HCA Holdings, Inc.
Form 424B4
March 11, 2011

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PROSPECTUS

Filed pursuant to Rule 424(b)(4)
Registration No. 333-171369

HCA Holdings, Inc.

126,200,000 Shares

Common Stock
$30.00 per share

We are offering 87,719,300 shares of our common stock, and the selling stockholders named in this prospectus are offering 38,480,700 shares of our common stock. We will not receive any proceeds from the sale of the shares by the selling stockholders.

This is an initial public offering of our common stock. Since November 2006 and prior to this offering, there has been no public market for our common stock. Our common stock has been approved for listing on the New York Stock Exchange under the symbol HCA.

Investing in our common stock involves a high degree of risk. See Risk Factors beginning on page 13 of this prospectus to read about factors you should consider before buying shares of our common stock.

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

	Per Share	Total
Initial price to public	$ 30.00	$ 3,786,000,000
Underwriting discount	$ 1.0875	$ 137,242,500
Proceeds, before expenses, to HCA Holdings, Inc.	$ 28.9125	$ 2,536,184,261
Proceeds, before expenses, to the selling stockholders	$ 28.9125	$ 1,112,573,239

To the extent that the underwriters sell more than 126,200,000 shares of common stock, the underwriters have the option to purchase up to an additional 18,930,000 shares from the selling stockholders at the initial price to the public less the underwriting discount.

The underwriters expect to deliver the shares against payment in New York, New York on or about March 15, 2011.

Joint Book-Running Managers

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

Barclays Capital
Credit Suisse
Deutsche Bank Securities
Goldman, Sachs & Co.
Morgan Stanley
Wells Fargo Securities

Senior Co-Managers

Credit Agricole CIB **Mizuho Securities USA Inc.** **RBC Capital Markets**
RBS **SMBC Nikko** **SunTrust Robinson Humphrey**

Co-Managers

Avondale Partners **Baird** **Cowen and Company** **CRT Capital Group LLC**
Lazard Capital Markets **Leerink Swann** **Morgan Keegan** **Oppenheimer & Co.**
Raymond James **Susquehanna Financial Group, LLLP**

Prospectus dated March 9, 2011.

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

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MARKET, RANKING AND OTHER INDUSTRY DATA

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

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

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PROSPECTUS SUMMARY

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

As used herein, unless otherwise stated or indicated by context, references to the Company, HCA, we, our or us refer to HCA Inc. and its affiliates prior to the Corporate Reorganization (as defined below) and to HCA Holdings, Inc. and its affiliates after the Corporate Reorganization. The term affiliates means direct and indirect subsidiaries of HCA Holdings, Inc. and partnerships and joint ventures in which such subsidiaries are partners. The terms facilities or hospitals refer to entities owned and operated by affiliates of HCA and the term employees refers to employees of affiliates of HCA.

Our Company

We are the largest non-governmental hospital operator in the U.S. and a leading comprehensive, integrated provider of health care and related services. We provide these services through a network of acute care hospitals, outpatient facilities, clinics and other patient care delivery settings. As of December 31, 2010, we operated a diversified portfolio of 164 hospitals (with approximately 41,000 beds) and 106 freestanding surgery centers across 20 states throughout the U.S. and in England. As a result of our efforts to establish significant market share in large and growing urban markets with attractive demographic and economic profiles, we currently have a substantial market presence in 14 of the top 25 fastest growing markets with populations greater than 500,000 in the U.S. and currently maintain the first or second position, based on inpatient admissions, in many of our key markets. We believe our ability to successfully position and grow our assets in attractive markets and execute our operating plan has contributed to the strength of our financial performance over the last several years. For the year ended December 31, 2010, we generated revenues of $30.683 billion, net income attributable to HCA Holdings, Inc. of $1.207 billion and Adjusted EBITDA of $5.868 billion.

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

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

these component services to other health care companies.

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

On November 17, 2006, HCA Inc. was acquired by a private investor group comprised of affiliates of or funds sponsored by Bain Capital Partners, LLC (Bain Capital), Kohlberg Kravis Roberts & Co. (KKR),

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Merrill Lynch Global Private Equity (MLGPE), now BAML Capital Partners (each a Sponsor), Citigroup Inc., Bank of America Corporation (the Sponsor Assignees) and HCA founder Dr. Thomas F. Frist, Jr. (the Frist Entities), a group we collectively refer to as the Investors, and by members of management and certain other investors. We refer to the merger, the financing transactions related to the merger and other related transactions collectively as the Recapitalization.

Since the Recapitalization, we have achieved substantial operational and financial progress. During this time, we have made significant investments in expanding our service lines and expanding our alignment with highly specialized and primary care physicians. In addition, we have enhanced our operating efficiencies through a number of corporate cost-saving initiatives and an expansion of our support infrastructure. We have made investments in information technology to optimize our facilities and systems. We have also undertaken a number of initiatives to improve clinical quality and patient satisfaction. As a result of these initiatives, our financial performance has improved significantly from the year ended December 31, 2007, the first full year following the Recapitalization, to the year ended December 31, 2010, with revenues growing by $3.825 billion, net income attributable to HCA Holdings, Inc. increasing by $333 million and Adjusted EBITDA increasing by $1.276 billion. This represents compounded annual growth rates on these key metrics of 4.5%, 11.4% and 8.5%, respectively.

Our Industry

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

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

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

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

time, increase our reimbursement related to providing services to individuals who were previously uninsured. On the other hand, the reductions in the growth in Medicare payments and the decreases in DSH payments will adversely affect our government reimbursement. Because of the many variables involved, including pending court challenges, the potential for

changes to the law as a result and efforts to amend or repeal the law, we are unable to predict the net impact of the Health Reform Law on us; however, we believe our experienced management team, emphasis on quality care and diverse service offerings will enable us to capitalize on the opportunities presented by the Health Reform Law, as well as adapt in a timely manner to its challenges.

Our Competitive Strengths

We believe our key competitive strengths include:

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

Reputation for High Quality Patient-Centered Care. Since our founding, we have maintained an unwavering focus on patients and clinical outcomes. We believe clinical quality influences physician and patient choices about health care delivery. We align our quality initiatives throughout the organization by engaging corporate, local, physician and nurse leaders to share best practices and develop standards for delivering high quality care. We have invested extensively in quality of care initiatives, with an emphasis on implementing information technology and adopting industry-wide best practices and clinical protocols. As a result of these efforts, we have achieved significant progress in clinical quality. As measured by the CMS clinical core measures reported on the CMS Hospital Compare website and based on publicly available data for the twelve months ended March 31, 2010, our hospitals achieved a composite score of 98.4% of the CMS core measures versus the national average of 95.3%, making us among the top performing major health systems in the U.S. In addition, as required by the Health Reform Law, CMS will establish a value-based purchasing system and will adjust hospital payment rates based on hospital-acquired conditions and hospital readmissions. We also believe our quality initiatives favorably position us in a payment environment that is increasingly performance-based.

Leading Local Market Positions in Large, Growing, Urban Markets. Over our history, we have sought to selectively expand and upgrade our asset base to create a premium portfolio of assets in attractive growing markets. As a result, we have a strong market presence in 14 of the top 25 fastest growing markets with populations greater than 500,000 in the U.S. We currently operate in 29 markets, 17 of which have populations of 1 million or more, with all but one of these markets projecting growth above the national average from 2009 to 2014. Our inpatient market share places us first or second in many of our key markets. We believe the strength and stability of these market positions will create organic growth opportunities and allow us to develop long-term relationships with patients, physicians, large employers and third-party payers.

Diversified Revenue Base and Payer Mix. We believe our broad geographic footprint, varied service lines and diverse revenue base mitigate our risks in numerous ways. Our diversification limits our exposure to competitive dynamics and economic conditions in any single local market, reimbursement changes in specific service lines and disruptions with respect to payers such as state Medicaid programs or large commercial insurers. We have a diverse portfolio of assets with no single facility contributing more than 2.3% of our revenues and no single metropolitan statistical area contributing more than 8.0% of revenues for the year ended December 31, 2010. We have also developed a highly diversified payer base, including approximately 3,000 managed care contracts, with no single commercial payer representing more than 8% of revenues for the year ended December 31, 2010. In addition, we are one of the country s largest providers of outpatient services, which accounted for approximately 38% of our revenues for the year ended

December 31, 2010. We believe the geographic diversity of our markets and the scope of our inpatient and outpatient operations help reduce volatility in our operating results.

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

Well-Capitalized Portfolio of High Quality Assets. In order to expand the range and improve the quality of services provided at our facilities, we invested over $7.5 billion in our facilities and information technology systems over the five-year period ended December 31, 2010. We believe our significant capital investments in these areas will continue to attract new and returning patients, attract and retain high-quality physicians, maximize cost efficiencies and address the health care needs of our local communities. Furthermore, we believe our platform, as well as electronic health record infrastructure, national research and physician management capabilities, provide a strategic advantage by enhancing our ability to capitalize on anticipated incentives through the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) and position us well in an environment that increasingly emphasizes quality, transparency and coordination of care.

Strong Operating Results and Cash Flows. Our leading scale, diversification, favorable market positions, dedication to clinical quality and focus on operational efficiency have enabled us to achieve attractive historical financial performance even during the most recent economic period. In the year ended December 31, 2010, we generated net income attributable to HCA Holdings, Inc. of $1.207 billion, Adjusted EBITDA of $5.868 billion and cash flows from operating activities of $3.085 billion. Our ability to generate strong and consistent cash flow from operations has enabled us to invest in our operations, reduce our debt, enhance earnings per share and continue to pursue attractive growth opportunities.

Proven and Experienced Management Team. We believe the extensive experience and depth of our management team are a distinct competitive advantage in the complicated and evolving industry in which we compete. Our CEO and Chairman of the Board of Directors, Richard M. Bracken, began his career with our company over 29 years ago and has held various executive positions with us over that period, including, most recently, as our President and Chief Operating Officer. Our President, Chief Financial Officer and Director, R. Milton Johnson, joined our company over 28 years ago and has held various positions in our financial operations since that time. Our six Group Presidents average approximately 20 years of experience with our company. Members of our senior management hold significant equity interests in our company, further aligning their long-term interests with those of our stockholders.

Our Growth Strategy

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

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

see the benefit of this investment.

Achieve Industry-Leading Performance in Clinical and Satisfaction Measures. Achieving high levels of patient safety, patient satisfaction and clinical quality are central goals of our business model. To achieve these

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

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

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

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

Corporate Reorganization

On November 22, 2010, HCA Inc. reorganized by creating a new holding company structure (the Corporate Reorganization). We are the new parent company, and HCA Inc. is now our wholly-owned direct subsidiary. As part of the Corporate Reorganization, HCA Inc. s outstanding shares of capital stock were automatically converted, on a share for share basis, into identical shares of our common stock. Our amended and restated certificate of incorporation, amended and restated bylaws, executive officers and board of directors following the Corporate Reorganization are the same as HCA Inc. s in effect immediately prior to the Corporate Reorganization, and the rights, privileges and interests of HCA Inc. s stockholders remain the same with respect to us as the new holding company. Additionally, as a result of the Corporate Reorganization, we are deemed the successor registrant to HCA Inc. under the Securities and Exchange Act of 1934, as amended (the Exchange Act), and shares of our common stock are deemed registered under Section 12(g) of the Exchange Act. As part of the Corporate Reorganization, we became a guarantor but did not assume the debt of HCA Inc. s outstanding secured notes. See Description of Indebtedness.

We have assumed all of HCA Inc. s obligations with respect to the outstanding shares previously registered on Form S-8 for distribution pursuant to HCA Inc. s stock incentive plan and have also assumed HCA Inc. s other equity

incentive plans that provide for the right to acquire HCA Inc. s common stock, whether or not exercisable. We have also assumed and agreed to perform HCA Inc. s obligations under its other compensation plans and agreements pursuant to which HCA Inc. is to issue equity securities to its directors, officers, or employees. The

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agreements and plans we assumed were each deemed to be automatically amended as necessary to provide that references therein to HCA Inc. now refer to HCA Holdings, Inc. Consequently, following the Corporate Reorganization, the right to receive HCA Inc. s common stock under its various compensation plans and agreements automatically converted into rights for the same number of shares of our common stock, with the same rights and conditions as the corresponding HCA Inc. rights prior to the Corporate Reorganization.

Risk Factors

Investing in our common stock involves substantial risk, and our ability to successfully operate our business is subject to numerous risks, including those that are generally associated with operating in the health care industry. Any of the factors set forth under Risk Factors may limit our ability to successfully execute our business strategy. You should carefully consider all of the information set forth in this prospectus and, in particular, should evaluate the specific factors set forth under Risk Factors in deciding whether to invest in our common stock. Among these important risks are the following:

- our substantial debt could limit our ability to pursue our growth strategy;
- our debt agreements contain restrictions that may limit our flexibility in operating our business;
- the current economic climate and general economic factors may adversely affect our performance;
- we face intense competition that could limit our growth opportunities;
- we are required to comply with extensive laws and regulations that could impact our operations;
- legal proceedings and governmental investigations could negatively impact our business; and
- uninsured and patient due accounts could adversely affect our results of operations.

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

Through our predecessors, we commenced operations in 1968. HCA Inc. was incorporated in Nevada in January 1990 and reincorporated in Delaware in September 1993. HCA Holdings, Inc. was incorporated in Delaware in October 2010. Our principal executive offices are located at One Park Plaza, Nashville, Tennessee 37203, and our telephone number is (615) 344-9551. Our website address is *www.hcahealthcare.com*. The information on our website is not part of this prospectus.

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The Offering

Common stock offered by HCA	87,719,300 shares
Common stock offered by selling stockholders	38,480,700 shares
Common stock to be outstanding after this offering	515,205,100 shares
Use of Proceeds	We estimate that the net proceeds to us from this offering, after deducting underwriting discounts and estimated offering expenses, will be approximately $2.5 billion. We intend to use the anticipated net proceeds to repay certain of our existing indebtedness, as will be determined following completion of this offering, and for general corporate purposes. Pending such application, we intend to use the anticipated proceeds to temporarily reduce amounts under our asset-based revolving credit facility and our senior secured revolving credit facility. As a result of this application of proceeds, this offering is subject to the conflict of interest provisions of Rule 5121 of the Financial Industry Regulatory Authority, Inc. Conduct Rules (FINRA Rule 5121). We will not receive any proceeds from the sale of shares of our common stock by the selling stockholders. The selling stockholders include the Sponsors, the Sponsor Assignees and certain members of management.
Underwriters option	The selling stockholders have granted the underwriters a 30-day option to purchase up to 18,930,000 additional shares of our common stock at the initial public offering price.
Dividend policy	We do not intend to pay dividends on our common stock for the foreseeable future following completion of the offering.
Risk Factors	You should carefully read and consider the information set forth under Risk Factors beginning on page 13 of this prospectus and all other information set forth in this prospectus before investing in our common stock.
Conflicts of Interest	Certain of the underwriters and their respective affiliates have, from time to time, performed, and may in the future perform, various financial advisory, investment banking, commercial banking and other services for us for which they received or will receive customary fees and expenses. See Underwriting. Merrill Lynch, Pierce, Fenner & Smith Incorporated and/or its affiliates indirectly own in excess of 10% of our issued and outstanding common stock, and is therefore deemed to be one of our affiliates and have a

conflict of interest within the meaning of FINRA Rule 5121. Additionally, because we expect that more than 5% of the net proceeds of this offering may be received by certain underwriters in this offering or their affiliates that are lenders under the senior secured credit facilities, this offering is being conducted in accordance with FINRA Rule 5121 regarding the underwriting of securities. FINRA Rule 5121 requires that a

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	qualified independent underwriter as defined by the FINRA rules participate in the preparation of the registration statement of which this prospectus forms a part and perform its usual standard of due diligence with respect thereto. Barclays Capital Inc. (Barclays Capital) has agreed to serve as the qualified independent underwriter for the offering. In addition, in accordance with FINRA Rule 5121, if Merrill Lynch, Pierce, Fenner & Smith Incorporated and/or its affiliates receives more than 5% of the net proceeds from this offering, it will not confirm sales to discretionary accounts without the prior written consent of its customers. See Underwriting Conflicts of Interest.
NYSE ticker symbol	HCA

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

assumes no exercise of the underwriters option to purchase additional shares of our common stock;

reflects the 4.505 to 1 stock split that we effectuated prior to the pricing of this offering; and

does not reflect (1) 50,525,942 shares of our common stock issuable upon the exercise of outstanding stock options at a weighted average exercise price of $8.58 per share as of December 31, 2010, of which 23,834,766 were then exercisable; and (2) 41,497,181 shares of our common stock reserved for future grants under our stock incentive plans effective upon the consummation of this offering.

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Summary Financial Data

The following table sets forth HCA Holdings, Inc. s summary financial data as of and for the periods indicated. The financial data as of December 31, 2010 and 2009 and for each of the three years in the period ended December 31, 2010 have been derived from HCA Holdings, Inc. s consolidated financial statements included elsewhere in this prospectus, which have been audited by Ernst & Young LLP. The financial data as of December 31, 2008 have been derived from HCA Holdings, Inc. s consolidated financial statements audited by Ernst & Young LLP that are not included herein.

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

	As of and for the Years Ended December 31,		
	2010	2009	2008
	(Dollars in millions, except per share amounts)		
Income Statement Data:			
Revenues	$ 30,683	$ 30,052	$ 28,374
Salaries and benefits	12,484	11,958	11,440
Supplies	4,961	4,868	4,620
Other operating expenses	5,004	4,724	4,554
Provision for doubtful accounts	2,648	3,276	3,409
Equity in earnings of affiliates	(282)	(246)	(223)
Depreciation and amortization	1,421	1,425	1,416
Interest expense	2,097	1,987	2,021
Losses (gains) on sales of facilities	(4)	15	(97)
Impairments of long-lived assets	123	43	64
	28,452	28,050	27,204
Income before income taxes	2,231	2,002	1,170
Provision for income taxes	658	627	268
Net income	1,573	1,375	902
Net income attributable to noncontrolling interests	366	321	229
Net income attributable to HCA Holdings, Inc.	$ 1,207	$ 1,054	$ 673
Earnings per share:			
Basic	$ 2.83	$ 2.48	$ 1.59
Diluted	$ 2.76	$ 2.44	$ 1.56
Weighted average shares (shares in thousands):			
Basic	426,424	425,567	423,699
Diluted	437,347	432,227	430,982

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	As of and for the Years Ended December 31,		
	2010	2009	2008
	(Dollars in millions, except per share amounts)		
Statement of Cash Flows Data:			
Cash flows provided by operating activities	$ 3,085	$ 2,747	$ 1,990
Cash flows used in investing activities	(1,039)	(1,035)	(1,467)
Cash flows used in financing activities	(1,947)	(1,865)	(451)
Other Financial Data:			
EBITDA(1)	$ 5,383	$ 5,093	$ 4,378
Adjusted EBITDA(1)	5,868	5,472	4,574
Capital expenditures	1,325	1,317	1,600
Operating Data(2):			
Number of hospitals at end of period(3)	156	155	158
Number of freestanding outpatient surgical centers at end of period(4)	97	97	97
Number of licensed beds at end of period(5)	38,827	38,839	38,504
Weighted average licensed beds(6)	38,655	38,825	38,422
Admissions(7)	1,554,400	1,556,500	1,541,800
Equivalent admissions(8)	2,468,400	2,439,000	2,363,600
Average length of stay (days)(9)	4.8	4.8	4.9
Average daily census(10)	20,523	20,650	20,795
Occupancy(11)	53%	53%	54%
Emergency room visits(12)	5,706,200	5,593,500	5,246,400
Outpatient surgeries(13)	783,600	794,600	797,400
Inpatient surgeries(14)	487,100	494,500	493,100
Days revenues in accounts receivable(15)	46	45	49
Gross patient revenues(16)	$ 125,640	$ 115,682	$ 102,843
Outpatient revenues as a percentage of patient revenues(17)	38%	38%	37%
Balance Sheet Data:			
Working capital(18)	$ 2,650	$ 2,264	$ 2,391
Property, plant and equipment, net	11,352	11,427	11,529
Cash and cash equivalents	411	312	465
Total assets	23,852	24,131	24,280
Total debt	28,225	25,670	26,989
Equity securities with contingent redemption rights	141	147	155
Stockholders deficit attributable to HCA Holdings, Inc.	(11,926)	(8,986)	(10,255)
Noncontrolling interests	1,132	1,008	995
Total stockholders deficit	(10,794)	(7,978)	(9,260)

(1) EBITDA, a measure used by management to evaluate operating performance, is defined as net income attributable to HCA Holdings, Inc. plus (i) provision for income taxes, (ii) interest expense and (iii) depreciation and amortization. EBITDA is not a recognized term under GAAP and does not purport to be an alternative to net income as a measure of operating performance or to cash flows from operating activities as a measure of liquidity. Additionally, EBITDA is not intended to be a measure of free cash flow available for management s discretionary use, as it does not consider certain cash requirements such as interest payments, tax payments and

other debt service requirements. Management believes EBITDA is helpful to investors and our management in highlighting trends because EBITDA excludes the results

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of decisions outside the control of operating management and that can differ significantly from company to company depending on long-term strategic decisions regarding capital structure, the tax jurisdictions in which companies operate and capital investments. Management compensates for the limitations of using non-GAAP financial measures by using them to supplement GAAP results to provide a more complete understanding of the factors and trends affecting the business than GAAP results alone. Because not all companies use identical calculations, our presentation of EBITDA may not be comparable to similarly titled measures of other companies.

Adjusted EBITDA is defined as EBITDA, adjusted to exclude net income attributable to noncontrolling interests, losses (gains) on sales of facilities and impairments of long-lived assets. We believe Adjusted EBITDA is an important measure that supplements discussions and analysis of our results of operations. We believe it is useful to investors to provide disclosures of our results of operations on the same basis used by management. Management relies upon Adjusted EBITDA as the primary measure to review and assess operating performance of its hospital facilities and their management teams. Adjusted EBITDA target amounts are the performance measures utilized in our annual incentive compensation programs and are vesting conditions for a portion of our stock option grants. Management and investors review both the overall performance (GAAP net income attributable to HCA Holdings, Inc.) and operating performance (Adjusted EBITDA) of our health care facilities. Adjusted EBITDA and the Adjusted EBITDA margin (Adjusted EBITDA divided by revenues) are utilized by management and investors to compare our current operating results with the corresponding periods during the previous year and to compare our operating results with other companies in the health care industry. It is reasonable to expect that losses (gains) on sales of facilities and impairment of long-lived assets will occur in future periods, but the amounts recognized can vary significantly from period to period, do not directly relate to the ongoing operations of our health care facilities and complicate period comparisons of our results of operations and operations comparisons with other health care companies. Adjusted EBITDA is not a measure of financial performance under accounting principles generally accepted in the United States, and should not be considered an alternative to net income attributable to HCA Holdings, Inc. as a measure of operating performance or cash flows from operating, investing and financing activities as a measure of liquidity. Because Adjusted EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is susceptible to varying calculations, Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures presented by other companies.

EBITDA and Adjusted EBITDA are calculated as follows:

	Years Ended December 31,		
	2010	2009	2008
	(Dollars in millions)		
Net income attributable to HCA Holdings, Inc.	$ 1,207	$ 1,054	$ 673
Provision for income taxes	658	627	268
Interest expense	2,097	1,987	2,021
Depreciation and amortization	1,421	1,425	1,416
EBITDA	5,383	5,093	4,378
Net income attributable to noncontrolling interests(i)	366	321	229
Losses (gains) on sales of facilities(ii)	(4)	15	(97)
Impairments of long-lived assets(iii)	123	43	64
Adjusted EBITDA	$ 5,868	$ 5,472	$ 4,574

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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RISK FACTORS

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

Risks Related to Our Business

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

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

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

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

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

primarily to amounts due directly from patients.

The amount of the provision for doubtful accounts is based upon management s assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal and state governmental and private employer health care coverage, the rate of growth in uninsured patient admissions and other collection indicators. At December 31, 2010, our allowance for doubtful accounts represented

approximately 93% of the $4.249 billion patient due accounts receivable balance. The sum of the provision for doubtful accounts, uninsured discounts and charity care increased from $7.009 billion for 2008 to $8.362 billion for 2009 and to $9.626 billion for 2010.

A continuation of the trends that have resulted in an increasing proportion of accounts receivable being comprised of uninsured accounts and a deterioration in the collectibility of these accounts will adversely affect our collection of accounts receivable, cash flows and results of operations. Prior to the Health Reform Law being fully implemented, our facilities may experience growth in bad debts, uninsured discounts and charity care as a result of a number of factors, including the economic downturn and increase in unemployment. The Health Reform Law seeks to decrease, over time, the number of uninsured individuals. As enacted, the Health Reform Law will, effective January 1, 2014, expand Medicaid and incentivize employers to offer, and require individuals to carry, health insurance or be subject to penalties. More than 20 challenges to the Health Reform Law have been filed in federal courts. Some federal courts have upheld the constitutionality of the Health Reform Law or dismissed cases on procedural grounds. Others have held unconstitutional the requirement that individuals maintain health insurance or pay a penalty and have either found the Health Reform Law void in its entirety or left the remainder of the law intact. These lawsuits are subject to appeal, and several are currently on appeal, including those that hold the law unconstitutional. It is difficult to predict the full impact of the Health Reform Law due to the law s complexity, lack of implementing regulations or interpretive guidance, gradual and potentially delayed implementation, pending court challenges and possible amendment or repeal, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the law. In addition, even after implementation of the Health Reform Law, we may continue to experience bad debts and have to provide uninsured discounts and charity care for undocumented aliens who are not permitted to enroll in a health insurance exchange or government health care programs and certain others who may not have insurance coverage.

Changes in government health care programs may reduce our revenues.

A significant portion of our patient volume is derived from government health care programs, principally Medicare and Medicaid. Specifically, we derived 40.7% of our revenues from the Medicare and Medicaid programs in 2010. Changes in government health care programs may reduce the reimbursement we receive and could adversely affect our business and results of operations.

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

Since most states must operate with balanced budgets and since the Medicaid program is often a state s largest program, some states can be expected to enact or consider enacting legislation designed to reduce their Medicaid expenditures. The current economic downturn has increased the budgetary pressures on many states, and these budgetary pressures have resulted, and likely will continue to result, in decreased spending, or decreased spending growth, for Medicaid programs and the Children s Health Insurance Program (CHIP) in many states. The Health Reform Law provides for material reductions to Medicaid DSH funding. Further, many states have also adopted, or are considering, legislation designed to reduce coverage, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems. Effective March 23, 2010,

the Health Reform Law requires states to at least maintain Medicaid eligibility standards established prior to the enactment of the law for adults until January 1, 2014 and for children until October 1, 2019. However, states with budget deficits may seek a waiver from this requirement to address eligibility standards that apply to adults making more than 133% of the federal poverty level. The

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Health Reform Law also provides for significant expansions to the Medicaid program, but these changes are not required until 2014. In addition, the Health Reform Law will result in increased state legislative and regulatory changes in order for states to comply with new federal mandates, such as the requirement to establish American Health Benefit Exchanges (Exchanges), and to participate in grants and other incentive opportunities.

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

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

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

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

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

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

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

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

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

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

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

the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;

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

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

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

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

the possibility that implementation of the provisions expanding health insurance coverage or the entire Health Reform Law will be delayed due to court challenges or revised or eliminated as a result of court challenges and efforts to repeal or amend the law. More than 20 challenges to the Health Reform Law have been filed in federal courts. Some federal district courts have upheld the constitutionality of the Health Reform Law or dismissed cases on procedural grounds. Others have held unconstitutional the requirement that individuals maintain health insurance or pay a penalty and have either found the Health Reform Law void in its entirety or left the remainder of the law intact. These lawsuits are subject to appeal, and several are currently on appeal, including those that hold the law unconstitutional.

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

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

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

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

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

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

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

how successful ACOs, in which we anticipate participating, will be at coordinating care and reducing costs or whether they will decrease reimbursement;

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

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

reductions to Medicare payments CMS may impose for excessive readmissions.

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

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

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

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

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

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

Our operations are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians, as well as our physicians. We compete with other health care providers in recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our hospitals, including nurses and other nonphysician health care professionals. In some markets, the availability of nurses and other medical support personnel has been a significant operating issue to health care providers. We may be required to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary or contract personnel. As a result, our labor costs could increase. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Certain proposed changes in federal labor laws, including the Employee Free Choice Act, could increase the likelihood of employee unionization attempts. To the extent a significant portion of our employee base unionizes, it is possible our labor costs could increase materially. When negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur during the negotiation process, and our continued operation during any strikes could increase our labor costs. In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required

ratios. If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control labor costs, could have a material, adverse effect on our results of operations.

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

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

billing and coding for services and properly handling overpayments;

relationships with physicians and other referral sources;

necessity and adequacy of medical care;

quality of medical equipment and services;

qualifications of medical and support personnel;

confidentiality, maintenance, data breach, identity theft and security issues associated with health-related and personal information and medical records;

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

licensure and certification;

hospital rate or budget review;

preparing and filing of cost reports;

operating policies and procedures;

activities regarding competitors; and

addition of facilities and services.

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

Our financial relationships with referring physicians and their immediate family members must comply with the Stark Law by meeting an exception. We attempt to structure our relationships to meet an exception to the Stark Law, but the

regulations implementing the exceptions are detailed and complex, and we cannot provide assurance that every relationship complies fully with the Stark Law. Unlike the Anti-kickback Statute, failure to meet an exception under the Stark Law results in a violation of the Stark Law, even if such violation is technical in nature.

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

If we fail to comply with the Anti-kickback Statute, the Stark Law, the FCA or other applicable laws and regulations, we could be subjected to liabilities, including civil penalties (including the loss of our licenses to operate one or more facilities), exclusion of one or more facilities from participation in the Medicare,

Medicaid and other federal and state health care programs and, for violations of certain laws and regulations, criminal penalties.

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

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

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

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

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

Should we be found out of compliance with any of these laws, regulations or programs, depending on the nature of the findings, our business, our financial position and our results of operations could be negatively impacted. See Business Legal Proceedings Government Investigations, Claims and Litigation.

Controls designed to reduce inpatient services may reduce our revenues.

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

maximize outpatient and alternative health care delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. For example, the Health Reform Law potentially expands the use of prepayment review by Medicare contractors by eliminating statutory restrictions on their use. Although we are unable to predict the effect these changes

will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

Our overall business results may suffer from the economic downturn.

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

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

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

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

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

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

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

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

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

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

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

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

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

We have incurred and will continue to incur both capital costs and operating expenses in order to implement our certified EHR technology and meet meaningful use requirements. These expenses are ongoing and are projected to continue over all stages of implementation of meaningful use. The timing of expenses will not correlate with the receipt of the incentive payments and the recognition of revenues. We estimate that operating expenses to implement our certified EHR technology and meet meaningful use will range from $125 to $150 million for 2011. Actual operating expenses could vary from these estimates. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, including having an enrollment record in PECOS, we will not be eligible to receive incentive payments that could offset some of the costs of implementing

EHR systems. Further, eligible providers that fail to demonstrate meaningful use of certified EHR technology will be subject to reduced payments from Medicare, beginning in federal fiscal year 2015 for eligible hospitals and calendar year 2015 for eligible professionals. Failure to implement certified EHR systems effectively and in a timely manner could have a material, adverse effect on our financial position and results of operations.

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

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

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

We operated 164 hospitals at December 31, 2010, and 74 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities combined revenues represented approximately 52% of our consolidated revenues for the year ended December 31, 2010. This concentration makes us particularly sensitive to regulatory, economic, environmental and competitive conditions and changes in those states. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in those states could have a disproportionate effect on our overall business results.

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

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

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

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

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

We are subject to litigation relating to our business practices, including claims and legal actions by patients and others in the ordinary course of business alleging malpractice, product liability or other legal theories. See Business Legal Proceedings. Many of these actions involve large claims and significant defense costs. We insure a portion of our

professional liability risks through a wholly-owned subsidiary. Management believes our reserves for self-insured retentions and insurance coverage are sufficient to cover insured claims arising out of the operation of our facilities. Our wholly-owned insurance subsidiary has entered into certain reinsurance contracts, and the obligations covered by the reinsurance contracts are included in its reserves for professional liability risks, as the subsidiary remains liable to the extent that the reinsurers do not meet their obligations under the reinsurance contracts. If payments for claims exceed

actuarially determined estimates, are not covered by insurance, or reinsurers, if any, fail to meet their obligations, our results of operations and financial position could be adversely affected.

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

We are exposed to market risk related to changes in market values of securities. The investments in debt and equity securities of our wholly-owned insurance subsidiary were $734 million and $8 million, respectively, at December 31, 2010. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At December 31, 2010, we had a net unrealized gain of $10 million on the insurance subsidiary s investment securities.

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

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

Risks Related to Our Indebtedness

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

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

- increasing our vulnerability to downturns or adverse changes in general economic, industry or competitive conditions and adverse changes in government regulations;

- requiring a substantial portion of cash flow from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flow to fund our operations, capital expenditures and future business opportunities;

exposing us to the risk of increased interest rates as certain of our unhedged borrowings are at variable rates of interest;

limiting our ability to make strategic acquisitions or causing us to make nonstrategic divestitures;

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

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

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

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

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

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

We may find it necessary or prudent to refinance our outstanding indebtedness with longer-maturity debt at a higher interest rate. In February, April and August of 2009 and, in March of 2010, for example, we issued $310 million in aggregate principal amount of 97/8% second lien notes due 2017, $1.500 billion in aggregate principal amount of 81/2% first lien notes due 2019, $1.250 billion in aggregate principal amount of 77/8% first lien notes due 2020 and $1.400 billion in aggregate principal amount of 71/4% first lien notes due 2020, respectively. The net proceeds of those offerings were used to prepay term loans under our cash flow credit facility, which currently bears interest at a lower floating rate. Our ability to refinance our indebtedness on favorable terms, or at all, is directly affected by the current global economic and financial conditions. In addition, our ability to incur secured indebtedness (which would generally enable us to achieve better pricing than the incurrence of unsecured indebtedness) depends in part on the value of our assets, which depends, in turn, on the strength of our cash flows and results of operations, and on economic and market conditions and other factors.

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

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

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

ability to, among other things:

- incur additional indebtedness or issue certain preferred shares;
- pay dividends on, repurchase or make distributions in respect of our capital stock or make other restricted payments;

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make certain investments;

sell or transfer assets;

create liens;

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

enter into certain transactions with our affiliates.

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

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

Risks Related to this Offering and Ownership of Our Common Stock

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

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

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

Prior investors have paid substantially less per share of our common stock than the price in this offering. The initial public offering price of our common stock is substantially higher than the net tangible book value per share of

outstanding common stock prior to completion of the offering. Based on our net tangible book value as of December 31, 2010 and upon the issuance and sale of 87,719,300 shares of common stock by us at the initial public offering price of $30.00 per share, if you purchase our common stock in this offering, you will pay more for your shares than the amounts paid by our existing stockholders for their shares and you will suffer immediate dilution of approximately $52.07 per share in net tangible book value. We also have a large number of outstanding stock options to purchase common stock with exercise prices that are below the estimated initial public offering price of our common stock. To the extent that these options are exercised, you will experience further dilution. See Dilution.

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

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

- quarterly variations in our results of operations;
- results of operations that vary from the expectations of securities analysts and investors;
- results of operations that vary from those of our competitors;
- changes in expectations as to our future financial performance, including financial estimates by securities analysts and investors;
- announcements by us, our competitors or our vendors of significant contracts, acquisitions, joint marketing relationships, joint ventures or capital commitments;
- announcements by third parties or governmental entities of significant claims or proceedings against us;
- new laws and governmental regulations applicable to the health care industry, including the Health Reform Law;
- a default under the agreements governing our indebtedness;
- future sales of our common stock by us, directors, executives and significant stockholders; and
- changes in domestic and international economic and political conditions and regionally in our markets.

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

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

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

The market price of our common stock could decline as a result of sales of a large number of shares of common stock in the market after this offering, or the perception that such sales could occur. These sales, or the possibility that these sales may occur, also might make it more difficult for us to sell equity securities in the future at a time and at a price that we deem appropriate. After the completion of this offering, we will have 515,205,100 shares of common stock outstanding. This number includes 126,200,000 shares that are being sold in this offering, which may be resold immediately in the public market.

We and the selling stockholders, our executive officers and directors and the Investors have agreed not to sell or transfer any common stock or securities convertible into, exchangeable for, exercisable for, or repayable with common stock, for 180 days after the date of this prospectus without first obtaining the written consent of two of the representatives of the underwriters. In addition, pursuant to stockholders agreements, we have granted certain stockholders the right to cause us, in certain instances, at our expense, to file registration statements under the Securities Act of 1933, as amended (the Securities Act) covering resales of our common stock held by them. These shares will represent approximately 72.9% of our outstanding common stock after this offering (69.3% if the overallotment option is exercised in full). These shares also may be sold pursuant to Rule 144 under the Securities Act, depending on their holding period and subject to restrictions in the case of shares held by persons deemed to be our affiliates. As restrictions on resale end or if these stockholders exercise their registration rights, the market price of our stock could decline if the holders of restricted shares sell them or are perceived by the market as intending to sell them. See Certain Relationships and Related Party Transactions Stockholder Agreements Management Stockholder s Agreement, Certain Relationships and Related Party Transactions Registration Rights Agreement, Shares Eligible for Future Sale and Underwriting.

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As of December 31, 2010, 427,458,800 shares of our common stock were outstanding, 23,834,766 shares were issuable upon the exercise of outstanding vested stock options under our stock incentive plans, 26,691,176 shares were subject to outstanding unvested stock options under our stock incentive plans and, effective upon the consummation of this offering, 41,497,181 shares will be reserved for future grant under our stock incentive plans. Shares acquired upon the exercise of vested options under our stock incentive plan will first become eligible for resale at any time after the date of this prospectus. Sales of a substantial number of shares of our common stock following the vesting of outstanding stock options could cause the market price of our common stock to decline.

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

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

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

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

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

We are controlled, and after this offering is completed will continue to be controlled, by the Investors. The Investors will indirectly own through their investment in Hercules Holding II, LLC (Hercules Holding) approximately 72.9% of our common stock after the completion of this offering (69.3% if the overallotment option is exercised in full). In addition, representatives of the Investors will have the right to designate a majority of the seats on our Board of Directors. As a result, the Investors will have control over our decisions to enter into any corporate transaction (and the terms thereof) and the ability to prevent any change in the composition of our Board of Directors and any transaction that requires stockholder approval regardless of whether others believe that such change or transaction is in

our best interests. So long as the Investors continue to indirectly hold a majority of our outstanding common stock, they will have the ability to control

the vote in any election of directors, amend our amended and restated certificate of incorporation or amended and restated bylaws or take other actions requiring the vote of our stockholders. Even if such amount is less than 50%, the Investors will continue to be able to strongly influence or effectively control our decisions.

Additionally, Bain Capital, KKR, and BAML Capital Partners 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.

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

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

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

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

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FORWARD-LOOKING STATEMENTS

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

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

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

changes in accounting practices;

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

future divestitures which may result in charges and possible impairments of long-lived assets;

changes in business strategy or development plans;

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delays in receiving payments for services provided;

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

potential adverse impact of known and unknown government investigations, litigation and other claims that may be made against us; and

other risk factors described in this prospectus.

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

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

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USE OF PROCEEDS

We estimate that the net proceeds we will receive from the sale of 87,719,300 shares of our common stock in this offering, after deducting underwriter discounts and commissions and estimated expenses payable by us, will be approximately $2.5 billion.

We will not receive any proceeds from the sale of 38,480,700 shares (57,410,700 if the underwriters exercise the option to purchase additional shares in full) of our common stock by the selling stockholders.

We intend to use the anticipated net proceeds from this offering to repay certain of our existing indebtedness, as will be determined following completion of this offering, and for general corporate purposes. Pending such application, we intend to use the anticipated proceeds to temporarily reduce amounts under our asset-based revolving credit facility and our senior secured revolving credit facility. Our asset-based revolving credit facility currently matures on November 16, 2012 and bears interest at LIBOR plus 1.25%. Our senior secured revolving credit facility matures on November 17, 2012 and will be extended to November 17, 2015 and currently bears interest at LIBOR plus 1.50%.

Affiliates of certain of the underwriters are lenders under our senior secured credit facilities and, accordingly, may receive a portion of the net proceeds from this offering through repayment of such indebtedness. See Underwriting Conflicts of Interest.

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DIVIDEND POLICY

Following completion of the offering, we do not intend to pay any cash dividends on our common stock for the foreseeable future and instead may retain earnings, if any, for future operation and expansion and debt repayment. Any decision to declare and pay dividends in the future will be made at the discretion of our Board of Directors and will depend on, among other things, our results of operations, cash requirements, financial condition, contractual restrictions and other factors that our Board of Directors may deem relevant. In addition, our ability to pay dividends is limited by covenants in our senior secured credit facilities and in the indentures governing certain of our notes. See Description of Indebtedness and Note 10 to our consolidated financial statements for restrictions on our ability to pay dividends.

On January 27, 2010, our Board of Directors declared a distribution to our stockholders and holders of vested stock options of $1.751 billion in the aggregate. On May 5, 2010, our Board of Directors declared a distribution to our stockholders and holders of vested stock options of $500 million in the aggregate. On November 23, 2010, our Board of Directors declared a distribution to our stockholders and holders of stock options of approximately $2.1 billion in the aggregate.

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CAPITALIZATION

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

- on an actual basis; and
- on an as adjusted basis to give effect to (1) the issuance of common stock in this offering and the application of proceeds from the offering as described in Use of Proceeds as if each had occurred on December 31, 2010, (2) the 4.505 to 1 stock split that was effectuated prior to the pricing of this offering, and (3) the payment of approximately $211 million in fees under our management agreement with the Sponsors in connection with this offering and the termination of the agreement. See Certain Relationships and Related Party Transactions Sponsor Management Agreement.

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

	December 31, 2010	
	Actual	As Adjusted
	(In millions)	
Cash and cash equivalents	$ 411	$ 411
Long-term obligations:		
Senior secured credit facilities(1)	$ 10,134	$ 7,816
Senior secured first lien notes(2)	4,075	4,075
Senior secured second lien notes(3)	6,079	6,079
Other secured indebtedness	322	322
Unsecured indebtedness(4)	7,615	7,615
Total long-term obligations	28,225	25,907
Equity securities with contingent redemption rights(5)	141	
Stockholders deficit:		
Preferred Stock		
Common stock: $.01 par value; 1,800,000,000 authorized shares; 427,458,800 shares issued and outstanding (actual); 515,178,100 shares issued and outstanding (as adjusted)(6)	4	5
Capital in excess of par value	386	3,029
Accumulated other comprehensive loss	(428)	(428)
Retained deficit	(11,888)	(12,040)
Stockholders deficit attributable to HCA Holdings, Inc.	(11,926)	(9,434)
Noncontrolling interests	1,132	1,132
Total stockholders deficit	(10,794)	(8,302)

Total capitalization	$ 17,572	$ 17,605

(1) Consists of, (i) a $2.000 billion asset-based revolving credit facility maturing on November 16, 2012 (the asset-based revolving credit facility) ($1.875 billion outstanding at December 31, 2010); (ii) a $2.000 billion senior secured revolving credit facility maturing on November 17, 2012 and to be extended to November 17, 2015 pursuant to the amended and restated joinder agreement entered into on November 8, 2010 (see Description of Indebtedness) (the senior secured revolving credit facility) ($729 million outstanding at December 31, 2010, without giving effect to outstanding letters of credit); (iii) a $2.750 billion senior secured term loan A facility maturing on November 17, 2012 ($1.618 billion outstanding at December 31, 2010); (iv) an $8.800 billion senior secured term loan B facility consisting of a $6.800 billion senior secured term loan B-1 facility maturing on November 17, 2013 and a $2.000 billion

senior secured term loan B-2 facility maturing on March 31, 2017 ($3.525 billion outstanding under term loan B-1 facility at December 31, 2010 and $2.000 billion outstanding under term loan B-2 facility at December 31, 2010); and (v) a 1.000 billion senior secured European term loan facility maturing on November 17, 2013 (291 million, or $387 million-equivalent, outstanding at December 31, 2010). We refer to the facilities described under (ii) through (v) above, collectively, as the cash flow credit facility and, together with the asset-based revolving credit facility, the senior secured credit facilities. We intend to use the net proceeds received by us in connection with our sale of 87,719,300 shares of our common stock to temporarily reduce obligations under our revolving credit facilities. See Use of Proceeds.

(2) In April 2009, we issued $1.500 billion aggregate principal amount of first lien notes at a price of 96.755% of their face value, resulting in $1.451 billion of gross proceeds, which were used to repay obligations under our cash flow credit facility after the payment of related fees and expenses. In August 2009, we issued $1.250 billion aggregate principal amount of first lien notes at a price of 98.254% of their face value, resulting in $1.228 billion of gross proceeds, which were used to repay obligations under our cash flow credit facility after the payment of related fees and expenses. In March 2010, we issued $1.400 billion aggregate principal amount of first lien notes at a price of 99.095% of their face value, resulting in approximately $1.387 billion of gross proceeds, which were used to repay obligations under our cash flow credit facility after the payment of related fees and expenses. In each case, the discount will accrete and be included in interest expense until the applicable first lien notes mature. As of December 31, 2010, there was $75 million of unamortized discount.

(3) Consists of $4.200 billion of second lien notes (comprised of $1.000 billion of 91/8% notes due 2014 and $3.200 billion of 91/4% notes due 2016) and $1.578 billion of 95/8%/103/8% second lien toggle notes (which allow us, at our option, to pay interest in kind during the first five years at the higher interest rate of 103/8%) due 2016. In addition, in February 2009 we issued $310 million aggregate principal amount of 97/8% second lien notes due 2017 at a price of 96.673% of their face value, resulting in $300 million of gross proceeds, which were used to repay obligations under our cash flow credit facility after payment of related fees and expenses. The discount on the 2009 second lien notes will accrete and be included in interest expense until those 2009 second lien notes mature. As of December 31, 2010, there was $9 million of unamortized discount.

(4) Consists of (i) an aggregate principal amount of $246 million medium-term notes with maturities in 2014 and 2025 and a weighted average interest rate of 8.28%; (ii) an aggregate principal amount of $886 million debentures with maturities ranging from 2015 to 2095 and a weighted average interest rate of 7.55%; (iii) an aggregate principal amount of $4.967 billion senior notes with maturities ranging from 2011 to 2033 and a weighted average interest rate of 6.62%; (iv) $1.525 billion of 73/4% senior notes due 2021 and (v) $9 million of unamortized debt discounts that reduce the existing indebtedness. For more information regarding our unsecured and other indebtedness, see Description of Indebtedness.

(5) The initial public offering of our common stock eliminates the contingent redemption rights.

(6) Subsequent to December 31, 2010, approximately 27,000 shares were issued upon exercise of outstanding options.

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

50,525,942 shares of our common stock issuable upon the exercise of outstanding stock options at a weighted average exercise price of $8.58 per share as of December 31, 2010, of which 23,834,766 were then exercisable; and

41,497,181 shares of our common stock reserved for future grants under our stock incentive plans, effective upon the consummation of this offering.

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DILUTION

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

Our net tangible book value as of December 31, 2010 was a deficit of ($13.7) billion or ($32.10) per share of our common stock, based on 427,458,800 shares of our common stock outstanding as of December 31, 2010. Dilution is determined by subtracting net tangible book value per share of our common stock from the initial public offering price per share of our common stock.

Without taking into account any other changes in such net tangible book value after December 31, 2010, after giving effect to the sale of 87,719,300 shares of our common stock in this offering at the initial public offering price of $30.00 per share, less the underwriting discounts and commissions and the estimated offering expenses payable by us, our pro forma as adjusted net tangible book value at December 31, 2010 would have been a deficit of ($11.4) billion, or ($22.07) per share. This represents an immediate increase in net tangible book value of $10.03 per share of our common stock to the existing stockholders and an immediate dilution in net tangible book value of ($52.07) per share of our common stock, to investors purchasing shares of our common stock in this offering. The following table illustrates such dilution per share of our common stock:

Initial public offering price per share of our common stock	$ 30.00
Net tangible book value (deficit) per share of our common stock as of December 31, 2010	$ (32.10)
Pro forma net tangible book value (deficit) per share of our common stock after giving effect to this offering	$ (22.07)
Amount of dilution in net tangible book value per share of our common stock to new investors in this offering	$ (52.07)

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

	Shares of our Common Stock Purchased		Total Consideration		Average Price Per Share of our Common Stock
	Number	Percent	Amount	Percent	
Prior purchasers	388,978,100(1)	76%	$ 4.404 billion	54%	$ 11.32
New investors	126,200,000(1)	24%	3.786 billion	46%	$ 30.00

Total	515,178,100	100%	$ 8.190 billion	100%	$	15.90

(1) Reflects 38,480,700 shares owned by selling shareholders that will be purchased by new investors as a result of this offering.

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

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SELECTED FINANCIAL DATA

The following table sets forth selected financial data of HCA Holdings, Inc. as of the dates and for the periods indicated. The selected financial data as of December 31, 2010 and 2009 and for each of the three years in the period ended December 31, 2010 have been derived from HCA Holdings, Inc. s consolidated financial statements appearing elsewhere in this prospectus, which have been audited by Ernst & Young LLP. The selected financial data as of December 31, 2008, 2007 and 2006 and for each of the two years in the period ended December 31, 2007 presented in this table have been derived from HCA Holdings, Inc. s consolidated financial statements audited by Ernst & Young LLP that are not included in this prospectus.

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

	As of and for the Years Ended December 31,				
	2010	2009	2008	2007	2006
	(Dollars in millions, except per share amounts)				
Summary of Operations:					
Revenues	$ 30,683	$ 30,052	$ 28,374	$ 26,858	$ 25,477
Salaries and benefits	12,484	11,958	11,440	10,714	10,409
Supplies	4,961	4,868	4,620	4,395	4,322
Other operating expenses	5,004	4,724	4,554	4,233	4,056
Provision for doubtful accounts	2,648	3,276	3,409	3,130	2,660
Equity in earnings of affiliates	(282)	(246)	(223)	(206)	(197)
Gains on sales of investments					(243)
Depreciation and amortization	1,421	1,425	1,416	1,426	1,391
Interest expense	2,097	1,987	2,021	2,215	955
Losses (gains) on sales of facilities	(4)	15	(97)	(471)	(205)
Impairments of long-lived assets	123	43	64	24	24
Transaction costs					442
	28,452	28,050	27,204	25,460	23,614
Income before income taxes	2,231	2,002	1,170	1,398	1,863
Provision for income taxes	658	627	268	316	626
Net income	1,573	1,375	902	1,082	1,237
Net income attributable to noncontrolling interests	366	321	229	208	201
Net income attributable to HCA Holdings, Inc.	$ 1,207	$ 1,054	$ 673	$ 874	$ 1,036
Per common share data:					
Basic earnings per share	$ 2.83	$ 2.48	$ 1.59	$ 2.07	(a)
Diluted earnings per share	$ 2.76	$ 2.44	$ 1.56	$ 2.03	(a)

Cash dividends declared per share	$ 9.43				(a)
Financial Position:					
Assets	$ 23,852	$ 24,131	$ 24,280	$ 24,025	$ 23,675
Working capital	2,650	2,264	2,391	2,356	2,502
Long-term debt, including amounts due within one year	28,225	25,670	26,989	27,308	28,408
Equity securities with contingent redemption rights	141	147	155	164	125
Noncontrolling interests	1,132	1,008	995	938	907
Stockholders deficit	(10,794)	(7,978)	(9,260)	(9,600)	(10,467)
Cash Flow Data:					
Cash provided by operating activities	$ 3,085	$ 2,747	$ 1,990	$ 1,564	$ 1,988
Cash used in investing activities	(1,039)	(1,035)	(1,467)	(479)	(1,307)
Capital expenditures	(1,325)	(1,317)	(1,600)	(1,444)	(1,865)
Cash used in financing activities	(1,947)	(1,865)	(451)	(1,326)	(383)

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	As of and for the Years Ended December 31,				
	2010	2009	2008	2007	2006
	(Dollars in millions, except per share amounts)				
Operating Data:					
Number of hospitals at end of period(b)	156	155	158	161	166
Number of freestanding outpatient surgical centers at end of period(c)	97	97	97	99	98
Number of licensed beds at end of period(d)	38,827	38,839	38,504	38,405	39,354
Weighted average licensed beds(e)	38,655	38,825	38,422	39,065	40,653
Admissions(f)	1,554,400	1,556,500	1,541,800	1,552,700	1,610,100
Equivalent admissions(g)	2,468,400	2,439,000	2,363,600	2,352,400	2,416,700
Average length of stay (days)(h)	4.8	4.8	4.9	4.9	4.9
Average daily census(i)	20,523	20,650	20,795	21,049	21,688
Occupancy(j)	53%	53%	54%	54%	53%
Emergency room visits(k)	5,706,200	5,593,500	5,246,400	5,116,100	5,213,500
Outpatient surgeries(l)	783,600	794,600	797,400	804,900	820,900
Inpatient surgeries(m)	487,100	494,500	493,100	516,500	533,100
Days revenues in accounts receivable(n)	46	45	49	53	53
Gross patient revenues(o)	$ 125,640	$ 115,682	$ 102,843	$ 92,429	$ 84,913
Outpatient revenues as a % of patient revenues(p)	38%	38%	37%	37%	36%

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Overview

We are the largest non-governmental hospital operator in the U.S. and a leading comprehensive, integrated provider of health care and related services. At December 31, 2010, we operated 164 hospitals, comprised of 158 general, acute care hospitals; five psychiatric hospitals; and one rehabilitation hospital. The 164 hospital total includes eight hospitals (seven general, acute care hospitals and one rehabilitation hospital) owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. In addition, we operated 106 freestanding surgery centers, nine of which are owned by joint ventures in which an affiliate of HCA is a partner, and these joint ventures are accounted for using the equity method. Our facilities are located in 20 states and England. For the year ended December 31, 2010, we generated revenues of $30.683 billion and net income attributable to HCA Holdings, Inc. of $1.207 billion.

On November 17, 2006, HCA Inc. was acquired by a private investor group comprised of affiliates of or funds sponsored by Bain Capital, KKR, MLGPE (now BAML Capital Partners), Citigroup Inc., Bank of America Corporation and HCA founder Dr. Thomas F. Frist, Jr., and by members of management and certain other investors. We refer to the merger, the financing transactions related to the merger and other related transactions collectively as the Recapitalization.

2010 Operations Summary

Net income attributable to HCA Holdings, Inc. totaled $1.207 billion for 2010, compared to $1.054 billion for 2009. The 2010 results include net gains on sales of facilities of $4 million and impairments of long-lived assets of $123 million. The 2009 results include net losses on sales of facilities of $15 million and impairments of long-lived assets of $43 million.

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

During 2010, consolidated admissions declined 0.1% and same facility admissions increased 0.1%, compared to 2009. Inpatient surgical volumes declined 1.5% on a consolidated basis and declined 1.4% on a same facility basis during

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

For 2010, the provision for doubtful accounts declined $628 million, to 8.6% of revenues from 10.9% of revenues for 2009. The combined self-pay revenue deductions for charity care and uninsured discounts increased $1.892 billion for 2010, compared to 2009. The sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of net revenues, uninsured discounts and

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charity care, was 25.6% for 2010, compared to 23.8% for 2009. Same facility uninsured admissions increased 5.4% and same facility uninsured emergency room visits increased 1.2% for 2010, compared to 2009.

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

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

Critical Accounting Policies and Estimates

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

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

Revenues

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

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

the financial impact of screening for and stabilizing emergency medical conditions. However, many factors are unknown regarding the impact of the Health Reform Law, including the outcome of court challenges to the constitutionality of the law and Congressional efforts to amend or repeal the law, how many previously uninsured individuals will obtain coverage as a result of the law or the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals and the payer mix.

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

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

Provision for Doubtful Accounts and the Allowance for Doubtful Accounts

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

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

accounts receivable. The estimated uninsured portion of Medicaid pending and uninsured discount pending accounts is included in our patient due accounts receivable balance.

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

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

The provision for doubtful accounts, as a percentage of revenues, declined from 12.0% for 2008 to 10.9% for 2009 and declined to 8.6% for 2010. Our decision to increase uninsured discounts during the second half of 2009 has directly contributed to the decline in the provision for doubtful accounts. However, the sum of the provision for doubtful accounts, uninsured discounts and charity care, as a percentage of the sum of net revenues, uninsured discounts and charity care increased from 21.9% for 2008 to 23.8% for 2009 and to 25.6% for 2010.

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

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

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

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

Professional Liability Claims

We, along with virtually all health care providers, operate in an environment with professional liability risks. Our facilities are insured by our wholly-owned insurance subsidiary for losses up to $50 million per occurrence, subject to a $5 million per occurrence self-insured retention. We purchase excess insurance on a claims-made basis for losses in excess of $50 million per occurrence. Our professional liability reserves, net of

receivables under reinsurance contracts, do not include amounts for any estimated losses covered by our excess insurance coverage. Provisions for losses related to professional liability risks were $222 million, $211 million and $175 million for the years ended December 31, 2010, 2009 and 2008, respectively.

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

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

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

Reserves for professional liability risks were $1.262 billion and $1.322 billion at December 31, 2010 and 2009, respectively. The current portion of these reserves, $268 million and $265 million at December 31, 2010 and 2009,

respectively, is included in other accrued expenses. Obligations covered by reinsurance contracts are included in the reserves for professional liability risks, as the insurance subsidiary remains liable to the extent reinsurers do not meet their obligations. Reserves for professional liability risks (net of $14 million and $53 million receivable under reinsurance contracts at December 31, 2010 and 2009, respectively) were

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$1.248 billion and $1.269 billion at December 31, 2010 and 2009, respectively. The estimated total net reserves for professional liability risks at December 31, 2010 and 2009 are comprised of $758 million and $680 million, respectively, of case reserves for known claims and $490 million and $589 million, respectively, of reserves for incurred but not reported claims.

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

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

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

Income Taxes

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

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

Results of Operations

Revenue/Volume Trends

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

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

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

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

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

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

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

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

	100%	100%	100%

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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 years ended December 31, 2010, 2009 and 2008 are set forth below.

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

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

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

We receive a significant portion of our revenues from government health programs, principally Medicare and Medicaid, which are highly regulated and subject to frequent and substantial changes. We have increased the indigent care services we provide in several communities in the state of Texas, in affiliation with other hospitals. The state of Texas has been involved in the effort to increase the indigent care provided by private hospitals. As a result of this additional indigent care provided by private hospitals, public hospital districts or counties in Texas have available funds that were previously devoted to indigent care. The public hospital districts or counties are under no contractual or legal obligation to provide such indigent care. The public hospital districts or counties have elected to transfer some portion of these available funds to the state s Medicaid program. Such action is at the sole discretion of the public hospital districts or counties. It is anticipated that these contributions to the state will be matched with federal Medicaid funds. The state then may make supplemental payments to hospitals in the state for Medicaid services rendered. Hospitals receiving Medicaid supplemental payments may include those that are providing additional indigent care services. Such payments must be within the federal UPL established by federal regulation. Our Texas Medicaid revenues included $657 million, $474 million and $262 million for the years ended December 31, 2010, 2009 and 2008, respectively, of Medicaid supplemental payments pursuant to UPL programs.

The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive payments beginning in 2011 for eligible hospitals and professionals that adopt and meaningfully use certified electronic health

record (EHR) technology. We estimate a majority of our eligible hospitals will attest to adopting, implementing, upgrading or demonstrating meaningful use of certified EHR technology during the fourth quarter of 2011, and we will not recognize any revenues related to the Medicare or Medicaid incentive payments until we are able to complete these attestations. We currently estimate that, during 2011 (primarily during our fourth quarter), the amount of Medicare or Medicaid incentive payments realizable (and revenues recognized) will be in the range of $275 million to $325 million. Actual incentive payments could vary from these estimates due to certain factors such as availability of federal funding for both Medicare and Medicaid incentive payments, timing of the approval of state Medicaid incentive payment plans by CMS and our ability

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to implement and demonstrate meaningful use of certified EHR technology. We have incurred and will continue to incur both capital costs and operating expenses in order to implement our certified EHR technology and meet meaningful use requirements. These expenses are ongoing and are projected to continue over all stages of implementation of meaningful use. The timing of recognizing the expenses will not correlate with the receipt of the incentive payments and the recognition of revenues. We estimate that operating expenses to implement our certified EHR technology and meet meaningful use will be in the range of $125 million to $150 million for 2011. Actual operating expenses could vary from these estimates. There can be no assurance that we will be able to demonstrate meaningful use of certified EHR technology, and the failure to do so could have a material, adverse effect on our results of operations.

Operating Results Summary

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

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

Equivalent admissions(b)	1.2	3.2	0.5
Revenue per equivalent admission	0.9	2.6	5.2
Same facility % changes from prior year(c):			
Revenues	2.1	6.1	7.0
Admissions(a)	0.1	1.2	0.9
Equivalent admissions(b)	1.4	3.4	1.9
Revenue per equivalent admission	0.6	2.6	5.1

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

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

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

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

The results of operations presented on a cash revenues basis for the years ended December 31, 2010, 2009 and 2008 were as follows:

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

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

generally accepted accounting principles. Because cash revenues is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, cash revenues, as presented, may not be comparable to other similarly titled measures of other health care companies.

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

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Years Ended December 31, 2010 and 2009

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Years Ended December 31, 2009 and 2008

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

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

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

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

Supplies, as a percentage of revenues, were 16.2% in 2009 and 16.3% in 2008. Supplies, as a percentage of cash revenues, were 18.2% in 2009 and 18.5% in 2008. Supply costs per equivalent admission increased

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2.1% in 2009 compared to 2008. Same facility supply costs increased 5.9% for medical devices, 4.0% for pharmacy supplies, 7.1% for blood products and 7.0% for general medical and surgical items in 2009 compared to 2008.

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

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

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

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

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

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

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

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

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

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Liquidity and Capital Resources

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