

Tenet's Q1 2006 Earnings Call Prepared Remarks

May 9, 2006

Trevor Fetter, President & Chief Executive Officer

Thank you, operator, and good morning everyone.

I trust that you've had an opportunity to review the press release we issued this morning with our first quarter results. I'll start by giving you an overview of the quarter, and then our Chief Operating Officer, Reynold Jennings, will provide some commentary on volumes.

I hope that you've seen our press release regarding the action yesterday evening by the Inspector General of HHS to exclude our hospital in San Diego from federal health programs. The IG made that announcement after we had prepared our remarks for this morning, but Peter Urbanowicz, our General Counsel, and I will be prepared to answer your questions about that matter during our Q&A.

The predominant themes in the quarter continued to be weak volumes, strong pricing and good cost control.

Three years ago, we had isolated but severe problems in pricing and clinical quality, and we had widespread problems in cost control, litigation, investigations, governance, labor relations and relations with uninsured patients. Since that time, we've either resolved, or are far along in resolving, each one of those issues.

But as we've been fixing the original problems, we've confronted two new challenges affecting the entire industry: bad debts and weak volumes. Today, bad debts appear to be stabilizing, while weak volumes remain our number one concern.

As we worked to resolve the problems that we faced three years ago, we built a solid foundation for the future. We are fighting the volume challenge with the same energy and creativity that we brought to the problems we faced at the end of 2002, and our success in these areas demonstrates that when our team sets out to fix something, we fix it. I am confident that we will do the same with volumes.

Let me turn to the results for the quarter.

We generated net income from continuing operations of \$15 million, or 3 cents per share, and EBITDA of \$216 million for the quarter, for a margin of 8.9 percent.

We use two different metrics to describe results in our earnings release: continuing operations and same-hospital. Both measures are important, but I'm going to refer primarily to same-

hospital numbers in my comments, as I believe those are the greatest interest to you. Same-hospital numbers are continuing operations excluding the six hospitals impacted by Hurricane Katrina. Operations in the Gulf Coast region are still sufficiently impaired that to include them in the discussion distorts the performance of our core business.

On a same-hospital basis, our EBITDA margin was 9.5 percent, a 50 basis point increase from last year's first quarter.

We identified five distinct items in our press release that had a net favorable contribution of \$1 million. We broke these out so that you could decide which of these items should be included in your individual assessments of our current earnings. These items include litigation and investigation costs, impairment and restructuring charges, costs related to Katrina, our unusual tax position and favorable adjustments from prior year cost report settlements.

As we have discussed in previous quarters, we also had a reversal of some temporary spikes in bad debt expense from the last half of '05, which we estimate added about \$5 million, or 1 cent per share, to earnings this quarter. I'll take you through the details on bad debt trends in just a few minutes.

As you know, the first quarter is typically our strongest of the year. The 3 cents we earned from continuing operations is above the consensus estimates for the quarter, but at this point, we are not going to refine or confirm the outlook for 2006 that we issued in March. Our practice has been to issue an outlook only once a year, and after only one quarter it would be premature to refine or confirm it.

Drilling down into the specifics of the quarter, let's start with volumes. The decline in volumes drives the outcome of virtually every other performance metric, and starting with volumes is the only way to place the quarter's results in context.

Same-hospital admissions declined by 3.3 percent relative to last year's first quarter. Nearly a third of the decline results from the deliberate elimination of service lines or operating entities. The more serious impact on earnings came from the 5.3 percent decline in same-hospital commercial managed care volumes.

Our acuity rose by one and a quarter percent from last year's first quarter, and by more than a half a percent from Q405. This was driven by increases in acuity in several of our service lines. In cardiology, we had volume losses in the less intense procedures. Cardiology volume was down 5 percent, but case mix was flat. In orthopedic and spine surgery, volumes were up by nearly 3 percent and case mix was up 2 percent. In pulmonary medicine, volume was down by 6 percent, but case mix was up by 6 percent. And in general surgery, volume was down by 4 percent and case mix was up 2 percent. These were the drivers of the increase in acuity for the quarter.

Let's turn to pricing, where we achieved very strong results for the third consecutive quarter. We recorded a 7.7 percent increase in same-hospital, Compact-adjusted net inpatient revenue per admission. On the outpatient side, the comparable metric increased by 11.9 percent. While the

increase in acuity helped slightly, these aggregate increases are especially impressive as they helped offset the adverse shift in our payor mix away from commercial managed care patients and toward managed Medicare and Medicaid.

The real strength becomes visible when we narrow our focus to just the commercial managed care piece of our business. For commercial managed care, net inpatient revenue per admission increased by 11.8 percent on a same-hospital basis. Our managed care team has done an excellent job of fixing our pricing problems and putting our hospitals on solid ground in pricing and contract terms. The missing piece is volume, and that's why Tenet's profit growth is critically dependent on volume growth. When we rebuild commercial managed care volumes, these impressive pricing gains will be reflected on the bottom line.

If we had generated the same commercial managed care volumes in the first quarter of 2006 as in the first quarter of 2005, we would have retained additional revenues of about \$50 million with 50 to 60 percent of that adding to EBITDA for the quarter. We estimate that retaining the managed care volume we lost over the past year would have added 110 to 125 basis points to our EBITDA margin.

Despite the recent declining volumes in commercial managed care, our aggregate portfolio yield on our inpatient business increased by 6.1 percent compared to the first quarter of 2005. You will recall that in our fourth quarter, we reported a year-over-year increase of 9.7 percent for our aggregate portfolio yield; so on a sequential basis, our improvement moderated a bit. We expect the moderation to continue as we reach the anniversary of some of these strong quarters.

These pricing increases offset the volume declines to create 3.1 percent growth in revenues on a same-hospital, Compact-adjusted basis.

We also continued to do a great job on cost control. Same-hospital controllable costs per adjusted patient day actually declined by 2.8 percent from Q405 to Q106.

On a year-over-year basis, our controllable operating expense per adjusted patient day rose by 5.2 percent. Not surprisingly, the line item with the greatest increase was supply expense, which increased 6.2 percent.

Despite a comparatively more severe decline in volumes, our growth rate in unit controllable costs of 5.2 percent is below our peers and further demonstrates the favorable impact of our discipline in cost control, which is now hard-wired throughout the company. Given what we've accomplished in pricing and costs, we've set the stage for strong growth in income when we generate growth in volumes.

Let's move on to bad debt.

On a same-hospital, Compact-adjusted basis, our bad debt ratio was 12.9 percent for the quarter, an increase of 110 basis points from a year ago, but a decline of 140 basis points from the 14.3 percent that we reported last quarter.

You will recall that in the past two quarters we isolated the impact of some systems conversion issues, which caused a temporary increase in bad debt expense. We told you that as we collected these delayed billings, we expected our bad debt ratio to show a temporary decline, reversing the earlier increase. This quarter we collected the remainder of these amounts, which reduced the first quarter's bad debt ratio by roughly 20 basis points, adding an estimated \$5 million to EBITDA.

Another trend in bad debt was that more of our uninsured patients were classified as "charity." In part, this is due to the elimination of the adult medically indigent program in Tennessee and the elimination of funding for undocumented immigrants in the California county where Doctors Medical Center of Modesto is located. The elimination or reduction of similar funds in Missouri and Georgia will continue to limit the uninsured, low income population from eligibility and further increase our charity care.

I am highlighting this growth in charity partly because I don't want anyone to conclude that we are making more progress on reducing bad debt than is actually the case. The other reason to highlight this change is to follow up on my comments last quarter about cost-shifting. Last quarter, I talked about cost-shifting from employer to employee. Well, here's another stark example of cost shifting: state and county governments simply deciding not to compensate hospitals for the care that we are providing to their residents, whom we have a federal mandate to care for. I think it's outrageous, and you've got to wonder when this situation is going to reach a breaking point.

The number of charity inpatients increased by 30 percent from last year's first quarter, on a same-hospital basis to over 2,800 patients. Total uncompensated inpatient care volume, defined as uninsured self pay and charity, rose 8 percent on a same-hospital basis since the first quarter of last year. It's a rough estimate, but we think that the total uncompensated care that we provide these people is costing us about a quarter billion dollars per year. That's cost, not charges or foregone revenues, which of course, would be considerably higher.

Since hospitals are the primary sector of the health care economy that is bearing the responsibility for these costs, again I've got to ask the question of when this situation reaches a breaking point and gains sufficient attention in federal, state and local governments.

We also had a very active quarter on the quality front. The major national managed care companies recognized Tenet's advances in quality by continuing to award our hospitals' Centers of Excellence designations for an ever-growing number of service lines.

Last quarter, we spoke in great detail about the UnitedHealth Care designations. This quarter, I'd like to spend some time telling you about our Cigna designations.

Cigna's policy is to re-evaluate all service line designations on an annual basis. This year, they expanded the number of service lines to 29 from 19, while simultaneously raising the volumes required to be eligible.

In 2005, 41 Tenet hospitals earned 95 service line designations as Centers of Excellence from Cigna. As of today, Tenet hospitals had achieved a 56 percent increase in Centers of Excellence designations, bringing our total Cigna designations to 149. To receive these designations requires the hospitals to receive 3 stars from Cigna on both patient outcomes and cost efficiency, offering significant advantages to both the patient and the payor.

In addition to these designations, 11 of our hospitals were named Cigna Certified Hospitals for Bariatric Surgery. Because Cigna awarded only 88 of these certifications across the country, Tenet's hospitals represent one-eighth of the national total. We hope that these certifications, along with the government's recent decision to cover some bariatric procedures, will influence other payors to cover these surgeries going forward.

We've got a number of initiatives to improve quality and grow volume. Our efforts to gain these Centers of Excellence designations are at the heart of these strategies.

To benefit from the cost efficiencies associated with these designations, some of the managed care payors are offering to reduce deductibles or eliminate co-pays. When you factor these incentives into the equation, the ability to link quality and efficiency to higher patient volumes becomes very real and very exciting.

Two and a half years ago, I declared that quality would be our strategy because it was the right thing to do. Period. But as these quality designations and plan designs intersect with consumerism, Tenet's investments in quality should show greater economic returns as well.

Let's now turn to cash flow.

Cash flow used by operating activities was negative \$321 million in the quarter. Including capital expenditures of \$117 million, free cash flow was negative \$438 million.

While our cash consumption was large, it's important to note that there were several unusual items adversely impacting cash this quarter:

First, payments toward restructuring, litigation costs and settlements, and discontinued operations totaled \$183 million. This includes a \$145 million payment to settle a securities class action lawsuit and a \$7 million payment to settle with Florida's attorney general.

Second, we paid \$97 million in the quarter to fund the entire 2005 401(k) matching contributions. This is substantially more than we paid a year ago because the Q105 funding represented only half the total 2004 contribution. We decided to change the timing of our funding in May 2004 for contributions for the period beginning July 1, 2004, which were then funded in the first quarter of 2005. We made this change to reduce costs and we estimate this change will save us nearly \$15-20 million annually, due to employee turnover and eligibility.

Third, our interest payments on long-term debt were \$123 million. There were additional payments of \$29 million this quarter compared to the prior year due to the additional debt that we issued in January 2005 and the timing of our interest payments.

The first quarter typically has a high cash burn, given the timing of our expenditures. If you look at 2005, for example, you'll see that cash flow improved in subsequent quarters during the year.

Unrestricted net cash at the end of March was \$975 million. In addition, we had another \$263 million in cash that's restricted as collateral for standby letters of credit.

Now, before I turn the floor over to Reynold, I'd like to call your attention to a series of organizational changes that we've made over the past few weeks. We appointed one of our senior operations executives to lead a group to execute our outpatient growth strategy. We also restructured our regional operations in Florida and the Southern States to better enable our regional leaders to focus on local market business development. I'm proud that we have been able to retain and recognize talented people from within the organization, and we've been able to recruit fresh talent from other fine companies.

With that as an overview, let me turn things over to Reynold for a deeper look at some of the volume building efforts underway in our hospitals.

Reynold Jennings, Chief Operating Officer

Thanks Trevor, and good morning.

I'd like to begin by commenting on Tenet's inpatient volumes in the first quarter. As Trevor mentioned, we saw a continuation of the aggregate volume decline we've experienced in recent quarters. Embedded in these numbers, however, is a more complex and positive story.

Fifteen of our hospitals actually had strong year-over-year growth in patient volumes. And 11 more had volumes about even with their first-quarter results last year. In other words, 26 hospitals – or about 40 percent of our portfolio – delivered reasonably good results in the quarter. The hospitals with the strongest growth were in Birmingham, Atlanta, Omaha, St. Louis, Memphis, the Carolinas and parts of Florida. Since many of these are historically among our strongest margin hospitals, we see this as good news.

On the other side of the coin, 14 of our hospitals – or about 20 percent of the portfolio – accounted for about 90 percent of our aggregate, year-over-year decline in volumes. This group included hospitals in Florida, California and Texas. Let me give you some detail about what affected these hospitals in the quarter:

- A. In Florida, the combination of a warm winter in the Northeast, and extensive damage from Hurricane Wilma seriously reduced tourism in the state, as well as the number of snowbirds who usually spend the winter there. These factors, along with a weaker than normal flu season, resulted in fewer admissions at five of our Florida hospitals. Also, hurricane damage to condo projects forced some, mostly elderly residents who live in the communities served by two of our hospitals, to find temporary housing outside the area. However, we believe that situation will reverse itself shortly.

- B. In California, our targeted growth initiative's planned de-emphasis of certain service lines accounted for about half of the volume decline there. We attribute the other half to our decision at two California hospitals to reject the unacceptably low capitation rates in a new contract offered by two large medical groups.
- C. In Texas, two hospitals we lease in Dallas accounted for 24 percent of the volume decline in that state. Business at those hospitals – Trinity and RHD Memorial – has been hurt this year by the uncertainty generated after their owner, the Metrocrest Hospital Authority, sought competitive bids to manage them once our lease expires in 2007. The balance of our volume decline in Texas was primarily the result of stiff competition from four new and maturing hospitals in Dallas and Houston.

So, to summarize, I'd say our volume results for the first quarter show that a significant portion of our portfolio is doing pretty well, especially in light of the general challenges faced by all hospitals these days. Our overall volume weakness is basically caused by 14 hospitals with very specific issues, and we are aggressively tackling those situations.

Let me now move to our Physician Sales and Service Program, which we launched last year. The results continue to be very encouraging. Our hospital management teams have had face-to-face meetings with about 11,000 of our 13,000 targeted doctors, and as a result, we have identified about 1,600 individual opportunities for service improvement at our hospitals.

Based on this experience, we've learned that there is nothing more positive in building and cementing relationships with our doctors than asking them to tell us about issues they have with the hospital and then taking quick action to resolve them. The physicians continue to express appreciation for the visits by our local hospital management teams and the efforts being made to respond to their needs.

On our last call, I gave you some examples of the service improvement opportunities we have identified, all of which fall into three categories: First, those that are easy to understand and resolve; second, those that can be resolved but will take some time; and thirdly, those for which we don't yet have a solution.

Thematically, these opportunities fall into seven broad categories:

1. Process improvement and throughput
2. Customer service
3. Modernization of our physical plants
4. Marketing/advertising/community outreach
5. Physician recruitment
6. Effective communication between hospital administrators and physicians, and
7. Scheduling, registration and pricing of outpatient services

Some components of our *Commitment to Quality* initiative are already implementing significant improvements in critical service areas such as the emergency department and surgery. With the

additional information we now have as a result our physician visits, we are focused on improving others areas within the hospital and also boosting the spirit of collaboration with our physicians. With regard to boosting that spirit of collaboration, let me give you three rather simple examples:

- First, physicians in one of our Houston hospitals told us that our outpatient order forms were difficult to use. We immediately worked with the physicians to redesign the forms and added carbonless copies to save both time and cost.
- Second, physicians in East Texas told us that a specialty group at a competing hospital was breaking up, and that gave our hospital leaders the opportunity to recruit two of those physicians to our hospital.
- And third, we found that the primary care physicians and endocrinologists in our El Paso hospitals were looking for educational opportunities in bariatric surgery. They were delighted when we quickly gave them copies of our new clinical service manual focused specifically on bariatric procedures.

These examples should make it clear that not all physician-friendly improvements need to be expensive. And, as an indication of how well our hospital managers are embracing the value of the physician visitation program, I can tell you that our data clearly shows the hospitals with the greatest volume challenges also happen to be the ones most actively using the program software tracking tool that we've implemented. I'm optimistic that we have much more value to harvest from this program.

Now let me talk about the operational effect of local hospital management stability. Of the 14 hospitals I spoke of that drove the lion's share of our aggregate volume decline in the first quarter, three were being managed by an interim chief executive officer and three others were being managed by newly hired permanent CEOs.

We lost six experienced hospital CEOs in December 2005, all of whom left because they had been recruited by larger, well-known hospital systems. I see that loss as a bittersweet consequence of our accomplishments in public quality scores, cost control and data-enriched decision making. Tenet's progress in these and other operational enhancement initiatives have made many of our hospital executives the target of executive search firms.

We are redoubling our efforts to retain our top talent, and one way we're doing that is by making sure our experienced hospital CEOs have a career ladder with us. Fortunately, we have been able to replace our hospital departing hospital executives with well-qualified internal candidates in almost half the cases. In addition, our external recruiting efforts have brought us some very good managers from other companies and hospital systems. I am excited about both the internal and external candidates' enthusiasm for being a part of our future.

Before I turn it back over to Trevor, let me mention that at the end of the first quarter we had virtually completed the latest wave of our targeted growth initiative. This involved eleven hospitals, including the remaining two in California, five in Florida, two in the Central Northeast, and two in Texas.

With that, I'll hand it back over to Trevor.

Trevor Fetter, President & Chief Executive Officer

Thank you Reynold, operator, we are ready now to begin the Q&A.

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