Mike Culotta  
LifePoint Hospital, Inc. - CFO

John Ransom  
Raymond James

PRESENTATION

John Ransom - Raymond James

The final session of the 2006 Raymond James Investor Conference. I'm happy to have Mike Culotta, CFO of LifePoint, rural hospital company has undergone, as you know, a big merger with crosstown competitor and peer, Province Healthcare. The company has struggled the last half of 2005, and we think that the 2006 estimates, which were well below the street—some of my peers are even worried about that, so.

The two things I would say, this company has a long-term track record particularly with the original spin-out of HCA, taking those single digit margins to 25%. And we do think time is the friend of the company, although I think the near-term headwinds in the industry have been stronger than most investor's would have thought. So, we believe this is a 2007 story, and hopefully, we'll see some evidence of progress by the back half of '06. And what's not helping us this quarter is just a so-so flu season. So, with that, I'll turn it over to Mike, and we look forward to his presentation. Thanks.

Mike Culotta - LifePoint Hospital, Inc. - CFO

John, thank you very much and -- it's working right? Okay, thank you. We'd like to thank everybody at Raymond James. Thank you all for being here. Again, John, thank you for having us here today. This has been a very busy week. We are at three conferences this week. What I want to do is not really go through the investor slide show. What I usually try to do is talk a little bit about what is going on currently. And I totally agree with John, we are a long-term play. There are some headwinds going on. But what I want to do is talk a little bit about a lot of the questions that you all are making.

First, I want to talk about the spin-outs. And I want you to think through from an analogy standpoint which is we were put together as the America's Group, which was a division of HCA. At that point in time, the hospitals had between about 9% and 11% margin. We have taken those hospitals to a 25% margin.

And again, what was happening there, if you recall, that was the old Columbia HCA. And it was the hub and spoke approach, they were not putting a lot of money into the hospitals. And I'm going to come back to that statement in a short period of time. But what we did is we spun-out with 23, we sold 5, we got down to 18. And then from there, we bought approximately 14 hospitals. So, I want to talk a little bit about that.

We also had physician issues. Prior to spin-out and after spin-out, because Columbia was not recruiting into the communities. Columbia was not putting Cap Ex into those communities. Columbia had been making promises that they didn't live up to. So we had a similar issue. We were seeing physician retention. We were seeing physician recruiting issues and retention, recruiting and relationships. And it took us a little bit of time to work through those.

But, what I want to do is go through-and, unfortunately, I don't have this on the website— but this is a slide show presentation that was presented to our board of directors, because our board of directors said, "hey, let's go back and take a look and talk about what happened with some of our acquisitions, and not so much from you alls standpoint but from their standpoint." They wanted to take a look at it.
Our first acquisition was a company, a little hospital called Putnam Community Hospital, located in Palatka, Florida. And at that time, we paid $43.5 million for it. Their revenues were about $52 million, $53 million. The projected to-date EBITDA since that time that we had in the model that was in our forecast, everything, was $43.3 million; of which we have now hit 107.4% of our projections. So, again, something that worked out there. And as you can see, you can see the graph’s actual— a little hard to read that from way out there.

I’ll come back to that one, but I want to jump to another one that we acquired from HCA, and this was something going through the spin; it was Athens Regional Medical Center, purchase price of $17 million, projected to-date EBITDA was $39.5 million. Our actual, as a percent of that forecast today, is 291.7%. HCA sold this hospital to us because a surgery center had just opened up.

So, again, looking back at some of the acquisitions we made. Lander Valley Medical Center, the reason we acquired that one, it was in the same county as Riverton, although it looked like we’ve only done about 76.8%, the two are working together. So, you’ve got to look at the two hospitals together in terms of what’s taking place there. Bluegrass was a small hospital, it’s like 5 million net patient revenue, about 80% of that number. But the other one I wanted to jump to was Logan Regional Medical Center, which we took a lot of abuse for when we acquired it. It was running net patient revenues of about $75 million, it was in bankruptcy, we paid $87.5 million for it. Our projected to-date EBITDA was about $46.1 million, but yet we’ve exceeded that; we’ve been at 159.2% of it.

So, I just want to talk a little bit about, historically, what has taken place there. And also when you look at the Province acquisition in terms of some of those hospitals, the majority of those hospitals came from a not-for-profit environment. So, there still continues to be opportunities with those hospitals for us to improve those hospitals. So, again, I just wanted to spend a little bit of time on that one.

I wanted to talk about the HCA acquisitions and where we are. We still have not received CON clearance, ok. It’s with the West Virginia authorities. They have not cleared the CON yet, which means you can’t buy the hospitals if you don’t have CON clearance. If we don’t receive clearance by March 17th, which is basically, I guess, next Friday, we can not close by the end of March 31st. We’ve gone to the credit agencies, preliminarily with them. We’ve also met with our banks, et cetera, but it’s going to take us about 2 weeks to market to get the funds, et cetera. So, if we don’t close-- if we don’t hear by March 17th from the CON, that’s our drop-dead date for us to be able to close by the end of the quarter. So, I just wanted to give you a quick update on that.

Physician recruiting and retention, that seems to be one of the things we’ve talked a little bit about; just to let you know, we’ve gone back, we’ve don’t studies. We’ve got all sorts of work done in terms of total physicians, by physician; by discharge; by gross revenue. Right now, we have approximately 1,862 admitting physicians— that is as of 1/1/06. Our goal is to recruit 182. So you see we are recruiting about 10% of those amounts; and they are broken down 31 this first quarter, 19 the second quarter, 100 the third quarter and 32 the fourth quarter.

Third quarter, as John can describe to you, is historically when either people are coming out of residence or people with children, physician’s with children, anybody with children would rather move during the summer time than they would at any other time to uproot the family. So, that’s another thing that is going on.

We are really keying in very hard on physician retention and physician relationships this year. Those are some of the things that occur in a handful of markets that we saw. And the key to it is there are several things that are going to take place. Next week, our CEOs are going to be going to training along with the COOs where there are COOs of hospitals. One with the division people, and they are going to go to Merritt Hawkins which is a very large company that does professional recruiting, they put out this nice little book, "Would the Last Physicians In America Please Turn Off the Lights."

And so it will be very interesting-- I want to read you a couple of things from the research they have done from this standpoint. It says, each— the first one here, sorry— "In the last 20 years, the number of U.S. medical schools have remained static. The number of medical students graduating each year and the number of residents coming out of U.S. training programs also has remained static at about 16,000 per year. No one saw a need to increase this number, just the opposite."
So, again, what you’re seeing is it becomes harder and harder every year to recruit physicians, and you are also seeing physicians leaving the practice. “Today, close to 25% of all physicians involved in active patient care in the U.S. are international medical graduate.” Again, to meet the needs there.

“Over 20% of the population is classified as rural by the U.S. Census Bureau, but less than 11% of practicing physicians are located in rural areas. The rural population is aging more rapidly than the general population and it’s specialists who provide the treatments and procedures that many older people need.” So, we know that, we are aware of it. We're spending the time. All of our CEO's, again, COO's will be going to this training. Their bonuses will be based on retention, recruiting, relationships and satisfaction scores from their physicians, patients, communities and employees; and we're going to be keying on that pretty hard.

Is this going to take a little bit of time? Sure. It’s going to take this year, probably a little bit into the first part of next year’s cycle. But again, it is something that is curable, that we strongly believe, it's curable, and we are taking great in-roads into it. We've already signed about 40 physicians this year to-date. They've not all started yet in the first quarter. We've had six start in January. I don't know how many have started in February at this point in time, but giving you a little bit of update on where we are with that.

Medicaid DSH, that seems to be a big question being asked. We have not received any letters of inquiry. If you go to our 10K, we give you very detailed information relating to DSH, by state, it’s $15.4 million. Alabama is about $3.7 million, Kansas $900,000, Kentucky $4.9 million, Louisiana $400,000, Mississippi $1.3 million, New Mexico $200,000, Tennessee $1.3 million, Texas $1.9 million, West Virginia $800,000. The Alabama on a full-run basis was 6.4. If you remember, that was something we said in the call at the beginning of the year, if you take a look at the $3.7 we lost $1.6 in the fourth quarter of '05. That takes you to 5.3, We didn’t have Selma as an Alabama hospital in the first quarter a year ago. You add another 1.2 to that and that gets to you the 6.4, 6.5 run-rate.

Discontinued Ops, Smith County, Ashland, Southern Indiana, should close on April the 1st. The cash proceeds will, obviously, be used to pay for any of the HCA hospitals and/or debt pay down. Palo Verde was transferred back to the county on January 1st. Bad debt from the standpoint-- just giving you a macro overview, we continue to see in some states denials. We continue to see in some states issues related to not putting as many people on the rolls, limiting the amount of rolls. Predominantly, where you see it in Texas, predominately where you see it, is obviously in Tennessee with the TennCare program. Those are two of the larger markets.

Answering that question, because we get a lot of these questions relating to why this Province and Life Point have differences in terms of the bad debt. You are going to see Life Point going up because of TennCare; we talked about that before in the call. The two items there is about in four markets. So, if you take a look at Las Cruces and where it’s located, Las Cruces has runs about 15% to 18% bad debt charity care, very close to the boarder. And in addition, the three Texas facilities are very close, are in an agricultural area. They did get a lot of agricultural type workers. They average around 22% bad debt. Those four hospitals represent about 31% of the pie of Province, the former Province facilities.

So, you can see when you weight that, you have a little bit higher bad debt area. So we do receive indigent funds from the state, from the counties and the cities in New Mexico; Texas we don't. Again, we're looking at continuation of what we talked about, the U.S. bank program we use in terms of rolling out the credit card. That worked very well in six of our hospitals that we rolled it out to. We are going to rollout another 24 the first quarter, and then we’re looking at what do we do with the other 22 or so throughout the end of the year. So, again, doing as much as we can from the standpoint of upfront cash collections.

One other state we are still seeing it is in Louisiana. We are still seeing displaced individuals that are in some of the cities where we have hospitals and, again, we still see some self pay. Good news on Louisiana, they did receive information from the federal government that the federal government is going to step in. If you remember, we talked about they were reducing those bills 12% to 17%, but we should see those funds coming in sometime either late first quarter or the beginning of second quarter. Our intent would not to be to book anything until such time as we see the cash coming in.
Medicare/Medicaid, I want to talk a little bit about Medicare/Medicaid. We talked about our rate this year was going to be about 2.6% to 2.8% growth. We've been coming off of two years of about 5.5% growth in revenues relating to Medicare. And we need to step back and talk about that real quick. The reason for that was the Medicare Drug Bill. If you remember, we received DSH payment, we were increased DSH to about 12.5%, if I remember the percentage. And in addition, the wage index, because we are below 1.0. The DSH occurred, if I remember, the date was on April 1, 2004. The wage index was October 1, 2004, so the impact of that positively impacted '04, it impacted '05. Its now grandfathered. We still get the funds, but you can see you don’t have that big increase swing.

So it’s basically just the market basket, plus or minus whatever the government comes to relating to that. The Medicaid, we've already discussed prior. Nothing that we've seen, nothing unusual since we've discussed in anything earlier, relating to any of the Medicaid programs that we've seen.

The other items, Valley View, we’re still working on that for Medicare certification. We’re hoping to get that sometime in the first quarter. The good news about Valley View is we are seeing the volumes higher than we had ever anticipated. But we still don’t have Medicare certification; you need that to be able to bill non-emergency Medicare/Medicaid, and there is several insurance providers. But the good news is it’s not a Coastal Carolina issue, where you're not seeing the volume, et cetera. We are getting some very good patients in there. We are getting some very good volumes in there. So, we believe that is going to do very, very well.

I think I have reached about most of the information I wanted to go over, and I’m trying to figure out how much time we have. I have no clue. I'm the last one of the day, between you and I don't know what. So, I'm probably going to open this up, if that's okay, and we’ll just open it for Q-and-A at this point. [Question and Answer Session not broadcast]