HCA INC/TN
Form 10-K
March 27, 2007

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

FORM 10-K

(Mark One)

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2006

OR

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

Commission File Number 1-11239

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

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

Registrant s telephone number, Including Area Code: **(615) 344-9551**
Securities Registered Pursuant to Section 12(b) of the Act: None
Securities Registered Pursuant to Section 12(g) of the Act: None

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

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

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

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

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of accelerated filer and large accelerated filer in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer o Accelerated filer o Non-accelerated filer þ

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

As of February 28, 2007, there were approximately 93,004,000 shares of Registrant s common stock outstanding. As of June 30, 2006, which was prior to Registrant s recapitalization, the aggregate market value of the common stock held by non-affiliates was approximately $16.1 billion. For purposes of the foregoing calculation only, Registrant s directors, executive officers and the HCA 401(k) Plan have been deemed to be affiliates.

DOCUMENTS INCORPORATED BY REFERENCE

None.

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PART I

Item 1. *Business*

General

HCA Inc. is one of the leading health care services companies in the United States. At December 31, 2006, we operated 173 hospitals, comprised of 166 general, acute care hospitals; six psychiatric hospitals; and one rehabilitation hospital. The 173 hospital total includes seven hospitals (six 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 107 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, England and Switzerland. The terms Company, HCA, we, our or us, as use herein, refer to HCA Inc. and its affiliates unless otherwise stated or indicated by context. The term affiliates means direct and indirect subsidiaries of HCA Inc. and partnerships and joint ventures in which such subsidiaries are partners. The terms facilities or hospitals refer to entities owned and operated by affiliates of HCA and the term employees refers to employees of affiliates of HCA.

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

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

On July 24, 2006, our Board of Directors approved and we entered into a Merger Agreement (the Merger Agreement and the transactions contemplated thereby the Merger) with Hercules Acquisition Corporation (Merger Sub), a Delaware corporation and a wholly owned subsidiary of Hercules Holding II, LLC (Hercules Holding), a Delaware limited liability company owned by a private investor group including affiliates of Bain Capital, Kohlberg Kravis Roberts & Co., Merrill Lynch Global Private Equity (each a Sponsor and together, the Sponsors), and affiliates of HCA founder Dr. Thomas F. Frist, Jr., (the Frist Entities , and together with the Sponsors, the Investors), pursuant to which Hercules Holding would acquire all of our outstanding shares of common stock for $51.00 per share in cash. The Merger Agreement was approved by our shareholders on November 16, 2006. The Merger, the financing transactions related to the Merger and other related transactions were consummated on November 17, 2006, had a transaction value of approximately $33.0 billion and are collectively referred to in this annual report as the Recapitalization. As a result of the Recapitalization, our outstanding common stock is owned by Hercules Holding, certain members of management and other key employees. Our common stock is no longer registered with the Securities and Exchange Commission (the SEC) and is no longer traded on a national securities exchange.

Available Information

We currently voluntarily file certain reports with the SEC, including annual reports on Form 10-K and quarterly reports on Form 10-Q. The public may read and copy any materials we file with the SEC at the SEC s Public Reference Room at 100 F Street, N.E., Washington, DC 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. We are an electronic filer and the SEC maintains an Internet site at http://www.sec.gov that contains the reports and other information we file electronically. Our website address is www.hcahealthcare.com. Please note that our website address is provided as an inactive textual reference only. We make available free of charge through our website our annual report on Form 10-K and quarterly reports on Form 10-Q, and all amendments to those

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reports as soon as reasonably practicable after such material is electronically filed with or furnished to the SEC. The information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

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

Business Strategy

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

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

maintain our commitment to ethics and compliance;

leverage our leading local market positions;

expand our presence in key markets;

continue to leverage our scale;

continue to develop enduring physician relationships; and

become the health care employer of choice.

Health Care Facilities

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

At December 31, 2006, we owned and operated 160 general, acute care hospitals with 38,754 licensed beds, and an additional six general, acute care hospitals with 2,127 licensed beds are operated through joint ventures, which are accounted for using the equity method. Most of our general, acute care hospitals provide medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic services and emergency services. The general, acute care hospitals also provide outpatient services such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology and physical therapy. Each hospital has an organized medical staff and a local board of trustees or governing board, made up of members of the local community.

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

At December 31, 2006, we operated six psychiatric hospitals with 600 licensed beds. Our psychiatric hospitals provide therapeutic programs including child, adolescent and adult psychiatric care, adult and adolescent alcohol and drug abuse treatment and counseling.

Outpatient health care facilities operated by us include freestanding surgery centers, diagnostic and imaging centers, comprehensive outpatient rehabilitation and physical therapy centers, outpatient radiation and oncology therapy centers and various other facilities. These outpatient services are an integral component of our strategy to develop comprehensive health care networks in select communities.

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

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Sources of Revenue

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

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

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

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

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

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

Our hospitals generally offer discounts from established charges to certain group purchasers of health care services, including private insurance companies, employers, HMOs, PPOs and other managed care plans. These discount programs generally limit our ability to increase revenues in response to increasing costs. See Item 1, Business Competition. Patients are generally not responsible for the total difference between established hospital gross charges and amounts reimbursed for such services under Medicare, Medicaid, HMOs or PPOs and other managed care plans, but are responsible to the extent of any exclusions, deductibles or coinsurance features of their coverage. The amount of such exclusions, deductibles and coinsurance has been increasing each year. Collection of amounts due from individuals is typically more difficult than from governmental or third-party payers. On January 1, 2005, we modified our policies to provide a discount to uninsured patients who do not qualify for Medicaid or charity care. These discounts are similar to those provided to many local managed care plans. In implementing the discount policy, we attempt to qualify uninsured patients for Medicaid, other federal or state assistance or charity care. If an

uninsured patient does not qualify for these programs, the uninsured discount is applied. See Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations Results of Operations Revenue/ Volume Trends.

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Medicare

Inpatient Acute Care

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

DRG rates are updated and DRG weights are recalibrated each federal fiscal year (which begins October 1). The index used to update the DRG rates (the market basket) gives consideration to the inflation experienced by hospitals and entities outside the health care industry in purchasing goods and services. However, for several years the percentage increases to the DRG rates have been lower than the percentage increases in the costs of goods and services purchased by hospitals. In federal fiscal year 2006, the DRG rate increase was market basket of 3.7%. For federal fiscal year 2007, the Centers for Medicare and Medicaid Services (CMS) set the DRG rate increase at full market basket of 3.4%. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provided for DRG rate increases for certain federal fiscal years at full market basket, if data for ten patient care quality indicators were submitted to the Secretary of the Department of Health and Human Services (HHS). On February 8, 2006, the Deficit Reduction Act of 2005 (DRA 2005) was enacted by Congress and expanded the number of quality measures that must be reported to receive a full market basket update to 21, beginning with discharges occurring in the third quarter of 2006. On November 24, 2006, CMS issued a final rule that expands to 26 the number of quality measures that must be reported, beginning in the first quarter of calendar year 2007, and requires, beginning in the third quarter of calendar year 2007, that hospitals report the results of a 27-question patient perspective survey. Failure to submit the required quality indicators will result in a two percentage point reduction to the market basket update. All of our hospitals paid under Medicare inpatient DRG PPS are participating in the quality initiative by the Secretary of HHS by submitting the quality data requested. While we will endeavor to comply with all data submission requirements as additional requirements continue to be added, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals.

In the Federal Register dated August 18, 2006, CMS changed the methodology used to recalibrate the DRG weights from charge based weights to cost relative weights under a 3-year transition period beginning in federal fiscal year 2007. The adoption of the cost relative weights is not anticipated to have a material financial impact to us. CMS is currently studying alternative DRG systems that would recognize severity of illness. It is anticipated that CMS will propose revisions to the DRG system to better recognize severity of illness for federal fiscal year 2008. It is uncertain as to what those revisions might be and what the financial impact could be to us.

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

Historically, the Medicare program has set aside 5.1% of Medicare inpatient payments to pay for outlier cases. CMS estimates that outlier payments were 3.52% and 3.96% of total operating DRG payments for federal fiscal years 2004 and 2005, respectively. For federal fiscal year 2006, CMS has established an outlier threshold of $23,600, which resulted in outlier payments of 4.62% as estimated by CMS. For federal fiscal year 2007, CMS has established an outlier threshold of $24,485. We do not anticipate that the change to the outlier threshold for federal fiscal year 2007 will have a material impact on our revenues.

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Outpatient

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

Hospital outpatient services paid under PPS are classified into groups called ambulatory payment classifications (APCs). Services for each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit. The APC payment rates were updated for calendar years 2005 and 2006 by market basket of 3.3% and 3.7%, respectively. However, as a result of the expiration of additional payments for drugs that were being paid in calendar year 2005, for calendar year 2006 there was an effective 2.25% reduction to the market basket of 3.7%, resulting in a net market basket of 1.45%. For calendar year 2007, MMA provides for a full market basket update, and on November 24, 2006 CMS published a final rule that updated payment rates for calendar year 2007 by the full market basket of 3.4%. In this final rule, CMS announced that it will require hospitals to submit quality data relating to outpatient care in order to receive the full market basket increase under the outpatient PPS beginning in calendar year 2009. CMS did not indicate what data must be submitted or other details of the program. Hospitals that fail to submit such data will receive the market basket update minus two percentage points for the outpatient PPS.

Rehabilitation

CMS reimburses inpatient rehabilitation facilities (IRFs) on a PPS basis. Under IRF PPS, patients are classified into case mix groups based upon impairment, age, comorbidities (additional diseases or disorders from which the patient suffers) and functional capability. IRFs are paid a predetermined amount per discharge that reflects the patient s case mix group and is adjusted for area wage levels, low-income patients, rural areas and high-cost outliers. For federal fiscal years 2005 and 2006, CMS updated the PPS rate for rehabilitation hospitals and units by market basket of 3.1% and 3.6%, respectively. For federal fiscal year 2007, CMS has updated the PPS rate for IRFs by market basket of 3.3%. However, CMS also applied reductions to the standard payment amount of 1.9% and 2.6% for federal fiscal years 2006 and 2007, respectively, to account for coding changes that do not reflect real changes in case mix. As of December 31, 2006, we had one rehabilitation hospital, which is operated through a joint venture, and 49 hospital rehabilitation units.

On May 7, 2004, CMS published a final rule to change the criteria for being classified as an IRF, commonly known as the 75 percent rule. CMS revised the medical conditions for patients served by rehabilitation facilities from ten medical conditions to 13 conditions. Pursuant to this final rule, a specified percentage of a facility s inpatients over a given year must be treated for one of these conditions. The final rule provides for a transition period during which the percentage threshold would increase. For cost reporting periods that began on or after July 1, 2004 and before July 1, 2005, the compliance threshold was set at 50% of the IRF s total patient population. For cost reporting periods beginning on or after July 1, 2005 and before July 1, 2006, the compliance threshold was set at 60% of the IRF s total patient population. For cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007, the compliance threshold is set at 65% of the IRF s total patient population. The compliance threshold will be set at 75% for cost reporting periods beginning on or after July 1, 2007. Implementation of the 75 percent rule has started to reduce our IRF admissions and can be expected to continue to significantly restrict the treatment of patients whose medical conditions do not meet any of the 13 approved conditions.

Medicare fiscal intermediaries have been given the authority to develop and implement Local Coverage Determinations (LCD) to determine the medical necessity of care rendered to Medicare patients where there is no national coverage determination. Some intermediaries have finalized their LCDs for rehabilitation services. A restrictive rehabilitation LCD has the potential to significantly impact Medicare rehabilitation payments. Some fiscal intermediaries have implemented LCDs that are more stringent than the 75 percent

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rule or have retroactively denied coverage based on new LCDs. The financial impact to us of the implementation of final rehabilitation LCDs throughout our markets is uncertain.

Psychiatric

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

On November 15, 2004, CMS published a final regulation to implement a PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units of general, acute care hospitals and critical access hospitals (IPF PPS). The new prospective payment system replaces the cost-based system for reporting periods beginning on or after January 1, 2005. IPF PPS is a per diem prospective payment system, with adjustments to account for certain patient and facility characteristics. IPF PPS contains an outlier policy for extraordinarily costly cases and an adjustment to a facility s base payment if it maintains a full-service emergency department. IPF PPS is being implemented over a three-year transition period with full payment under IPF PPS to begin in the fourth year. Also, CMS has included a stop-loss provision to ensure that hospitals avoid significant losses during the transition. CMS has established the IPF PPS payment rate in a manner intended to be budget neutral and has adopted a July 1 update cycle. Thus, the initial IPF PPS per diem payment rate was effective for the 18-month period January 1, 2005 through June 30, 2006. CMS updated payments under the IPF PPS for rate year 2007 (July 1, 2006 to June 30, 2007) by 4.5% (reflecting the blend of the 4.6% update for IPF TEFRA and the 4.3% update for IPF PPS payments). The market basket update accounts for moving from a calendar year to a rate year (the annual market basket is estimated to be 3.4%). As of December 31, 2006, we had six psychiatric hospitals and 36 hospital psychiatric units.

Other

Under PPS, the payment rates are adjusted for the area differences in wage levels by a factor (wage index) reflecting the relative wage level in the geographic area compared to the national average wage level. For federal fiscal year 2006, CMS applied an occupational mix adjustment factor to the wage index amounts for the first time, but limited the adjustment to 10% of the wage index. CMS increased the occupational mix adjustment to 100% for inpatient PPS effective for federal fiscal year 2007 in the final rule published on October 11, 2006.

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

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

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

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

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(MACs). Hospital companies will have the option to work with the selected MAC in the jurisdiction where a given hospital is located or to use the MAC in the jurisdiction where the hospital company s home office is located. We have requested that CMS enable us to use more than one MAC but less than the 12 MACs where our hospitals are located. CMS awarded the first of the MAC contracts on July 31, 2006. Jurisdiction 3, which includes the states of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming, was awarded to Noridian Administrative Services. HCA operates six hospitals in Jurisdiction 3 and Mutual of Omaha continues to serve as their fiscal intermediary. An additional seven jurisdictions are expected to be awarded in July and September of 2007, and the remaining seven jurisdictions are expected to be awarded in September 2008. All of these changes could impact claims processing functions and the resulting cash flow. We cannot predict the impact that these changes could have on our cash flow.

Effective January 1, 2007, as a result of DRA 2005, reimbursements for ASC overhead costs are limited to no more than the overhead costs paid to hospital outpatient departments under the Medicare hospital outpatient prospective payment system for the same procedure. In the Federal Register dated August 23, 2006, CMS announced proposed regulations that, if adopted, would change payment for procedures performed in an ambulatory surgery center (ASC), effective January 1, 2008. Under this proposal, ASC payment groups would increase from the current nine clinically disparate payment groups to the 221 APCs used under the outpatient prospective payment system for these surgical services. CMS estimates that the rates for procedures performed in an ASC setting would equal 62% of the corresponding rates paid for the same procedures performed in an outpatient hospital setting. Moreover, under the proposed regulations, if CMS determines that a procedure is commonly performed in a physician s office, the ASC reimbursement for that procedure would be limited to the reimbursement allowable under the Medicare Part B Physician Fee Schedule. Under this proposal, all surgical procedures, other than those that pose a significant safety risk or generally require an overnight stay, which would be listed by CMS, would be payable as ASC procedures. This will expand the number of procedures that Medicare will pay for if performed in an ASC. CMS indicates in its discussion of the proposed regulations that it believes that the volumes and service mix of procedures provided in ASCs would change significantly in 2008 under the revised payment system, but that CMS is not able to accurately project those changes. If the proposal is adopted, more Medicare procedures that are now performed in hospitals may be moved to ASCs, reducing surgical volume in our hospitals. Also, more Medicare procedures that are now performed in ASCs may be moved to physicians offices. Commercial third-party payers may adopt similar policies. CMS has announced that the final rule to implement a revised ASC payment system will be published in a separate rule in 2007.

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

Managed Medicare

Managed Medicare plans relate to situations where a private company contracts with CMS to provide members with Medicare Part A, Part B and Part D benefits. Managed Medicare plans can be structured as HMOs, PPOs, or private fee-for-service plans.

Medicaid

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

Since states must operate with balanced budgets and since the Medicaid program is often the state s largest program, states can be expected to adopt or consider adopting legislation designed to reduce their

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Medicaid expenditures. DRA 2005, signed into law on February 8, 2006, includes Medicaid cuts of approximately $4.8 billion over five years. In addition, proposed regulatory changes, if implemented, would reduce federal Medicaid funding by an additional $12.2 billion over five years. On January 18, 2007, CMS published a proposed rule entitled Medicaid Program; Cost Limits for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership . The proposed rule, if finalized, could significantly impact state Medicaid programs. It is uncertain if such rule will be finalized. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position and results of operations.

Managed Medicaid

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

Annual Cost Reports

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

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

Managed Care and Other Discounted Plans

Most of our hospitals offer discounts from established charges to certain large group purchasers of health care services, including managed care plans and private insurance companies. Admissions reimbursed by managed care and other insurers were 36%, 42% and 42% of our total admissions for the years ended December 31, 2006, 2005 and 2004, respectively (prior to 2006, managed Medicare admissions, 6% of 2006 admissions, were classified as managed care). Managed care contracts are typically negotiated for one-year or two-year terms. While we generally received annual average yield increases of six to seven percent from managed care payers during 2006, there can be no assurance that we will continue to receive increases in the future.

Hospital Utilization

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

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The following table sets forth certain operating statistics for our hospitals. Hospital operations are subject to certain seasonal fluctuations, including decreases in patient utilization during holiday periods and increases in the cold weather months.

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

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

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

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

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

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

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

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

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

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

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

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

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

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Competition

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

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

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

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

Another major factor in the competitive position of a hospital is management s ability to negotiate service contracts with purchasers of group health care services. Managed care plans attempt to direct and control the use of hospital services and obtain discounts from hospitals established gross charges. In addition, employers and traditional health insurers are increasingly interested in containing costs through negotiations with hospitals for managed care programs and discounts from established gross charges. Generally, hospitals compete for service contracts with group health care services purchasers on the basis of price, market reputation, geographic location, quality and range of services, quality of the medical staff and convenience. The importance of obtaining contracts with managed care organizations varies from community to community, depending on the market strength of such organizations.

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

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

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

Regulation and Other Factors

Licensure, Certification and Accreditation

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

Certificates of Need

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

State Rate Review

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

Utilization Review

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

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

Federal Health Care Program Regulations

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

Anti-kickback Statute

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

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

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

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

As authorized by Congress, the OIG has published safe harbor regulations that outline categories of activities that are deemed protected from prosecution under the Anti-kickback Statute. Currently, there are statutory exceptions and safe harbors for various activities, including the following: investment interests, space rental, equipment rental, practitioner recruitment, personnel services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, freestanding surgery centers, ambulance replenishing, and referral agreements for specialty services. The fact that conduct or a business arrangement does not fall within a safe harbor, or that it is identified in a fraud alert or advisory bulletin or as a risk area in the Supplemental Compliance Guidelines for Hospitals, does not automatically render the conduct or business arrangement illegal under the Anti-kickback Statute. However, such conduct and business arrangements may lead to increased scrutiny by government enforcement authorities. Although the Company believes that its arrangements with physicians have been structured to comply with current law and available interpretations, there can be no assurance that regulatory authorities enforcing these laws will determine these financial arrangements do not violate the Anti-kickback Statute or other applicable laws. An adverse determination could subject the Company to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal health care programs.

Stark Law

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

CMS has issued two phases of regulations implementing the Stark Law, which became effective on January 4, 2002 and July 26, 2004, respectively, and which created several additional exceptions. A third phase is expected to be issued by March 2008. While these regulations help clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of them for enforcement purposes.

In 2003, Congress passed legislation that modified the hospital ownership exception to the Stark Law by creating an 18-month moratorium on allowing physicians to own interests in new specialty hospitals. During the moratorium, HHS was required to conduct an analysis of specialty hospitals, including quality of care provided and physician referral patterns to these facilities. MedPAC was also required to study cost and payment issues related to specialty hospitals. The moratorium applied to hospitals that primarily or exclusively treat cardiac, orthopedic or surgical conditions or any other specialized category of patients or cases designated by regulation, unless the hospitals were in operation or development before November 18, 2003, did not

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increase the number of physician investors, and met certain other requirements. The moratorium expired on June 8, 2005. In March 2005, MedPAC issued its report on specialty hospitals, in which it recommended that Congress extend the moratorium until January 1, 2007, modify payments to hospitals to reflect more closely the cost of care, and allow certain types of gainsharing arrangements. In May 2005, HHS issued the required report of its analysis of specialty hospitals in which it recommended reforming certain inpatient hospital services and ambulatory surgery center services payment rates that may currently encourage the establishment of specialty hospitals and implementation of closer scrutiny of the processes for approving new specialty hospitals for participation in Medicare. Further, HHS suspended processing new provider enrollment applications for specialty hospitals until January 2006, creating in effect a moratorium on new specialty hospitals. DRA 2005, signed into law February 8, 2006, directed HHS to extend this enrollment suspension until the earlier of six months from the enactment of DRA 2005 or the release of a report regarding physician owned specialty hospitals by HHS. On August 8, 2006, HHS issued its final report, in which it announced that it would resume processing and certifying provider enrollment applications for specialty hospitals. HHS also announced that it will require hospitals to disclose any financial arrangements with physicians. HHS has not announced when it will begin collecting this data, the specific data that hospitals will be required to submit or which hospitals will be required to provide information.

Similar State Laws

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

HIPAA and BBA-97

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) broadened the scope of certain fraud and abuse laws by adding several criminal provisions for health care fraud offenses that apply to all health benefit programs. HIPAA also added a prohibition against incentives intended to influence decisions by Medicare beneficiaries as to the provider from which they will receive services. In addition, HIPAA created new enforcement mechanisms to combat fraud and abuse, including the Medicare Integrity Program, and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds. Federal enforcement officials now have the ability to exclude from Medicare and Medicaid any investors, officers and managing employees associated with business entities that have committed health care fraud, even if the officer or managing employee had no knowledge of the fraud. HIPAA was followed by the Balanced Budget Act of 1997 (BBA-97), which created additional fraud and abuse provisions, including civil penalties for contracting with an individual or entity that the provider knows or should know is excluded from a federal health care program.

Other Fraud and Abuse Provisions

The Social Security Act also imposes criminal and civil penalties for making false claims and statements to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered or for misrepresenting actual services rendered in order to obtain higher reimbursement, billing for unnecessary goods and services, and cost report fraud. Criminal and civil penalties may be imposed for a number of other prohibited activities, including failure to return known overpayments, certain gainsharing arrangements, billing Medicare amounts that are substantially in excess of a provider s usual charges, offering remuneration to influence a Medicare or Medicaid beneficiary s selection of a health care provider, making or accepting a payment to induce a physician to reduce or limit services and soliciting or receiving any remuneration in return for referring an individual for an item or service payable by a federal healthcare program. Like the Anti-kickback Statute, these provisions are very broad. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, as well as accurately prepare cost reports.

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

The Federal False Claims Act and Similar State Laws

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

In some cases, whistleblowers, the federal government and some courts have taken the position that providers who allegedly have violated other statutes, such as the Anti-kickback Statute and the Stark Law, have thereby submitted false claims under the False Claims Act. A number of states in which we operate have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court.

HIPAA Administrative Simplification and Privacy Requirements

The Administrative Simplification Provisions of HIPAA require the use of uniform electronic data transmission standards for certain health care claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the health care industry. HHS has issued regulations implementing the HIPAA Administrative Simplification Provisions and compliance with these regulations became mandatory for our facilities in October 2003, although CMS accepted noncompliant claims through September 30, 2005. HHS has proposed a rule that would establish standards for electronic health care claims attachments. In addition, HIPAA requires that each provider apply for and receive a National Provider Identifier by May 2007. We believe that the cost of compliance with these regulations has not had and is not expected to have a material adverse effect on our business, financial position or results of operations.

HIPAA also requires HHS to adopt standards to protect the privacy and security of individually identifiable health-related information. HHS issued regulations containing privacy standards and compliance with these regulations became mandatory during April 2003. The privacy regulations control the use and disclosure of individually identifiable health-related information, whether communicated electronically, on paper or orally. The regulations also provide patients with significant new rights related to understanding and controlling how their health information is used or disclosed. HHS released final security regulations that became mandatory during April 2005 and require health care providers to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is maintained or transmitted electronically. We have developed and enforce a HIPAA compliance plan, which we believe complies with HIPAA privacy and security requirements and under which a HIPAA compliance group monitors our compliance. The privacy regulations and security regulations have and will continue to impose significant costs on our facilities in order to comply with these standards.

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Violations of HIPAA could result in civil penalties of up to $25,000 per type of violation in each calendar year and criminal penalties of up to $250,000 per violation. In addition, there are numerous legislative and regulatory initiatives at the federal and state levels addressing patient privacy concerns. Facilities will continue to remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These statutes vary and could impose additional penalties.

EMTALA

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

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

Corporate Practice of Medicine/ Fee Splitting

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

Health Care Industry Investigations

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

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

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

Both federal and state government agencies have increased their focus on and coordination of civil and criminal enforcement efforts in the health care area. The OIG and the Department of Justice have, from time to time, established national enforcement initiatives, targeting all hospital providers, that focus on specific billing practices or other suspected areas of abuse.

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

Commencing in 1997, we became aware we were the subject of governmental investigations and litigation relating to our business practices. As part of the investigations, the United States intervened in a number of *qui tam* actions brought by private parties. The investigations related to, among other things, DRG coding, outpatient laboratory billing, home health issues, physician relations, cost report and wound care issues. The investigations were concluded through a series of agreements executed in 2000 and 2003 with the Criminal Division of the Department of Justice, the Civil Division of the Department of Justice, various U.S. Attorneys offices, CMS, a negotiating team representing states with claims against us, and others. In January 2001, we entered into an eight-year Corporate Integrity Agreement (the CIA) with the Office of Inspector General of the Department of Health and Human Services. Violation or breach of the CIA, or other violation of federal or state laws relating to Medicare, Medicaid or similar programs, could subject us to substantial monetary fines, civil and criminal penalties and/or exclusion from participation in the Medicare and Medicaid programs and other federal and state health care programs. Alleged violations may be pursued by the government or through private *qui tam* actions. Sanctions imposed against us as a result of such actions could have a material, adverse effect on our results of operations and financial position.

Health Care Reform

Health care is one of the largest industries in the United States and continues to attract much legislative interest and public attention. In recent years, various legislative proposals have been introduced or proposed in Congress and in some state legislatures that would effect major changes in the health care system, either nationally or at the state level. Many states have enacted, or are considering enacting, measures designed to reduce their Medicaid expenditures and change private health care insurance. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand states Medicaid systems. Some states, including the states in which we operate, have applied for and have been granted federal waivers from current Medicaid regulations to allow them to serve some or all of their Medicaid participants through managed care providers. Hospital operating margins have been, and may continue to be, under significant pressure because of deterioration in pricing flexibility and payer mix, and growth in operating expenses in excess of the increase in PPS payments under the Medicare program.

Compliance Program and Corporate Integrity Agreement

We maintain a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. The program is intended to monitor and raise awareness

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of various regulatory issues among employees and to emphasize the importance of complying with governmental laws and regulations. As part of the ethics and compliance program, we provide annual ethics and compliance training to our employees and encourage all employees to report any violations to their supervisor, an ethics and compliance officer or a toll-free telephone ethics line.

Our CIA with the OIG is structured to assure the federal government of our overall federal health care program compliance and specifically covers DRG coding, outpatient PPS billing and physician relations. We underwent major training efforts to ensure that our employees learned and applied the policies and procedures implemented under the CIA and our ethics and compliance program. The CIA also included testing for outpatient laboratory billing in 2001, which was replaced with skilled nursing facilities billing in 2003. The CIA has had the effect of increasing the amount of information we provide to the federal government regarding our health care practices and our compliance with federal regulations. Under the CIA, we have numerous affirmative obligations, including the requirement that we report potential violations of applicable federal health care laws and regulations and have, pursuant to this obligation, reported a number of potential violations of the Stark Law, the Anti-kickback Statute, EMTALA and other laws, most of which we consider to be nonviolations or technical violations. This obligation could result in greater scrutiny by regulatory authorities. Although no government agency has taken any adverse action related to the CIA disclosures, the government could determine that our reporting and/or our resolution of reported issues has been inadequate. Breach of the CIA and/or a finding of violations of applicable health care laws or regulations could subject us to repayment requirements, substantial monetary penalties, civil penalties, exclusion from participation in the Medicare and Medicaid and other federal and state health care programs and, for violations of certain laws and regulations, criminal penalties.

Antitrust Laws

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

Environmental Matters

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

Insurance

As is typical in the health care industry, we are subject to claims and legal actions by patients in the ordinary course of business. Our facilities are insured by our wholly-owned insurance subsidiary for losses up to $50 million per occurrence. The insurance subsidiary has obtained reinsurance for professional liability risks generally above a retention level of $15 million per occurrence. We also maintain professional liability insurance with unrelated commercial carriers for losses in excess of amounts insured by our insurance subsidiary. Effective January 1, 2007, our facilities will generally be self-insured for the first $5 million of per occurrence losses.

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

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on the cause of the property damage. These deductibles range from $500,000 per claim up to 5% of the affected property values for certain flood and wind and earthquake related incidents.

Employees and Medical Staffs

At December 31, 2006, we had approximately 186,000 employees, including approximately 49,000 part-time employees. References herein to employees refer to employees of affiliates of HCA. We are subject to various state and federal laws that regulate wages, hours, benefits and other terms and conditions relating to employment. Employees at 21 and 16 of our hospitals were represented by various labor unions at December 31, 2006 and 2005, respectively. We consider our employee relations to be satisfactory. Our hospitals have experienced some recent union organizational activity. We had elections at seven hospitals in Florida in the fourth quarter of 2006 and an election at one hospital in California in February 2007. We do not expect such efforts to materially affect our future operations. Our hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate. In some markets, nurse and medical support personnel availability has become a significant operating issue to health care providers. To address this challenge, we have implemented several initiatives to improve retention, recruiting, compensation programs and productivity. This shortage may also require an increase in the utilization of more expensive temporary personnel.

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

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

Risk Factors

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

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

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

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Since completing the Recapitalization, we are highly leveraged. As of December 31, 2006, our total indebtedness was $28.408 billion. Our high degree of leverage could have important consequences, including:

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

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

Our Debt Agreements Contain Restrictions That Limit Our Flexibility In Operating Our Business.

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

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

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

Under our senior secured credit facilities we will be required to satisfy and maintain specified financial ratios. Our ability to meet those financial ratios can be affected by events beyond our control, and there can be no assurance that we will meet those ratios. A breach of any of these covenants could result in a default under both of our senior secured

credit facilities. Upon the occurrence of an event of default under our senior secured credit facilities, our lenders could elect to declare all amounts outstanding under our senior secured credit facilities to be immediately due and payable and terminate all commitments to extend further credit. If we were unable to repay those amounts, the lenders under our senior secured credit facilities could proceed against the collateral granted to them to secure each such indebtedness. We have pledged a significant portion

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of our assets as collateral under our senior secured credit facilities and our existing senior secured notes. If any of the lenders under our senior secured credit facilities accelerate the repayment of borrowings, there can be no assurance that we will have sufficient assets to repay our senior secured credit facilities and our outstanding notes.

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

The health care business is highly competitive, and competition among hospitals and other health care providers for patients has intensified in recent years. Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. In 2005, CMS began making public performance data related to ten quality measures that hospitals submit in connection with their Medicare reimbursement. On February 8, 2006, DRA 2005 was enacted by Congress and expanded the number of quality measures that must be reported to 21, beginning with discharges occurring in the third quarter of 2006. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these 21 quality measures, patient volumes could decline. In addition, DRA 2005 requires that CMS expand the number of quality measures in future years. On November 1, 2006, CMS announced a final rule that expands to 26 the number of quality measures that must be reported, beginning in the first quarter of calendar year 2007, and requires, beginning in the third quarter of calendar year 2007, that hospitals report the results of a 27-question patient perspective survey. The additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes.

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

Section 507 of MMA provided for an 18-month moratorium on the establishment of new specialty hospitals. The moratorium expired on June 8, 2005. However, HHS suspended processing new provider enrollment applications for specialty hospitals until January 2006, creating, in effect, a new moratorium on specialty hospitals. DRA 2005 directed HHS to extend this enrollment suspension until the earlier of six months from the enactment of DRA 2005 or the release of a report regarding physician owned specialty hospitals by HHS. On August 8, 2006, HHS issued its final report, in which it announced that it would resume processing and certifying provider enrollment applications. As a result of the moratorium being rescinded, we face additional competition from an increased number of specialty hospitals, including hospitals owned by physicians currently on staff at our hospitals. In addition, HHS announced that it will require all hospitals to disclose any physician ownership and certain financial arrangements with physicians. HHS has not announced when it will begin collecting this data, the specific data that hospitals will be required to submit or which hospitals will be required to provide information.

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.

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The amount of the provision for doubtful accounts is based upon management s assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal and state governmental and private employer health care coverage, the rate of growth in uninsured patient admissions and other collection indicators. At December 31, 2006, our allowance for doubtful accounts represented approximately 86% of the $3.972 billion patient due accounts receivable balance, including accounts, net of estimated contractual discounts, related to patients for which eligibility for Medicaid coverage was being evaluated (pending Medicaid accounts). For the year ended December 31, 2006, the provision for doubtful accounts increased to 10.4% of revenues compared to 9.6% of revenues in 2005. Adjusting for the effect of the uninsured discount policy implemented January 1, 2005, the provision for doubtful accounts was 14.1% and 12.4% of revenues for the years ended December 31, 2006 and 2005, respectively.

A continuation of the trends that have resulted in an increasing proportion of accounts receivable being comprised of uninsured accounts and a deterioration in the collectibility of these accounts will adversely affect our collection of accounts receivable, cash flows and results of operations.

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

The Medicare program will reimburse 70% of bad debts related to deductibles and coinsurance for patients with Medicare coverage, after the provider has made a reasonable effort to collect these amounts. On March 30, 2006, the United States District Court for the Western District of Michigan entered a final order in *Battle Creek Health System v. Thompson,* which provided that reasonable collection efforts have not been satisfied as long as the Medicare accounts remained with an external collection agency. The case is under appeal at the United States Court of Appeals for the Sixth Circuit. We utilize extensive in-house and external collection efforts for our accounts receivable, including deductible and coinsurance amounts owed by patients with Medicare coverage. However, we utilize a secondary collection agency after in-house and primary collection agency efforts have been unsuccessful. As a result of the *Battle Creek* decision, we contacted CMS and outlined our collection process and the reasons for our belief that Medicare bad debts could be claimed for reimbursement after exhaustion of collection efforts at the primary collection agency, but while the accounts were still pending with the secondary collection agency. CMS has responded to us consistent with the *Battle Creek* decision. We are in continued discussions with CMS concerning the proper timing to claim reimbursement for Medicare bad debts. We incur approximately $30 million of Medicare bad debts per year that are subject to the *Battle Creek* decision. We are unable to predict the outcome of the *Battle Creek* case or CMS s final answer on the use of external collection agencies. We are currently evaluating possible modifications to our accounts receivable collection processes that will both provide us with reasonable collection results and comply with CMS s interpretation of reasonable collection efforts.

Changes In Governmental Programs May Reduce Our Revenues.

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

Effective January 1, 2007, as a result of DRA 2005, reimbursements for ASC overhead costs are limited to no more than the overhead costs paid to hospital outpatient departments under the Medicare hospital outpatient prospective payment system for the same procedure. On August 8, 2006 CMS announced proposed regulations that, if adopted, would change payment for procedures performed in an ASC, effective January 1, 2008. Under this proposal, ASC payment groups would increase from the current nine clinically disparate payment groups to the 221 Ambulatory Procedure Classification groups (APCs) used under the outpatient prospective payment system for these surgical services. CMS estimates that the rates for procedures performed in an ASC setting would equal 62% of the corresponding rates paid for the same procedures performed in an outpatient hospital setting. Moreover, under the proposed regulations, if CMS determines

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that a procedure is commonly performed in a physician s office, the ASC reimbursement for that procedure would be limited to the reimbursement allowable under the Medicare Part B Physician Fee Schedule. In addition, under this proposal, all surgical procedures, other than those that pose a significant safety risk or generally require an overnight stay, which would be listed by CMS, would be payable as ASC procedures. This will expand the number of procedures that Medicare will pay for if performed in an ASC. CMS indicates in its discussion of the proposed regulations that it believes that the volumes and service mix of procedures provided in ASCs would change significantly in 2008 under the revised payment system, but that CMS is not able to accurately project those changes. If the proposal is adopted, more Medicare procedures that are now performed in hospitals, such as ours, may be moved to ASCs reducing surgical volume in our hospitals. Also, more Medicare procedures that are now performed in ASCs, such as ours, may be moved to physicians offices. Commercial third-party payers may adopt similar policies.

On August 1, 2006, CMS announced a final rule that refines the DRG payment system. CMS announced that it is considering additional changes effective in federal fiscal year 2008. We cannot predict the impact that any such changes, if finalized, would have on our revenues. Future realignments in the DRG system could also reduce the margins we receive for certain specialties, including cardiology and orthopedics. In fact, the greater popularity of specialty hospitals in recent years has caused CMS to focus on payment levels for such specialties. Any such change in the payments received for specialty services could have an adverse effect on our revenues and could require us to modify our strategy. Other Medicare payment changes may also affect our revenues. See Item 1. Business Sources of Revenue. DRG rates are updated and DRG weights are recalibrated each federal fiscal year. The index used to update the market basket gives consideration to the inflation experienced by hospitals and entities outside the health care industry in purchasing goods and services. MMA, as amended by DRA 2005, provides for DRG increases using the full market basket if data for certain patient care quality indicators is submitted quarterly to CMS, and using the market basket minus two percentage points if such data is not submitted. While we will endeavor to comply with all data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all of our hospitals.

Since states must operate with balanced budgets and since the Medicaid program is often the state s largest program, states can be expected to adopt or consider adopting legislation designed to reduce their Medicaid expenditures. DRA 2005, signed into law on February 8, 2006, includes Medicaid cuts of approximately $4.8 billion over five years. In addition, proposed regulatory changes, if implemented, would reduce federal Medicaid funding by an additional $12.2 billion over five years. On January 18, 2007, CMS published a proposed rule entitled Medicaid Program; Cost Limits for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership. The proposed rule, if finalized, could significantly impact state Medicaid programs. It is uncertain if the rule will be finalized. States have also adopted, or are considering, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states Medicaid systems. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position and results of operations.

Demands Of Nongovernment Payers May Adversely Affect Our Growth In Revenues.

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

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

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

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

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

If We Fail To Comply With Extensive Laws And Government Regulations, We Could Suffer Penalties Or Be Required To Make Significant Changes To Our Operations.

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

billing for services;

relationships with physicians and other referral sources;

adequacy of medical care;

quality of medical equipment and services;

qualifications of medical and support personnel;

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

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

licensure;

hospital rate or budget review;

operating policies and procedures; and

addition of facilities and services.

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

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

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

If we fail to comply with the Anti-kickback Statute, the Stark Law, the False Claims Act or other applicable laws and regulations, or if we fail to maintain an effective corporate compliance program, we could be subjected to liabilities, including civil penalties (including the loss of our licenses to operate one or more facilities), exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs and, for violations of certain laws and regulations, criminal penalties. See Item 1, Business Regulation and Other Factors.

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

We Have Been The Subject Of Governmental Investigations, Claims And Litigation

Commencing in 1997, we became aware that we were the subject of governmental investigations and litigation relating to our business practices. The investigations were concluded through a series of agreements executed in 2000 and 2003. In January 2001, we entered into an eight-year Corporate Integrity Agreement (CIA) with the OIG. Under the CIA, we have numerous affirmative obligations, including the requirement that we report potential violations of applicable federal health care laws and regulations and have, pursuant to this obligation, reported a number of potential violations of the Stark Law, the Anti-kickback Statute, EMTALA and other laws, most of which we consider to be nonviolations or technical violations. Although no government agency has taken any adverse action related to the CIA disclosures, the government could

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

In September 2005, we received a subpoena from the Office of the United States Attorney for the Southern District of New York seeking the production of documents. Also in September 2005, we were informed that the SEC had issued a formal order of investigation. Both the subpoena and the formal order of investigation relate to trading in our securities. We are cooperating fully with these investigations.

Subsequently, we and certain of our executive officers and directors were named in various federal securities law class actions and several shareholders have filed derivative lawsuits purportedly on behalf of the Company. Additionally, a former employee filed a complaint against certain of our executive officers pursuant to the Employee Retirement Income Security Act, and we have been served with a shareholder demand letter addressed to our Board of Directors. We cannot predict the results of the investigations or any related lawsuits or the effect that findings in such investigations or lawsuits adverse to us may have on us. We have, however, reached an agreement in principle for the settlement of the derivative lawsuits.

On July 24, 2006, we announced that we had entered into the Merger Agreement. In connection with the Merger, we are aware of eight asserted class action lawsuits related to the Merger filed against us, certain of our executive officers, our directors and the Sponsors, and one lawsuit filed against us and one of our affiliates seeking enforcement of contractual obligations allegedly arising from the Merger. Certain of these lawsuits, though not all, are the subject of an agreement in principle to settle. Additional lawsuits pertaining to the Merger could be filed in the future. These proceedings are described in greater detail under Item 3, Legal Proceedings.

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

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

Controls Designed To Reduce Inpatient Services May Reduce Our Revenues.

Controls imposed by Medicare 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

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more stringent cost controls are expected to continue. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

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

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

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

accounting and financial reporting;

billing and collecting accounts;

coding and compliance;

clinical systems;

medical records and document storage;

inventory management; and

negotiating, pricing and administering managed care contracts and supply contracts.

We are in the process of implementing projects to replace our payroll and human resources information systems. Management estimates that the payroll and human resources system projects will require total expenditures of approximately $333 million to develop and install. At December 31, 2006, project-to-date costs incurred were $295 million ($160 million of the costs incurred have been capitalized and $135 million have been expensed). Management expects that the system development, testing, data conversion and installation will continue through 2007.

State Efforts To Regulate The Construction Or Expansion Of Hospitals Could Impair Our Ability To Operate And Expand Our Operations.

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

Our Facilities Are Heavily Concentrated In Florida And Texas, Which Makes Us Sensitive To Regulatory, Economic, Environmental And Competitive Changes In Those States.

We operated 173 hospitals at December 31, 2006, and 73 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities combined revenues represented approximately 51% of our consolidated revenues for the year ended December 31, 2006. This concentration makes us particularly sensitive to regulatory, economic, environmental and competition changes in those states. Any material change in the

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current payment programs or regulatory, economic, environmental or competitive conditions in those states could have a disproportionate effect on our overall business results.

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

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

We are currently contesting claims for income taxes, interest and penalties proposed by the IRS for prior years aggregating approximately $678 million through December 31, 2006. The disputed items include the deductibility of a portion of the 2001 government settlement payment, the timing of recognition of certain patient service revenues in 2000 through 2002, the method for calculating the tax allowance for uncollectible accounts in 2002 and the amount of insurance expense deducted in 1999 through 2002.

During 2006, the IRS began an examination of our 2003 through 2004 federal income tax returns. The IRS has not determined the amount of any additional income tax, interest and penalties that it may claim upon completion of this examination or any future examinations that may be initiated. See Management s Discussion and Analysis of Financial Condition and Results of Operations Pending IRS Disputes.

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

We are subject to litigation relating to our business practices, including claims and legal actions by patients and others in the ordinary course of business alleging malpractice, product liability or other legal theories. See Item 3, Legal Proceedings. Many of these actions involve large claims and significant defense costs. We insure a substantial portion of our professional liability risks through a wholly-owned subsidiary. Management believes our insurance coverage is sufficient to cover 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 $2.129 billion and $14 million, respectively, at December 31, 2006. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. The fair value of investments is generally based on quoted market prices. At December 31, 2006, we had a net unrealized gain of $25 million on the insurance subsidiary s investment securities.

We are also exposed to market risk related to changes in interest rates and periodically enter into interest rate swap agreements to manage our exposure to these fluctuations. Our interest rate swap agreements involve the exchange of fixed and variable rate interest payments between two parties, based on common notional principal amounts and maturity dates. The net interest payments based on the notional amounts in these agreements generally match the timing of the cash flows of the related liabilities. The notional amounts of the

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swap agreements represent balances used to calculate the exchange of cash flows and are not assets or liabilities of HCA. Any market risk or opportunity associated with these swap agreements is offset by the opposite market impact on the related debt. See Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations Quantitative and Qualitative Disclosures About Market Risk.

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

The Investors indirectly own approximately 97.5% of our capital stock due to the Recapitalization. As a result, the Investors have control over our decisions to enter into any corporate transaction and have the ability to prevent any transaction that requires the approval of shareholders. For example, the Investors could cause us to make acquisitions that increase the amount of our indebtedness or sell assets.

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

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

None.

Item 2. ***Properties***

The following table lists, by state, the number of hospitals (general, acute care, psychiatric and rehabilitation) directly or indirectly owned and operated by us as of December 31, 2006:

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

In addition to the hospitals listed in the above table, we directly or indirectly operate 107 freestanding surgery centers. We also operate medical office buildings in conjunction with some of our hospitals. These office buildings are primarily occupied by physicians who practice at our hospitals.

We maintain our headquarters in approximately 918,000 square feet of space in the Nashville, Tennessee area. In addition to the headquarters in Nashville, we maintain regional service centers related to our shared services initiatives. These service centers are located in markets in which we operate hospitals.

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

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Item 3. ***Legal Proceedings***

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

Government Investigation, Claims and Litigation

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

Governmental Investigations

In September 2005, we received a subpoena from the Office of the United States Attorney for the Southern District of New York seeking the production of documents. Also in September 2005, we were informed that the SEC had issued a formal order of investigation. Both the subpoena and the formal order of investigation relate to trading in our securities. We are cooperating fully with these investigations.

Securities Class Action Litigation

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

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

On June 27, 2006, we and each of the defendants moved to dismiss the consolidated amended complaint, and these motions are still pending.

Shareholder Derivative Lawsuits in Federal Court

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

On January 23, 2006, the Court consolidated these actions as *In re HCA Inc. Derivative Litigation*, lead case number 3:05-CV-0968. The court stayed this action on February 27, 2006, pending resolution of a motion to dismiss the consolidated amended complaint in the related federal securities class action against us. On

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March 24, 2006, a consolidated derivative complaint was filed pursuant to a prior court order. On November 8, 2006, we reached an agreement in principle for the settlement of this consolidated action. The proposed settlement is subject to definitive documentation and court approval.

Shareholder Derivative Lawsuit in State Court

On January 18, 2006, a then current shareholder filed a derivative lawsuit, purportedly on behalf of our company, in the Circuit Court for the State of Tennessee (Nashville District), against our Chairman and Chief Executive Officer, President and Chief Operating Officer, Executive Vice President and Chief Financial Officer, other executives, and certain members of our Board of Directors. This lawsuit is substantially identical in all material respects to the consolidated federal litigation described above under Shareholder Derivative Lawsuits in Federal Court. The Court stayed this action on April 3, 2006, pending resolution of a motion to dismiss the consolidated amended complaint in the related federal securities class action against us. On November 8, 2006, we reached an agreement in principle for the settlement of this action. The proposed settlement is subject to definitive documentation and court approval.

ERISA Litigation

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

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

Merger Litigation in State Court

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

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

Under the terms of the memorandum, we, the other named parties and the plaintiffs have agreed to settle the lawsuit subject to court approval. If the court approves the settlement contemplated in the memorandum, the lawsuit will be dismissed with prejudice. We and the other defendants deny all of the allegations in the lawsuit. Pursuant to the terms of the memorandum, Hercules Holding agreed to waive that portion in excess

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of $220 million of any termination fee that it has a right to receive under the Merger Agreement. Also, we and the other parties agreed not to assert that a then current shareholder s demand for appraisal is untimely under Section 262 of the General Corporation Law of the State of Delaware (the DGCL) where such shareholder submitted a written demand for appraisal within 30 calendar days of the shareholders meeting held to adopt the Merger Agreement (with any such deadline being extended to the following business day should the 30th day fall on a holiday or weekend). We and the other parties also agreed not to assert that (i) the surviving corporation in the Merger or then current shareholder who was entitled to appraisal rights may not file a petition in the Court of Chancery of the State of Delaware demanding a determination of the value of the shares held by all such shareholders if such petition is not filed within 120 days of the effective time of the Merger so long as such petition is filed within 150 days of the effective time, (ii) a then current shareholder may not withdraw such shareholder s demand for appraisal and accept the terms offered by the Merger if such withdrawal is not made within 60 days of the effective time of the Merger so long as such withdrawal is made within 90 days of the effective time of the Merger and (iii) that a then current shareholder may not, upon written request, receive from the surviving corporation a statement setting forth the aggregate number of shares not voted in favor of the Merger with respect to which demands for appraisal have been received and the aggregate number of holders of such shares if such request is not made within 120 days of the effective time of the Merger so long as such request is made within 150 days of the effective time.

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

On October 23, 2006, the Foundation for Seacoast Health filed a lawsuit against us and one of our affiliates, HCA Health Services of New Hampshire, Inc., in the Superior Court of Rockingham County, New Hampshire. Among other things, the complaint seeks to enforce certain provisions of an asset purchase agreement between the parties, including a purported right of first refusal to purchase a New Hampshire hospital, that allegedly are triggered by the Merger. The Foundation initially sought to enjoin the Merger. However, the parties reached an agreement that allowed the Merger to proceed, while preserving the plaintiff s opportunity to litigate whether the Merger triggered the right of first refusal to purchase the hospital and, if so, at what price the hospital could be repurchased. The court has adopted a procedural schedule for addressing these issues that includes a trial in June 2007.

General Liability and Other Claims

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

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

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

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

We held a special meeting of shareholders on November 16, 2006. The following matter was voted upon at the meeting:

	Votes in Favor	Votes Against	Abstentions
To adopt the Agreement and Plan of Merger, dated as of July 24, 2006, by and among the Company, Hercules Holding II, LLC, a Delaware limited liability company, and Hercules Acquisition Corporation, a Delaware corporation and a wholly-owned subsidiary of Hercules Holding II, LLC	283,539,958	31,968,124	4,830,055

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PART II

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

Our outstanding common stock is privately held, and there is no established public trading market for our common stock. As of February 28, 2007, there were 653 holders of our common stock. See Item 7, Management s Discussion and Analysis of Financial condition and Results of Operations Liquidity and Capital Resources Financing Activities for a description of the restrictions on our ability to pay dividends.

In January 2005, our Board of Directors approved an increase in our quarterly dividend from $0.13 per share to $0.15 per share. The Board declared the initial $0.15 per share dividend payable on June 1, 2005 to shareholders of record at May 1, 2005. In January 2006, our Board of Directors approved an increase in our quarterly dividend from $0.15 per share to $0.17 per share. The Board declared the initial $0.17 per share dividend payable on June 1, 2006 to shareholders of record at May 1, 2006 and an additional dividend payable September 1, 2006 to shareholders of record on August 1, 2006. We did not pay a quarterly dividend during the fourth quarter of 2006.

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

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

	2006	2005	2004	2003	2002
Summary of Operations:					
Revenues	**$ 25,477**	$ 24,455	$ 23,502	$ 21,808	$ 19,729
Salaries and benefits	**10,409**	9,928	9,419	8,682	7,952
Supplies	**4,322**	4,126	3,901	3,522	3,158
Other operating expenses	**4,057**	4,039	3,797	3,676	3,341
Provision for doubtful accounts	**2,660**	2,358	2,669	2,207	1,581
(Gains) losses on investments	**(243)**	(53)	(56)	(1)	2
Equity in earnings of affiliates	**(197)**	(221)	(194)	(199)	(206)
Depreciation and amortization	**1,391**	1,374	1,250	1,112	1,010
Interest expense	**955**	655	563	491	446
Gains on sales of facilities	**(205)**	(78)		(85)	(6)
Transaction costs	**442**				
Impairment of long-lived assets	**24**		12	130	19
Government settlement and investigation related costs				(33)	661
Impairment of investment securities					168
	23,615	22,128	21,361	19,502	18,126
Income before minority interests and income taxes	**1,862**	2,327	2,141	2,306	1,603
Minority interests in earnings of consolidated entities	**201**	178	168	150	148
Income before income taxes	**1,661**	2,149	1,973	2,156	1,455
Provision for income taxes	**625**	725	727	824	622
Net income	**$ 1,036**	$ 1,424	$ 1,246	$ 1,332	$ 833
Financial Position:					
Assets	**$ 23,675**	$ 22,225	$ 21,840	$ 21,400	$ 19,059
Working capital	**2,502**	1,320	1,509	1,654	766
Long-term debt, including amounts due within one year	**28,408**	10,475	10,530	8,707	6,943
Minority interests in equity of consolidated entities	**907**	828	809	680	611
Equity securities with contingent redemption rights	**125**				

Stockholders (deficit) equity	**(11,374)**	4,863	4,407	6,209	5,702
Cash Flow Data:					
Cash provided by operating activities	**$ 1,845**	$ 2,971	$ 2,954	$ 2,292	$ 2,648
Cash used in investing activities	**(1,307)**	(1,681)	(1,688)	(2,862)	(1,740)
Cash (used in) provided by financing activities	**(240)**	(1,212)	(1,347)	650	(934)
Operating Data:					
Number of hospitals at end of period(a)	**166**	175	182	184	173
Number of freestanding outpatient surgical centers at end of period(b)	**98**	87	84	79	74
Number of licensed beds at end of period(c)	**39,354**	41,265	41,852	42,108	39,932
Weighted average licensed beds(d)	**40,653**	41,902	41,997	41,568	39,985
Admissions(e)	**1,610,100**	1,647,800	1,659,200	1,635,200	1,582,800
Equivalent admissions(f)	**2,416,700**	2,476,600	2,454,000	2,405,400	2,339,400
Average length of stay (days)(g)	**4.9**	4.9	5.0	5.0	5.0
Average daily census(h)	**21,688**	22,225	22,493	22,234	21,509
Occupancy(i)	**53%**	53%	54%	54%	54%
Emergency room visits(j)	**5,213,500**	5,415,200	5,219,500	5,160,200	4,802,800
Outpatient surgeries(k)	**820,900**	836,600	834,800	814,300	809,900
Inpatient surgeries(l)	**533,100**	541,400	541,000	528,600	518,100
Days revenues in accounts receivable(m)	**53**	50	48	52	52
Gross patient revenues(n)	**$ 84,913**	$ 78,662	$ 71,279	$ 62,626	$ 53,542
Outpatient revenues as a % of patient revenues(o)	**36%**	36%	37%	37%	37%

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(a) Excludes seven facilities in 2006, 2005, 2004, and 2003; and six facilities in 2002 that are not consolidated (accounted for using the equity method) for financial reporting purposes.
(b) Excludes nine facilities in 2006, seven facilities in 2005, eight facilities in 2004 and four facilities in 2003 and 2002 that are not consolidated (accounted for using the equity method) for financial reporting purposes.
(c) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.
(d) Weighted average licensed beds represents the average number of licensed beds, weighted based on periods owned.
(e) Represents the total number of patients admitted to our hospitals and is used by management and certain investors as a general measure of inpatient volume.
(f) Equivalent admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Equivalent admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The equivalent admissions computation equates outpatient revenue to the volume measure (admissions) used to measure inpatient volume, resulting in a general measure of combined inpatient and outpatient volume.
(g) Represents the average number of days admitted patients stay in our hospitals.
(h) Represents the average number of patients in our hospital beds each day.
(i) Represents the percentage of hospital licensed beds occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.
(j) Represents the number of patients treated in our emergency rooms.
(k) Represents the number of surgeries performed on patients who were not admitted to our hospitals. Pain management and endoscopy procedures are not included in outpatient surgeries.
(l) Represents the number of surgeries performed on patients who have been admitted to our hospitals. Pain management and endoscopy procedures are not included in inpatient surgeries.
(m) 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.
(n) 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.
(o) Represents the percentage of patient revenues related to patients who are not admitted to our hospitals.

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

HCA INC.

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

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

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

Forward-Looking Statements

This Annual Report on Form 10-K includes certain disclosures which contain forward-looking statements. Forward-looking statements include all statements that do not relate solely to historical or current facts, and can be identified by the use of words like may, believe, will, expect, project, estimate, anticipate, plan, initiat These forward-looking statements are based on our current plans and expectations and are subject to a number of known and unknown uncertainties and risks, many of which are beyond our control, that could significantly affect current plans and expectations and our future financial position and results of operations. These factors include, but are not limited to, (1) the ability to recognize the benefits of the Recapitalization and the effect of the Recapitalization on our customer, employee and other relationships, (2) the impact of the substantial indebtedness incurred to finance the Recapitalization, (3) increases in the amount and risk of collectibility of uninsured accounts and deductibles and copayment amounts for insured accounts, (4) the ability to achieve operating and financial targets and achieve expected levels of patient volumes and control the costs of providing services, (5) possible changes in the Medicare, Medicaid and other state programs that may impact reimbursements to health care providers and insurers, (6) the highly competitive nature of the health care business, (7) changes in revenue mix and the ability to enter into and renew managed care provider agreements on acceptable terms, (8) the efforts of insurers, health care providers and others to contain health care costs, (9) the outcome of our continuing efforts to monitor, maintain and comply with appropriate laws, regulations, policies and procedures and our corporate integrity agreement with the government, (10) changes in federal, state or local regulations affecting the health care industry, (11) the ability to attract and retain qualified management and personnel, including affiliated physicians, nurses and medical support personnel, (12) the outcome of governmental investigations by the United States Attorney for the Southern District of New York and the SEC, (13) the outcome of certain class action and derivative litigation filed with respect to us, (14) the possible enactment of federal or state health care reform, (15) the availability and terms of capital to fund the expansion of our business, (16) the continuing impact of hurricanes on our facilities and the ability to obtain recoveries under our insurance policies, (17) changes in accounting practices, (18) changes in general economic conditions, (19) future divestitures which may result in charges, (20) changes in business strategy or development plans, (21) delays in receiving payments for services provided, (22) the outcome of pending and any future tax audits, appeals and litigation associated with our tax positions, (23) potential liabilities and other claims that may be asserted against us, and (24) other risk factors described in this Annual Report on Form 10-K. As a consequence, current plans, anticipated actions and future financial position and results may differ from those

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HCA INC.
MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

expressed in any forward-looking statements made by or on behalf of HCA. You are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented in this report.

2006 Operations Summary

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

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

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

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

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

Business Strategy

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

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

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HCA INC.
MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Business Strategy (Continued)

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

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

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

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

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

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

Become the Health Care Employer of Choice. We will continue to use a number of industry-leading practices to help ensure that our hospitals are a health care employer of choice in their respective communities. Our staffing initiatives for both care providers and hospital management provide strategies for recruitment, compensation and productivity to increase employee retention and operating efficiency at our hospitals. For example, we maintain an internal contract nursing agency to supply our hospitals with high

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HCA INC.
MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Business Strategy (Continued)

quality staffing at a lower cost than external agencies. In addition, we have developed several proprietary training and career development programs for our physicians and hospital administrators, including an executive development program designed to train the next generation of hospital leadership. We believe that our continued investment in the training and retention of employees improves the quality of care, enhances operational efficiency and fosters employee loyalty.

Critical Accounting Policies and Estimates

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

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

Revenues

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

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital s emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the individual to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual s ability to pay for treatment. Federal and state laws and regulations, including but not limited to EMTALA, require, and our commitment to providing quality patient care encourages, the provision of services to patients who are financially unable to pay for the health care services they receive.

We do not pursue collection of amounts related to patients who meet our guidelines to qualify as charity care; therefore, they are not reported in revenues. The revenues associated with uninsured patients who do not meet our guidelines to qualify as charity care have generally been reported in revenues at gross charges. Patients treated at our hospitals for nonelective care, who have income at or below 200% of the federal poverty level, are eligible for charity care. The federal poverty level is established by the federal government and is based on income and family size. On January 1, 2005, we modified our policies to provide discounts to uninsured patients who do not qualify for Medicaid or charity care. These discounts are similar to those provided to many local managed care plans.

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

Critical Accounting Policies and Estimates (Continued)

Revenues (Continued)

Due to the complexities involved in the classification and documentation of health care services authorized and provided, the estimation of revenues earned and the related reimbursement are often subject to interpretations that could result in payments that are different from our estimates. A hypothetical 1% change in net receivables that are subject to contractual discounts at December 31, 2006 would result in an impact on pretax earnings of approximately $32 million.

Provision for Doubtful Accounts and the Allowance for Doubtful Accounts

The collection of outstanding receivables from Medicare, managed care payers, other third-party payers and patients is our primary source of cash and is critical to our operating performance. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to amounts due directly from patients. An estimated allowance for doubtful accounts is recorded for all uninsured accounts, regardless of the aging of those accounts. Accounts are written off when all reasonable internal and external collection efforts have been performed. We consider the return of an account from the primary external collection agency to be the culmination of our reasonable collection efforts and the timing basis for writing off the account balance. Writeoffs are based upon specific identification and the writeoff process requires a writeoff adjustment entry to the patient accounting system. We do not pursue collection of amounts related to patients that meet our guidelines to qualify as charity care. Charity care is not reported in revenues and does not have an impact on the provision for doubtful accounts.

The amount of the provision for doubtful accounts is based upon management s assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal, state, and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical writeoffs and recoveries at facilities that represent a majority of our revenues and accounts receivable (the hindsight analysis) as a primary source of information in estimating the collectibility of our accounts receivable. We perform the hindsight analysis quarterly, utilizing rolling twelve-months accounts receivable collection and writeoff data. At December 31, 2006, the allowance for doubtful accounts represented approximately 86% of the $3.972 billion patient due accounts receivable balance, including accounts, net of the related estimated contractual discounts, related to patients for which eligibility for Medicaid assistance or charity was being evaluated (pending Medicaid accounts). At December 31, 2005, the allowance for doubtful accounts represented approximately 85% of the $3.404 billion patient due accounts receivable balance, including pending Medicaid accounts, net of the related estimated contractual discounts. The provision for doubtful accounts was 10.4% of revenues in 2006, 9.6% of revenues in 2005 and 11.4% of revenues in 2004. Our uninsured discount policy, which became effective January 1, 2005, resulted in $1.095 billion and $769 million in discounts to the uninsured being recorded during 2006 and 2005, respectively. Adjusting for the effect of the uninsured discounts, the provision for doubtful accounts was 14.1% and 12.4% of revenues for the years ended December 31, 2006 and 2005, respectively. See Supplemental Non-GAAP Disclosures, Operating Measures Adjusted for the Impact of Discounts for the Uninsured. Days revenues in accounts receivable were 53 days, 50 days and 48 days at December 31, 2006, 2005 and 2004, respectively. Management expects a continuation of the challenges related to the collection of the patient due accounts. Adverse changes in the percentage of our patients having adequate health care coverage, general economic conditions, patient accounting service center operations, payer mix, or trends in federal, state, and private employer health care coverage could affect the collection of accounts receivable, cash flows and results of operations.

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HCA INC.
MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (Continued)

Critical Accounting Policies and Estimates (Continued)

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

The approximate breakdown of accounts receivable by payer classification as of December 31, 2006 and 2005 is set forth in the following table:

	% of Accounts Receivable		
	Under 91 Days	91 180 Days	Over 180 Days
Accounts receivable aging at December 31, 2006:			
Medicare and Medicaid	13%	1%	2%
Managed care and other insurers	21	4	4
Uninsured	20	11	24
Total	54%	16%	30%
Accounts receivable aging at December 31, 2005:			
Medicare and Medicaid	13%	2%	2%
Managed care and other insurers	21	4	4
Uninsured	21	11	22
Total	55%	17%	28%

Professional Liability Claims

We, along with virtually all health care providers, operate in an environment with professional liability risks. Prior to 2007, a substantial portion of our professional liability risks was insured through a wholly-owned insurance subsidiary. Reserves for professional liability risks were $1.584 billion and $1.621 billion at December 31, 2006 and December 31, 2005, respectively. The current portion of these reserves, $275 million and $285 million at December 31, 2006 and 2005, respectively, is included in other accrued expenses. Obligations covered by reinsurance contracts are included in the reserves for professional liability risks, as the insurance subsidiary remains liable to the extent reinsurers do not meet their obligations. Reserves for professional liability risks (net of $42 million and $43 million receivable under reinsurance contracts at December 31, 2006 and 2005, respectively) were $1.542 billion and $1.578 billion at December 31, 2006 and 2005, respectively. Reserves and provisions for professional liability risks are based upon actuarially determined estimates. The independent actuaries estimated reserve ranges, net of amounts receivable under reinsurance contracts, were $1.321 billion to $1.545 billion at December 31, 2006 and $1.373 billion to $1.589 billion at December 31, 2005. Reserves for professional liability risks represent the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known.

The reserves for professional liability risks cover approximately 3,000 and 3,300 individual claims at December 31, 2006 and 2005, respectively, and estimates for unreported potential claims. The time period required to resolve these claims can vary depending upon the jurisdiction and whether the claim is settled or litigated. The estimation of the timing of payments beyond a year can vary significantly. Changes to the estimated reserve amounts

are included in current operating results. Due to the considerable variability that is inherent in such estimates, there can be no assurance that the ultimate liability will not exceed management s estimates.

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

Critical Accounting Policies and Estimates (Continued)

Professional Liability Claims (Continued)

Provisions for losses related to professional liability risks were $217 million, $298 million and $291 million for the years ended December 31, 2006, 2005 and 2004, respectively. We recognized reductions in our estimated professional liability insurance reserves of $136 million, $83 million and $59 million during 2006, 2005 and 2004, respectively. These reductions reflect the recognition by the external actuaries of our improving frequency and severity claim trends. This improving