, may be moved to ASCs, reducing surgical volume in our hospitals. Also, more Medicare procedures that are now performed in ASCs, such as ours, may be moved to physicians offices. Commercial third-party payers may adopt similar policies.

Hospital operating margins have been, and may continue to be, under significant pressure because of deterioration in pricing flexibility and payer mix and because of growth in operating expenses in excess of the increase in PPS payments under the Medicare program.

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.

Medicaid

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

Since states must operate with balanced budgets and since the Medicaid program is often the state s largest program, states can be expected to adopt or consider adopting legislation designed to reduce their Medicaid expenditures. DRA 2005 includes Medicaid cuts of approximately $4.8 billion over five years. On May 29, 2007,

Table of Contents

CMS published a final rule entitled Medicaid Program; Cost Limits for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership. A moratorium was placed on this rule, delaying its implementation until 2008. However, when the moratorium expires next year, this final rule could significantly impact state Medicaid programs. In its proposed form, this rule was expected to reduce federal Medicaid funding by $12.2 billion over five years. As a result of the moratorium on implementing the final rule, the impact of the final rule is uncertain. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position and results of operations.

Managed Medicaid

Managed Medicaid programs relate to situations where states contract with one or more entities for patient enrollment, care management and claims adjudication. The states usually do not abdicate 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.

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 revenue, 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 prior years 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 managed care and other insurers were 42%, 42% and 36% of our total admissions for the years ended December 31, 2004, 2005 and 2006, respectively (prior to 2006, managed Medicare admissions, 6% of 2006 admissions, were classified as managed care). Managed care contracts are typically negotiated for one-year or two-year terms. While we generally received annual average yield increases of six to seven percent from managed care payers during 2006, there can be no assurance that we will continue to receive increases in the future.

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 the past several years the number of freestanding surgery centers and diagnostic centers (including facilities owned by physicians) in the geographic areas in which we operate has increased significantly. As a result, most of our hospitals operate in a highly competitive environment. The rates charged by our hospitals are intended to be competitive with those charged by other local hospitals for similar services. In some cases, competing hospitals are more established than our hospitals. Some

Table of Contents

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 tax revenues, and are exempt from sales, property and income taxes. Such exemptions and support are not available to our hospitals. In certain localities, there are large teaching hospitals that provide highly specialized facilities, equipment and services which may not be available at most of our hospitals. We are facing increasing competition from physician-owned specialty hospitals and freestanding surgery centers for market share in high margin services.

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

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

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

Another major factor in the competitive position of a hospital is management s 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 are increasingly interested in containing 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. 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. 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 Regulation.

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

Admissions and average lengths of stay continue to be negatively affected by payer-required preadmission authorization, utilization review and payer pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Increased competition, admission constraints and payer pressures are expected to continue. To meet these challenges, we intend to expand many of our facilities or acquire or

Table of Contents

construct new facilities to better enable the provision of a comprehensive array of outpatient services, offer discounts to private payer groups, upgrade facilities and equipment, and offer new or expanded programs and services.

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. Effective January 1, 2007, our facilities are generally self-insured for professional liability risks for the first $5 million of per occurrence losses. Our facilities are insured by our wholly-owned insurance subsidiary for losses up to $50 million per occurrence above the $5 million self-insured limit. 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. Self-insured claims are paid out of our operating cash flow and are charged against these self-insurance reserves. Claims for all losses occurring prior to January 1, 2007 will continue to be paid by our insurance subsidiary.

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 fail to meet their obligations, our results of operations and financial position could be adversely affected.

We purchase, from unrelated insurance companies, coverage for directors and officers liability and property loss in amounts that we believe are customary for our industry. The directors and officers liability coverage includes a $25 million corporate deductible for the periods prior to the Recapitalization and a $1 million corporate deductible subsequent to the Recapitalization. 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.

Environmental Matters

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

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 Investigation, Claims and Litigation

Commencing in 1997, we became aware we were the subject of governmental investigations and litigation relating to our business practices. As part of the investigations, the United States intervened in a number of qui tam actions brought by private parties. The investigations related to, among other things, DRG coding, outpatient laboratory billing, home health issues, physician relations, cost report and wound care issues. The investigations were concluded through a series of agreements executed in 2000 and 2003 with the Criminal Division of the Department of Justice, the Civil Division of the Department of Justice, various U.S. Attorneys offices, CMS, a negotiating team representing states with claims against us, and others. In January 2001, we entered into an eight-

year CIA with the Office of Inspector General of the Department of Health and Human Services. We paid total settlement costs, including interest, of approximately $900 million in 2001 and $942 million in 2003 related to the government investigations. Violation or breach of the CIA, or other violation of federal or state laws relating to Medicare, Medicaid or similar programs, could subject us to substantial monetary fines, civil and criminal penalties and/or exclusion from participation in the Medicare and Medicaid programs and other federal and state health care programs. Alleged violations may be pursued by the government or through private *qui tam* actions. Sanctions imposed against us as a result of such actions could have a material adverse effect on our results of operations and financial position.

Securities Class Action Litigation

In November 2005, two putative federal securities law class actions were filed in the United States District Court for the Middle District of Tennessee seeking monetary damages on behalf of persons who purchased our stock between January 12, 2005 and July 13, 2005. These substantially similar lawsuits assert claims pursuant to Sections 10(b) and 20(a) of the Exchange Act, and Rule 10b-5 promulgated thereunder, against us and our Chairman and Chief Executive Officer, President and Chief Operating Officer, and Executive Vice President and Chief Financial Officer, related to our July 13, 2005 announcement of preliminary results of operations for the quarter ended June 30, 2005.

On January 5, 2006, the court consolidated these actions and all later-filed related securities actions under the caption *In re HCA Inc. Securities Litigation*, case number 3:05-CV-00960. Pursuant to federal statute, on January 25, 2006, the court appointed co-lead plaintiffs to represent the interests of the asserted class members in this litigation. Co-lead plaintiffs filed a consolidated amended complaint on April 21, 2006. We believe that the allegations contained within these class action lawsuits are without merit.

On June 27, 2006, we and each of the defendants moved to dismiss the consolidated amended complaint, and these motions are still pending. The lead plaintiffs have agreed to settle this litigation for payment by HCA of $20 million, inclusive of costs and attorneys fees. The settlement is subject to approval by the court and the putative class members.

Shareholder Derivative Lawsuits in Federal Court

In November 2005, two then shareholders each filed a derivative lawsuit, purportedly on behalf of our company, in the United States District Court for the Middle District of Tennessee against our Chairman and Chief Executive Officer, President and Chief Operating Officer, Executive Vice President and Chief Financial Officer, other executives, and certain members of our Board of Directors. Each lawsuit asserts claims for breaches of fiduciary duty, abuse of control, gross mismanagement, waste of corporate assets, and unjust enrichment in connection with our July 13, 2005 announcement of preliminary results of operations for the quarter ended June 30, 2005 and seeks monetary damages.

On January 23, 2006, the Court consolidated these actions as *In re HCA Inc. Derivative Litigation*, lead case number 3:05-CV-0968. The court stayed this action on February 27, 2006, pending resolution of a motion to dismiss the consolidated amended complaint in the related federal securities class action against us. On March 24, 2006, a consolidated derivative complaint was filed pursuant to a prior court order. On November 8, 2006, we reached an agreement in principle for the settlement of this consolidated action. The proposed settlement is subject to definitive documentation and court approval.

Shareholder Derivative Lawsuit in State Court

On January 18, 2006, a then shareholder filed a derivative lawsuit, purportedly on behalf of our company, in the Circuit Court for the State of Tennessee (Nashville District), against our Chairman and Chief Executive Officer, President and Chief Operating Officer, Executive Vice President and Chief Financial Officer, other

executives, and certain members of our Board of Directors. This lawsuit is substantially identical in all material respects to the consolidated federal litigation described above under Shareholder Derivative Lawsuits in Federal Court. The Court stayed this action on April 3, 2006, pending resolution of a motion to dismiss the consolidated amended complaint in the related federal securities class action against us. On November 8, 2006, we reached an agreement in principle for the settlement of this action. The proposed settlement is subject to definitive documentation and court approval.

ERISA Litigation

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

On January 13, 2006, the court signed an order staying all proceedings and discovery in this matter, pending resolution of a motion to dismiss the consolidated amended complaint in the related federal securities class action against HCA. On January 18, 2006, the magistrate judge signed an order (1) consolidating Thurman s cause of action with all other future actions making the same claims and arising out of the same operative facts, (2) appointing Thurman as lead plaintiff, and (3) appointing Thurman s attorneys as lead counsel and liaison counsel in the case. On January 26, 2006, the court issued an order reassigning the case to United States District Court Judge William J. Haynes, Jr., who has been presiding over the federal securities class action and federal derivative lawsuits.

Merger Litigation in State Court

We are aware of six asserted class action lawsuits related to the Merger filed against us, our Chairman and Chief Executive Officer, our President and Chief Operating Officer, members of the Board of Directors and each of the Sponsors in the Chancery Court for Davidson County, Tennessee. The complaints are substantially similar and allege, among other things, that the Merger was the product of a flawed process, that the consideration to be paid to our shareholders in the Merger was unfair and inadequate, and that there was a breach of fiduciary duties. The complaints further allege that the Sponsors abetted the actions of our officers and directors in breaching their fiduciary duties to our shareholders. The complaints sought, among other relief, an injunction preventing completion of the Merger. On August 3, 2006, the Chancery Court consolidated these actions and all later-filed actions as *In re HCA Inc. Shareholder Litigation*, case number 06-1816-III.

On November 8, 2006, we and the other named parties entered into a memorandum of understanding with plaintiffs counsel in connection with these actions.

Under the terms of the memorandum, we, the other named parties and the plaintiffs agreed to settle the lawsuit subject to court approval. If the court approves the settlement contemplated in the memorandum, the lawsuit will be dismissed with prejudice. We and the other defendants deny all of the allegations in the lawsuit. Pursuant to the terms of the memorandum, Hercules Holding agreed to waive that portion in excess of $220 million of any termination fee that it has a right to receive under the Merger Agreement. Also, we and the other parties agreed not to assert that a then shareholder s demand for appraisal was untimely under Section 262 of the General Corporation Law of the State of Delaware (the DGCL) where such shareholder submitted a written demand for appraisal within 30 calendar days of the shareholders meeting held to adopt the Merger Agreement (with any such deadline being extended to the following business day should the 30th day fall on a holiday or weekend). We and the other parties also agreed not to assert that (i) the surviving corporation in the Merger or then shareholder who was entitled to appraisal rights may not file a petition in the Court of Chancery

Table of Contents

of the State of Delaware demanding a determination of the value of the shares held by all such shareholders if such petition was not filed within 120 days of the effective time of the Merger so long as such petition was filed within 150 days of the effective time, (ii) a then shareholder may not withdraw such shareholder s demand for appraisal and accept the terms offered by the Merger if such withdrawal was not made within 60 days of the effective time of the Merger so long as such withdrawal was made within 90 days of the effective time of the Merger and (iii) that a then shareholder may not, upon written request, receive from the surviving corporation a statement setting forth the aggregate number of shares not voted in favor of the Merger with respect to which demands for appraisal have been received and the aggregate number of holders of such shares if such request was not made within 120 days of the effective time of the Merger so long as such request was made within 150 days of the effective time. We and the other parties also agreed to a payment of attorney fees, as awarded by the court, of up to $12.4 million.

Two cases making similar allegations and seeking similar relief on behalf of purported classes of then shareholders have also been filed in Delaware. These two actions have also been consolidated under case number 2307-N and are pending in the Delaware Chancery Court, New Castle County. We believe this lawsuit is without merit and plan to defend it vigorously. We further believe the claims asserted in this lawsuit are subject to the November 8, 2006 agreement in principle to settle the Merger litigation and shareholder derivative lawsuits.

On October 23, 2006, the Foundation for Seacoast Health filed a lawsuit against us and one of our affiliates, HCA Health Services of New Hampshire, Inc., in the Superior Court of Rockingham County, New Hampshire. Among other things, the complaint seeks to enforce certain provisions of an asset purchase agreement between the parties, including a purported right of first refusal to purchase a New Hampshire hospital, that allegedly are triggered by the Merger and other prior events. The Foundation initially sought to enjoin the Merger. However, the parties reached an agreement that allowed the Merger to proceed, while preserving the plaintiff s opportunity to litigate whether the Merger triggered the right of first refusal to purchase the hospital and, if so, at what price the hospital could be repurchased. On May 25, 2007, the court granted HCA s motion for summary judgment disposing of the Foundation s central claims. The Foundation has filed an appeal from the final judgment.

General Liability and Other Claims

On April 10, 2006, a class action complaint was filed against us in the District Court of Kansas alleging, among other matters, nurse understaffing at all of our hospitals, certain consumer protection act violations, negligence and unjust enrichment. The complaint is seeking, among other relief, declaratory relief and monetary damages, including disgorgement of profits, of $12.25 billion. A motion to dismiss this action was granted on July 27, 2006, but the plaintiffs have appealed this dismissal. We believe this lawsuit is without merit and plan to defend it vigorously.

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

Employees and Medical Staffs

At December 31, 2006, we had approximately 186,000 employees, including approximately 49,000 part-time employees. References herein to employees refer to employees of affiliates of HCA. We are subject to various state and federal laws that regulate wages, hours, benefits and other terms and conditions relating to

Table of Contents

employment. Employees at 21 and 16 of our hospitals were represented by various labor unions at December 31, 2006 and 2005, respectively. We consider our employee relations to be satisfactory. Our hospitals have experienced some recent union organizational activity. We had elections at one hospital in California in February 2007 and July 2007 and at another hospital in California in February 2007 and April 2007. We do not expect such efforts to materially affect our future operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate. In some markets, nurse and medical support personnel availability has become a significant operating issue to health care providers. To address this challenge, we have implemented several initiatives to improve retention, recruiting, compensation programs and productivity. This shortage may also require an increase in the utilization of more expensive temporary personnel.

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.

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, 2006:

State	Hospitals	Beds
Alaska	1	238
California	5	1,504
Colorado	7	2,246
Florida	38	9,900
Georgia	12	2,124
Idaho	2	476
Indiana	1	278
Kansas	4	1,286
Kentucky	2	384
Louisiana	11	1,748
Mississippi	1	130
Missouri	7	1,222
Nevada	3	1,075
New Hampshire	2	295
Oklahoma	2	942
South Carolina	3	740
Tennessee	13	2,297
Texas	35	9,896
Utah	6	932
Virginia	10	2,963
International		
Switzerland(1)	2	220
England	6	704
	173	41,600

(1) On July 20, 2007, we sold our Switzerland operations for approximately $394 million.

Table of Contents

In addition to the hospitals listed in the above table, we directly or indirectly operate 107 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.

We maintain our headquarters in approximately 914,000 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.

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.

Table of Contents

REGULATION

Our operations are subject to a variety of federal, state and local laws and regulations. The reimbursements we receive for services rendered to patients covered by the federal Medicare and Medicaid program are extensively regulated and are described in Business Government Health Programs and Our Business. Other major regulatory requirements are briefly discussed below.

Licensure, Certification and Accreditation

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

Certificates of Need

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

State Rate Review

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

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by quality improvement organizations to assess the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of DRG classifications and the appropriateness of cases of extraordinary length of stay or cost.

Table of Contents

Quality improvement organizations may deny payment for services provided, may assess fines and also have the authority to recommend to HHS that a provider that is in substantial noncompliance with the appropriate standards be excluded from participating in the Medicare program. Most nongovernmental managed care organizations also require utilization review.

Federal Health Care Program Regulations

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

Anti-kickback Statute

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

The Office of Inspector General at HHS (OIG), among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse and waste. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. As one means of providing guidance to health care providers, the OIG issues Special Fraud Alerts. These alerts do not have the force of law, but identify features of arrangements or transactions that may indicate that the arrangements or transactions violate the Anti-kickback Statute or other federal health care laws. The OIG has identified several incentive arrangements, which, if accompanied by inappropriate intent, constitute suspect practices, including: (a) payment of any incentive by the 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 that provide that, if the physician s income fails to reach a predetermined level, the hospital will pay any portion of the remainder, (f) low-interest or interest-free