

July 28, 2022

Gurbir S. Grewal  
Director  
Division of Enforcement  
U.S. Securities and Exchange Commission  
100 F Street, NE  
Washington, DC 20549

**RE: Request for an investigation of HCA Healthcare, Inc.'s misleading statements and inadequate disclosures.**

The SOC Investment Group (“SOC IG”) requests that the Securities and Exchange Commission (“SEC”) investigate misleading statements and inadequate disclosures by HCA Healthcare, Inc. (“HCA”) since at least 2014. Our examination of HCA’s SEC filings, public statements by company executives, and Medicare records available from the U.S. Department of Health and Human Services (“HHS”) reveals that:

1. Since at least 2014, HCA has consistently explained its corporate strategy to investors by noting that higher hospital admissions reliably translate into high company earnings, and that emergency departments are one of the key mechanisms through which hospitals can increase their admission rates, and have routinely reported increasing emergency department and overall admissions as a positive indicator to investors. HCA has also described a variety of initiatives, including investment spending programs, to increase the capacity of its emergency departments, with the understanding that such increased capacity would lead to increased hospital admissions and increased earnings.
2. Since at least 2014, Medicare data shows that HCA’s hospitals have admitted a much higher percentage of emergency department patients than the national average for acute care hospitals, and a higher percentage than can be explained by a model based on geography and diagnosis.
3. For over a decade, Medicare regulators at HHS have identified high levels of emergency department admissions as a potential indicator of improper practices, and at least two major, publicly traded hospital companies—Community Health Systems (“CHS”) and Health Management Associates (“HMA”), have been subject to enforcement actions as a result of investigation into their elevated rates of emergency department admissions. Moreover, one of these companies—HMA—utilized physician staffing provider EmCare, Inc. which was subject to a related enforcement action resulting in a \$29.8 million fine in 2017. HCA is currently a partner in a joint venture with EmCare, through which EmCare provides physician staffing services to a significant but undisclosed number of HCA hospitals.

By failing to disclose that it may be at elevated risk of an adverse enforcement action, and by further failing to disclose that its hospitals have emergency admissions rates that are well above both the national average and the expected rate based on diagnosis and geography, HCA renders its multiple statements connecting admissions, revenues, and earnings misleading. A reader of HCA’s financial

statements would not be aware that the actions the company has taken to boost emergency department admissions have resulted in emergency admissions levels comparable to those of hospital companies in the past that have faced investigation, prosecution, and multi-million dollar fines. Moreover, such a reader would never learn from HCA's filings either that it has entered into a joint venture with a firm implicated in those investigations and subject to a fine itself, or that this entity apparently provides staffing services to a significant share of HCA's hospital portfolio.

While the "Risk Factors" section of HCA's most recent 10-K includes boilerplate disclaimers that broadly allude to the possibility of liability, these generic statements provide investors with none of the context necessary to properly assess HCA's financial risk. For example, HCA merely acknowledges that, "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," and notes "proper classification of inpatient admission" and "preparing and filing cost reports"<sup>1</sup> among many other regulatory standards that the company must meet. No reader could reasonably assess the likelihood of any such penalties or changes, let alone know that HCA at that time had already matched the level of above-average and above-expectations emergency admission rates that precipitated investigations of other hospital companies and consequent enforcement actions. Moreover, there appear to be no disclosures whatsoever in HCA's 10-K or any other SEC filing concerning the joint venture with EmCare, the extent to which EmCare provides services to HCA hospitals, or past enforcement actions to which EmCare has been subject. Consequently, a reader of HCA's financial statements would not know that a physician staffing service that had been fined for excessive and improper emergency department admissions was providing services to multiple HCA hospitals.

We urge the SEC to review this complaint and the information herein, and take all appropriate action to ensure that going forward, readers of HCA's financial statements receive accurate information concerning the company's business practices and associated risks.

### **The SOC Investment Group**

The SOC Investment Group works with pension funds sponsored by unions affiliated with the Strategic Organizing Center, a coalition of unions representing millions of members, to enhance long term shareholder value through active ownership. These funds have over \$250 billion in assets under management and are also substantial HCA shareholders.

### **Background on HCA**

HCA is the largest hospital system in the United States, reportedly with 175 hospitals in 19 states.<sup>2</sup> Originally founded in 1968 and headquartered in Nashville, HCA was taken private by a consortium of private equity funds including KKR in 2006. The Company returned to the public market in 2011,<sup>3</sup> and it

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<sup>1</sup> HCA Healthcare, Inc., Annual Report (Form 10-K) 49 (Feb. 18, 2022), *available at* <https://d18rn0p25nwr6d.cloudfront.net/CIK-0000860730/9eb42636-f4dd-45c9-9eac-1fcf2b3b397d.pdf>.

<sup>2</sup>*Id.* at 61

<sup>3</sup> Clare Baldwin & Alina Selyukh, *HCA Raises \$3.79 Billion in Largest U.S. PE-Backed IPO*, REUTERS, Mar. 9, 2011, *available at* <https://www.reuters.com/article/us-hca/hca-raises-3-79-billion-in-largest-u-s-pe-backed-ipo-idUSTRE7280NV20110310>

has shown steady and strong revenue and profit growth since that date. For 2021, HCA reported receiving \$58.8B in revenues and \$7.05B in profits.<sup>4</sup>

### **Legal Authority**

Rule 10b-5, promulgated under Section 10(b) of the Exchange Act, makes it unlawful for any person “[t]o make any untrue statement of a material fact or to omit to state a material fact necessary in order to make the statements made, in the light of the circumstances under which they were made, not misleading . . . in connection with the purchase or sale of any security.”<sup>5</sup> This applies to any information released to the public by the issuer and its subsidiaries.<sup>6</sup> Section 17(a)(2) of the Securities Act makes it unlawful for any person to “obtain money or property by means of any untrue statement of a material fact or any omission to state a material fact necessary in order to make the statements made, in light of the circumstances under which they were made, not misleading.”<sup>7</sup>

### **HCA’s Misleading Statements and Inadequate Disclosures**

Since at least 2014, and in some cases reaching back to 2010, HCA executives have routinely cited increased hospital admissions as a key driver of revenue and earnings, while identifying emergency departments as playing a potentially significant role in increasing admissions. For instance, in late 2011, HCA’s then-Chairman and CEO Richard Bracken told investors that the emergency department was the source of “about 60%” of HCA admissions,<sup>8</sup> while by 2017 HCA CFO William Rutherford noted that 70% of admissions originated in the emergency department.<sup>9</sup> More recently, when discussing HCA’s pandemic-related decline in admissions and revenue, Mr. Rutherford immediately pivoted to discussing the emergency department and its potential role in restoring revenue to pre-pandemic levels, stating:

At this point, it's reasonable to expect 2% to 3% declines on '19 levels just because we're seeing either demand changes in the marketplace, have to assess consumer behavior, if you will, when will people be comfortable returning to a health care setting, what happens with some of the lower acuity. As you know, our emergency room traffic is still down 15% to 20% from pre-COVID levels. The majority of that is in the lower acuity emergency room visits, but we'll have to see how that rebounds. So I think for the—at least where we stand today, we're still going to see some softness from '19 levels. But as we've also mentioned, as you know, we've been able to offset that with the acuity and the intensity of the patients we are serving.<sup>10</sup>

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<sup>4</sup> Ayla Ellison, HCA Posts \$7B Annual Profit, Plans to Add 8 Hospitals, BECKER’S HOSPITAL CFO REPORT, Jan. 27, 2022, available at <https://www.beckershospitalreview.com/finance/hca-posts-7b-annual-profit-plans-to-add-8-hospitals.html>.

<sup>5</sup> 17 CFR § 240.10b-5 (“Rule 10b-5”).

<sup>6</sup> SEC, Existing Regulatory Protections Unchanged by Either H.R. 3606 or S. 1933, *available at* <https://www.sec.gov/info/smallbus/acsec/ongoinginvestorprotections.pdf>.

<sup>7</sup> 15 USC § 77q(a)(2).

<sup>8</sup> Richard Brackman, HCA, HCA Holdings at Lazard Capital Markets Healthcare Conference (Nov. 16, 2011). See Appendix to this submission, p. 3.

<sup>9</sup> William Rutherford, HCA, HCA Healthcare Inc. at Citi Global Healthcare Conference (Dec. 6, 2017). See Appendix to this submission, p. 12.

<sup>10</sup> William Rutherford, HCA, HCA Healthcare Inc. at Credit Suisse Healthcare Conference (Nov. 10, 2020). See Appendix to this submission, p. 21.

Later in this same interview, Mr. Rutherford elaborated on his point about lower acuity emergency room traffic when responding to a question asking if reduced emergency room admissions would be associated with higher acuity and margins:

Maybe traditionally, it was 17%, 18% admission rate, we're now about 20%. I think we said on my comments, if you look at the—we're, in essence, about 20% decline in overall ER, we're about 28% decline in our lower acuity, but still 14% decline in the higher acuity. And I think I also said our admissions through the ER were down about 2%. So it still is affecting a little bit of the flow, but not nearly as much as the—just the ER volume stat by itself would indicate . . . But I think the big issue now will be just what does demand settle in at, and what is the profile of the patients that we are seeing? With the loss of the lower acuity, the higher-acuity patient generally is bringing a higher revenue with it that maybe brings a higher margin profile. And that's what we're seeing now.<sup>11</sup>

Mr. Rutherford's statements in this interview dovetail with comments made by HCA CEO Samuel Hazen at an investor conference in 2012, where he spelled out HCA's strategy to improve earnings by increasing admissions and revenue from the emergency department. The components of this strategy included accelerating the speed with which patients are processed through the emergency department, increased trauma capability, increased capacity (e.g., more emergency room beds), and increased marketing, which Mr. Hazen summarized saying, "I think we've marketed our emergency rooms in a way that showcases the performance and capabilities, and the combination of those four things I think are really driving the activity in our markets."<sup>12</sup>

In subsequent years, HCA executives have reiterated each of the four strategic elements Mr. Hazen laid out. For instance, in 2014 Ravi Chari, then HCA's VP for Clinical Excellence, in explaining how the company was seeking to improve emergency department operations, emphasized the company's efforts to shape how physicians make medical decisions, noting "some key characteristics that we found about physicians . . . competitive of course. So, you can tell him how you are doing against the peers and that will raise the game."<sup>13</sup> In 2016, while discussing increased trauma capabilities at HCA hospitals, Mr. Hazen stated that, "Our goal is to keep the patient internalized within the HCA system . . . We believe that strategy has a lot of headroom." In 2020, Mr. Hazen drew a direct connection between HCA's investments in expanding emergency departments and occupancy levels, noting that, "In the face of all these new beds that we've added over the years, our occupancy levels continue to go up." Finally, HCA executives have continued to stress their "aggressive" marketing efforts aimed at getting more patients to visit emergency departments, with Mr. Hazen stating in July 2020 (in the midst of the pandemic) that, "We have a very aggressive campaign, both operationally from a patient safety standpoint as well as a communication standpoint, with our patients."<sup>14</sup>

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<sup>11</sup> *Id.*

<sup>12</sup> Sam Hazen, HCA, HCA Q2 2012 Earnings Call (Aug. 6, 2012) *available at* <https://seekingalpha.com/article/783971-hca-holdings-ceo-discusses-q2-2012-results-earnings-call-transcript>.

<sup>13</sup> Ravi Chari, HCA, HCA Holdings Inc. at Wells Fargo Health Conference (June 18, 2014). See Appendix to this submission, p. 33.

<sup>14</sup> Sam Hazen, HCA, HCA Q2 2020 Earnings Call (July 22, 2020), *available at* <https://www.fool.com/earnings/call-transcripts/2020/07/22/hca-healthcare-hca-q2-2020-earnings-call-transcrip.aspx>.

These statements from HCA executives help to build a series of connections in the reader's mind linking increased emergency department admissions to increased hospital admissions to increased company revenue and finally to increased profits. Each of these links has a corresponding element within HCA's articulated strategy: Aggressive marketing of emergency departments helps draw patients to HCA facilities, while increased investment in trauma treatment capability as well as expansion in the number of emergency beds increases the likelihood of patients being seen rather than transferred to another hospital. Finally, the focus on physician decision making in order to reduce patient time in the emergency department and hence that department's throughput helps boost admissions. At no point in these presentations do HCA executives acknowledge the potential risk of enforcement actions stemming from excessive emergency admissions, nor do they disclose that HCA's level of emergency department admissions has risen far above the national average, and well above the level that can be explained by increased acuity or a distinctive geography.

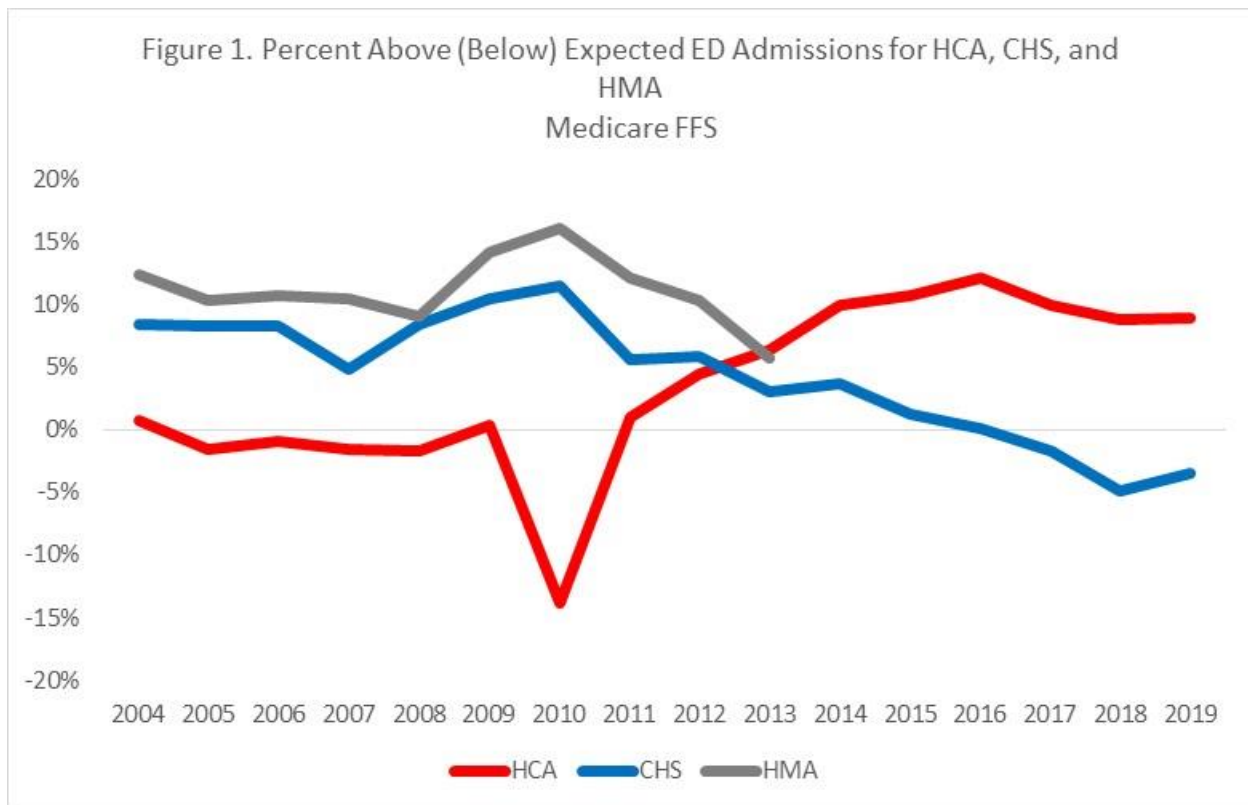
### **HCA's High Level of Emergency Admissions**

Further research suggests that the risk incurred by HCA investors is not just theoretical. Our analysis of Medicare claims data shows that HCA's inpatient admission rates through its emergency departments ("ED admission rates") are quite high for many years. From a review of lawsuits, we have also learned of whistleblowers within HCA hospitals that have raised significant concerns internally about the emergency department and admission practices there, which gives ample reason to believe that HCA's practices may attract federal scrutiny.

Our efforts to analyze whether HCA's high emergency department admission rates are perhaps due to the system seeing a more acute patient population on average than its peers – and therefore more commonly in need of inpatient admission – do not seem to make that case.<sup>15</sup> In fact, our analysis suggests that HCA has emergency department admission rates that are much higher than we would expect, given the patients they are seeing. This can be seen in Figure 1, which shows HCA's average percent above or below its expected emergency department admission rates across years.

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<sup>15</sup> To calculate hospitals' expected ED admission rates, we first calculate a national average ED admission rate by Federal Fiscal Year for each combination of the following patient- and hospital-based characteristics: patient age, patient sex, patient principal diagnosis, and hospital rural/urban designation. Upon finding these national rates, we then multiply them by the corresponding number of ED encounters at each qualifying hospital within that given characteristic combination group; this provides the hospital's expected number of ED admissions for that group. To determine the overall number of expected ED admissions at a hospital, we aggregate the expected ED admissions totals for all applicable groups for the given FFY. We then calculate a hospital's total number of potentially excess ED admissions by subtracting the "expected" ED admissions total for that hospital from the actual number of inpatient ED admissions reported for that hospital. Further methodology can be provided.



This analysis raises strong concerns that many of HCA’s Medicare emergency department admissions are unnecessary, and therefore potentially at risk of clawback in terms of payment and other possible penalties from federal authorities. This problem, as far as our analysis is concerned, is not small. Even though we are only looking at Medicare fee-for-service (“FFS”) claims in our analysis, we find that HCA may have been unnecessarily admitting tens of thousands of Medicare FFS patients through their emergency departments each year in recent years, and their hospitals may have brought in nearly \$2B in overpayments from Medicare FFS from federal fiscal year (“FFY”) 2008 through 2019.<sup>16</sup>

This data analysis dovetails with similar assessments from whistleblowers and from academic research. A lawsuit filed several years ago against HCA by a whistleblower physician also presented data analysis of Medicare claims and other data sets, and that lawsuit’s analysis found a similar pattern whereby the system stood out with much higher admission rates compared to its peers.<sup>17</sup> Further, a recently released academic study by professors from Emory University and The University of Pennsylvania shows a

<sup>16</sup> Based upon an analysis by the Service Employees International Union of claims data from the Medicare Inpatient and Outpatient Standard Analytic Files. A 2006 study found that, on average, Medicare paid about \$5,000 more in reimbursement for an inpatient admission than it did for a corresponding outpatient discharge. Multiplying that figure by the roughly 370,000 potentially excess ED admissions that we calculate at HCA hospitals from FFY 2008 through 2019, we estimate that HCA may have been overpaid by the Medicare program by more than \$1.8B over this time. For the 2006 study, see *In Hospital Observation Struggle, Uncertain Outcomes May Justify Inpatient Admissions*, 15 REPORT ON MEDICARE COMPLIANCE 1 (Oct. 23, 2006).

<sup>17</sup> Amended Complaint at ¶¶ 289–96, *United States of America et al ex rel. Ruiz v. Hospital Corporation of America et al*, No. 3:17-cv-01280 (M.D. Tenn., Sept. 19, 2017). There was no judicial resolution of the issue, as the relator voluntarily dismissed the action without prejudice.



similar finding.<sup>18</sup> Different sources, using publicly available data, have therefore come to the same conclusion—that HCA’s admission rates are noticeably higher than their peers. This research suggests that the risks to shareholders from HCA’s emergency department practices are not simply theoretical; evidence already suggests that the system stands out in a way that may attract regulatory attention.

Moreover, this pattern of outlier emergency department admission rates was found for other publicly traded systems—CHS and HMA, as noted earlier—more than a decade ago,<sup>19</sup> and these systems were ultimately investigated by federal and state governments for allegations made regarding unnecessary admissions through the emergency department.<sup>20</sup> In fact, HCA’s behavior now looks very similar to these other systems at the time they were investigated, as is clear in Figure 1. After extensive investigations, each system entered into settlement agreements with the federal government whereby each system agreed to pay multimillion dollar penalties and to enter into Corporate Integrity Agreements (“CIAs”) with the federal government.<sup>21</sup> Therefore, it is clear that potentially unnecessary ED admissions are a subject that the government has shown an interest in investigating for enforcement purposes. Even if the practices that led to HCA’s outlier status were defensible, HCA’s outlier status itself is a material indicator of risk that the company should be disclosing alongside its discussions of emergency department admissions, new investments, and marketing.

Furthermore, we believe that it is likely that HCA leaders know their emergency department admission rates are high and that their rates stand out among their peers. HCA executives have emphasized to investors how much they track metric performance from within their hospitals,<sup>22</sup> including specifically looking at inpatient admission rates through their emergency departments. As noted above, when asked at a recent investor conference about the system’s average emergency department admission rates, HCA CFO Rutherford said that the company’s rate had traditionally been about 17–18%, but during the COVID-19 pandemic it had risen to about 20%.<sup>23</sup> Finally, the enforcement actions taken against CHS and HMA over the past decade were high-profile events that executives at other hospital companies would be

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<sup>18</sup> David H. Howard & Guy David, *Hospital Ownership and Managerial Influence over Treatment Decisions: The Case of Admissions from the Emergency Department*, (Nov. 16, 2021), available at [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3964725](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3964725)

<sup>19</sup> For example, CtW Investment Group sent letters to CHS’s Board of Directors in 2010 and 2011 that showed analysis of CHS’s ED admission rates and requested information related to these findings; CHS publicized these letters with its shareholders in April 2011. See Community Health Systems, Inc., Current Report (Form 8-K) (Apr. 18, 2011), available at <https://www.sec.gov/Archives/edgar/data/1108109/000095012311036243/g26886e8vk.htm>. CtW also sent letters to HMA in 2011 that raised questions about their high ED admission rates as well, though it does not appear that HMA shared these letters directly with investors.

<sup>20</sup> See Community Health Systems, Inc., Current Report (Form 8-K) (Apr. 15, 2011), available at <https://www.sec.gov/Archives/edgar/data/1108109/000095012311036162/g26879e8vk.htm>. See also Health Management Associates, Inc., Quarterly Report (Form 10-Q) 16 (Aug. 3, 2011), available at <https://www.sec.gov/Archives/edgar/data/792985/000119312511208148/d10q.htm>

<sup>21</sup> See Press Release, U.S. Department of Justice, *Community Health Systems Inc. to Pay \$98.15 Million to Resolve False Claims Act Allegations* (Aug. 4, 2014), available at <https://www.justice.gov/opa/pr/community-health-systems-inc-pay-9815-million-resolve-false-claims-act-allegations>. See also Press Release, U.S. Department of Justice, *Hospital Chain Will Pay Over \$260 Million to Resolve False Billing and Kickback Allegations; One Subsidiary Agrees to Plead Guilty* (Sept. 25, 2018), available at <https://www.justice.gov/opa/pr/hospital-chain-will-pay-over-260-million-resolve-false-billing-and-kickback-allegations-one>.

<sup>22</sup> HCA, HCA Holdings Inc. at Wells Fargo Healthcare Conference (June 18, 2014). See Appendix to this submission, pp. 32 ff.

<sup>23</sup> William Rutherford, HCA, HCA Healthcare Inc. at Credit Suisse Healthcare Conference (Virtual) (Nov. 10, 2020). See Appendix to this submission, p. 23.

aware of, and consequently those executives would recognize that similar levels of emergency department admissions, relative to the national average or expectations, would carry increased risk of adverse enforcement actions.

### **Joint Venture with EmCare Raises Disclosure Concern**

As noted above, physician staffing provider EmCare, Inc. provided staffing services to HMA, and was implicated in HMA's emergency admissions practices such that EmCare entered into a settlement with the federal government, paying a fine of \$29.8 million in 2017.<sup>24</sup> EmCare also entered into a five-year Corporate Integrity Agreement with the federal government. It appears to be the case that HCA entered into a joint venture with EmCare in 2011, and that through this joint venture EmCare provides staffing services to many HCA hospitals. However, HCA has never disclosed specifics regarding this joint venture or any information relevant to understanding how it may affect company strategy, operations, or financial performance, other than to include it in a list of Delaware subsidiaries. Nevertheless, past filings by EmCare's parent company Envision HealthCare Corp. give sufficient insight into the relationship between these companies to conclude that HCA should be disclosing considerably more information about it to investors.

In 2014, Envision's then-President and CEO Bill Sanger stated that Envision's penetration into HCA's hospitals was "[p]robably about 60% on a single service, and about 30% of multiple services" and that the company was planning to grow even further within the system.<sup>25</sup> In its 2017 10-K—its final annual report before being taken private in 2018—Envision disclosed that 20% of its total revenues came from HCA alone.<sup>26</sup> Since Envision reported \$7.8 billion in revenue for 2017, that would imply about \$1.5 billion in revenue from its relationship with HCA. In the same year, HCA's total revenue was \$43.6 billion, meaning that the payments to Envision amounted to 3.4% of HCA's revenue. Moreover, given the joint venture relationship that exists between HCA and EmCare, the financial significance of this relationship to HCA may be underestimated, as we do not know how revenue or earnings at the joint venture level are being divided between the partners or accounted for by HCA. We note that Envision's website currently lists two executives whose job titles are for "HCA Operations," while no other leadership job titles appear to be devoted solely to any outside company. In our own research of online job postings and other sources, we have seen indications that more than 100 of HCA's hospitals have current relationships with Envision or one of its subsidiaries.

We believe that EmCare/Envision's relationship with HCA, including the enforcement action and settlement, should have been and should be disclosed in much greater detail by HCA (again, other than including the joint venture in a list of subsidiaries, HCA discloses nothing about this relationship). Clearly, if EmCare has been implicated in improper admissions or billing practices at HMA, and EmCare plays a significant role at HCA, readers of HCA's financial statements would find a clear description of the relationship material to their assessment of the company going forward. But those same readers would

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<sup>24</sup> Press Release, U.S. Department of Justice, *EmCare, Inc. to Pay \$29.8 Million to Resolve False Claims Act Allegations* (Dec. 19, 2017), available at <https://www.justice.gov/usao-wdnc/pr/emcare-inc-pay-298-million-resolve-false-claims-act-allegations>.

<sup>25</sup> Bill Sanger, President & CEO, Envision Healthcare, Q2 2014 Envision Healthcare Holdings Inc. Earnings Call (Aug. 6, 2014). See Appendix to this submission, p. 46. Note that the transcript of this earnings call in the accompanying Appendix (obtained from [Lexis-Nexis](https://www.lexisnexis.com)) gives the first figure in this quote as 60%, while an on-line version at the Seeking Alpha website has this figure as 50%. See <https://seekingalpha.com/article/2392575-envision-healthcare-holdings-evhc-ceo-william-sanger-on-q2-2014-results-earnings-call-transcript>.

<sup>26</sup> Envision Healthcare Corp., Annual Report (Form 10-K) 8–9 (Mar. 1, 2018), available at <https://www.sec.gov/Archives/edgar/data/0001678531/000167853118000033/evhc10k20171231.htm>.



be unlikely to discover the relevant facts for themselves, as even a widely publicized enforcement action is extremely unlikely to list all companies with which a subject firm has business relationships. Consequently, HCA should be disclosing its relationship to EmCare in greater detail, sufficient for readers to recognize any potential risks to HCA's operations or reputation, as well as to understand the significance of this relationship to HCA.

**Conclusion**

We believe that HCA executives have repeatedly made statements concerning its emergency department admissions practices that, absent disclosure and discussion of HCA's outlier status among hospitals nationally with respect to emergency department admissions, are misleading to investors. As we have argued, HCA executives are very likely to be aware both of the company's outlier status and that similarly situated companies in the recent past have been subject to adverse enforcement actions. At the same time, absent disclosure from HCA, readers of its financial statements are very unlikely to learn about HCA's outlier status or understand the risks that status presents. Consequently, we urge the SEC to consider the information presented in this complaint and to undertake any necessary investigation to substantiate and address our concerns.

Sincerely,

A handwritten signature in blue ink, appearing to read "Dieter Waizenegger". The signature is stylized and includes a large, sweeping flourish at the end.

Dieter Waizenegger  
Executive Director

**Appendix: transcripts from investor conferences cited by the SOC Investment Group (SOC IG) in its request for an investigation of HCA Healthcare, Inc.'s misleading statements and inadequate disclosures.**

The transcripts compiled in this Appendix were downloaded from Lexis-Nexis in Microsoft Word format on or about July 22, 2022. Headers from the individual transcripts were preserved from those original downloads.

MS Word formatting issues made it unfeasible to add page numbering to this document.

- A. HCA Holdings at [Lazard Capital Markets Healthcare Conference](#), Nov. 16, 2011 (footnote 8 of SOC IG filing)
- B. HCA Healthcare Inc. at [Citi Global Healthcare Conference](#), Dec. 6, 2017 (footnote 9 of SOC IG filing)
- C. HCA Healthcare Inc. at [Credit Suisse Healthcare Conference](#), Nov 10, 2020 (footnotes 10 and 23 of SOC IG filing)
- D. HCA Healthcare Inc. at [Wells Fargo Healthcare Conference](#), June 18, 2014 (footnotes 13 and 22 of SOC IG filing)
- E. Q2 2014 [Envision Healthcare Holdings Inc. Earnings Call](#), Aug. 6, 2014 (footnote 25 of SOC IG filing).

# HCA Holdings Inc at Lazard Capital Markets Healthcare Conference - Final

FD (Fair Disclosure) Wire

November 16, 2011 Wednesday

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**Length:** 4284 words

## Body

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### Corporate Participants

\* Richard Bracken

HCA Holdings, Inc. - Chairman and CEO

\* Sam Hazen

HCA Holdings, Inc. - President, Operations

\* Milt Johnson

HCA Holdings, Inc. - President and CFO

### Conference Call Participants

\* Todd Slater

Lazard Capital Markets - Analyst

### Presentation

TODD SLATER, ANALYST, LAZARD CAPITAL MARKETS: Okay, great. I think we'll get started. Good afternoon, everybody. Hopefully, it's been a good two days, strong finish here though. I'm very pleased to have HCA with us as our next presenter. Obviously, you're all aware, the Company is a leading provider of healthcare services in the country, with over 160 hospitals, over 100 surgery centers among other assets.

I've had the privilege of working with the Company through various phases of their life since the '90s. And all along, it's had among the strongest assets and strongest management teams in the business. We're fortunate to have a number of members of the management team here today, namely Richard Bracken, the CEO; Milt Johnson, the CFO; Sam Hazen, President of Operations, and we've also got always reliable Vic Campbell and Mark Kimbrough in the audience as well.

So with that, I'll pass it over to Richard who'll tell you more about their story and take your questions.

RICHARD BRACKEN, CHAIRMAN AND CEO, HCA HOLDINGS, INC.: Thank you. I'm not so sure how reliable Vic and Mark are, but they are your access points for the Company and of course, they're in our IR shop and would be pleased to entertain any questions you have about the Company or strategies as well.

I thought what I'd do today is take a minute and for those of you that may not be as familiar with the Company give you a few thoughts about our broad strategies and how we think about our positioning in the marketplace.

I think the most important thing to know about HCA is we have an asset portfolio that is not like any others in the business. We've been working on the development of this portfolio for 40 years. This is not replicable. We have 164 hospitals, 100 surgery centers, largely in the southern part of America east to west.

We operate in America's largest cities. We're not a rural provider, we're an urban provider. We operate a network of facilities. That is, we typically don't have just a single hospital in a market; we have four, five, six hospitals and complimentary allocation services, whether it be ambulatory surgery clinics, urgent care, freestanding emergency departments and the like. And it's this network strategy that we -- as we define it that gives us a tremendous position in the marketplace.

In these markets, in these large cities, we typically operate anywhere from 20% to 40% market share. It's consistent and in most cases and across most service lines, it's either stable or growing. Because of our size, obviously, we are the largest private delivery system in America. We have a very large market share position in America hospital services, about 5% of all hospital services in America comes to an HCA hospital. Put that in a little different perspective, about one in every 22 emergency department visits that occur in America occur at an HCA hospital. It's a big footprint, we touch a lot of people and we think it's a powerful position as we go forward in a changing healthcare marketplace.

I would also mention that, when we think about growth and we think about how to grow this big system over time, we don't rely on just a single strategy or a single market or a single agenda. It's a large asset base with a lot of inherent organic growth included in these markets. Our markets tend to be larger population centers, they tend to grow faster than the average growth rates in America, they tend to have unemployment at lower rates than most of America. We have a concentration of facilities in Texas and Florida, as you know, larger growth states in America. And so this core asset base has a lot of organic growth built in.

And so when we think about growing the Company over time, it's organic growth plus acquisitions. And we bring up acquisitions, because we do feel that the industry is beginning to go through a consolidation phase. If you think about lot of the changes that are occurring in DC, the potential pressure that could be on the system at large, a lot of them of the more marginal players come up for acquisition and we are certainly a player in that strategy.

The most important thing, another important thing I'd like to underscore about the Company is our production of free cash flow, I'll show you some numbers in just a moment. But we have a very strong production of free cash flow. We can either deleverage, which is our preferred application, or look at strategic alternatives, which we've done a fair number here in the last few months.

And then finally, as a growth strategy, smaller in size, but certainly important over time, is how we leverage the scale of the Company. We have created a lot of internal competencies in our organization, supply chain, revenue cycle, staffing and we have now put these together in a wholly owned subsidiary and are selling that to third parties and we've got a pretty good trajectory anticipated for that as well. And finally, we see as really the cost driver, cost reduction driver in years to come is, how we take out clinical variation and the care that we provide, and we think that's just a new agenda for how hospitals will manage the cost agenda.

These are the numbers that we highlighted on our third quarter call. I won't go through all of them, but let me just point out a couple. We continue to have strong revenue growth. The Company, because of this strategy that I just articulated, the markets that we're in, how we position ourselves from a network perspective, we continue to yield strong volume growth, 3.8% same-facility growth in the quarter.

And another feature of growth is our emergency department visits, up 4.9%. These are very robust growth rates and do well to position the growth of the Company. About 60% of our admissions come through our emergency department. When we're growing at this rate, 4.9% in markets that are growing about 1.5% to maybe even 1.75%, this is a way to continue to bring patients to our hospitals. And then in the third quarter, we did have a very strong cost management performance at 0.5% growth, which was necessary as we saw some shift in our service business. I would draw your attention to the 19.3% margin number at the bottom, certainly an industry-leading number. We have been able to maintain that number or closely maintain that number despite the shifts in the business.

I won't try to walk through all of our operating strategies. Let me just say a couple of things in general about how we think about our operating strategy. First of all, it's a balanced one. It's built around growth what I've just described. It's built around cost, ability to leverage size and scale. And importantly, it's also built upon how well we service [this] and provide healthcare to our patients. We, as you would expect, have a robust agenda in each of these areas. They are well resourced, they are tested, they are proven, they're delivering the goods, we are comfortable with our strategy and the direction we're going.

Our ability to continue to be [adjoined] at dealing with cost management and taking cost out of the system is certainly a benefit that our size and scale provides. I would also mention on the quality front, there is no sustainable business model in our business without a high level of patient service and quality. We've clearly advanced the agenda significantly here. We've been recognized by the Joint Commission, 76 out of 405 hospitals recognized nationally as being among the best performance, we continue to excel in CMS scores. These are not just statistics that we're proud of, they're important and the care we provide, how we position ourselves with the managed care players and how -- really how efficiently we provide this healthcare.

I would just make a comment quickly. We did close on an important transaction here in October with our HealthONE. This HealthONE is a system of hospitals that we operate in the Denver market. We have been operating them in a partnership format structure. For the last 16 years, we've been operating and managing partner. We ran the business, we knew it well, we had the opportunity to buy our partner out. We did so, we completed that transaction, we estimate that to be \$0.12 accretive next year. It's one of the strongest markets in our portfolio and we're delighted to have been able to acquire their percentage, the remaining percentage ownership.

It's an important reflection of how we run hospitals. These were hospitals that weren't performing this well 16 years ago. We've been able to buy them, we've been able to create community foundations for the not-for-profit partner. We've been able to create value that they invest elsewhere in the community, in turn we've been able to create a significant enterprise and we're delighted and expect to be in the Denver market for many years to come.

Let me just give you these couple of numbers here to think about. I mentioned free cash flow as a strength of the Company in addition to our portfolio and our operating performance and margins. This bar chart here, from 2006 to current, shows cash flows provided by operating activities in the light blue bars. The dark blue bars are capital expenditures, the little light green bars are distributions to non-controlling interest. Most important bar to look at is the purple bar there, which is free cash flow in 2006.

In 2007 post capital expenditures, we didn't have free cash flow. We have changed that dramatically and as you can see, over the last handful of years, last year at \$1.5 billion free cash flow. This gives us a tremendous amount of strategic opportunity, whether it's paying down debt, moving on those acquisitions I talked about, buying back shares like we did recently with the Bank of America position or other strategic alternatives. This is really a very important feature of how we will continue to create value for our shareholders.

And finally, let me just -- let's close and get to questions, because I know that's what you really -- we really want to spend some time on is, we have, since we did our LBO, really refinanced all of that debt. I won't go through all the debt transactions, but as you can see, we've basically moved them back a substantial number of years, we reduced the interest cost. And so we have really strengthened our balance sheet.

So with that, let's take some questions, Todd. And we'll -- between the three of us, we'll try to field anything that might be on your minds.

TODD SLATER: You bet. Thanks for the overview. Maybe I'll just kick it off. I was talking with Sam before we came in the room here. Lots of moving parts in the industry, in the business right now, whether it's absolute volumes, the mix of volumes and a number of different respects. Can you talk about how you go about juggling these things on a shorter-term and a longer-term basis, as you think about operating the business and sort of making longer-term strategic decisions?

RICHARD BRACKEN: Well, we always have that dilemma, how do you deal with the short-term pressures, at the same time deal with making the investments necessary to position the Company for the long haul. And so, I think, we've done really a pretty good job of that. All those numbers that I showed you about third quarter and the like, the cash production, the capital expenditures, considers investments for the long term. We have invested significantly in our electronic health records. And you might say, why is this important? Certainly important from a service perspective, that's better care for the patients, takes out redundancy in the system and the like. It's also the database for managing the business much better.

As we think about the future of hospitals and healthcare, we have to continue to take cost out of the equation -- appropriately take cost out of the equation, the electronic health record is that way to do that. All of our hospitals or virtually all of our hospitals just met the CMS Meaningful Use conditions Stage 1. Only about 15% of the hospitals in America have met this test. So we've continued to invest significantly in technology. We've continued to address the clinical quality agenda and how to improve the service, the outcomes that our patients get.

So we have a focus on the long term, there's no doubt about it. In the short term, we leveraged the size and scale of the Company to pull cost out of the system. That network strategy is not only about growth, is not only about new patients, it's also about how to control costs. Because in a market if we have 6 or 8 or 10 hospitals, we don't replicate infrastructure at every hospital, we put them in regional centers. And it's this focus on short-term cost efficiencies, as well as a long-term investment that we think is the right balance. So all of our agendas have to be both short-term focused and long-term -- with a long-term view.

Anything else from you guys over there?

TODD SLATER: Maybe just following up on the tail end of that answer. Cost side of things have been managed very well, how do you sort of think about the major cost items and the opportunities are [sustainable] -- I guess one, sustainability of what you've done and two, some of the incremental opportunities you might have?

RICHARD BRACKEN: Sam, why don't you start with that and maybe, Milt, you can add overall perspective?

SAM HAZEN, PRESIDENT, OPERATIONS, HCA HOLDINGS, INC.: Well, the third quarter, as Richard indicated, was a very strong quarter for the Company from a cost standpoint. Part of that performance was driven by the operating leverage that we created with the great volumes that we had in the third quarter. Hospital business is very heavily fixed cost oriented and the more volume and more traffic we can run through our hospitals, the more leverage we get on our average cost and you saw that played out significantly in the third quarter.

Having said that, we did make some adjustments in some of our discretionary spending, in some of our other areas of focus with labor management in particular, where we were able to reduce our unit cost in a manner that yielded these results. We're not seeing anything that would suggest that our trends would change dramatically as we move through the short term here. Our wage inflation, we think, is in check with past trends. Our supply cost trends are believed to be consistent with where we've been over the past few years and if we can continue to have the volumes that we've had over the past few quarters, we think we can maintain a pretty good cost trend into the foreseeable future.

MILT JOHNSON, PRESIDENT AND CFO, HCA HOLDINGS, INC.: Yes, maybe I'd just add to that. Our cost agenda never takes a pause. We have a list of initiatives to drive through next year. I think, we'll have successful initiatives around supply cost, opportunities again to effectively manage supplies in the OR, a pharmacy initiative as well, which is bringing some benefits already, but I think more benefits for next year. And then, of course, on our physician spend,



as we look at some ideas about how to slow that cost curve, that's been our largest -- our fastest increase in expense over the last two years, and I think we'll be successful in making some headway with that in next year as well.

RICHARD BRACKEN: One of the things that you might not have thought about is, we have 164 hospitals often working on the same market dynamic problems. We find the solutions that work in one hospital and we of course then move them across the system at large, just a very efficient way to introduce change into the Company.

TODD SLATER: Audience, any questions here? Right here in the front?

Questions and Answers

UNIDENTIFIED AUDIENCE MEMBER: (inaudible - microphone inaccessible)

RICHARD BRACKEN: Okay. The question was around our capital expenditures, a slowing down in recent years, any implications for the business. We went into our LBO very well capitalized. The Company was very well capitalized pre-LBO and we maintained our fully capitalized company throughout the LBO. We were able to slow down because the economy slowed down, the competition slowed down, spending as well, so we were able to slow down with the overall marketplace.

We have not undercapitalized the Company, we feel that it's very well, routine maintenance, repairs and maintenance, routine investments are adequate at these levels and so we don't see this as a problem at all. We got high earlier, we had a lot of big projects that we had been building, that have worked themselves out of the system. But as we go forward, this is a \$1.6 billion or so, or \$1.4 billion, \$1.6 billion, that's kind of where we see that moving over time.

MILT JOHNSON: And Richard, one thing to remember back in 2006, when you saw us hit that high mark of \$1.9 billion, you recall that we purchased the Kansas City market in 2003.

RICHARD BRACKEN: That's right.

MILT JOHNSON: But that market needed significant capital investment. We committed about \$600 million, \$650 million of capital and 2006 had some of the run-out of that capital commitment. So we had a major market that we've recapitalizing, and that's one reason it was at \$1.9 billion. And we didn't have to repeat that level, because we haven't had another Kansas City since then.

UNIDENTIFIED AUDIENCE MEMBER: (inaudible - microphone inaccessible)

MILT JOHNSON: Question was, how much did we invest in healthcare IT in 2011 and what's our estimate for '12? Sure. Well, first of all, and healthcare IT is a pretty wide area for us. With respect to the HITECH initiative itself, approximately \$45 million to \$50 million. Overall, IT spend across the whole -- from all the IT will probably be somewhere, I think, in about the \$200 million level for the whole company for the whole year. And we're spending most of our capital now on some sort of clinical initiative. We're pretty much over the past years completed most of our financial system upgrades and [most will look like] clinical quality or health IT-directed spend.

TODD SLATER: Maybe you mentioned in your prepared remarks about consolidation, sort of the beginning of the consolidation phase. How do you sort of view that landscape a) in terms of the availability and b) in-market sort of tuck-in deals versus making major acquisitions in new markets?

RICHARD BRACKEN: If I were to rate how we think about acquisitions, the most desirable ones are as you call them the in-market, let's say, tuck-in deals, that would work for us. I mean, where we have a presence, where we have a market share, where we have an infrastructure in place, this is where -- if there are acquisition opportunities, we can turn them the quickest and most efficiently. We would look at different markets and new markets, but we want to be in those markets in a significant way.

Our strategy is not to be in a single small hospital, in a market where we have no other collateral business or no sort of view to get there. We like to buy where we have concentrations of assets, where we have established payer

relationships, where we know that physician dynamics, this is where we can acquire. We're very disciplined acquirers, we get to look at just about everything out there and we've come -- we think about acquisitions really in a graded fashion.

TODD SLATER: How do you sort of view the availability out there and then the quality that's out there?

RICHARD BRACKEN: Okay. So this is the question about the pipeline and -- there are a lot of -- there are increasing numbers of hospitals available for acquisition. I would say the pipeline tends to be weighted now with projects that we're not particularly interested, it didn't fit that scenario that I just described. Real hospital, small facilities, the Northeast, upper Midwest where -- this isn't where we have a concentration of assets.

Having said that, we have seen an uptick in hospitals that do meet the criteria we've articulated. We've done a number of [heart] hospitals in and around our Texas hospitals. We have recently purchased a hospital in South Florida where we have a big concentration of business. I mentioned the HealthONE acquisition. So it's fewer according to our criteria, but in both situations the number of properties are increasing, availability are increasing.

TODD SLATER: Any questions in the audience at this point? I'm sort of curious about reimbursement. You mentioned quality statistics. How are you seeing those tied to reimbursement at this point and what's the sort of the status of managed care relationships, negotiations and then how do you see that evolving in the next, call it five years?

RICHARD BRACKEN: So, Milt, why don't you talk about where our managed care book is, then I'll make a couple of comments on quality.

MILT JOHNSON: Sure. Sure. I mean, we've got about 60 -- about two-thirds of our managed care revenue for 2012 under contract at about an average rate of approximately 6% is our current positioning. And just to make one comment on that is, is we do have certain contracts with quality tied in, but it's not a significant amount of the revenue that has that component, but wherever we do have it, we generally have met that. I mean, mostly it's set up usually as a penalty rather than as an upside as well, but it's not been an issue for us at all in managed care.

TODD SLATER: Did you see any evolution of increased risk bearing, we hear about it in some markets, but not others, is that something you think is going to happen eventually in the business?

RICHARD BRACKEN: I think, eventually is the key word there. I think we'll see more of that over time. There's certainly not a sea change out there right now for that. There will be projects, we will have projects. We will have pilot projects with the payers in various markets, but the vast majority of the business will be on the -- for the near term, will certainly be on the traditional contracting approaches.

TODD SLATER: Any more in the audience at the moment? If not, I'll maybe ask a final one here on volumes. Certainly your utilization numbers have been pretty strong, especially compared to what seems to be a fairly sluggish environment. I guess, do you perceive that you're taking share and maybe outline how you're doing that, because I think in one of the answers before you said as a key to sustaining the leverage on the cost is to continue to drive that volume? So how are you going to keep that going?

RICHARD BRACKEN: Well, we do think we have picked up share -- the data that we have through the second quarter, which is the most recent data available for most of our markets, not all of our markets would indicate that we have picked up some modest share in a very stagnant market. The marketplace has maybe grown half a point to maybe a point at the most on the inpatient side and our activity levels are north of that in these particular markets. So we have picked up some share, we believe somewhere in the 25 basis points to 30 basis points.

Within some service lines that are key to our initiatives, we've seen performance there as well in growth. So we're stable to growing in pretty much most of our service lines. Now, there is scattered performance across our portfolios as you can imagine, where we have some hospitals in certain markets not achieving growth and others achieving tremendous growth. But our volume strategies are very comprehensive. They're centered around deployment of capital, they're centered around creating access to our system, they're centered around our physician initiatives and

quality initiatives. So the combination of those are what we believe will yield a decent volume growth for the Company going forward.

TODD SLATER: Okay, great. I think our time is up. I appreciate the whole executive team for being here. And next up in this room is Varian Medical. Thank you.

RICHARD BRACKEN: Thank you very much.

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## HCA Healthcare Inc at Citi Global Healthcare Conference - Final

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### Body

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#### Corporate Participants

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HCA Healthcare, Inc. - SVP

\* William B. Rutherford

HCA Healthcare, Inc. - CFO and EVP

#### Conference Call Participants

\* Ralph Giacobbe

Citigroup Inc, Research Division - Director

#### Presentation

RALPH GIACOBBE, DIRECTOR, CITIGROUP INC, RESEARCH DIVISION: I'm Ralph Giacobbe. I cover the managed care and health care facility space at Citi. Welcome to the conference. We're pleased to have HCA here with us today. As you guys know, HCA's one of the largest hospital companies in the U.S. Impressive size and scale, urban markets, largely sort of an organic story, although we've seen some M&A of late. With us from the company today, we've got CFO, Bill Rutherford; and from IR and Government Relations, we've got Vic Campbell; as well as Mark Kimbrough here up front.

So I've got a number of questions that I'll sort of rattle through and then hope to sort of open it up and see if there're any questions, and certainly welcome questions from the audience, sort of, as we move along.

## Questions and Answers

RALPH GIACOBBE: So I guess the -- let me start, and I hate to sort of start with this, but I will anyway. Let's start with tax reform just because it's sort of so topical and I think there has been some debate in the market around -- it's a clear positive, I think, for HCA, but there are some questions around sort of how you guys think of or are there nuances to sort of potential offsets that we should consider as we think about the benefit and how it flows to the bottom line?

WILLIAM B. RUTHERFORD, CFO AND EVP, HCA HEALTHCARE, INC.: Yes, I think today it's really a matter of degree of good and we'll have to wait to see what is the final bill that comes out here, but HCA being a full taxpayer, and so 20% corporate tax rate will benefit us. To your point what other kind of aspects of that bill might be offsets to us, the one we'll keep our eye on is what do they do with interest deductibility, take the House or the Senate bill that does have a small impact, but it will still be a positive benefit for us. That's the -- that's probably the biggest item in there that we'll have to see in addition to the timing of when the reduction flows through. And so when we give our '18 guidance, hopefully, by then, we'll have a final bill and a better model, and we'll be able to communicate what our guidance is but, to me, it's really a degree of good that goes into contributing to cash flow from the company, by which we look to see what is the best way to allocate that.

RALPH GIACOBBE: Okay. And then what about -- so the potential sort of repeal of individual mandate, how big or not of an issue is that? I mean, it's obviously in one bill and not the other. I mean, how much of a push is there to try to get that?

WILLIAM B. RUTHERFORD: It's a great question, and I think, ultimately, it's yet to be seen. I think our view and opinion is that mandate didn't have a lot of teeth to it is why people bought health insurance in the exchanges. I think the primary reason they bought health insurance in the exchanges was to take advantage of subsidy assistance that was there, not necessarily to avoid a tax penalty. So with that mandate gone, the ultimate question will be how many people will no longer buy health insurance because that mandate is not there, but the subsidies are still there. So I think we're just going to have to wait to see how the enrollment period plays out. But I think, our initial read right now, there might be some impact on the margin, but I'm not so sure we see a large scale defection of people buying insurance because of that mandate. There were a lot of exemptions to how people could avoid that, but we'll just -- we'll have to wait and see. I think, primarily, people choose to buy insurance in the exchanges from the subsidies that they have available and as long as those maintain, I think that's what is the primary impact of enrollment.

RALPH GIACOBBE: Okay. Fair enough.

VICTOR L. CAMPBELL, SVP, HCA HEALTHCARE, INC.: And I guess one other thing I'd add with the whole tax bill, our competition is not for profit. It's not investor-owned companies by and large, so those entities won't have any benefits out of the tax bill that we will. In fact, there's some risk to the not-for-profit industry in this area, so net-net it's very beneficial for us.

RALPH GIACOBBE: Okay. I'm going to move on from tax reform, but I want to give the audience sort of -- does anyone want to sort of stay on this topic? Is there anything incremental that anybody wants to ask around tax reform?

UNIDENTIFIED ANALYST: What about the immediate expensing of capital expenditure?

WILLIAM B. RUTHERFORD: Yes. That would be a benefit. Probably about 15% to 20% of our growth capital would be in equipment leases that would qualify for that accelerated depreciation, really a time value of money. We would've gained that over time, but now we can accelerate in year 1. So that is a benefit. We haven't quantified it yet until we see the final bill of how the asset classifications play out in that. When we give our '18 guidance, we'll give our best view of the impact, but that will be a positive. We enjoy some bonus depreciation, accelerated depreciation, now this will give us more as a 100% expensing on equipment.

UNIDENTIFIED ANALYST: (inaudible)

WILLIAM B. RUTHERFORD: Yes (inaudible) of growth capital, that's right.

RALPH GIACOBBE: Okay. Let's sort of move on from that. The other sort of big, I guess, story this week, a sort of mega-merger with between sort of retail and health insurance. And then even today, we've had sort of United buying the physician segment of DaVita. So a lot of things sort of going on around you. I guess, let's just start really high level in terms of how you think things like that do or don't impact sort of HCA and how you're positioned to maybe even combat some of those competitive...

WILLIAM B. RUTHERFORD: Yes, it's a great question and it's a common question we've received. And clearly, the lines are getting blurred as these mergers occur. I think the impact to us is yet to be seen. On the Aetna-CVS, with their position around MinuteClinics, those clinics are in our markets today. And so I'm not really sure I see that dynamic changing for us. Generally those are very low acuity kind of services that are being provided in there. If that model changes materially, then we'll have a new competitor in the market that we'll have to deal with, but that's not unusual to us. We have competitors all throughout our market whether it be urgent care or outpatient side. But that alone, I think probably the -- I see the most immediate opportunities around pharmacy pricing more so than on disrupting the provider space, but we'll see in terms of what they tend to do with that MinuteClinic business. But I don't really register that as a material disruptor for our networks and our markets as it is today. In many respects, we may have downstream clinical affiliations as they need specialist work or more tertiary services, so the HCA network can be the system of choice in those circumstances. So we'll just have to see how that plays out, but right now, lines are blurred. We'll see what they do to get more and more in the provider space. But right now, through those MinuteClinics, I don't view that as a material threat of our volume trends.

On -- this morning, one will have to see that's brand-new. These physician groups, HCP, they're in our markets today, that are risk-bearing entities for both Medicare Advantage and commercial, and we'll see if their strategy changes, but they -- we've been dealing with those for some time, decades and we'll continue to deal with them. So we'll see what they may do to reposition that, but I don't really register that as a material disruptor force at this stage either.

RALPH GIACOBBE: What about sort of moving up the acuity stream? So to your point, I get its sort of the retail lower acuity, but we are seeing sort of move into or maybe even partner with sort of high acuity products like ASCs, for instance, with obviously the intention to try and accelerate sort of the pull out of the hospital setting to seemingly the lower cost setting within ASC. And I think at United's recent Analyst Day, I think, they -- I think there was a pretty big number thrown out in terms of the percentage they thought of total joints that are going to be moving to the outpatient setting by 2025, something like close to 50%. So just your thoughts on that because that, I'm assuming, would have more of a detrimental impact to the extent that it's accelerating.

WILLIAM B. RUTHERFORD: Sure it is. But 2 things: one, I think that move from inpatient to outpatient has been with us for a long time. There're always going to be procedures moving. HCA's strategy, as you may know, is to build these large integrated networks in the markets. It's not just a hospital company. We have over 135 surgery centers ourselves, outpatient imaging, diagnostic, freestanding ED and urgent care. So we have this broad network that as business may move from an inpatient to outpatient setting, we're there to receive that and provide that care. And so that dynamic's there. And now to the extent, a payer gets into that and is more aggressive directing it, that may be a factor we'll have to kind of measure and compete against. To me, it'd be interesting to watch the scale by which it can occur. It takes a long time across all of our 42 markets to build enough provider scale to have a meaningful move in that versus if you have a presence in some markets. But I think there're 2 points in your question. One is just this natural movement of inpatient to outpatient and what is that pace going to be. I view that trend as about the same pace it's been for the past several years. I don't know if that's going to be accelerating. Yes, clearly, knees and joint replacements might be moving into ASCs, but there are other procedures that are backfilling that on the inpatient side. So that rotation has been there. To the extent it does move, we have an outpatient surgery network to be able to capture that and we'll see how that plays out.

VICTOR L. CAMPBELL: And I think, the one other point to when you think of us, we're not everywhere. I mean, we are very focused. We talk about 42 markets, but we're really, what, maybe 15 of our markets are really...



WILLIAM B. RUTHERFORD: 80%.

VICTOR L. CAMPBELL: Yes, drive 80% of this business. So that's where we are. That's where our emphasis is. We're not trying to go anywhere. We don't want to. We want to stay in these core markets, be big, be a full-set provider. And in fact, we can probably work with these and there may, in fact, be some benefits down the road as a result of that, but I wouldn't want to be -- back in the old days of HCA, we were just the hospitals, hospital companies and we were hospitals all over in lots of states and we didn't have material positions. Now we have material positions or we're not in the market and we're not just inpatient. We're really much, much broader. So I think that -- I think our strategy -- we've got to stay true to our strategy and build depth, breadth and...

WILLIAM B. RUTHERFORD: I think that's a hugely important point that's sometimes not fully understood with HCA. Our model is to build these networks, and broad-based delivery networks with broad access points and deep service line capability, so we can be the provider system of choice. As a composite share, we have about 24%, 25% share in those markets. So if you're just operating individual verticals in there, it's hard to gain that durability. We've seen competitors come and go in various niches. So the network value and the network capability is really an important aspect to how HCA approaches these markets and creates, I think, a really durable model. We believe that provider system of choice is delivering the best quality and the best cost structure while delivering the best patient service. So to the extent, there are going to be new entrants trying to pull some verticals in there, but it's hard to keep that as a durable model unless you have the whole network in our view and that's what we're investing in.

RALPH GIACOBBE: Any change in strategy around physician employment, just given sort of the competitive threats? Is there some sort of race to the physician given sort of the push, right, because it seems like whoever owns the position is going to have that level of potential?

WILLIAM B. RUTHERFORD: It comes and goes. I kind of view it as a fairly stable environment in the employment. We're a large employer of physicians, but we still -- only about 10% of our affiliated physicians are employed. I would tell you it's not nearly as hot as it was in, say, 2011 and '12 where everybody was employing physicians and we were. We were almost doubling our complement every year. Now we're kind of opportunistic, if you will, or rounding out a service or a network where we're employing. So it's still continuing, but I don't really see this large inflection growth. It's kind of at a steady pace this year. '11, '12, early parts of '13, you saw really dramatic ramp of employment. Ours is at a pretty steady state.

RALPH GIACOBBE: Is there a way to entice, I hate to use that word, but how do you keep your physicians, even the affiliated one, continuing to sort of refer to that network, right, because seemingly what you're going to have is other players, including managed care, that could potentially even pay a physician more dollars to move a patient into an ASC that -- you have none of that sort of that flexibility. So I guess, I'm just trying to think of within your doc network or physician network, what are the levers that you have that can keep more of that volume captive to you?

WILLIAM B. RUTHERFORD: Well, you are talking about the discretionary piece to. Remember, 70% of our inpatient admissions originate through the emergency room. So for physician strategies, it's pretty much what it's always been, you've got to cater to those physicians in terms of making their professional lives easier, having up-to-date capital equipment, making sure that you have full service line capability, making sure you got great nurses, making sure that your OR you can schedule efficiently and effectively, and that you provide really a professional environment for them to practice both clinically as well as administrative ease. And so technology is a part of that, our nurses that -- are part of that, our operational efficiency is part of that. And so we have a long track record of working with over close to 40,000 physicians to help them practice in our facilities. And it's really where you kind of compete. You have to compete on quality, compete on service. We have to make sure we've got the best equipment and up-to-date facilities, and give the medical office space that's congruent to our facilities and that's what -- where they choose to practice necessarily where a payer may tell them to direct their business to.

VICTOR L. CAMPBELL: In our capital investments, we really have stepped up over the last -- what, if you look back over the last 5 or 6 years, we've been bumping up capital year in and year out. It's -- obviously, it's to meet the demands of the physician and the needs there and that's going to continue to grow probably even into next year.

RALPH GIACOBBE: Yes, kind of see the point. There's a question there.

UNIDENTIFIED ANALYST: Capital spending's ramped up over the past couple of years. Have those demands become more stringent or why the increase?

WILLIAM B. RUTHERFORD: I think there's 2 things driving our increase in capital. Number one is opportunities we see to put capital on the market to capture growth that we see, demand that is coming down. And number two, some of that capital is going to the ground because we're at high occupancy levels, almost record occupancy levels for the company. And if we don't put that capital to expand our capacity, then it could be a potential growth limiter in the future. So really the capital and the increase is growth capital, and that's really reflective and we tell our team it's a reflective of the sign of how bullish we are to see opportunities continue to grow as demand for services over the long run continue to grow in our marketplace. So it's growth, and it's to put capital to meet occupancy and capacity issues.

VICTOR L. CAMPBELL: And it goes back to those key markets. I mean, Dallas-Fort Worth and Nashville.

WILLIAM B. RUTHERFORD: Miami, we're putting \$650 million...

VICTOR L. CAMPBELL: These markets are exploding in growth. And you've got -- and most of these markets we'll have 2 other competitors, and they're pretty full. And so it's not like I can go get your business and take it all from an insurer or what have you and vice versa. There's nobody to come and can take all of our business. So there're good opportunities in these markets to continue to reinvest capital. The one thing that you haven't -- you see a little bit of improvement on the capital return, but a lot of our capital projects take 24 to 36 months to really get the payoff, so we should be seeing more benefits of that over the next 2 to 3 years.

WILLIAM B. RUTHERFORD: But we have seen growth in our return on invested capital. I look at this trend of companies that are increasing their capital spend, at the same time increasing our return on invested capital. And over the past couple of years, you've seen HCA do that. And we've also been decreasing our cost of capital, and we're generating -- that's creating a situation where we're generating cash flow from ops really at strong levels and then as we continue to deploy that, that continues to fuel the growth.

RALPH GIACOBBE: And you've been -- so just going to growth. I mean, you've been growing organic revenue at least this year a little bit over 3%. You've certainly been much better than a lot of your peers. But at the same time, it's, nonetheless, sort of driven margin compression and we haven't really seen much EBITDA growth this year. So I guess, sort of, as we look ahead, if you level set and say -- I'm sure there is an expectation from you all that you're going to sort of improve that revenue, but to the extent that you don't, is the mindset essentially, look, if our top line can only grow 3% or 3.5%, we're looking at marginal EBITDA growth on that? Or is there an opportunity or mindset where at 3% or 3.5% you could hold the line on margin.

WILLIAM B. RUTHERFORD: There are many factors that drive margin. I think our mindset is that we can grow our top line more than at 3% or 3.5%. That '17 is a soft year for us, it's generally a volume story for us. Both our revenue per unit and our cost trends are relatively stable and we're pleased with those. We're in a period that we are -- we in '17 expected 2% to 3% volume around that 1.2% to 1.4% number, so it's a volume picture and a little bit softer commercial one. So our mindset is that as we look at the macros, when we look at the population growth of our markets, the favorable economic indicators that we see, employment trends, our capital programs coming onboard, our ability to do incremental acquisitions and our continued approach to the market of building these networks that we can return to our 4% to 6% top line trends. It's generally 2% to 3% volume and 2% to 3% pricing, somewhere in that neighborhood. Now that's over a long period of time. We'll have periods where we're above that and periods where we may be below that like this year. But we still think the fundamental basis of what HCA is built on is a growing demand for health services and these large attractive markets are there and we're positioned very well to meet that.

VICTOR L. CAMPBELL: And at the high levels, we're going to improve our margin. And at the lower levels in that range, we're going to maintain margin. So that's how we look at it.

RALPH GIACOBBE: Okay. And then we're sort of at the time of the year where we're always sort of -- well, I guess, we're always looking ahead, but particularly this time of the year and as we think about kind of 2018, I know you obviously haven't given guidance at this point, but maybe refresh us on some of the positives, negatives as we think about next year. We obviously have Oklahoma and the divestitures we have, some of the Medicaid reductions and, I don't know if there's more visibility on some of that at this point that you can share. Just maybe share with us some of those positives and negatives.

WILLIAM B. RUTHERFORD: Well, yes, you mentioned, we do anticipate completing the OU divestiture somewhere around the end of the year. So that will have just a reported takeaway of EBITDA about \$170 million -- \$160 million to \$170 million, that's a 70-30 joint venture. So there's 30% of minority interest, noncontrolling interest on that, so that will be a factor when we go into '18. I think everybody knows what we've been talking about it. We have continued contribution of acquisitions we completed this year. Haven't sized that yet. We'll size that when we do give our guidance for '18. Those are the 2 ones worth noting. For those of you who follow us, we don't anticipate another string of hurricanes next year that we experienced this year. So that will give you a reported delta of between normalizing for the hurricane effect. And absent that, you have typical pluses and minuses that may be out there. We do have some Medicaid reductions in the State of Florida. We're somewhat optimistic that we can get some of those restored, so roughly \$25 million or so a quarter and we'll have to see how that plays out as we go into next year. And those...

RALPH GIACOBBE: Already this -- that already started.

WILLIAM B. RUTHERFORD: Yes, it started July 1. Yes, so there's -- and there are some pieces of that that again, not fully material for HCA, but we think we can get restored at some point in time next year. Other than that, I would just tell you there is typical puts and takes that happen in a company the size of HCA.

RALPH GIACOBBE: Just going back to the deals real quick. I know you haven't sized the contribution on the EBITDA line, but I think you have sized the contribution of the revenue that you sort of bought.

WILLIAM B. RUTHERFORD: Yes. So we've completed the Houston acquisitions. We anticipate completing the Memorial Savannah some time end of the year, maybe early first quarter, depending on regulatory review. And we're going to have to wait to see exactly when the timing of that is. When we give '18, we'll give you the exact number, but it's roughly \$1.3 billion, \$1.4 billion of total revenue of all of our acquisition portfolios that have recently been completed or in the portfolio right now.

RALPH GIACOBBE: And just remind us the margin profile, like -- that what you bought it at?

WILLIAM B. RUTHERFORD: Relatively small, in terms of today's margin.

RALPH GIACOBBE: Yes.

WILLIAM B. RUTHERFORD: Yes. So that's kind of our view. We believe we could bring HCA's capital, we could bring HCA's operational network to over time bring those facilities up to our -- not necessarily to our company hours, but to our mid-teen number over time.

RALPH GIACOBBE: And last one on this, I promise. But the typical ramp of this. So is it year 1 you can get 500 basis points improvement...

WILLIAM B. RUTHERFORD: Yes, it's a great question.

RALPH GIACOBBE: 700. What's -- because it's a ramp -- I mean, it's a long ramp to get close to (inaudible).

WILLIAM B. RUTHERFORD: I tell you, it varies. Generally when we do an acquisition that is in market like Houston, where we already have a network, we already have an organizational support structure in place, the ramp in those facilities could be quicker because we've already got the operational infrastructure to build it on top of an existing network. We go into a new market like Savannah, it's going to take a little bit longer time compared to an in-market

time because you've got a new community you're in or you've got a large tertiary facility. So I would tell you that's a longer period of time than if you were doing kind of an in-market we could fold into an existing network.

RALPH GIACOBBE: Sure. And in the in-market one in terms of fairly quick, what's a normal ramp roughly?

WILLIAM B. RUTHERFORD: I'd say within 24 months, we should be ramped as new.

RALPH GIACOBBE: Okay. All right.

WILLIAM B. RUTHERFORD: 12 to 24 months. It's so site specific depending on where those opportunities are, but generally, we can -- 12 months to 24 months, we're ramping up in those facilities. Sometimes you have to make some investments because they haven't had the capital investment, sometimes you have to work on programs and physicians. You may have to do some technology things. So that takes a little bit of time before you start seeing that kind of hit us in full mode.

RALPH GIACOBBE: Okay. Fair enough. You've seen mixed pressures now for, I think, it's probably a little over a year now in terms of sort of the commercial volume kind of really falling off. I guess, what do you attribute that disproportionately to one thing over another? What do you sort of qualify around that? And then, are there strategies like what else can you do to sort of at least stabilize or potentially improve those managed care volumes?

WILLIAM B. RUTHERFORD: So we just started seeing softer commercial volume starting about third quarter of '16, about the second half. We've done pretty deep analysis to try to understand what are some of the drivers of that. I have to remind we're still comparing to a very hot period of time in '14, '15, even the first half of '16 where we're seeing very robust commercial demand in our markets. I mean, sometimes 3%, 4% period-over-period demand. Best of our view, demand looks like it's kind of flatline level in our markets and we've seen the volume impact of that. Haven't been able to pinpoint if there's only one thing that is contributing to that. It leads us to believe these are -- tend to be cyclical. They come and go. There is a series of kind of individual things that I think contribute to that. We've seen birthrates in this country lower and birthrates in our markets lower. I think that has some impact. We don't have the health insurance exchange ramp we did in the past couple of years and, say, we got about 4% to 5% decline and that's inside of our commercial volume trends. We are showing softer ED volume in some of our markets and -- but we're comparing to a period where we were growing ED volumes 4% to 5%, we're now hovering around that 1%, so you don't have the pull through. So I don't think there is anything structural that we've been able to identify or anything there that is unique. I think it's a combination of factors, overall, related to demand in that marketplace. I think as we step back on the other side and look at the macros, see favorable demographics, population, economic indicators that, I think, over time, we'll return to what historical norms have been.

RALPH GIACOBBE: Let me pause. Are there any questions in the audience?

UNIDENTIFIED ANALYST: Yes, just back to the tax bill for a second. In the Senate tax bill, it talks about a 4% Medicare cut. Any comment on that? Or potential for 4% Medicare cut?

VICTOR L. CAMPBELL: Yes. That's the pay go that would kick in if it's not waived. All indications are from leadership that that will be waived. They're not going to waive it as they're into the tax bill because they got to get the tax bill passed. But once it's passed we've been given assurances that that's not going to happen, that it will be waived. Clearly, the Democrats will support waiving it, if the tax bill passes. Right now, they're not going to support waiving it. They want to block the tax bill. So we'll have to -- one thing has to happen at a time, but we are not concerned about that. We think it will be waived. It's been waived in previous times, many times, sort of look at it as a debt ceiling that gets pushed.

RALPH GIACOBBE: On your call this past quarter, you alluded to perhaps better commercial rates, I think, starting in 2019. Just what's the rationale for that and what's the...

WILLIAM B. RUTHERFORD: Yes, I'm not so sure we're seeing better rates. We have pretty good visibility into our contracts, where 75%, 80% contracted for '18, 35% to 40% for '19, and what we see are rates and terms and

conditions that are pretty consistent with our historical trends. I think we did talk about that we might look at shorter contracting periods to leave that door open if we needed to go back for increased rates because of some of the macro environments of pair mix changes didn't reverse back on themselves. But I'm not so sure we see those right now, but we think we've got -- we're positioned very well. If we needed to, we could go back and enter into those negotiations. But I think today, the way I characterize it, our rates and terms and our managed care book is pretty consistent with our recent trends.

RALPH GIACOBBE: Okay. There is a question back there.

UNIDENTIFIED ANALYST: Two quick questions. One, if -- how big is Virginia for you guys? And if they expand Medicaid, what kind of impact would that have on your business?

WILLIAM B. RUTHERFORD: So Virginia is probably our, what, fourth or fifth largest state. We're in Richmond, Northern Virginia and Southwest Virginia. I'm not so sure we'll see expansion. Vic can talk about it to the degree of what we know expansion to have been. I think there are probably more Medicaid payment reform that plays out and maybe some eligibility changes on the side. Honestly, in our states that have expanded Medicaid, it hasn't been that big of a benefit for us. Only about 15% of our beds are in expansion states. Our 2 big ones Texas and Florida obviously haven't. So it really will depend on what Virginia does with Medicaid payment reform before we would see what the benefit is.

UNIDENTIFIED ANALYST: Okay. And other question is, I think in the Affordable Care Act, there was a provision that said, your inpatient prospective payment system would get cut by, I think, 20 basis points in '16 and then 75 basis points in '17 through '19. So just curious if parts of the Affordable Care Act get repealed, like the individual mandate, would you guys expect to get some of those -- that -- those base -- that 240 basis points, some or all of that back?

VICTOR L. CAMPBELL: We'd love to, but it's not going to happen. I mean, that's built in. And the way we've looked at it, those cuts are built in from -- for time and it's built into our expectations. One thing I might say on Medicare rates going into '18, and you were talking about deltas 1 year over next, well actually, it appears we'll have a little better Medicare increase in '18 than we've had in previous years for a variety of factors, but net-net we've -- we pitched everybody that if you start cutting back the Affordable Care Act coverage, then we ought to get our cuts back, but really what we've done is we've laid that out there to make it clear don't cut us anymore for something else. We've got plenty of cuts in line, but the industry does not anticipate they'll be reversed.

UNIDENTIFIED ANALYST: Can you talk about, I don't know if you can because we're mid quarter, but just where volumes have been this quarter given the anticipation of seasonality with high deductible plans kind of kicking in for people from procedure volumes?

WILLIAM B. RUTHERFORD: Yes, you're right. We don't comment on current quarters. So refer to my comments to kind of third quarter volume trends. As a general thing, over the past 4 or 5 years, you tended to see some increase in the fourth quarter due to deductibles and co-pays reset. It's generally in your outpatient, kind of, your discretionary business. We actually didn't see that last year. We were thinking people are kind of receiving care throughout the year, so we'll have to wait to see what fourth quarter volumes is to do to really provide commentary on what kind of the seasonality those deduct and co-pay resets might have.

UNIDENTIFIED ANALYST: Okay. And then can you also just talk about your capital structure into 2018 with your credit ratings and then your own positive outlook from Moody's and kind of where you see that trending?

WILLIAM B. RUTHERFORD: Yes. I think maintaining that is kind of where it's trending. We'd love to have some upgrades and be investment grade. We meet with them every year. I'm not so sure we see that with our current leverage ratio, which is well within our stated ranges. As you may know, we say 3.5x to 4.5x leverage for HCA. We are hovering around 3x. We moved a little north in the third quarter as we completed acquisitions and the earnings aren't yet. So I think we're still in that 4x level, maybe a little south of that. So I think we feel very strong and positive about the capital structure of the company. When I think about capital allocation and our use of cash flow, it's a pretty

balanced and I think disciplined approach. Our first priority is tend to our internal capital needs, which we've talked about. In today's interest rate environment, we're comfortable with the leverage and the debt of the balance sheet, so then we look at what is the best way to return value to shareholders and, as you know, we've been a pretty active purchaser of our own stock for the past several years. So between capital investment and share repurchase or shareholder returns, we think the company is positioned very well. And then, with our leverage, if acquisitions continue to make themselves available, we have plenty of capital capacity to execute on those strategic acquisitions as we see.

UNIDENTIFIED ANALYST: Just one question back on the occupancy rates. You guys say that you're running really high. Does that exacerbate the payer mix issue as some of the lower-paying population is growing faster than the higher-paying population you may have to make just as they come?

WILLIAM B. RUTHERFORD: I think it could, but I'll tell you it hasn't yet because it's not -- we're not turning away business if you will. We're really trying to forecast into the future and that comment was made -- yes, we're running high occupancy, but it's not like we're turning away business across the company, but we need to put capacity on the ground. And the decisions I make today, it may take 2 to 3 years to get ahead of that. So as you forecast growth and you forecast occupancy, that's really where that comes into play. I think, theoretically, your question is right. It could in any individual unit, but it hasn't been a factor for us yet.

RALPH GIACOBBE: You've been pretty steadfast in sort of 4% to 6% EBITDA growth rate...

WILLIAM B. RUTHERFORD: Over the long run.

RALPH GIACOBBE: Over the long run, and certainly, this past year EBITDA has grown marginally.

WILLIAM B. RUTHERFORD: I know. Yes, I know.

RALPH GIACOBBE: And when we think about -- so over time, when we think about sort of the -- at least the recent history, that does include a reform period that sort of popped and we're well behind that. So why not ratchet down the 4% to 6%. It's not to say that you can't try to get to 4% to 6%, but why not ratchet down that expectation to something more manageable, especially, given the backdrop in some of the prices we've seen, not just for one quarter now but for a little bit over a year.

WILLIAM B. RUTHERFORD: Yes, it's...

VICTOR L. CAMPBELL: Ralph, weren't you one of the guys who was beating us up when we were beating the 5% year in and year out. Don't you need...

RALPH GIACOBBE: I actually, I actually was not...

VICTOR L. CAMPBELL: You were one ... okay, okay. All right.

RALPH GIACOBBE: I wasn't one of those.

WILLIAM B. RUTHERFORD: We had a period of about 12 quarters when we were posting well in excess of that 4% to 6%. It's a very valid question. I think the way I'll respond to it is we need longer time. We're not willing to call off what our current thesis is when I look at all those macros after a couple of quarters of softness. We've been through cycles before. I think we would need a longer period of time, but I go back to those macros. When we look at demographic and economic and our capital plan and our ability to do complementary acquisitions and our approach to the market, we still feel reasonably comfortable in that number. And we've said for a while that there'll be periods where we'll be below that and will be periods when we're above it. Unfortunately, this is a period where we're below that. So we'll need a little more time before I think we want to adjust that long-term guidance for the company. If I look at our 5-year trend, we're well within that and we're in the down period. And as we go into '18, we'll give our view for what we think '18 will look like.



RALPH GIACOBBE: There's a lot in the market on value-based care. A lot of it seems to be fluff, more than anything else, in terms of the some of the big numbers that are -- at least the big numbers that are being thrown out in terms of how many billions are value-based care arrangements. I guess -- that being said, there is clearly a move toward value-based care. There's sort of no denying it. So I guess, how do you view your position in that environment? How can you succeed sort of in that environment? And what's the willingness and appetite to take more risk?

WILLIAM B. RUTHERFORD: I think about that on 2 planes. One is, I think we believe in the thesis of value-based care. People want more health value for their dollar. And I think the formula for value -- system -- what systems deliver the best clinical quality in the best cost structure or delivering the best patient service. So HCA's view of this value-based discussion is we want to be the value-based provider system. And everything we're doing and all the investments we're making is to be the provider system of choice on those 3 planes. The value-based care often gets diverted to just the revenue question and taking risk or not risk. And not all of that changes the value equation. It doesn't necessarily mean you're going to deliver a higher quality and better cost service. So HCA's position is to invest into our delivery network capability and be that provider system of choice. If the revenue model moves and HCA is large enough, I can assure you we have every revenue and experiment of every revenue model that we have from pay-for-performance, from bundle payment, from episodic risk to global risk. So we have that throughout HCA, as we can pilot those models and we can learn from them and if they work, we can transport them. But we don't see that moving in an accelerated fashion in the marketplace, as you would think by reading the headlines that you read. But we're prepared to if it does because you have to make those investments as a provider to be -- have all of those components in there.

VICTOR L. CAMPBELL: And some of our markets really have moved faster. We're doing things in Miami we're not doing anywhere else, and we've been doing it for a long time. We don't talk a lot about it because on -- it's not material to the company overall, but we've been very successful in a number of pilots. So we're not sitting here saying, well, we can do pilots. We're actually -- we've got them underway.

WILLIAM B. RUTHERFORD: And we're not saying we don't believe in them. We believe in the thesis of value-based care as people want more health value for their purchase. And we believe as a provider network, the way we accomplish that is to ensuring we deliver the best clinical quality and the best cost structure and still provide the best patient service and that's what our operational strategies are focused on.

RALPH GIACOBBE: Any question out there? Since there is no question, I'm going to sort of go back to a report that we wrote on the adjusted admission statistic and sort of put you a little bit on the spot in terms of -- we think it has its flaws in terms of using gross revenues that are sort of largely irrelevant. So why do you -- why do we still use that stat? Why is it relevant in your mind today? And why not just provide more outpatient transparency?

WILLIAM B. RUTHERFORD: Well, we try to give you outpatient surgery, so that's really where the dollar driver is. And we give ED volume, and that's where the driver is. I think, your point I understand completely and it's well taken. I think it's the accepted proxy in the marketplace and so that's what we're being asked to provide and we'll provide it. It's not that we're not willing to give you other view of our outpatient trends, we try to do that when we report outpatient surgery and emergency room. That's where the majority of your outpatient revenue gets generated, the rest is around test and procedures on there. So I think the adjusted admission and the outpatient factor that you speak of is just a historical metric that's easy for everybody to kind of compare across on. And it's not because we're not willing to give you outpatient transparency. We'll continue to talk about outpatient trends. We'll continue to invest heavily in the outpatient trends. And so we're not relying just purely on that one statistic. We'll try to give others as time goes by.

RALPH GIACOBBE: Okay. And then -- you have a question.

UNIDENTIFIED ANALYST: Just wanted to touch on leverage? So you said you're around 4x. Do you think you could operate the business at 7x as a private company?

WILLIAM B. RUTHERFORD: How should I answer that, Vic?

VICTOR L. CAMPBELL: Yes, we should.

WILLIAM B. RUTHERFORD: We have before.

VICTOR L. CAMPBELL: We like where we are right now.

RALPH GIACOBBE: There is new accounting rules going into effect in terms of revenue and recognition, bad debt policies in 2018. Anything we should be aware of or consider as we think of sort of HCA? Is there any -- does a cleanup happen in terms of or is that always constantly going on? Or how should we think about anything...

VICTOR L. CAMPBELL: I don't think there's any cleanup. I think it's purely a financial reporting metric. You -- we will no longer report to provision for bad debts on the face of the income statement. We'll still give you our uncompensated care in our public and kind of our SEC filings. I think that may be a positive because the bad debt line item alone sometimes gets undue attention and we've always tried to talk about the total uncompensated care portfolio, which is charity bad debts and uninsured discounts, so that really is the only factor, that revenue recognition, but it doesn't change really how we state revenue on the income statement. It's just -- or how we record it or anything else. It's just a reporting metric.

RALPH GIACOBBE: We're behind in time, but I have one more that I just wanted to hit on. Just the M&A, we haven't talked a lot about, sort of, M&A. You've, obviously, sort of stepped up your efforts and opportunistically acquired sort of this year. So as we think more broadly as we look ahead, do you see more of those opportunities? Vic, you mentioned some of the potential pressures maybe even coming for the not-for-profits, whether that's tax-related, 340B related. I mean, do -- because you've talked for a while about being opportunistic of wanting to buy more, just the opportunities haven't presented. Is the dynamic really shifting now in your view?

WILLIAM B. RUTHERFORD: I think it potentially is. We even talked about it in our third quarter call, we're seeing the pipeline is busy -- busier than it's ever been. We've always been willing, but we want to be a discerning buyer. We want to be in strong markets with quality assets and that's really our first kind of filters on that. And generally speaking, we've been organically driven. We haven't done any market acquisitions. The drivers for those type of systems that would be attracted to HCA, generally, there are some economic concerns, they don't have access to capital, there is uncertainty about the future, why they want to join an HCA network, and we're seeing more and more discussions on that. There are a lot of other variables that drive whether they'll actually be consummated in a deal, but potentially in the future, we should see more -- could see than we have at least over the past several years for HCA.

RALPH GIACOBBE: Okay, we'll leave it at that.

WILLIAM B. RUTHERFORD: All right. Thank you, everyone.

VICTOR L. CAMPBELL: Thank you.

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# HCA Healthcare Inc at Credit Suisse Healthcare Conference (Virtual) - Final

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## Body

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### Corporate Participants

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### Conference Call Participants

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### Presentation

ALBERT J. WILLIAM RICE, RESEARCH ANALYST, CRÉDIT SUISSE AG, RESEARCH DIVISION: All right. Hello, everybody. Sorry, we're a couple minutes delayed there, but we're ready to get going. We're happy to have -- next up presenting is HCA Healthcare. Bill Rutherford is the Chief Financial Officer and Senior Vice President. We also have Mark Kimbrough on the line, Vice President of Investor Relations.

Thanks, guys, for participating again in our conference this year. I'm sorry we're having to do it virtually. But, hopefully, next year we'll be back in the sunnier places.

### Questions and Answers

ALBERT J. WILLIAM RICE: What -- maybe as a way to just kick it off, if that's all right, Bill. The company reported 2 weeks ago, strong results. I think I would love to just hear a couple of things, a couple of points that you would highlight, you'd want to make sure people take away, thinking about how HCA is doing in the midst of this pandemic.

WILLIAM B. RUTHERFORD, EXECUTIVE VP & CFO, HCA HEALTHCARE, INC.: Well, I think the company has done incredibly well during this pandemic. Obviously, 2020 has thrown several cycles of COVID with us, starting with

what we saw in March and April, where we were ordered to suspend elective procedures across the majority of our facilities. Then we went into the reboot process and recovered, if you will.

And then we saw the second surge in July and August, where we had some voluntary suspension, as we reported in our third quarter call. And then as we saw September and October begin to return to close to pre-pandemic levels, not all the way, and we can go through specific statistics on there. And then today, as widely reported, you're starting to see beginning signs of additional COVID volume hit us in a couple of places. So we're going to go through these cycles on there. And we're -- need a few more months to find a stable period.

But ultimately, the questions are how is that going to impact some of the dynamics that HCA historically drew on for its growth profile. How will that ultimately impact demand in the marketplace as we go forward for '21 and beyond. How will it impact mix, if there's economic changes out there. And ultimately, will the competitive landscape change at all. So all those are dimensions that we'll have to continue to evaluate as we go through this.

And it was one of the reasons, A.J., we wanted to give at least an early look into our thinking for '21. And that's what we did on the third quarter call. You heard Sam walk through our thinking that we still believe that because of all the volatility and the unusual trends we saw in 2020, it's appropriate to anchor our volume into 2019 levels. And what we're seeing today and what we anticipate is potentially 2% to 3% declines on our inpatient admissions from '19 levels as we see these factors play out. We anticipate having to continue to serve COVID patients throughout 2021.

And so that was really our attempt to give you an early look into how do we see, at least right now, some of that landscape playing out. And clearly, there still remains a lot of uncertainties, and there are certain things that could throw different cycles at us. But we feel very confident and, honestly, very proud about how HCA has responded through the cycles.

I think the resiliency of the organization has really shown in multiple ways. When you consider that we are probably the largest provider of COVID patients throughout the country -- as we talked about, over 60,000 patients to date, 40,000 just in the third quarter -- and as we've managed through those different cycles, we've had financial resiliency to respond to that. We've had the balance sheet capability. And I think that culminated in our announcement to return almost \$6 billion of CARES Act funding, either repay early through the accelerated payments or the provider relief fund.

So we feel as good as we can about the company's response and our ability to continue to manage through different cycles that we may see in the coming months and quarters.

ALBERT J. WILLIAM RICE: Right. That's a great overview. So when you think about where we're at in terms of a rebound in volume. Obviously, you're taking up these COVID patients, which are making up a percentage of your mix, but you also probably have some of the traditional volume still not yet come back. Can you sort of give us some sense of where you assess relative to pre-COVID levels you are with and without the incremental COVID patients you're getting, maybe?

WILLIAM B. RUTHERFORD: Yes. I mean, if you just look at the third quarter, we reported, what, 3.8% admission decline and we had about 8% of our admissions were COVID. And those declines, as we started to give the monthly trends, we started to see that improve towards the end of the quarter. July and August influenced that dramatically, mainly because we had some voluntary suspension of activity in there. So we're still running below '19 levels. And it fluctuates month by month, there are some trends they have. So I think that really led us that I see is still being likely.

At this point, it's reasonable to expect 2% to 3% declines on '19 levels just because we're seeing either demand changes in the marketplace, have to assess consumer behavior, if you will, when will people be comfortable returning to a health care setting, what happens with some of the lower acuity. As you know, our emergency room traffic is still down 15% to 20% from pre-COVID levels. The majority of that is in the lower acuity emergency room visits, but we'll have to see how that rebounds.

So I think for the -- at least where we stand today, we're still going to see some softness from '19 levels. But as we've also mentioned, as you know, we've been able to offset that with the acuity and the intensity of the patients we are serving. We're seeing the people that are returning to health care setting are those higher acuity service lines, which makes sense, more medically urgent, if you will.

We are seeing a more favorable mix of patients than pre-COVID. Medicare patients are slower to return than our commercial patients, and that's got a favorable mix dynamic. And then as you mentioned, COVID is providing some offset to those volume declines just because of the acuity of the COVID patients that we are seeing. So there's a lot of variables that are playing into that revenue view.

And so if the COVID starts to subside, which we hope it does, and potentially that's a door for patients to return. To the extent COVID's still there, it does provide some acuity as we may see some softness in other areas. So I (inaudible)...

ALBERT J. WILLIAM RICE: And then early days...

WILLIAM B. RUTHERFORD: But I think it's fair to assess that our current thinking is that we're still going to be running a little below '19 levels in many of our volume statistics.

ALBERT J. WILLIAM RICE: Okay. And then early days, there was a concern that the COVID patients weren't being adequately reimbursed. I know the industry as a whole was feeling that. There has been some, obviously, relief with many of these add-on payments that have come in. And I don't know what adjustments managed care guys have made, but do you feel like -- it sounds like it's more in line with the corporate average type of product. But what do you sense...

WILLIAM B. RUTHERFORD: Yes, I don't think I can make a claim that we're not being adequately reimbursed. I think with the Medicare DRG add-on, with the HRSA payments recognizing that there are uninsured COVID and they're eligible for some payments. And then the commercial COVID is really following underneath our commercial contracts.

So those patients do consume a lot of resources. As you know, they've got a much higher length of stay, on an average north of 7. They've got an ICU occupancy level higher than average, and consuming all the supplies and pharmaceuticals. So there is a very high resource consumption, if you will, with those COVID patients, and it results in -- and I think necessary for some of those reimbursement add-ons.

But in terms of that, I don't think I can make any claim that it's not adequate. I think today, there are -- I think the commercial payers are providing payment for those services appropriately. And I think the government is, too. So I think that's kind of steady state for us right now.

ALBERT J. WILLIAM RICE: And as you mentioned, the emergency room volume continues to be under pressure. That's pretty much across the board. Are you able -- because you have other access points, are you able to see that volume is showing up in an urgent care center or a physician office? Or do you think that volume is just choosing not to get care right now?

WILLIAM B. RUTHERFORD: I think it's a little bit of mix. We are seeing some urgent care volume growth. We're trying to parse our urgent care volume growth with how much of that may be COVID-related, because there's a fair number of that or people coming in for COVID testing inside our urgent care. So we don't want to get a false indicator. I think even when I exclude the COVID, there's still some softness in the urgent care side on that. Net-net, it's up, but a lot of it is because we're seeing a lot of COVID diagnostic traffic in the urgent care.

I do think a signal for us is our schedule in our physician clinics that we employ and are affiliated with. And we're seeing, for the most part, the primary care schedules filling out and returning to pre-COVID levels. And that generally for us can be a precursor, if you will, of future activity. So I think that's a positive viewpoint, I would say, that we are seeing people return to their physician office traffic and physician clinic. And we'll have to see how that settles out over time.



But I think today, just the emergency room softness is somewhat just people staying at home, where maybe before they would have sought some treatment, and seeing if they can wait some of that out. It may be a factor. I've seen some reports. I don't have the data. So just that may be leading to when you do see them and they show up, they maybe have a little bit more acute status because they've put off some care. So I think all those dynamics are at play.

But I think realistically, today, we have seen a little bit of softening. Is it permanent or not? I think that's too -- we can't make those calls. But if we do see a vaccine, if you do see some advanced therapeutic treatments throughout '21, will that return? I think there's a reasonable possibility that that may begin to return to some normal if we start seeing some treatment and vaccine capabilities in the marketplace.

ALBERT J. WILLIAM RICE: If you're in the emergency room, you're seeing the high acuity volume there. I think that would probably imply that you would see the admission rate on those visits to the ER be higher than it has traditionally been. Are you seeing that?

WILLIAM B. RUTHERFORD: We are. Maybe traditionally, it was 17%, 18% admission rate, we're now about 20%. I think we said on my comments, if you look at the -- we're, in essence, about 20% decline in overall ER, we're about 28% decline in our lower acuity, but still 14% decline in the higher acuity. And I think I also said our admissions through the ER were down about 2%. So it still is affecting a little bit of the flow, but not nearly as much as the -- just the ER volume stat by itself would indicate.

ALBERT J. WILLIAM RICE: Okay. You talked about the doctors, you're seeing their business in your primary care clinics and so forth come back. I was curious, has this -- I don't know that you had a posture for continuing to add clinics aggressively or primary care practices, but has this either changed your view on that or created opportunities because doctors are saying, "Hey, I need to align with my hospital partner a little closer to give us the [opportunity] over the last 6 months?"

WILLIAM B. RUTHERFORD: Yes. I think the latter. I do think we're going to see opportunities. We kind of call them these pop-up opportunities that originate because you may have a physician group that because of all the uncertainty chooses to align with the health system, and that gives us the opportunity, or they see that the HCA network is able to kind of weather through this and return to normal. And that is giving us the opportunity to align with some physician groups in our markets that maybe without this, they would have stayed independent or affiliate of some sort.

I can't say it has changed our broad view of physician employment or physician affiliation. I still think that is a very important aspect of us building out our networks, but that really hasn't changed our philosophical view is that we want to find multiple ways to partner with the physicians in the community. And some communities that are more of an employment-based community that needs employment, some of those that are still in affiliated community, can we have other structures to help them strengthen their clinic capabilities and give them the setting to practice. So it will still vary.

And so really, what you end up having is more opportunistic opportunities to come up when a certain group wants to align or take this as an opportunity and align with the HCA network.

ALBERT J. WILLIAM RICE: Okay. I do have an e-mail question that's come in. It's asking, "Wondering if HCA is able to comment on labor dynamics, specifically nurse burnout and work conditions with PPE shortages?"

WILLIAM B. RUTHERFORD: Yes. It's a very fair question and I think it is a real issue out there. I think there are market-by-market dynamics, but that's an area that we're having to pay attention to, especially in these markets that are going through these peaks and valleys of surges. That is a stressful time. And you are at risk of having a higher turnover than trends, and we're having to use premium labor to maybe backfill and support that. And it is a tough time for them.

I think we're in a reasonable -- a good position to respond to that and try to have pressure valves to alleviate that. We'll use our internal staffing company, our HealthTrust Workforce Solutions, to be able to be a pressure valve for

that and provide some relief for existing nurses and transport into critical care units as necessary. But that is a real dynamic. And it's an area that's going to, I think, provide pressure on the system as a whole. I think we're in a pretty good position to respond to it. But it does provide some short-term risk, if you will, because we have to use some premium labor to compensate for that.

So we'll have to see. I hope over time, it begins to settle. But it's real. As you think about these peaks and valleys we had in the second quarter, you then had them in July and August, you're beginning to see it again. It does take a toll on those caregivers, and we have to be able to provide the ability to relieve them as we can.

ALBERT J. WILLIAM RICE: Yes. And when you think about wage updates, I would think the shortage and the need for -- or the tightness in supply and the need for temporary labor is one dynamic, but the need for wage increase tend to be a little bit economically driven than other things. Are you seeing any change in sort of your permanent workforce that need to increase wages?

WILLIAM B. RUTHERFORD: Yes, I can't call a change now. There are pockets. And clearly, what happens with the overall supply and demand of the clinical workforce will be a dynamic that we'll have to assess going forward into '21 and '22. And I think there might be larger macroeconomic trends that will play a factor into that.

In the short term, clearly, there are some pressures because some nurses aren't able to enter into maybe other float pools or premium labor pools and actually willing to travel. And there are premiums being paid to compensate for that. How long standing or how durable that is, I don't know. I tend to believe those may be short-term dynamics. And we'll have to wait a little bit longer to see what are the longer-term dynamics of just the workforce as a whole.

ALBERT J. WILLIAM RICE: And then one of the other things of ongoing debate throughout this pandemic has been the interplay between ambulatory surgery centers and inpatient or even -- or outpatient surgery. Are you seeing -- there was speculation on the one hand, we'd see more moves to ASCs because people would want to be avoiding COVID patients. On the other hand, we've seen speculation that people might come back to the hospital because they want to be around an inpatient facility if they need it. So can you say you've seen any discernible change there?

WILLIAM B. RUTHERFORD: I can't say discernible. Actually, our ASC cases are down more than our hospital-based outpatient cases. And I think that's largely because of some of the lower acuity GI and endo procedures in the ASCs are being put off and deferred, and we'll have to see whether they return.

I think the area where it has most implication is -- continues to be in the orthopedic area. And whether -- that was a trend that was occurring pre-pandemic. And I think it's a trend that will continue post-pandemic. It may have stepped up a little bit, but I don't think it's been material for us on there. But I do think evaluating the appropriate setting of care, having the physician's comfort of operating in an outpatient setting will continue to be there. But we'll just have to see.

I don't think, really, that we've seen this major shift yet on there, outside of just maybe some trends that were already underway. It may have accelerated a hair there, but nothing I think that is just -- you're seeing this big old shift from an inpatient to an outpatient at any one time.

So -- and all of our settings were down relatively close to about the same percentage points. So I think that's just, overall, a little bit of compression of the demand for services, and whether it's consumer behavior putting off or whether they're finding alternative cares, whether it be our inpatient settings or hospital outpatient or an ASC, they're all staying relatively close in terms of the declines that we're seeing there.

ALBERT J. WILLIAM RICE: Right. Another area that's gotten a lot of play in the pandemic is the whole idea of virtual care and telemedicine. What is HCA doing there? And have you stepped up your involvement with that and through your physicians and so forth?

WILLIAM B. RUTHERFORD: Yes. Absolutely, we have. And obviously, it played a hugely important role in the first phase of the pandemic, and we've talked about that before. That was really an area of learning that we've identified in terms of how we can accelerate and bring all the resources of HCA to bring new services or products to market.

Pre-pandemic, we were -- we had a telehealth initiative, but it was kind of just going on its own pace. We were maybe doing 500 telehealth visits a day across the network. All of a sudden, in about 72 hours, we were doing 10,000 telehealth visits a day and even north of that.

And recently, as we think about telehealth, there's really 3 dimensions of telehealth that we're seeing, we're funding and we're investing in. There is the physician to patient telehealth, so say it's within your primary care clinic or your urgent care and you want a televisit. And so that is going to continue to be with us for a while. I don't know what percentage of the visits it will ultimately be. We know in the early stages, it was maybe 20%, 30%. It may settle down into high teens, I don't know.

But that's an important part, and we have the capability and now it is an expectation that you have that. But we're seeing patients comfortable returning to the clinic. So it's not as high as it was in the peak of the pandemic.

The second stage of telehealth is our provider to provider outreach. It may be what we've had in place for a while from a tertiary facility, providing neuro consults to a non-urban facility or behavioral health consults or other services on there. And we see that as a growing demand. We've got probably 400 to 500 sites that are doing that provider-provider.

And then really, I think, a new area of telehealth that we did experience in the COVID area is inside the walls of the hospital. It may be our hospitalists interfacing with patients in the hospital bed, it may be our intensivists or remote intensivists, telehealth visits into ICU patients. So we really think those 3 dimensions create a growth opportunity for us going forward.

ALBERT J. WILLIAM RICE: A big part of the HCA story this year has been the cost reduction and cost structure -- cost restructuring, I guess. Can you comment a little bit on what you did? I know the company acted quickly in the face of the pandemic. And maybe delineate, what have you done sort of temporary and what have you done that may be more sustainable? And...

WILLIAM B. RUTHERFORD: Yes, we put that under kind of our financial resiliency umbrella term. And as we -- we have really our phase 1 efforts, and those were our immediate actions. And we did everything we could to drop the cost structure of the company very quickly. Those are mostly around our discretionary cost areas and some of our variable costs because, as you know, we committed not to have any HCA employee lose their job during this pandemic. So we're committed to kind of full staffing on that. We had some pandemic pay program.

So our early steps were cutting back marketing, cutting back travel, cutting back repairs, some contract services, making sure we dropped our variable cost structure when the volume declined, and we dropped a lot of our premium labor areas. We tried to manage overtime down. We eliminated contract labor as much as we could. We shrunk some of our PRN pool. So all of those immediate variable costs were part of our phase 1 that we executed late March, early April, and we started to see the benefit of that in May and June. And it was really part of the recovery that we have.

And then we moved into our phase 2 efforts that were still underway. And some of those have already been implemented, some of those are to be implemented. Those are maybe more of those areas where we're looking at are there redundant efforts that we have across the organization we can eliminate, how do we think about field support levels. We've talked about on our call, are there other areas that are prime for a shared service kind of structure? Laboratory, we learned through this, is an area.

We've, pre-pandemic, operated really decentralized lab versus other areas we've consolidated, whether it be supply chain, revenue cycle, HR or IT support. Even pharmacy, we've consolidated a lot of our pharmacy operations. So we've identified a new opportunity for us as a lab shared service environment where we can bring the scale of HCA

and lab. And I think that has an efficiency play as well as allow us to make sure that we've got the lab capabilities and turnaround time in play.

We've talked about telehealth as an opportunity. We've talked about some redundancy around field support. We still are organized around geographic support structures, and we support those with common elements. And we're looking at can we move those up a little bit. So we really are in the middle of our phase 2 resiliency that we think will continue to occur throughout '21.

We think some of those phase 2 resilient may help offset if we do begin to see some pressures or cost come back into the system, either because of the labor trends that we talked about earlier or some of these discretionary efforts that we held. Eventually, we're going to have to turn back on at maybe a reduced level, but at some pace we can use these new efforts to try to counterbalance that.

But I think what we've learned through here, we're confident in the organization's ability to kind of respond from a cost structure to the environment that we see. And I think that has been proven out here over the past several months, of course.

ALBERT J. WILLIAM RICE: Interesting. I remember you highlighted the lab work on the call as a new initiative. I think a few years ago, you were working on a pilot in Denver with one of the large lab guys, and then you were also working on your own thing in Florida. Have you landed on the Florida model? Is that what I'm [missing]?

WILLIAM B. RUTHERFORD: Yes. I think that's fair. We have had a consolidated lab in our South Florida market for some time, we call it IRL, Integrated Regional Labs. Over the past couple of years, we've taken it to across the state of Florida. And now, we're taking that same capability into markets. And we actually have a rollout plan, market by market.

The other one you mentioned was really this idea of can you combine outpatient reference lab infrastructure with inpatient hospital lab and bring those together for efficiencies. And we've tried that from time to time in market with moderate success. But we think the better model for us right now seems to be utilizing our traditional shared service, bringing scale, bringing consolidation, bringing best practices and standardization within the HCA side and not necessarily move after kind of that outpatient reference lab activity right now.

ALBERT J. WILLIAM RICE: Right. No, that makes sense. One of the areas -- I mean, as significant for you, maybe more so than I would have thought for a more urban-oriented hospital operator, is labor and delivery. That's been always a good business line for you. There's been a lot of discussion about the volatility in the labor market. I think Florida published that their births were down 10% in the summer in 1 month, August, which seemed way off the chart. Do you have any thoughts on what you're seeing with respect to that trend? And...

WILLIAM B. RUTHERFORD: No, we're speculating like everybody else that come November, December, might we see a spike in births as everybody was quarantined early on, I don't know. We are seeing some softness in our deliveries. It hasn't necessarily affected our neonatal intensive care unit volume, though. We're seeing reasonable trends in that area on there. Sometimes there's a correlation. So we are seeing a couple of points decline in just deliveries. We're not seeing that 10%.

But what we are using and trying to utilize as a precursor, new appointments into our employed OB/GYN practices. New patients can give us a reasonable insight to kind of the pipeline, if you will, that may occur. And as I said before, and it holds true for OB/GYN, we are seeing the schedule of new patients in OB/GYN practices begin to return to what our historical norms were. So we don't know for sure with that. I think it may be a little bit of precursor that over the coming months that we may see that improve sequentially from what we're seeing right now.

ALBERT J. WILLIAM RICE: When you talk about your cost restructuring efforts, it sounds like they're more not so much focused on supply costs, either devices or pharmaceuticals. But I wondered in the midst of this pandemic, has there been any change on that side of the cost side?

WILLIAM B. RUTHERFORD: Yes. I mean, we have several supply cost initiatives in our resiliency plan, and one of them is in the medical device area. And that is working with our clinicians about choosing the most effective product for the services on there. And do we have a little bit of an opportunity to use this as a backdrop, that's important that we play with that. You always have to walk a careful line in that effort on there.

We're also -- got -- have an initiative in our supply chain around, what we say, clinically equivalent alternatives, whether that be on pharmaceuticals or whether that be on other medical efforts on there, that are we utilizing some efforts that may not have the clinical data that suggests there's a difference in that. And working with our clinical operations group, our chief medical officers, with our affiliates, to try to utilize evidence-based data on the suggestion of maybe there's a therapeutic treatment that was being utilized. But the evidence isn't quite there that it's clinically efficient and try to manage that over time as well.

And then we just have a host of other just, what I would call, normal supply chain initiatives, whether that be contracting initiatives and the like that are underway. So almost every functional area within HCA has a road map, if you will, or a work stream under our resiliency planning effort.

ALBERT J. WILLIAM RICE: Okay. And one of the other things you did in reaction to the pandemic was to pull back a little bit on capital spending for this year. The story of the last few years has been the above-average capital spending driving above-average growth. How do we think about the impact of the pullback for the next few years? Has that been targeted in such a way that it won't make much difference? Or should we think it will have a little bit of moderating impact in there?

WILLIAM B. RUTHERFORD: Right now, I don't think it has any real impact to our growth profile. Many of the projects we dialed back were in the very, very early stages. And we did dial back on the projects that were near completion. And as you know, those are generally -- especially our larger projects that are long-lived projects. It may take you 2 years to go through the construction process, and when that opens, it takes you another year or 2 years to begin to see the return on that.

So the pipeline we've had over the past couple of years is still going to feed, I think, in the intermediate term. And we were obviously very attentive to the projects that we did scale back on making sure it didn't compromise growth over the long run. Some of those were maybe freestanding EDs that we paused. And until we see how the ED volume settles out, we don't think that's going to compromise growth in any material way right now.

And I think those were necessary steps in the environment that we've seen. And as you heard about, we've slowly turned a few of those back on. And I still think \$3 billion, maybe a little less than that, is a target for us in 2020. As we go into '21, I sense it's going to be somewhere between where we are this year and what our historical norms are. It could be somewhere in that 3.5, but we'll have to wait for the planning side. And I think that gives us ample capital capacity to meet growth opportunities that we see in the market and still provide a reasonable level of return for us.

ALBERT J. WILLIAM RICE: So as we said earlier, one of the things you did on the Q3 call was give some parameters around expectations for next year. What -- when you look at that, what are the biggest, in your mind, puts and takes that are great variability there?

WILLIAM B. RUTHERFORD: Yes. No doubt in my mind that it's going to -- and sorry, this is a throw, it's going to be the volume demand and it's going to be the profile of that volume demand. And obviously, what we're seeing now is soft volume. But what we are seeing is just a higher intensity and it's overcoming the volume impact. Mix might still be there, but rarely do you have mix change, material, in any one period of time. That's generally a slow burn. But if you had some really macroeconomic changes, it may affect mix.

But I think the big issue now will be just what does demand settle in at, and what is the profile of the patients that we are seeing? With the loss of the lower acuity, the higher-acuity patient generally is bringing a higher revenue with it that maybe brings a higher margin profile. And that's what we're seeing now. And as we go into '21, we'll have to see, does that continue or do things move back to normal level. We feel very confident in our ability to manage the cost,

given whatever the revenue profile that we seem to be dealing with. So I think the real dynamics are going to be those 2 factors.

The others are in play, will mix continue to be positive for us, will the Medicare population be slower to return, will we see a return of the commercial, that's a driver. I don't know if I see material changes in the uninsured trends right now, absent some big change in an overall economy. I'm actually hopeful that the vaccine is coming out early, and depending on how quickly that can reach population, that may settle that a little bit. But just the demand profile and then the mix of the patients we do serve or the acuity of the patients we do serve will determine our revenue profile that I think will largely drive it.

And as we talked on our call, we think we've got a couple of months here. We think where we're at, we're getting a reasonable parameter on that. We may have to widen our expectations to provide some flexibility in there, but we got a reasonable view of where that might be, at least for the short or intermediate term going forward.

ALBERT J. WILLIAM RICE: And then any update on -- I think you were thinking you'd give the government money back maybe by the end of the year. Is that going to happen? Where does that leave you pro forma? And obviously, buybacks and dividends have been a part of the HCA story historically, will that be revisited fairly quickly, early next year?

WILLIAM B. RUTHERFORD: Yes. Well, I think the majority of the repayment can be done by the end of the year. There are some complicated steps you have to go through just in [taking that]. We're working with the agencies, making good progress, but feel comfortable to get our share of the provider relief funds paid, and I think the majority of the accelerated payments will be. But we have to do that entity by entity. So that will, I think, mostly be done. There may be some that trickles into next year.

But even after that, as you've mentioned, we're still in a very strong place relative to our historical trends on the balance sheet. Our leverage will still be well below our historical range of 3.5 to 4.5 pro forma, probably 3.2, somewhere in that range. And so that does give us the opportunity to evaluate when is the right time to return to our historical kind of capital allocation profile, when is the right time to consider resuming the dividend, when is the right time to consider resuming the share repurchase program. And then obviously, what our capital investment might be.

And right now, as we've said, as we're going through our planning, I think we are anticipating coming out in the first quarter, announcing what our intentions are going to be. We haven't made any decision yet. But as we go through the balance of the year and come in and announce in the fourth quarter, given further insight, that's where we'll talk about when we think about resuming those areas.

And a lot of it -- you look at our view of the position of the company, which is very strong, as we get a read on the marketplace and kind of the stable environment we're in, I think those are really the 2 factors that will influence our decisions on that.

ALBERT J. WILLIAM RICE: That's great. All right. With that, I think we'll have to wrap it up. I really appreciate HCA participating again this year. And Bill and Mark, thanks for doing it. And thanks, everybody, for dialing in. We'll see everyone soon.

WILLIAM B. RUTHERFORD: All right. Thank you, A.J., and thank you, everyone.

ALBERT J. WILLIAM RICE: Take care.

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## HCA Holdings Inc at Wells Fargo Healthcare Conference - Final

FD (Fair Disclosure) Wire

June 18, 2014 Wednesday

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**Length:** 4980 words

### Body

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#### Corporate Participants

\* Bill Rutherford

HCA Holdings, Inc. - CFO

\* Vic Campbell

HCA Holdings, Inc. - SVP

\* Ravi Chari

HCA Holdings, Inc. - VP of Clinical Excellence

#### Conference Call Participants

\* Gary Lieberman

Wells Fargo - Analyst

#### Presentation

GARY LIEBERMAN, ANALYST, WELLS FARGO: Good morning, everybody. Welcome to day two of the Wells Fargo Healthcare Conference. I am Gary Lieberman, Wells Fargo's healthcare facilities analyst. We're very happy to have HCA with us this morning.

HCA is the largest for-profit hospital provider in the United States with 165 hospitals located in 20 states and providing about 5% of all acute care hospital services. With us today from the Company is Bill Rutherford, CFO; Dr. Ravi Chari and Vic Campbell. Also, we have Mark Kimbrough with us here today.

So, I've a number of questions for the Company, but if anyone in the audience has a question, please put your hand up and we'll bring a microphone to you. Alternatively, there is a way for you to text the questions to me. So, if you'd like to do that we can do that also. So, thanks for being here guys.



## HCA Holdings Inc at Wells Fargo Healthcare Conference - Final

So why don't we start out with how the Company thinks about doing potential acquisitions?

BILL RUTHERFORD, CFO, HCA HOLDINGS, INC.: So when I think about acquisitions, I think about it in kind of two tracks. One is what I may refer to as tuck-in acquisitions. And these are acquisitions that we will do and pursue in our existing marketplace. And we've done (Conference Instructions).

So when I think about acquisitions, I think about tuck-in acquisitions and those are acquisitions that we will pursue within existing markets. And they are generally to complement our existing footprint. For example, we did three in Tampa last year. We've done a few in past. We did one in Miami previously, got a couple of letter of intents. Generally, they are smaller acquisitions. And we'll continue to see those opportunities and explore those really to round out our footprint in an existing market.

Then I'll think of new market acquisitions. And generally speaking, HCA in new markets wants to take a meaningful position. You likely won't see us do one hospital acquisition in a new market. We want to a meaningful position. So generally speaking, they are larger systems in place.

And so, we'll evaluate these new market acquisitions through a series of filters. And the first filter will be our assessment of the macros of that market; what is the population, the demographics, the economic condition is. We'll look at the position of the potential acquiree or the target. Do they have reasonable market share, are they well positioned, they have decent reputation in the marketplace, etcetera. Then we'll look to see do we believe we can bring our HCA processes and technology to bring reasonable improvement and then finally, obviously is the cost of entry and what type of a multiple, if you will, that we have to pay.

HCA is very interested in exploring opportunities in new markets. In any given year, we evaluate new market opportunities on there. So we continue to evaluate those, both domestically and internationally. The international markets, the issue has been really the multiple valuations in those international markets are higher than the United States and higher than our trading multiple, so that creates a barrier for us to a degree to go into there. But our goal is to find high-quality acquisitions that can deliver long-term shareholder value. And when we can find those, we're very interested.

The timetable associated with those, they operate at their timetable, not necessarily ours. So they generally have a longer cycle to go through on those. So we're hopeful we'll continue to see those opportunities and explore them when they become available.

GARY LIEBERMAN: What trends have you seen develop due to the Affordable Care Act and how does it compare with your expectations?

BILL RUTHERFORD: Well, we'll restrict our comments to the first quarter. We were very encouraged with the signs we saw in the reform for first quarter. As we mentioned in our release, it is early -- when I think of reform, I think about it in two prongs; Medicaid expansion and health exchanges. HCA operates in 20 states, but only four of our states initially decided to expand Medicaid, was California, Colorado, Nevada and Kentucky. Very encouraging signs in those states, but only represents about 12% of our bed capacity.

But in the first quarter, we saw pretty dramatic growth in Medicaid utilization, but conversely, dramatic decrease in our uninsured volume. Our uninsured admissions in those four states for the first quarter were down about 29%. As many of you know, the industry has been seeing 6% to 10% growth, so really dramatic changes in there. But it is a small number for HCA on a relative basis to our size.

When I think about exchanges, again, encouraging signs in the first quarter for exchanges. We saw about 1,700 exchange admissions in the first quarter, relatively small. HCA will do -- did 440,000 admissions in the first quarter. But in the first quarter, we saw a nice progression; doubling of the volume in February over January, doubling of the volume in March over February. I think that was really a reflection of the surge in enrollment that happened late in the cycle.

## HCA Holdings Inc at Wells Fargo Healthcare Conference - Final

So, very encouraging signs, pretty much on track with our expectations for the first quarter. When we release second quarter, we'll give information of what we're seeing and kind of validate those assumptions. One of the interesting points on that is the key question for the exchange is, how much of that is newly insured? And I'm sure all of us read the reports and the surveys. The best thing we need to do is go look at those patients that we had seen in that quarter, had we seen them previously and what was the coverage. And what that told us, we had seen about half of those previously. And a third of those were newly insured, or that they were previously uninsured and now they're covered by exchange products.

So, we are using that as one reference point and we'll continue to update that. I said we think we'll need six to nine months to kind of see how that settles out to draw any conclusions on our assumptions, but encouraging signs is how I'll characterize it.

GARY LIEBERMAN: Okay. Is there a question in the audience?

Questions and Answers

UNIDENTIFIED AUDIENCE MEMBER: (inaudible - microphone inaccessible)

BILL RUTHERFORD: Not yet. It's still early on the first quarter. It's natural to think that people are newly insured that that may result in increased utilization, now they have coverage. It's hard to quantify that and was hard for us to quantify that in the first quarter. But we'll continue to keep our eye on it.

The other question related to that, are you seeing any -- are there any kind of distinguishing characteristics of that new exchange volume relative to intensity or how they access the health system or so forth? And that's a great question. The answer is, not yet. But it's a relatively small land for us, and as we release second quarter, we'll give some more insight into that. But as of the first quarter, kind of the characteristics of that new population was fairly similar than the rest of our -- to the rest of our volume.

UNIDENTIFIED AUDIENCE MEMBER: (inaudible - microphone inaccessible)

BILL RUTHERFORD: So, HCA's strategy is creating breadth and depth in our markets. So, we have a range of other provider services in our existing markets. It's anchored by our acute care hospitals, but you may know we are the large provider of outpatient surgery centers. We've got 116 surgery centers. We've got outpatient imaging and radiation oncology and a leading employer of physicians. So, our strategies on acquisitions also include ambulatory settings in our existing markets and we've been active in that space for a number of years as we build out what we refer to as the comprehensive or an integrated delivery network in our existing markets. So the answer is, yes, we do explore acquisitions around the ambulatory side in complementary services in our marketplace.

GARY LIEBERMAN: So, maybe based on that or separately, what businesses do you think HCA is most interested in expanding into?

BILL RUTHERFORD: Well, how quickly will the enrollment move into utilization and we all have [forecasting] that. And what will be the slope line? Will it ramp up very quickly, find its level and stay there till the next enrollment period, will it be a natural enrollment, all of those. There's really six or seven major variables in our reform assumption and probably in -- many of your models starts with enrollment, starts with what's the enrollment in our markets and what's our market share on that. And then it moves to what is your assumption on that new enrollment of newly insured versus just previously insured and converting maybe from an individual small group product. So, all of those are variables that come into play when you try to forecast in a way we forecasted and gave our earnings guidance for 2014.

So, I mean all of those are -- I don't know if they are difficult, but you just make assumptions and then you try to update them relative to what your belief was. We used our internal assessments or market assessments, discussion with payers, outside consultants to help us with that. We think we've got a range of reasonable scenarios on that.

## HCA Holdings Inc at Wells Fargo Healthcare Conference - Final

UNIDENTIFIED AUDIENCE MEMBER: (inaudible - microphone inaccessible)

BILL RUTHERFORD: So, Parallon, for those of you who don't know, this is a (inaudible) we create that we create -- we put our service offerings underneath there. The premise for Parallon is that we've got really what we think are some world-class services that we've developed internally for HCA over the decade, really around supply chain management, our HealthTrust Purchasing Group, around revenue cycle and consolidating our shared services environment. And we think we've got really a leading industry service and we've got a growing demand in the marketplace. If you look underneath Parallon, really four key business lines underneath there; supply chain, revenue cycle, labor management, around workforce solutions and staffing. And then we do some technology consulting to clients underneath in there.

And we're very bullish on the opportunities for Parallon. Many know that we are the outsource provider for LifePoint. We're implementing Catholic Healthcare Partners. We've got a range of individual clients. We're very pleased with the progress of Parallon thus far. Our focus is on creating a really strong service company and delivering quality services and executing to our clients. And so, we don't talk a lot about it externally on there, but it's creating really nice opportunities for us. Our pipeline is pretty robust and so we're very bullish on it.

And we've got a deep experienced management team, to your point, existing within Parallon, running each one of our business units, as well as at the Parallon enterprise. So we're very pleased with the growth of Parallon. And we think the opportunities in the near term to continue really growing what we think is a leading healthcare services company is in front of us.

GARY LIEBERMAN: Dr. Chari, maybe you can talk about some of the clinical initiatives this year.

RAVI CHARI, VP OF CLINICAL EXCELLENCE, HCA HOLDINGS, INC.: Thanks, Gary. So I think, as Bill mentioned, a lot of our differentiation, a lot of our strategic focus is on how we build breadth and depth in the service markets. And we have a lot of points that we've invested in, whether it be access points to what Bill has spoken to. And what we really want to complement that with is a better way that we can move towards our disciplined operational culture in terms of financial and operational side into the clinical side.

And so, we've gone back and really looked to stay how can we have better insight and awareness of what the product is that we are creating in our markets. And our fundamental focus is always the patient care and we look at a key aspect in allowing us to deliver care is how do we reduce variation and how do we engage physicians. And we call that program in our approach to managing that clinical excellence. And there's really several key points in terms of how do we go back organizationally to manage and deploy this that were important to that structural element to make us effective in executing.

One of them fundamentally was the data themselves. How do we understand our current performance and how do we understand where the opportunities are. In terms of data, we really understood then that there's two aspects that we have to understand and articulate and discuss it with our physicians. Really, it turns out to be what is our current performance. And then as we engage in a conversation, we'd say what does good look like?

In terms of current performance, I think everybody is aware there is external reporting measures and that provides one component of how do we measure ourselves in terms of delivery of healthcare. Those can be anything from core measures to other elements that are being measured by other agencies. We went beyond that and have recently created a clinical data warehouse, which allows us to see and have insight into clinical care that's somewhat unprecedented.

We can look at the delivery of care and articulate between the presentation time, in the time at which certain medications or orders were written and performed. And it allows us to align a lot more effectively what is clinical effectiveness literature and how we're actually performing. And this has really formed the foundational basis as we start conversations with physicians. And so this ability to see performance for the first time is really new and exciting.

## HCA Holdings Inc at Wells Fargo Healthcare Conference - Final

The other thing we did to complement that is to address this question of what does good look like, we've created a knowledge center, which combines both evidence-based medicine, but also it allows us to harvest HCA's best demonstrated practice and leverage our intellectual capital expense across the 165 facilities. But that's undoubtedly as someone already has discovered a good method or the best method to deploy some of these care priorities. And so, between the data that tells us what are we doing, what does good look like, we formed a second element to execute that was really critical, which we perform -- high performing clinical team, which moves us toward this idea of a high reliable clinical organization or high reliable organization.

And the core element that we've found that's important to execute on is, number one, not only having physicians involved with that discussion, so we engaged them in a dialog to improve care, but more importantly, we've created ownership and accountability for that team. And so, those are the elements between data, both our own performance, what does good look like and an execution strategy and surrounding it with the resources, both in terms of leadership and people to drive the high performing clinical team. That's the structural elements we had to put in place and control systems we put in place. And underneath that then we had to prioritize what are the areas that we want to align up to, as Bill says, the key service lines that we can -- to align clinical performance with the strategic imperative that we have in our markets.

And so, we came down with several key target areas that we felt would not only improve care, but broaden our capability as an organization. One of the first areas we reached out to and starting to impact significantly is the area of sepsis. What that does obviously, that's a [nagging] cause of mortality for inpatients currently, but allows us to really understand where are touch points and execution points in the ED and sometimes even before the ED, the ICU and the floor. And so with that, in the last year, we've reduced the mortality in that category by 4.6% and that's on a base of 85,000 patients. And we're continuing to expand that and it does align with our strategic priorities, which are engage in EMS, becoming the provider of choice, increasing the capacity to be perceived as managing complex medical conditions and forces us to raise our games in the ICU, as well as on the floor level to manage these patients.

Our second and third areas that we're looking at to continue that are cardiovascular, as well as vent management and we have tucked in there ortho and spine. And all of these are programmatic approaches that we have that are driven by data with physician led teams to improve patient care.

GARY LIEBERMAN: And how long does it take for that to sort of reach maturity or is it always sort of an ongoing process?

RAVI CHARI: It really is an ongoing process, and we have to define these as a start and an end point. So, the way we put this together is with the program we have, we leverage both the corporate team, as well as a division-based performance improvement team. And we have a phase that approximately -- to initially do the analysis, followed by the initial project plan of six weeks and then up to six months to a year to have it finally completely installed. And then we move into more of a maintenance phase, where we have, just like our operating reports, we have quarterly operating reports on these focus areas to ensure that we have continued highlight in these areas.

VIC CAMPBELL, SVP, HCA HOLDINGS, INC.: Ravi, tell them how much data we're collecting each day quickly, and then also the willingness of doctors. I've been around a long time and we -- if we try to do this stuff few years back, doctors would have gone across the street.

RAVI CHARI: So, I think that as Vic said, the key thing when we started, this is almost three and a half years old, the first concern we really had is, while we understand that a lot of the variation in healthcare is driven by physicians choices, and unfortunately a lot of the choices aren't necessarily based on science, but based on practice history or maybe not so much keeping up with the new and the interest in medical practice and care. The concern was that it could be off-putting, because it could be either antagonistic or challenging. And we found that data worth was the key element that allowed us to engage in a way that leverages some key characteristics that we found about physicians, truth seekers, problem solvers, and in fact, competitive of course. So, you can tell him how you are doing against the peers and that will raise the game.

## HCA Holdings Inc at Wells Fargo Healthcare Conference - Final

So, we went back and our first struggle was really how do we actually get accurate data and we've gone back, as Vic said, and we've created the clinical data warehouse, which brings forward all of our electronic health record into a database, which flows over a million individual units a day, anywhere from 30 to 300 different discrete elements on a given patient. 80% of the those data right now are unstructured, 20% are structured and we're right now leveraging the structured components of the data that allow us to see things, such as if you transfuse somebody, what was the pre-transfusion hemoglobin or hematocrit. If you had someone present with sepsis and we know best practice is to perform these three, four steps within a certain timeframe, how often did we do it? And if we didn't do it, why? And that frames in levels of dialog, where it talks about what is the care element and how consistently did you do it. We leverage our medical staff, our medical leadership to ensure that the areas that we choose to look at is measurable and actionable items are agreed upon broadly. And so it's not a discussion about the person and the near misses, but the process and how can we improve it.

And Vic, I think lastly to your point, one of the things that we really found over the few years is the receptiveness of physicians is really high at this time. We did some focus discussion groups and really physicians not only want to know what's going on in healthcare, [unlike] we're talking about reform and whatnot, but more importantly they want to know how am I doing. And if we can help them do better, but also provide feedback for them, it's lacking in the change that are going on right now in healthcare with inclusion or exclusion from provider panels and whatnot due to the sensitivity that allows us to be a valued partner and it gives them voice in how they can impact change and impact their own scores or how they're perceived.

UNIDENTIFIED AUDIENCE MEMBER: (inaudible - microphone inaccessible)

RAVI CHARI: We have actually created the data warehouse with servers architecture what we call the plumbing and it's complete. We're flowing data accurately since the summer of last year, we did our first internal audit on it in the third quarter of last year, optimized it and we've had useful data that we're actually using to manage our care since October 1 of last year. So it's actually functional.

We have several ways that we use it. We use it from -- all the way from real-time reporting in understanding our ED, our surgical time in terms of our surgical performance area that Bill has alluded to, in terms of operational data to underpin that. We've moved it ahead in blood, sepsis, antimicrobial stewardship, where we are starting to use other care orders or bed administration records to pull in to reflect back data. So it's actually functional right now.

GARY LIEBERMAN: So, maybe based on that or separately, what businesses do you think HCA is most interested in expanding into?

BILL RUTHERFORD: What businesses are expanding?

GARY LIEBERMAN: Or lines or service?

BILL RUTHERFORD: So when I think about breadth and depth, our strategy is to create these comprehensive delivery networks in our markets, anchored by our hospitals, complemented by ambulatory settings, surgery centers, imaging, physicians. So we continue to expand our access points in there, whether it be urgent cares or freestanding EDs. And so, we're interested in expanding our geographic footprint and creating access points in our existing markets. And then we organize, to Dr. Chari's point, around patient conditions, cardiology, neurosciences, ortho, women's, ED and create these deep service capabilities.

So our physician strategies, our capital deployment strategies are all centered around that breadth and depth of service capabilities in our existing markets. Then we previously talked about our view of entering new markets.

So that's how I would answer. We are interested in continuing to grow our markets. Our capital deployment strategy is a very important aspect of that. We spent just under \$2 billion of CapEx last year. We signaled, we anticipate that going to \$2.2 billion in 2014. And to me that's a reflection of the opportunities that we see in our existing markets. We've got three new hospitals under construction right now. We've got some major plant and facility renovation and

## HCA Holdings Inc at Wells Fargo Healthcare Conference - Final

we've got corresponding capital deployments for growth strategies, whether that's freestanding emergency rooms, expansion of surgical suites or increasing bed capacity.

GARY LIEBERMAN: Can you talk a little bit about your strategy of either employing physicians or using third parties to contract for services?

BILL RUTHERFORD: Yes. So in a -- I'll ask Ravi, but prior to me taking this job, I was in -- over the -- our physician services organization. And if you looked really around 2009, 2010 and 2011, you saw a lot of disruption in the physician marketplace in virtually every community in the country and ours was no exception. And we had accelerated growth of employing physicians during that time period, because there was a lot of disruption. There was income pressures on that community-based physicians. There was the uncertainty of the future and a flight to security. We have a pretty robust internal recruiting department. The younger physicians generally want to be employed, don't have the administrative burdens of their practice. Since the past year or two, that's kind of leveled and normalized. We continue to be active in the physician employment space, but it doesn't have the slope line that it did during 2010, 2011 and early 2012, so we have been able to stabilize there.

Then I'll move into hospital-based physicians. Generally, emergency room hospitalists, anesthesiologists, radiologists, pathologists and a growing area around intensivists. Historically, hospitals across the country, at least community hospitals, did not employ hospital-based physicians. We contracted that with generally local groups. Well, with this advent of employing physicians, we started to employ hospital-based physicians, hospitalists and emergency room primarily, because it was important to our clinical strategies and our operational strategies that we have alignment between the physicians and hospitals.

So we still do that but we also have alternative structures. You mentioned (inaudible) . We have joint ventures and several joint ventures with hospital-based companies, where we can enter into some win-win relationships that we can leverage their experience and infrastructure around managing hospital-based physicians, and we can get in favorable kind of contractual terms and we have structures where we can align strategically and clinically. So we have emergency room strategies around process flow, or door to balloon times or hands-off to an emergency room in the floor, the ICUs. We can work collaboratively in a structured approach with those hospital-based groups. And then it gives them access to growing market share. So that's been a key strategy for us around the hospital-based physicians.

GARY LIEBERMAN: What should we think about in terms of HCA's priority for use of cash?

BILL RUTHERFORD: So, we think we've demonstrated over the years a balanced approach to our use of cash. There was a couple of kind of impressive numbers I think. If you look at since our IPO, we've generated \$11.3 billion of cash flow from operations. We spent \$5.6 billion in CapEx. As I told you, just under \$2 billion last year, \$2.2 billion earlier. We have completed \$2.4 billion in acquisitions, a large portion of that was our acquisition of our HealthONE partnership, the other 50% that we completed in Denver. We've spent \$3.2 billion in dividends, \$2.75 billion in share repurchase. We've completed [\$1.25 billion] just in the past six months. And we have restructured \$11 billion of our debt. We brought our average weighted cost of interest down almost 200 basis points to close to 5.8% on a pretty large debt portfolio on there. So, \$28 billion, if you wanted to know.

And so, our priority of use of cash flow will depend on what the marketplace is. I think we would prefer to find high-quality acquisitions that have continued growth opportunities that can return shareholder value. To the extent that those don't materialize for a variety of reasons in the marketplace, then we have demonstrated we have other opportunities to utilize that cash flow to either grow the Company or deliver shareholder value.

UNIDENTIFIED AUDIENCE MEMBER: (inaudible - microphone inaccessible)

BILL RUTHERFORD: We did explore it, but I'd tell you, probably that's not our model. We have six hospitals in London. So we're familiar with it and we've been international in our past. We've, long time ago, had hospitals in Australia and so forth before. So we have some familiarity with those international marketplaces. But to your question,

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is there a likelihood that we go small? There is a likelihood, but probably doubtful. We want to provide a meaningful position. We think that's what our model is based on and scale. Now you might find some maybe smaller, kind of, [entry] relationships. But for the most part, if we're looking in a new market acquisition international, it would make sense for us to find a meaningful relationship or provider with some meaningful share would be our primary desire.

VIC CAMPBELL: [Can't] let you back in Boston. I thought they banned you to Singapore.

UNIDENTIFIED AUDIENCE MEMBER: (inaudible - microphone inaccessible)

VIC CAMPBELL: Okay, good decision.

GARY LIEBERMAN: Great. Well, I think that's (inaudible) time. Thank you very much for being here.

BILL RUTHERFORD: Thanks for having us. Appreciate it really.

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**Load-Date:** June 21, 2014

# Q2 2014 Envision Healthcare Holdings Inc Earnings Call - Final

FD (Fair Disclosure) Wire

August 6, 2014 Wednesday

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**Length:** 9576 words

## Body

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### Corporate Participants

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Envision Healthcare Holdings Inc - President & CEO

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Envision Healthcare Holdings Inc - CFO & COO

### Conference Call Participants

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\* Gary Taylor

Citigroup - Analyst

\* Josh Raskin

Barclays Capital - Analyst

\* Matthew Gilmore

Robert W. Baird & Co. - Analyst

Presentation

OPERATOR: Welcome to the Envision Healthcare Holdings second-quarter 2014 conference call.

(Operator Instructions)

Today's conference is being recorded.

If you have any objections, you may disconnect at this time. Now I will turn the call over to Craig Wilson, General Counsel. Thank you. You may begin.

CRAIG WILSON, GENERAL COUNSEL, ENVISION HEALTHCARE HOLDINGS INC: Thank you.

I would like to welcome everyone to Envision Healthcare second quarter 2014 earnings conference call, and introduce our speakers, Bill Sanger, President and CEO; and Randy Owens, CFO and COO. Before we begin, let me remind you that some information provided during this call may include forward-looking statements that are based on certain assumptions, and are subject to a number of risks and uncertainties as described in our SEC filings, and actual results may vary materially.

Forward-looking statements in the press release that we issued today, along with our remarks today are made as of today, August 6, 2014, and we undertake no duty to update them as actual events unfold. Today's remarks are also included -- also include certain non-GAAP financial measures, including adjusted EBITDA, adjusted free cash flow, and adjusted EPS.

You can find a reconciliation of these measures in the tables included with our press release, which is also available in the Investor Relations section of our website at [www.evhc.net](http://www.evhc.net). All comparisons included in our presentation today, are for second quarter 2014 through second quarter 2013, unless otherwise noted.

Now I will turn the call over to our President and CEO, Bill Sanger.

BILL SANGER, PRESIDENT & CEO, ENVISION HEALTHCARE HOLDINGS INC: Thank you, Craig, and good afternoon to everyone.

Q2 was another successful quarter for Envision Healthcare. Revenue was up 19.6%, adjusted EBITDA up 26.6%, and adjusted EPS was \$0.28. The overall -- the majority of our growth continues to be organic, which we believe to be the result of our integrated service offerings across all business segments.

60% of our revenue growth was driven by net new contract wins, 25% from same-store, and 15% from acquisitions. EmCare's net new contract wins continue at a record pace, and contributed 15.4% to the overall revenue growth of 21.2%.

AMR delivered its strongest performance in many years, with 16.7% revenue and 33.1% EBITDA growth. EmCare's second quarter revenue growth of 21.2% was primarily driven by 20.3% organic growth, of which 15.4% was from net new contract wins. Same-store contract growth increased substantially from Q1 and from prior year, partially driven by the benefits of healthcare reform. New starts in the quarter are projected to drive approximately \$85 million in annualized net new revenue. When combined with the starts from Q1, our first six months of new contract wins are expected to produce approximately \$200 million in annualized new revenues.

Late in the quarter, we announced the acquisition of Phoenix Physicians, which is expected to add an estimated \$125 million in annualized revenues, and approximately 800,000 patient encounters. This acquisition expands our presence in South Florida, adds new service offerings, and further advances our market-centric strategy.

The acquisitions also brought us two new service lines, pediatrics and OB/GYN hospitalists, which we see as an additional platform for growth. This acquisition provides a substantial opportunity to cross-sell our integrated service offerings to these new hospital clients, and likewise to cross sell new services to our current and our future hospital partners.

On the innovation front, EmCare continues to be a market leader. We recently added a new offering to our suite of technology solutions. This offering, which we refer to as DASH, stands for direct admit systems for hospitals, and further extends our integrated model into the community physician's office.

This innovation utilizes proprietary software that improves coordination of care between our hospitalists and community physicians by streamlining the hospital direct admission process. Currently, there are a dozen hospitals and 650 community providers utilizing our system. We believe that this, as we expand this technology, we will further solidify our existing relationships, facilitate our organic growth, and provide a platform for further integration with AMR and Evolution Health.

At AMR, net revenue growth of 16.7%, and adjusted EBITDA growth was 33.1%. Revenue growth was primarily driven by new contract wins and same market increases, which was partially driven by the positive aspects of healthcare reform. We are benefiting from our large 911 contract wins of 2013, as well as wins in first half of the year. In addition, we continue to be successful with our IFT and managed transportation businesses. This is the result of improved sales approach in targeted markets, better on-time performance for ambulance transports, and new managed transportation agreement wins.

At AMR, we had 150-basis point improvement in operating margins, from leveraging our higher revenue base, market rationalizations, and our investments in technology. Our technology investments, while not yet fully implemented, have resulted in more effective crew scheduling and deployments. We are very encouraged by these exceptional results at AMR, and believe our improved win rates, our market-centric strategy, and acquisition pipeline will enhance our growth and further solidify us as the market leader. On the Evolution front, we continue to push forward with health plans and health system collaboration. We have begun implementing services with Fundamental in initial target markets.

As a reminder, Evolution Health entered into a national agreement with Fundamental to provide post-acute care services throughout their organizations. We have also entered into post-acute pilots with hospital systems in Texas and California, as well as a pilot in Nevada with a major health plan. We are confident these pilots will result in long-term relationships with health systems and health plans, and provide a basis for further expansion of the program.

Recently, Evolution Health was awarded six projects by CMS for the Bundled Payment Care Improvement Initiative. Under these programs, Evolution Health will provide post-acute comprehensive care to certain Medicare patients, beginning January 2015. We believe these programs provide Evolution Health the opportunity to be a proactive participant in the formation of post-acute care bundling, and risk-adjusted reimbursement methodologies.

I would now like to comment on the outlook for the remainder of the year. Given the traction we are seeing with our net new contract wins, our robust organic pay and acquisition pipeline, complemented by early benefits of healthcare reform, we are increasing our annual guidance, of which Randy will provide more details.

Before I turn the call over to Randy, I would like to take this opportunity to thank our 33,000 team members and affiliate clinicians for their constant commitment to our patients, our partner hospitals, and fellow colleagues. Without the team's efforts -- without the team's tireless efforts, these extraordinary results would never be possible.

Thank you.

RANDY OWENS, CFO & COO, ENVISION HEALTHCARE HOLDINGS INC: Thank you, Bill.

And as highlighted in the earnings release we just posted, our net revenue for the second quarter was \$1.08 billion, a 19.6% increase driven by a 21.2% increase at EmCare, and a 16.7% increase at AMR. As noted, adjusted EBITDA for the quarter was \$134.2 million, an increase of 26.6%. Adjusted EBITDA margin was 12.5%, an increase of 70 basis points.

We reported a net loss for the quarter of \$2 million, compared to net income of \$9.6 million in 2013. The reduction in net income was primarily attributable to a \$66.4 million pretax charge related to the early debt extinguishment in June 2014, offset by lower interest expense from debt retirement from 2013. Adjusted EPS in the quarter was \$0.28, and GAAP diluted EPS was a negative \$0.01.

EmCare net revenue was \$690 million in the quarter, and increased 21.2%. Of that increase, 73% came from net new contract wins, 23% came from same-store, and the remainder came from acquisitions. In addition to our record-setting net new contract wins, we saw significant increase in our same-store growth, driven by additional ED volumes.

On a same-store basis, year-over-year revenue increased 5.5%, from an increase in weighted patient encounters of 5.3%. For ED and hospitalist services, volume increases in Medicaid expansion states were 5.6%, compared with volume increases in non-Medicaid expansion states of 4.1%.

Total EmCare self-pay volume mix dropped 200 basis points in the first half of the year from 20.1% at the end of last year to 18.1% in Q2, a further reduction in self-pay of 40 basis points from Q1. We believe this highlights the continuing payer mix shift, and increased utilization of previously uninsured patients.

Within Medicaid expansion states, self-pay mix was 400 basis points lower in the second quarter of 2014 compared to the year end 2013, and a further reduction in self-pay of 160 basis points from the first quarter. We saw a corresponding increase in Medicaid and Medicaid HMO mix.

While EmCare is almost 50% of our volume is in Texas and Florida, which at this time have not expanded the Medicaid program, the overall health reform impact is not as significant as it may be in the future, if those states provide some expansion or make a change to their Medicaid programs. With contract growth in the last year of non-expansion states like Texas and Florida, approximately 23% of our current volume is in Medicaid expansion states.

From a rate perspective, ED net revenue per visit increased 2.9% in the quarter, due to the impact of changes in payer mix and rate increases. This is primarily offset by lower revenue per encounter and other service lines, which included changes in one of our anesthesia MSA contracts, lower Medicare census at Evolution Health, and the start-up of the UHS joint venture.

Total revenue related to health reform payer mix changes and parity was \$9.7 million in the quarter. This included parity revenue of \$7.3 million. Year-to-date, revenue from mix changes and parity was approximately \$18 million.

EmCare adjusted EBITDA increased 23.4% to \$87.1 million, with an EBITDA margin improvement of 20 basis points to 12.6%. This includes a 1.5 -- includes a \$1.5 million in acquisition costs, primarily for the recent Phoenix Physicians acquisition in June.

This margin difference is largely due to improvements in operating insurance and general administrative costs, offset by increased compensation costs as a percent of net revenue. While margins improved, our compensation costs were higher as a percent of net revenue due to an 80 basis point increase in start-up costs from a 200% increase in revenue from new contract wins over the last year.

Start-up costs in Q2 were 20 basis points lower than what we saw in Q1. We have seen success in lowering our start-up costs, and expect to see this continue on a per contract basis over time. To put these into perspective, expenses that we incur to start up a new contract represent approximately a half turn of EBITDA for each contract start, which we believe is an effective investment for obtaining new contracts. Now on a same contract basis, the increase in volume and rate have led to an improvement in margins of 230 basis points year-over-year.

AMR net revenue was \$385.3 million, an increase of 16.7%. Of that increase, organic revenue was 57% from contract wins and same market increases, and 43% came from acquisitions. Organic growth was driven by a 5% increase in net new contract wins, and a 4.6% increase in existing market revenue. In existing markets, our weighted volume increased by 3.6%, and revenue for transport by 1%.

Same market volume increases in Medicaid expansion states were 4.4%, and 1.5% in non-expansion states. The increase in revenue per trip was primarily driven by an improvement in payer mix, as the result of lower self-pay and higher Medicaid mix in Medicaid expansion states.

Total AMR self-pay volume mix dropped 250 basis points in the first half of the year, from 19.3% at year end to 16.8% in the second quarter 2014, an additional 30 basis point reduction in self-pay from the first quarter. The reduction in self-pay in Medicaid expansion states was approximately 400 basis points, with a slightly higher increase in Medicaid and Medicaid HMO mix. The net impact of mix changes in existing

markets contributed approximately \$3.8 million in additional revenue in the quarter, and \$6 million year-to-date.

AMR adjusted EBITDA for the quarter increased 33.1% to \$47.1 million. The increase is attributable to a combination of revenue growth and improved efficiencies as highlighted by Bill. Adjusted EBITDA margins increased 150 basis points to 12.2%. Compensation and benefits as a percent of net revenue was lower by 250 basis points, primarily related to operating efficiencies, and the impact of the TMS acquisition as managed transportation expenses are primarily included in operating expense.

When combined together, comp and benefits and operating expenses declined 180 basis points over the second quarter 2013. Insurance expense was higher as a percent of net revenue, due to a \$1.2 million in unfavorable prior-year insurance development, compared to a favorable adjustment of \$0.3 million in Q2 of 2013.

Cash flow provided by operating activities improved significantly due to improved earnings, reduction in EmCare DSO, and lower interest payments. Operating cash flow was \$63.7 million in the quarter, compared to a \$12.7 million outflow last year for a net improvement of \$76.4 million. Accounts receivable increased \$22.8 million in the quarter, compared to \$13.8 million last year due to the impact of accelerated contract growth.

The net cash impact of growth was improved due to a three-day decrease in EmCare's DSO in the quarter. During the quarter, we saw a significant decrease in Medicare enrollment related collection delays on order balances and recent contract starts. July cash was also very positive, and we continue to expect a reduction in EmCare DSO throughout the year.

Net cash used in investment activities was \$184.6 million, compared to \$23 million last year, and primarily driven by acquisitions of \$163.5 million in the quarter. Net cash provided by financing activities was \$92.5 million, compared to net cash used in financing activities of \$7.4 million. This net change was primarily due to the bond refinancing in June 2014. Adjusted free cash flow improved by \$62.3 million, and was \$43.5 million in the quarter, compared to a cash outflow of \$18.8 million last year.

From our strong results in the first half of the year, our continued growth prospects and benefits from healthcare reform, we are revising our 2014 annual guidance. We expect 2014 adjusted EPS to be \$1.15 to \$1.20, up from our previous guidance of \$1.10 to \$1.15, and 2014 adjusted EBITDA to be \$553 million to \$558 million, up from our previous guidance of \$538 million to \$545 million.

Our guidance assumes that healthcare reform benefits continue, but we have not assumed that volumes we saw in the quarter will continue at the same level, or mix will change significantly as we are unable to predict those trends at this time. Our previous guidance assumes some level of acquisition activity in 2014, and the net impact of recently completed acquisitions is included in our guidance, with a larger benefit expected in 2015.

Bill?

BILL SANGER: Thank you, Randy. Operator, we would now like to open the call for questions.

Questions and Answers

OPERATOR: (Operator Instructions)

Andrew Schenker, Morgan Stanley.

ANDREW SCHENKER, ANALYST, MORGAN STANLEY: Great. Thanks. Good afternoon. Maybe just talking a little bit more on the reform benefit here. I am just doing some back of the envelope math. It sounds like if you were running about 20% uninsured volumes on an expansion state, its down 400 basis points, if that is correct. So you are assuming about 25% decline. Obviously, still strong number, but a little bit lower than what we have been seeing from maybe some of the hospitals. Could you maybe talk about the trends you are seeing in those expansion states, and also incorporate in that anything you are seeing on the exchange side of things? Thanks.

BILL SANGER: Yes, Andrew, it's hard to compare specifically with what the hospitals are showing. Obviously, we have been seeing each month a continuing change in that mix. So as I mentioned, the change in self-pay mix in Q2 was even more than what we saw in the initial quarter. So look, I would expect that would continue. Some of that is dependent on utilization, and in some cases people understanding what coverage they have and utilizing those services.

So on the exchange side, we have some data. I think it is a little benefit at this time. We had been seeing some improved volumes. So for example, in May, based on what we could track, we had a 0.5% of our volume that we saw was from exchanges. That includes the 1% in June. So while we have not made any major assumptions here, we are seeing some increase in trends in the non-expansion states as well.

ANDREW SCHENKER: Okay. And just maybe following up on that, on the volume side in general, is there any way to narrow it, and identify what increased volumes maybe are attributed to Medicaid specifically? And more specifically, any guess on how many of them were previously uninsured and utilizing more entering the system, more versus just a mix shift or overall just greater utilization? Thanks.

BILL SANGER: Well, I think, Andrew, it's hard to be probably as specific as what you are asking. Clearly, if you look at the significant mix shift, 400 basis points here in expansion states moving to Medicaid, we believe obviously, that the increase in volume is -- health reform is clearly a factor in that increase in volume. And we saw more of that increase continuing throughout the second quarter. So, as I said in the talking points, we've not really assumed a same level of volume in the back half of the year. We've assumed basically about half of the volume that we saw in the quarter, we used that in terms of our kind of coming up with our guidance.

ANDREW SCHENKER: Thanks.

OPERATOR: Ryan Daniel, William Blair.

RYAN DANIELS, ANALYST, WILLIAM BLAIR & COMPANY: Yes. Thanks for taking the question. Bill, maybe one for you on Evolution. Given the success you are seeing there with Foundation, the new CMS award, and then the new pilots. I am curious if you could talk a little bit about, one, the capacity you have to manage a greater influx of patients? And then, number two, as you expand that, will that be something you look to do internally through hiring, or is that maybe an area of focus for M&A going forward?

BILL SANGER: Ryan, it will be a combination of M&A in target markets, as well as growth internally. They are distinct markets in which we have identified through our relationships with these pilot systems, as well as with various health plans. We've targeted certain acquisitions in those markets, but we have a very excellent capacity of growing organically, for the number of providers we have in these various marketplaces. So you'll see a combination of both.

RYAN DANIELS: Okay. Perfect. Maybe two reform-related questions, and I will hop off. Just first, you mentioned that a lot of your volumes and EmCare in particular, are in non-expansion states like Texas and

Florida at present. I'm curious if you have any thoughts on the potential for those two, actually see this Medicaid expansion after the election cycle? That's number one.

BILL SANGER: Well, let's answer the first one. We don't have any first-hand knowledge. We have heard, particularly in Florida, rumor of discussions occurring relative to the state in 2015 looking at some type of Medicaid expansion. I can't give you specifics of that. But I do know that there are a group of Republican states, that are giving serious consideration relative to expanding the Medicaid program.

RYAN DANIELS: Okay. Perfect. And then second one, just on Medicaid parity. There has been a handful of states now that are pushing to move that into 2015. I am curious, two-fold. Number one, if you think ED would be included in that? And then number two, if you have done any work to see how much exposure you have to those potential states that are extending it? Thanks.

BILL SANGER: Yes, Brian, we don't have a lot of data at the moment in terms of what that could mean in those states, and look, I don't know if that would include ED services. Obviously, we, I think, with others in the industry through associations or whatever, are obviously very active in trying to communicate the fact that there is such a shortage of physicians. People can't get access unless they utilize those services, which is why you are seeing some of these volume increases. So, I don't know that we have anything definitive on that.

RYAN DANIELS: Okay. Thanks again.

OPERATOR: Ralph Jacoby, Credit Suisse.

RALPH JACOBY, ANALYST, CREDIT SUISSE: Great. Thanks. Just want to maybe delve into the same-store stats on the EmCare side a little bit. You had the 5.3% volume, obviously, a strong showing. Within ED, it was 4.2%, sort of suggesting much higher volume in non-ED. And then similar on the other side, pricing up 0.2% overall, with ED up 2.9%, suggesting sort of pricing in the non-ED was sort of much lower. So, just trying to understand those moving parts, and reconcile the volume in the pricing.

RANDY OWENS: Yes. Well, let me just kind of go through a couple of those points again, because there was a lot of stats that I went through here. So when you look at -- overall, we had a 5.3% increase in volume, okay, on a same-store basis, okay. When you look at ED in hospitalist, and that's really where we, obviously, anticipated more of those volume changes related to reform, we actually saw higher volume increases in the Medicaid expansion states. That was 5.6%. But we also saw strong volumes in the non-Medicaid or the non-expansion states. That is the 4.1%. So we saw strong volumes really, across the country in all of our contracts.

From a rate perspective, you're right, we had about 3% on the ED. I mentioned a couple of items that were driving some of the lower yield on some of the other services. And some of that again, was a change we had in one of our MSA contracts, where the revenue on that is lower this year than it was last year. And since there is no volume on that, it really goes straight to rate.

On the Evolution Health side, which obviously is part of EmCare, there has been more of a focus on looking at sort of managed care and commercial patients as we start thinking about that model. And so, we didn't have as many of the Medicare census, which just on a revenue basis is the higher number. And in the third thing I mentioned in the UHS joint venture, remember, we just started that, and we did start that initially with existing contracts that we had. And so, we did go through and lower subsidies in some of those contracts, which impacted some of that yield, and for example, hospitalist and anesthesia. Obviously, long-term, we are very excited about the joint venture and new contracts that will be coming, so we feel very good about that.

RALPH JACOBY: Okay. All right. That's helpful. And then, just back to sort of the reform question. I may have missed this or misunderstood, did you say that the total sort of revenue related to reform and parity was \$9.7 million in the quarter, and that the parity revenue was \$7.3 million?

RANDY OWENS: That's correct.

RALPH JACOBY: Okay.

RANDY OWENS: \$[18] million year-to-date in total.

RALPH JACOBY: And so, in the quarter, that is \$2.4 million from ACA to the revenue line?

RANDY OWENS: Yes. Remember, our EmCare, it's a little lower, one. We didn't see as much, I think as others did in the first quarter. So, we saw some more -- most of that really was in the -- obviously, in the second quarter when you look at, even the year-to-date numbers. And given EmCare is 23% of our volumes in the Medicaid states, then we expected a lower number. We will see how that goes with the expansion side, as we are just starting to see data, of sort of additional utilization in some of those states as well. That is the pass-through, or what do you keep, sort of down to the EBITDA line of that revenue versus the -- to the physicians? Well, Ralph, it does vary, obviously, depending on market and initial markets. I think we have always said that overall, on a mature basis, we would expect to retain probably 50%, 60% of that. Some of that we will share with our joint venture partners obviously, and some of that goes with physicians, and sharing with our partners through some subsidy changes, as well as the joint venture arrangements. So that's what I would consider.

RALPH JACOBY: Okay. And then last one if I could. Just the non-controlling interest line. It looked like it was sort of zeroed out this quarter. Why is that, or maybe how do we think about that line item going forward?

RANDY OWENS: Well, I think, Ralph, we have talked about that a little bit before, is that when you look at the level of activity, the level of start-ups and the level activity in the joint -- the UHF obviously, just started up, so we don't expect to have any significant profit sharing here, especially early on. And even with HCA, there is still a lot of new activity. And so with start-up costs, they will start out as lower margins and tend to balance that out. So I think by the end of the year we could see some number in there. My best estimate at this point, it's hard to say, it could be a few million. But those tend to -- would tend to see that probably later in the year, as contracts and starts tend to mature.

RALPH JACOBY: All right. Thank you.

OPERATOR: [Derrick Ellrich], Deutsche Bank.

DARREN LEHRICH, ANALYST, DEUTSCHE BANK: Thanks. It's Darren Lehrich from Deutsche. I wanted to start out with a question here, just on the AMR IFT trends. They definitely are looking a lot better. I guess, I just wanted to hear from you, Randy, that the numbers again just on same-store weighted transports, and what you are seeing there? And then, I guess just more strategically, Bill, can you just share with us what you think you are doing any different, that is seeing some of these -- the AMR volume trends start to really improve here?

BILL SANGER: Sure. While, Randy is pulling all those numbers, Darren, I will --

RANDY OWENS: Yes. Well, I got that, Bill, and then I will turn it over to you. So Darren, our total volume on a same market basis was up 3.6%, okay. Now, when you -- what the other point I had, was if you looked at in Medicaid expansion states, our volumes are actually 4.4%, so even higher. But we still saw positive



volumes in non-expansion states. That was 1.5%, and so, overall it was 3.6%, really growth in both the 911 and in the IFT. And I will turn it over to Bill to kind of talk about some of the differentials.

BILL SANGER: Yes, as I highlighted, we have taken a different approach towards the IFT market, which is very consumer-oriented. We have, substantially through changes in our deployment improved our on-time performance, which is a critical component of IFT contracting. In addition, we have changed the scale and scope of our sales team. So I think a combination of those factors has really been beneficial for us in terms of signing some system contracts, which has really been the driving force towards IFT growth.

DARREN LEHRICH: That's helpful. And then, I guess, just going back to the uninsured numbers. I think you gave us the mix figures, so we can probably calculate. But just to confirm, you saw about 10% reduction overall in uninsured ED visits, is that the right way to think about it, Randy? And can you just talk a little bit about trending through the quarter, whether that level improved as you went through the quarter?

RANDY OWENS: Yes. I think if you look at overall -- I guess, there is kind of two pieces to that, Darren. So if you look at that in the first half of the year, you have gone from -- for all of EmCare, from 20% down to 18%. So let call it 10% or 200 basis points, okay? The real difference -- and obviously -- well, in the first quarter when we measured it, it was about 160 basis points of change, and then it grew to 200. So we are continuing to see some continued movement in the Medicaid side, I think as people realize well, what they have and utilize those services.

But the bigger impact when you look at EmCare is really on the Medicaid expansion space. So given that is just 23% of our volume today, it is not as significant when you look at the total. But when you look at those expansion states, I think it's fairly consistent with what we have seen or heard from others, is that we had a 400 basis point reduction in the Medicaid expansion states. Again, most of that went straight to Medicaid or Medicaid HMO. So we have definitely seen a much larger reduction in those Medicaid expansion states.

DARREN LEHRICH: Okay. That's great. Thanks a lot.

RANDY OWENS: You bet.

OPERATOR: Frank Morgan, RBC Capital Markets.

FRANK MORGAN, ANALYST, RBC CAPITAL MARKETS: Good afternoon. Hoping you could provide some commentary on anything you are seeing in the acuity level of these patients presenting in the ED, either in expansion states or non-expansion, whether it's Medicaid or exchange?

RANDY OWENS: Yes, Frank. I don't have any hard stats here, but look, in general, our acuity levels are a little lower, I think as you would anticipate. I think a lot of these, as we saw previously, even back to the Massachusetts and whatnot, is that a lot of these are not real true emergencies, but utilizing them for primary care, because they can't get access to a physician. So we have seen some lower acuity, and obviously, that affects the yield some. But I haven't seen anything where it was materially different.

BILL SANGER: Yes, Frank. Generally speaking, if you look at the Medicaid population, compared to the rest of the patients we see, it is a lower acuity because of the use of primary care. And just because of the expansion, we haven't seen an increase in acuity due to expansion at all.

FRANK MORGAN: Okay. And then I was hoping maybe just a little bit of color on how you see the future contracts coming up, opportunities on the AMR side? And do you see any larger deal opportunities on the EmCare side, like you did with the Phoenix transaction? Thanks.

BILL SANGER: Sure. Let's take AMR first. Look, we continue to grow our IFT business through some of the differentiating strategies that I just shared with the question that Darren just asked. As it relates to some of the larger 911s, we have signed several smaller 911 contracts, and we are still awaiting two major contracts that we have talked about for a while. And I will just digress here a moment, because I think it is important you understand what the dynamics of the 911 marketplace.

In Buffalo, where Metro is the incumbent, and recently got a 90 day extension as the community, in particular, they look at whether or not a change is appropriate at this time. We continue to be confident that there are many agreements out there under our competitors that will go out to bid, and we'll be successful in the future. San Diego, which has been delayed for almost a year now, is really up at the state level. The state of California has essentially, taken a very aggressive position in looking at the RFPs, particularly those that are being released by cities versus counties, and are reviewing of all city RFPs. So we expect that to take a little time.

Along the same lines, we do feel very encouraged those will come out, and we will be successful in the future. We have also applied for Certificate of Need in the spirit of Arizona, which we believe we'll hear very soon. The State of Arizona was a very restrictive state, and with some of the challenges with our competitors of that state, some of the providers and some of the insurers have asked us to go into the state to ensure that the 911 transport is intact, and that communities won't be left in a solo position.

As it relates to EmCare, one of our real differentiating factors with EmCare has been our ability to sign national agreements. We have continued to expand our relationship with HCA. There are other systems, that are in the RFP process. We are part of a response to those RFPs, and are relatively confident, Frank, that we will be successful in those contracts on a go forward basis.

FRANK MORGAN: And maybe on the acquisition side of EmCare?

BILL SANGER: Yes, on EmCare, obviously we announced a sizable acquisition for us. I will say there are several acquisitions that are out there in the marketplace, at least the size of Phoenix Physicians. And we believe that those acquisitions would best be suited under a relationship with EmCare, and we will continue to work through those acquisitions.

FRANK MORGAN: Thank you.

OPERATOR: Brian Tanquilut, Jefferies.

BRIAN TANQUILUT, ANALYST, JEFFERIES & CO.: Hello, good afternoon, and congratulations.

BILL SANGER: Thank you, Brian. Bill, just wanted to follow-up to those comments you made to Frank's questions. So, as we think about the contracting pipeline for EmCare, do you mind just giving us some color on what sizes you are seeing, and then what types of agreement these are? Are these, fill the ER, hospitalist, or are these more diversified bundled agreements, and are they national in scale, or are they more regional? Probably about 30% or 40 % of our contracts that are in the pipeline are related to cross-selling or related to system agreements. We've been very successful in signing multiple contracts, whether it's for hospitalist ED, or for our new emerging service line, which is combination of surgery, anesthesia and hospitalist. We do sign the single contracts, but they're becoming less and less prevalent. Particularly as you look at our pipeline, the majority of those are for multiple bundled services.

BRIAN TANQUILUT: Okay. And then, Randy, as we think about the guidance, you raised the guidance slightly here for the year. What sort of reform expectations have you baked in, for the back half of this year, into that guidance adjustment?

RANDY OWENS: Well, we have, and I guess given specific numbers here, what I would say, is that, one, we don't expect any big change in sort of parity. If you will remember initially, we had \$17 million to \$20 million already included in our initial guidance. And so, we are seeing numbers that are a little above that, but not significantly more.

I think from a guidance standpoint, obviously, there is some conservatism there. We saw significant volumes in the quarter, and we've not made the assumption that that's going to continue at the same rate. It may, but that's something that's hard to predict at this time. So look, we think there was a pretty solid increase in guidance, given kind of where we are in the range. And I do think that there is some opportunity to see some additional health reform benefits throughout the year. And we will need a little bit more time on that, especially in some of the exchange or non-expansion states.

BRIAN TANQUILUT: Got it. Last question for me. As we think about the HCA joint venture and the UHS joint venture, how penetrated -- I know you said UHS is in very early stages, but how penetrated would you say we are now in the HCA book at this point?

BILL SANGER: Probably about 60% on a single service, and about 30% of multiple services. So we believe there is a fair amount of runway left.

BRIAN TANQUILUT: Got it. Thanks.

OPERATOR: A.J. Rice, UBS.

A.J. RICE, ANALYST, UBS: Hello. Thanks. First off, I think in the prepared remarks, you mentioned a lot of the opportunities you are pursuing on the Evolution health side. I know when we exited the year last year, you were running about \$110 million annualized run rate. Is it materially different now? And if these opportunities come to fruition, might it be materially different next year? Any sense of where that's at, that you could provide?

BILL SANGER: Yes, it's too early to provide guidance relative to just Evolution Health. There's not material change at this point in time. These multiple pilots that we have throughout the country are really a test of our performance. We are very, very confident based on the patients we have seen so far, that these will translate into pretty significant contracts over the next 12 months.

A.J. RICE: Okay. And maybe just flush out a little bit further if you could, what Bill, you described as the pediatric or OB/GYN hospitalist opportunity? Are we focused mainly, on the type of NICU management type opportunity that we have seen some others in the broadly-defined space go after? Or are you looking at something more broad than that?

BILL SANGER: No, we really, at this point in time, have not really focused on the NICU. When we talk about OB/GYN and pediatrics, it's primarily related to the hospitalist, non-intensive care space.

A.J. RICE: Any sense of about how big that opportunity would be, or what the competitive landscape is that you could share maybe?

BILL SANGER: I think the competitive landscape is very fragmented. It's too early to say what we believe the expansion opportunity of those two sub specialties of hospitalist will be. But we been asked historically, by many of our clients, particularly as it relates to pediatric hospitalists.

A.J. RICE: Okay. All right. Thanks a lot.

OPERATOR: Kevin Fischbeck, Bank of America Merrill Lynch.

KEVIN FISCHBECK , ANALYST, BOFA MERRILL LYNCH: Okay, great. Thanks. Obviously, you have raised guidance or beat the high end of your range as far as the quarter goes. I think when you provided guidance, you had basically just kind of an estimate about what you would look like. So, is it right to assume that, really, the coming in above the high end of the range is largely that the June month came in better? Or were there any other factors that have led to the upside in the quarter?

RANDY OWENS: Well, I think that's fair. Obviously, we saw an improving performance throughout the quarter. I think I mentioned, even from a volume perspective, we continued to see that. So I think that's fair.

BILL SANGER: I think we are also trending improvements in our cost structure, and particularly at AMR. And we continue to see that on a go forward basis, and we believe will continue to see margin improvement at both of the operating divisions.

KEVIN FISCHBECK : Okay. Why -- when you think about the guidance, it sounds like you are being conservative I guess, and a number of other companies are being conservative on guidance. But as far as the volumes go, is there a reason to assume that the volumes really won't persist at these levels? Any better sense and kind of, why the volumes were so weak over the last few quarters. And why this was the quarter where it snapped back?

RANDY OWENS: Well, I think -- well, I guess a couple things. One, it's hard to predict -- and it's going out there on a limb to assume that everything is going to continue at the same rate. So, I think that's probably why you are seeing a lot of people be conservative, until you have more history, right, and to your point.

But Q1, as we all know, was challenging for us, and for everyone, especially on a comp basis, given weather and the last year's flu and all that stuff, so it was -- And it does seem as though it is taking a little longer, when you look at additional volumes. Or at least on the Medicaid side, we saw more of that. And kind of to your point, volume is sort of improving a little bit every month, and we saw a lot more of that in Q2. I think we all just want to see, a longer period of time, before you're going to commit to that kind of a volume level.

BILL SANGER: Yes, keep in mind, like the rest of the industry, these volume trends are really only over the last couple three months at most. And for us to really call it a trend, we would like to see at least another quarter. We are somewhat encouraged by the volume increases, but cautious, just to get too aggressive at this point in time.

KEVIN FISCHBECK : So this is -- the volume increases, obviously, it is better in reform states, but is it still pretty strong in the non-reform states. So that has at least signaled that potentially this was something broader-based, at least that makes sense.

RANDY OWENS: Yes, and I think, Kevin, I think again, I have heard others, and I think we are in the same boat of where it -- we felt like it would take longer to get a feel for the exchange side of things, just given the late enrollments and all that kind of stuff, and what we saw on the Medicaid side. So, I think we are encouraged by the fact that the volumes again, were really solid across the whole -- all the country including those non expansion. And I think that is where it probably, that may be more telling in the next quarter, when you look at sort of those volume trends.

KEVIN FISCHBECK : And then I guess, it makes sense when you say that the ER volumes might be higher in reform states, but I was little surprised that the ambulance volumes were higher. Is there a reason why that would happen? Was it more inter-facility transports that was driving that? Or I mean, I just think -- try to struggle for why ambulance service would go up in an expansion state?

BILL SANGER: Yes, it was really both. But keep in mind, the IFT is really a function of admissions within hospitals. And so, with higher admissions, more transports. And as more Medicaid patients came into the

hospitals, we are transporting those to different locations. So it is a combination of both. I think the 911 increases were, frankly, just result of the season, and the IFT we may have seen a result of the expansion.

KEVIN FISCHBECK : All right. Great. Thanks.

OPERATOR: Gary Taylor, Citi.

GARY TAYLOR, ANALYST, CITIGROUP: Hello, good afternoon. A couple questions. One, Randy, when you talked about, when you broke out the parity and ACA revenue impact in 2Q, and you said \$2.4 million for ACA, what exactly are you measuring there? Is that just healthcare exchange revenue or -- ?

RANDY OWENS: It's really Medicaid. And when you look at it, it's really looking at saying, what did we see in terms of, the reduction in self-pay compared to the increase in Medicaid, in terms of volumes and mix? And really sort of applying that kind of rate differential, okay, is basically what that is.

GARY TAYLOR: So basically, it's a pick up in that Medicaid revenue versus self-pay, where I guess the presumption that all of the self-pay movement is attributable to expansion I guess is the --?

RANDY OWENS: Well, again, kind of from a math -- we literally just took -- obviously, we know what we get on the self-pay. Obviously, looking at that reduction in that self-pay, and we know what we get, obviously, on the Medicaid side. So it really is, again, sort of comparing those two, and that rate differential.

GARY TAYLOR: For the full 200 basis point decline in self-pay, you measured that?

RANDY OWENS: Yes, yes.

GARY TAYLOR: Okay. And then you commented, when you looked at just EmCare and the revenue per visit, and you commented on a few things, UHS JV, the Medicare census at Evolution. The first time you went through it, I thought you mentioned change in anesthesia. And I thought you said MSA contract, and I was thinking MSO contract. But -- ?

RANDY OWENS: Well, I guess, you can use interchange -- if you recall, we had for a period of time a contract with a Pinnacle anesthesia on the MSO side, that we'd purchased a number of years ago. The group was bought by a third-party, and so there was a restructuring of that agreement still in place over the initial term with some restructuring of that. And this year, they're just in this period of lower sort of revenue base on that. So that's really what I'm referencing there.

GARY TAYLOR: Okay. So it's kind of a mix thing?

RANDY OWENS: Yes.

GARY TAYLOR: And then --

RANDY OWENS: There's no volume on that, and so it all -- it just goes straight to rate.

GARY TAYLOR: Right, got it. And then, Bill, I just wanted to kind of ask you kind of theoretically, when you look at EmCare, you've been signing new contracts. You've been willing to take subsidy out. I guess, kind of the market perception is that you're willing to trade EBITDA margin percentage for gross EBITDA dollars. And obviously, the market's rewarded you for making that trade. How do you think that impacts EmCare margins longer-term? If we look over the last 10 years or so, we've seen those margins march 8%, 9%, 10%, 12%, 13 %. But over the next few years, as you continue to kind of cross-sell multiple services, is the margin really topped out? Does it come down? Is it still a gross dollar profit play versus margin play, or do you think it can be both still?

BILL SANGER: Yes, really, if you look at our margins, they've been pretty stable this point in time. Frankly, the margins that we see through our joint venture integrated model are consistent with the overall margins. What you're seeing, is a little bit of a compression from our 13% down to 12.8%. That really has to do with, we're starting up so many contracts.

And as you start-up these contracts, we're not buying the group, and so we have to re-enroll. We have to add new physicians, some physicians leave. And so, we are pretty confident that we would not see erosion. Frankly, as we stabilize these relationships, I expect EmCare's margins over time to continue to increase and get back in that 13% range.

GARY TAYLOR: Okay. And then, finally, is there any rough guess on what the sort of non same-store contracts comprise in terms of -- or how much they are weighing on the consolidated margin?

RANDY OWENS: Well, they all have -- I don't have -- off the top of my head anything in total, in terms of if you look at that. I know your question, in terms of new contracts, what the blended margin is on sort of the new contracts. I'll tell you, and just as a reference point, it's not unusual for us to see, so for example, let's say a mature contract margin is more in that sort of mid teens range, to where you may start in a low single-digit, depending on the hospital and how many physicians you have to recruit. But with buyouts and everything, you could have that go from a low to mid single-digit. And could take 6 to 12 months to get to that mature margin again, depending on the dynamics of that contract.

And so, that's what we try to highlight here was that. And while we had an increase in that, it's really just a function of, we added so many new contracts. And so, we tried to think about it and frame it up as saying, when you look at that investment, it's about a half turn, if you think of it in a multiple perspective. So obviously, we're very willing and comfortable doing that. We think that's a pretty cheap investment to get new contracts.

GARY TAYLOR: Okay. Thank you.

RANDY OWENS: Thanks.

OPERATOR: Josh Raskin, Barclays.

JOSH RASKIN, ANALYST, BARCLAYS CAPITAL: Hello, thanks. I was wondering if I could just start, do you have -- I know they will be in the 10-Q -- but it is always helpful, the volume, the payer mix for the volumes?

RANDY OWENS: Yes, Josh. I don't have it in front of me, in terms -- you mean in terms of all the different payer classes, you mean, in terms of the volumes?

JOSH RASKIN: Yes, the Medicaid, and the self-pay --

RANDY OWENS: I don't have it -- in general, what I would tell you is that, really both AMR and EmCare, if you look at especially the Medicaid expansion states, most of that change, the lowering of self-pay, really went straight to Medicaid/Medicaid HMO. There was some minor changes in, for example, Medicare, nothing material. There's some slight increases on the commercial, again, nothing really significant. So, I don't think you will see a lot when you go through there. It is more averages moving, at this point, into sort of Medicaid or Medicaid HMO.

JOSH RASKIN: Okay. I mean, it was just stuff like the first quarter, for example, that self-pay percentage actually didn't move, just because of that mechanic of the numbers. So just felt we could -- maybe I will follow-up off-line and wait for the Q. And then second question, just Medicaid pending, can you remind me

what your procedures are around, how you are classifying, individuals that show up with no insurance, because Medicaid is pending. Did you learn anything from the first quarter, i.e. were you being more conservative or more aggressive? Have you figured out sort of where that equilibrium is?

RANDY OWENS: Well, I don't know that I would say there is any sort of big lessons learned. I think we've talked about, when we see a patient if they don't have Medicaid, let's say at this point, we reflect them initially as uninsured. Okay? And then obviously, once we know that whether we help qualify them or the hospital does or whatever, and that they are qualified for Medicaid, or if it was an exchange or something different, then we would obviously change that financial class once we bill the different payer, albeit Medicaid or whatever.

So, that process I don't think is that different, where in some cases it can happen fairly quickly. But sometimes it may, it can take, I don't know, a 30 days or whatever. I don't think there is a big change in that process. And but it is common to have what we call transfers, if you will, from a payer mix standpoint as you go through. We did see more transfers in the first half of this year. I don't know there is a big difference between Q1 and Q2, just especially on the Medicaid side, just because that -- I think it was -- maybe there was a little more confusion, and people applying or getting applied to Medicaid than probably what we'd seen in the past.

JOSH RASKIN: Right. That's what I was asking. So when you say, that is more transfers in payers mix around Medicaid, that means that as you looked back at the first quarter, it turns out individuals you had previously classified as uninsured were now Medicaid, or was it the other way around?

RANDY OWENS: Well, no Medicaid, so for -- and again that always happens. So for example, if somebody came in today, and did not have a Medicaid card, or was not a part of that program, we would initially reflect them as uninsured. And then, obviously, if we were to qualify them or then bill Medicaid, whether it's a week later or a month later, then obviously, that would then change to a Medicaid, and you would reflect it, at that point in time. That has always been the case, but I would say there has been more volume, just because of the change in reform in that.

JOSH RASKIN: Right. Got you. Okay. And just one last question on Phoenix acquisition. I know it was only, I think, a couple weeks in the second quarter. But do you have an estimate as to the EBITDA contribution in the second half, or should we think of the margins as something lower than EmCare overall, or just maybe any parameters for that?

RANDY OWENS: Well, I guess, we haven't, Josh, I guess, we haven't put out specific numbers on that. I would say that we expect -- I think that margin today would be a little lower than the EmCare blended margin. From our standpoint, part of that thought process in the acquisition was the real opportunity around additional services and selling of the revenue. And there was also some cost synergies, and that's going to take a little while. And that's why we commented that, that really next year, not only do you have the full-year benefit, but I think in this next six months you'll be able to work through some of those cost synergies, as well as try to enhance some of the revenue opportunities.

JOSH RASKIN: Okay. So if I threw in \$5 million in the second half, I would be in the ballpark, is that fair?

RANDY OWENS: That is probably rational.

JOSH RASKIN: Okay. Thanks.

OPERATOR: Whit Mayo, Robert Baird

MATTHEW GILMORE, ANALYST, ROBERT W. BAIRD & CO.: Hey, thanks. This is actually Matthew Gilmore in for Whit today. Just a few quick ones. First as a follow-up to Ryan's question from earlier, as you think about the Medicaid expansion beyond this year, I know you mentioned Florida. There are a couple other states that are also kind on the bubble like Pennsylvania, Indiana, and Virginia. So can you sort of help size up what the exposure is to those states in particular?

BILL SANGER: Well, we have a fair amount of business in Indiana, as well as Pennsylvania. I cannot tell you exactly what percentage of our business is in there, but I would say that between those two states alone, we probably have 60 contracts. And like I said earlier, there are several Republican states that are really giving serious thought to it. I think Indiana is probably ahead of the curve, and many states are really looking at that Indiana program that is being put forth by the Governor, and should probably serve as a model for any Republican state expansion.

MATTHEW GILMORE: Okay. Thanks. And then on, just sort of curious what your view is of the freestanding ED industry? I know that subsector has kind of gotten a lot of attention recently. But just curious, how you see this, is it a growth opportunity in terms of ER staffing or a potential competition? And any kind of general thoughts would be helpful. Thanks.

BILL SANGER: Sure. I think if you look at freestanding EDs, so I have a personal viewpoint on that, and I'll share that with you. There is about, right now, about 400 to 500 freestanding EDs, about 20% of those, frankly, are in Houston, and about 25% of those are in the state of Texas. Our biggest challenge with freestanding EDs is really competition for board certified physicians. We really haven't seen a drop in volume.

As you well know, the freestanding EDs do not see a lot of patients. And a lot of those are patients that generally, would go to an urgent care center, because the general population is very confused as to what is the difference between the freestanding ED in a strip mall, and an urgent care center in a strip mall. And they use them interchangeably.

So I do think we will see further expansion. I do believe that the majority of expansion we see in the future will be affiliated with hospitals. If you follow the industry, you know there's a fair amount of legislative action at the state level afoot, to try to ensure that these freestanding EDs have the scope and scale of services that their EDs provide at the hospital setting. So I do think that you will see more in the future. But at this point in time, we don't see them as a major threat to ED volume.

MATTHEW GILMORE: Okay, great. Thank you very much.

OPERATOR: Thank you. At this time, I have no further questions.

CRAIG WILSON: Okay. Thank you, everyone, for your support of the Company and interest. Good night.

OPERATOR: Thank you. That does conclude the call for today. You may disconnect your phone lines at this time.

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