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BODY:

MODERATOR: Thank you, everyone. Thanks for joining us for our next presentation. Pleased to have with us management representatives from **HCA,** as you know, one of the nation's leading for profit hospital companies. Vic Campbell, Senior Vice President, will be leading today's discussion. Vic is a longtime veteran of **HCA,** having joined the Company in 1972. Held a variety of responsibilities in that time period and currently leads Corporate Communications and Government Relations. Also joining us today, Mark Kimbrough, Vice President and Head of Investor Relations.

You should have a note card either in your information package or there are additional note cards that are available in the room and we'll certainly look for your contribution to the question and answer portion of today's prepared comments. Thanks, everyone, and Vic, let me turn the podium to you.

VIC CAMPBELL, SVP, CORPORATE COMMUNICATIONS AND GOVERNMENT RELATIONS, **HCA,** INC.: Chris, thank you. Good morning, everyone. It's always fun to be in this hotel. It has very fond memories to me because 15 years ago, my wife and I actually honeymooned here. So I get weak in the knees every time I walk into this place, but it's great to be here. Chris, thanks for having us here. I assume they have the conference here to celebrate an anniversary for us, so this is our 15th anniversary.

I'll try to be very brief. I think that's the agenda here. It's hard for a Southerner to be brief, but I will try to do that and quickly walk you through a key points and then Mark and I would be glad to answer any questions.

The first slide that we have here really tells you who we are. And any of you that have seen us in recent years knows that this is our standard slide. It really shows who we are, differentiates us we think from anyone else in this business. This Company has been around -- I've been there 33 years -- it's been around for about 35, 36 years. We've been small. We've been large. We are now I guess large relative to others in our business, but a little smaller than we were at one time. We have a very focused strategy and that is to be in large markets and have leading market share positions in those markets, build both inpatient and outpatient services in the markets that we're in. We have 190 hospitals today. Roughly 92 outpatient surgery centers, a growing number of imaging centers and other outpatient activities. Again, all in these markets. I think we're in 15 of the 16 fastest growing large U.S. cities in the United States. So that is what we're all about and our strategy is focused on that.

This slide depicts really what we think is going to drive our future success. I'm going to touch on a few of these briefly with some additional slides. This really to us is what gives us confidence in our future. First, the aging population gives us confidence; people like me are getting older. We are using health care a lot more. I can speak to that myself. That's both the bad news and the good news.

We've also seen an improving economy. As many of you know over the last few years with the downturn in the economy, clearly, our results suffered. Hospital results suffered somewhat. Increasing copays and deducts, people without insurance, in particular in some of our larger markets like Houston, where that was very difficult. The economy clearly is getting better and we're seeing that reflected in our numbers today.

Again, the market positions is the key to our Company. Capital investments, we are a large investor. Fortunately, we have that capital to reinvest in the markets we're in. We know those markets so there's less risk to putting that capital there than to going in new markets, although occasionally we'll venture out as we did a couple of years ago, three years ago now, in Kansas City, made $1 billion investment. And I might add Kansas City turned the corner the first quarter of this year, became accretive to earnings and really starting to move forward. Outpatient strategy, I want to discuss -- our quality patient safety initiatives, I'm not going to dwell on those, but I should. To be perfectly honest, I think that is the key to what's driving our hospital success. We have really stepped up medication safety programs, bar coding; we're moving to electronic position order entry. A number of areas, and this builds comfort. It builds No. 1, better care for our patients; it makes our doctors happy; it makes our nurses happy. Long term, we think it will drive success. We also think that over time, whether it's Medicare pay for performance or managed care, they're going to recognize the difference in quality and outcomes and we're going to be positioned well there.

Bad debts -- we'll talk about it briefly, as we always do. Stable pricing environment. I think that's critical to understand both the Medicare and managed care pricing environment. It's very stable. We're getting 6 to 7% price increases on our managed care business, where 70% of our contracts for next year, 2006, are already in place. So it gives us good visibility there.

The Medicare pricing environment is not quite as good as it was two years ago. I guess this is probably our best year in Medicare pricing. It will tick down a little bit next year, but still, we think a solid pricing

increase. And then finally, the use of our cash flows.

Real quick on a couple of these slides, we sometimes lose track of where we've been in this country with patient volumes. We focus about last quarter and the next quarter. But you can see from this we went through a period of about 15 years, where inpatient volumes declined and they have now turned the corner. They have moved fairly well. They were a little softer in 2003 because we think of the economy copays and deducts. They've stabilized and are running at reasonable levels today. The outpatient growth continues to be very strong and we think it will continue into the foreseeable future. Most of that driven by technology.

This slide shows you where we think volumes are going to go. This is an inpatient slide. Outpatient volumes would actually be greater than this, but as we did our work last year and our strategic planning with some outside consultants, we tried to look at what the baby boomers are going to do to demand. We also cut our numbers back because of increasing copays, deducts, other pressures, moves to outpatient to try to come up with what we thought inpatient admission growth would be over the next 10, 15 years. Our number is about 1.5% and if you really look at adding the growth in our markets, we'd probably be a little higher than that because we're in faster growth markets in the U.S.

Capital expenditures, again, you have these slides so I won't spend a lot of time on them. We're spending about 1.6 billion or investing about 1.6 billion a year now. We were a little higher than that a couple of years ago because we were building some new hospitals. We actually are looking at the potential of building some new hospitals over the next few years in the markets we're in. But we think this is a steady, good opportunity to reinvest in the markets where we are.

Outpatient business is a business that many of you are aware, if you go back two and three years ago, we were losing market share. We found ourselves, as hospital operators, more focused on that hospital campus and thinking that we could treat not only the inpatients on our campus, but we could also treat the outpatients because we had the capacity to do it. We had the operating rooms. We had the imaging capability, so we were trying to build our outpatient business in the easiest place we knew and that was around the hospital.

We found that that was not going to work. Today's environment, people don't want to go to a large hospital, go to the main campus, if in fact they can get something done a little bit quicker somewhere else, more convenient. So we stepped up, made a decision. Again, it's been about a year and a half, two years ago now, put a team in place, put capital behind them, and really have stepped out in terms of both building outpatient businesses off the campuses of our hospitals as well as buying them. And this slide just depicts a number of the transactions that have taken place in the last several months. We've bought 20 to 30 imaging centers, 8 to 10 surgery centers. We expect to continue at a run rate something similar to that in the future. Our outpatient numbers, the last 2 or three quarters, Mark, have really begun to show the impact of that. We think it's just really the beginning.

On the expense side, we like all of our expense lines except for bad debt. If you really look at our overall

operating expenses per adjusted admission, the first slide up there, you can see we've had very slow growth, which is obviously good. The second line looks at really cash operating expenses, which also is a good number.

Our wage rates -- our biggest expense in this business is labor. We've steadily held our wage rates somewhere in the 4.5 to 5% range. We expect that to continue. In the markets we're in, we're not seeing great pressures for that to go higher. And also on the supply side, we're starting to do a little better there. We've had some challenges in the supply area, in particular, some of the ones that are noted up in the far right corner in terms of the really medical devices and some of the pharmacy things, we think we're going to begin to slow those down a little bit and we can talk about that during the Q&A.

The bad debt line clearly has been the biggest problem for all the hospital companies and all hospitals across the country. It's driven by the growing number of uninsured. We had real problems really for a year or two with the rapid growth in the number of uninsured in places like Houston and other markets that we were in. It clearly drove our bad debts much higher than what we had seen historically. We've had a couple of quarters now as I think most of you are aware where the trend lines have looked better. We hope that that will continue. We're not predicting. We have in our guidance that we provided earlier in the year basically expected our bad debt to continue at around the levels that you've seen in the first quarter, but we'll report on that as the year goes. It's clearly the line item that is the least predictable in the business we're in, and obviously makes the biggest difference in where we go. But as you can see from this slide and our second slide, our numbers have looked a little bit better over the last couple of quarters.

The last slide will just remind you, this is really -- when Jack Bovender is around, this is the only slide he likes to use. And basically it tells you what we can do with our cash. And as we look at how we use this Company's cash, which is really strong cash flow, we can use it five ways.

We can reinvest in capital, which is first and foremost, the best place we think we can put our capital and get our returns and you've seen that.

Secondly, share repurchase. We are big believers when the opportunity presents itself, when interest rates are low as they were late last year, stock was under some pressure, it was time to really step that up. We bought $1.5 billion of stock late last year at under $40 a share. We look smarter than we probably really are, but it was good timing. We will continue to look whenever opportunities present themselves. Is it the right thing to do with shareholder cash? And we look at this Company as belonging to you, the shareholder. And we're going to try to use that cash in the best way to get the best total return to you. Sometimes it's share repurchase. It may be dividends. We initiated our dividend policy now I guess two years ago, we really stepped up. We think a 20, 25% payout is about the right level to be on dividends and we're running at about a $0.60 payout right now.

Acquisitions, we are not an acquisitive Company. You don't see us our buying a hospital here or a hospital there, but when an opportunity presents itself to buy a system like we did in Kansas City a couple years ago,

$1 billion transaction, long-term opportunity to improve earnings, that's exactly what we're willing to do.

And then finally, debt repayment, we like a balance sheet that's in the mid '50s. We're higher than that now, but we were willing to step it up when it made sense to turn it around. And I might say our cash flow has been so strong this year that we're really about a year ahead of our schedule that we really, when we stepped into our share repurchase late last year, we thought it would take us a good bit longer to get our balance sheet back to where we'd like to have it and cash flow was driven there much quicker.

With that, I'm going to sit down, Chris and let you take over.

MODERATOR: Thanks very much, Vic. That was a very helpful and detailed overview. A couple of times in the course of your prepared comments, you talked about the relationship between the overall economy and your business, particularly in the context of admissions and bad debt dynamics. Can you talk about kind of within the context of the second quarter, obviously not yet released, but what you think have been kind of the admission trends that you're seeing and what's your outlook relative to kind of admissions behavior as you look into the second half of the year?

VIC CAMPBELL: All right, Chris. Thank you. I guess the one thing -- I've been doing this for 33 years and I've been pretty consistent in 33 years to never address admission trends interim quarter. And I will stick with my guns one more time. Mainly because we think monthly admission trends can really mislead you. If your admissions are really strong in a month and you're talking about them, that may be great, but if they are uninsured admissions and they are not paying you, it's not so great, maybe because there's an extra day this year versus last year. So we really think to be perfectly honest you need a full quarter's data to really be reflective.

I guess our feeling about admissions, if you go back to 2000 through 2002, our admissions grew about 2.5% a year on a same facility basis. We love that run rate. We obviously lost it in 2003. We think it was primarily economy and also increasing co-pays and deducts and also a move in the outpatient -- very aggressive outpatient shifts. So our admissions growth was very soft in '03. We picked it back up in '04, '05. We're running somewhere around 1, 1.5 on inpatient admissions and that's sort of what the last couple of quarters have shown if you back out flus and other activities. So we build into our expectations somewhere in the neighborhood of 1, 1.5 in the inpatient admissions and then we think the outpatient side of our business is going to grow better than that, more in the 2 to 2.5.

MODERATOR: And I guess what would need to transpire in the course of thinking about the first half of the year for you to change that second-half outlook?

VIC CAMPBELL: What would transpire? Obviously, we look at it every quarter as we report earnings and then we'd look at it and build on that basis.

MODERATOR: There's a lot going on and not a lot going on in Washington relative to health care all at the

same time. Obviously, Congress is relatively blocked by a couple of non-policy matters. But there are some interesting initiatives that are being discussed. I'd love you to comment on two of them. One is MedPAC and now folks on the hill are talking about DRG refinement as a way to think about changing some incentives that are built into the DRG program. Can you talk about that at a high level and what that might mean for **HCA?** And connected to that, the moratorium on specialty hospitals is here -- set to expire; it doesn't feel like there's going to be an immediate replacement of that, and what's your view relative to the moratorium on the specialty hospital front?

VIC CAMPBELL: Right. My favorite place, Washington, where I spend at least a day or two a week, it seems like. There's a lot of talk as there is every year. It's interesting. Over the years, there's always been discussion about DRG refinement, changes that can take place. I think what's happened is it's talked about more publicly and you and others follow it more closely and so you're looking at well, what's going to happen and what's not, which I think is good.

As we look at every one of the proposed changes, we analyze it. It's always not exactly what it looks like on the surface, so you've to dig in and look at an individual company, individual hospital. Some of the proposals you've got enough data to really come out of it and say, this is better for us or not. To be perfectly honest, what we're seeing right now in the ones that we have enough data on, we don't see a material change in our reimbursement either way. Some of them surprisingly are positive and some of them are nominally negative, but nothing really big.

All the talk about changes in cardiology payments and then orthopedic and surgical payments as an effort to try to slow down the growth of the specialty hospitals, number one, doesn't work. It's only a Medicare change and Medicare is a small piece of the business. So in my conversations with any member of Congress that says that's the way to fix it, the answer is that is not the way to fix it because they don't take Medicaid and they don't take uninsured. So I'm not sure. CMS doesn't seem quite as enamored with that payment fix as MedPAC does and CMS is going to call the shots at the end of the day.

In terms of what happens with the specialty moratorium, CMS did give us all sort of a six-month breather. June 8th, the moratorium officially expired, but CMS came in and said until the 1st of the year -- at least until the 1st of the year, we won't grant any new licenses. So we're still working away.

Grassley and Bachus have the best bill out there; it basically says physicians should not be able to own and self refer. It's a loophole in the law. It's the right decision. A lot of people understand it. A lot of people don't understand it, so we'll see where it sorts out. It's not the end of the day, but we still will continue to work very hard to see that that loophole is closed.

MODERATOR: If there was one provision or one component to a refinement proposal you'd like to see included to benefit your portfolio of hospitals, what would that one provision or one condition be?

VIC CAMPBELL: Well I guess again, in terms of refinement, I'm not sure. One thing I would like to see is

banning of the physician ownership loophole because I think that is -- number one, it ought to be outlawed today.

If there was one thing, I think over time, we're big supporters of pay for performance. Now that's a pretty generic statement, but we really believe the world is going there. Now, the world may get there in three years, may get there in ten years, but pay for performance we think if done right -- and we're going to make sure we're at the table in these discussions, too, which doesn't guarantee anything. They could be all done wrong, but we really believe pay for performance has some merits and should be pursued. And I know McClellan and Levitt want to go there.

MODERATOR: Let me remind folks that if you have a question on an index card, there's some people circulating around that can pick those up from you and there's also microphones available and the gentleman in the white shirts if you raise your hand and want to pose a question, we can take a question via that format as well.

Vic, maybe before we take our first question from the audience, one last. You guys obviously are engaged in a divestiture process right now with ten hospitals. Is there more portfolio refinement that you could envision as you move through this year and into next year, either in terms of additions or in terms of additional divestitures?

VIC CAMPBELL: In terms of additions, we're not working on anything major in the inpatient area. We are doing a lot in the outpatient area. You will continue to see us make acquisitions in the outpatient area pretty aggressively in the markets we're in if the price is right. If the price isn't right, we'll build it in those markets.

On the inpatient side, we'd look at another Kansas City opportunity, but you just never quite know when that's going to present itself. So we'll always be watching for that.

On the divestiture side we, year in and year out, take a look. We have been since we did our big divestitures back in 1998 and we spun off LifePoint and Triad. Every year we've taken a look again. We've always looked; it doesn't make sense to do another spinoff. Those were tremendously successful and beneficial to the shareholder that was willing to hang in there and LifePoint and Triad had done extraordinarily well.

We could never quite come up with enough assets that were really underperforming to do another spin, so that's what led us to the hospital sale of these ten, which are not bad hospitals. They just happen not to fit our portfolio of being in a big market with a potential to grow that market share.

We'll continue to look at that. There are a few of those that we're selling now we thought would be part of a market a few years ago on the edges, but they really just didn't do that. So again, we'll look at it. We don't like to flip hospitals by any means. We like to be a long-term provider, but they will be from time to time pruning the assets.

MODERATOR: And when would you expect to close those ten?

VIC CAMPBELL: Our goal is to get it done by the end of this year. We've had obviously a lot of interest, both publicly and privately. We're going through a process; a lot of due diligence with the first group of interested buyers trying to refine it down and whether we go to one, two, or three or what, but we're getting pretty close to getting to that next stage.

MODERATOR: Thank you. Let me pause now. Questions, either via the microphone or via the cards?

UNIDENTIFIED AUDIENCE MEMBER: Yes, I just had two questions. I guess one, if you could maybe talk a little about the surgery trends in your business. I know there were some questions Q1 as to what was going on with that. It looked kind of weak across sector. And then two, just a separate question, if you could talk a little bit about your outpatient surgery strategy. And I know you've mentioned you were anti kind of physician ownership. So just a question as to whether or not you include physicians in the ownership of your centers?

VIC CAMPBELL: Let me address the physician ownership because it is somewhat confusing, especially certain people in Washington. What's the difference between a specialty hospital with physician ownership and an outpatient surgery center. And then I'll let Mark address the surgery trends.

What we've looked at on the inpatient hospital business, there is a law that's in place and the stark law specifically has provisions of when physicians can have ownership and cannot have ownership in health-care facilities. Outpatient surgery centers from the beginning of time and beginning of stark have always been excluded. They have a Safe Harbor, because an outpatient surgery center is seen more as an outgrowth of a physician office. Because of technology, physicians can do things today that they obviously couldn't do five, 10, 15 years ago. So outpatient surgery center, physician office, that's in one bucket over here. And that's why we differentiate and the world differentiates it.

On the limited service specialty hospital, it's clearly a loophole. Stark (ph) says that a hospital cannot carve out its heart department and joint venture with its doctors. Yet, someone can cross the street, take our doctors, and carve out our heart department and create a hospital and get it licensed under a "whole hospital exemption." We think that has been terribly abused. And I think CMS recognizes that. They are wrestling with that. There's a lot of resistance among Republicans in general to say doctors can't invest in things. And I understand, but this is a loophole. It is something that is being abused and we're hopeful that that one thing will get closed. Do you want to talk about surgery trends?

MARK KIMBROUGH, VP & HEAD OF IR, **HCA,** INC.: The surgical trends, I guess overall, just to paint the picture, have been pretty good. Quarter to quarter, the surgical growth has varied, obviously. In the first quarter, the thing we ran into and I think most people are focused upon is our net revenue per adjusted admission and the lack of acuity growth that we saw year over year. And to be quite honest, that will vary from quarter to quarter and we see it.

The one thing that you have to take into consideration, we had about 1% I think surgical growth in the quarter as I recall. I don't have that number right here on top of me. But the one thing you have to think about in terms of the total proportion of your business is your medicals or your surgical business. In the first quarter, obviously, we had a higher degree of medical in proportion to the surgical. The surgical that we did have was less let's say intensive in nature. And so your revenue per unit, your revenue per unit growth associated with that business, obviously, you don't see the year-over-year change to growth. And that created our net revenue per adjusted admission as somewhat of a compression I think as people were looking at it and trying to understand what was going on.

As we look at net revenue per adjusted admission -- let's just talk about this right now as we're talking about surgical -- is our managed care business in the pricing, as Vic mentioned earlier, is good. We have virtually all of our contracts in place for 2005; 70% of our contracts in place for 2006, at rates of 6 to 7%. So our rates are in place. Contract terms virtually are the same year-over-year; there has been no change in our contract terms in some time actually that I can remember.

So pricing from our perspective, we feel pretty good about pricing. The one variable will be the complexity of the business that you see coming in the door, and that's going to vary. And that can vary from month to month, quarter to quarter.

I'll take you back to the third quarter of 2004. We saw a very similar trend there where the acuity levels and the growth there just didn't occur. It rebounded in the fourth quarter. First quarter, the acuity level or the growth or the lack of acuity growth in the first quarter also put a little pressure on our net revenue per adjusted admission growth.

But I'll close with this. Our surgical volumes were very focused upon growing our surgical volumes, increasing surgeries. And we believe that obviously we can and will grow them, but from quarter to quarter, you will see some variations there in the types of business coming through the door.

MODERATOR: That's probably an appropriate pausing point. Mark and Vic, thank you very much for being here. We appreciate it. For those who want to follow us through a breakout session -- (technical difficulty).

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