Adam Todd Feinstein, Analyst, Barclays Capital, Inc.

It's a great pleasure to have HealthSouth here today. As everyone knows, HealthSouth is the leading rehab hospital operator, and has been a real focusing for us for several years. And just have been very impressed watching the company's growth in recent years. And really I've said this before, I think HealthSouth is the best turnaround I've seen in the healthcare services space as the company really refocused and was able to reduce its debt and, at the same time, is showing some of the strongest volume growth within the entire healthcare space, so great pleasure to have them here today.

The company's CFO, Doug Coltharp is joining us here. I also want to point over to Ed Fay, the company's Treasurer and Mary Ann Arico, pardon me the company's Head of IR. And so, I guess, we got a few slides we're going to go through, and then we have our new fireside chat format. And I guess, something also came to my attention, I understand you're a Lehigh grad and so, is Lehigh really playing Duke in NCAA tournament, is that just a rumor?

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer

Friday, so make sure that you choose your brackets wisely. You don't want to go up against those patriot conference champs.

Adam Todd Feinstein, Analyst, Barclays Capital, Inc.

Yes, I've heard that from a few colleagues who are also a part of the Lehigh group. So, well, good. So, well, great, if you want to touch on the slides, and I'll turn over to you.

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer

Yeah, I'm just going to hit a couple of slides to provide an overview of the company and set the stage for our discussion very quickly. And as I do that, I want to just quickly bring your attention to our standard FD disclosure on forward-looking statements.

So this is a slide that I think really summarizes some of the things that Adam mentioned in his introduction. We are the largest owner and operator of inpatient rehabilitation services in the country by a very wide margin, and you see some of our market share statistics depicted in the center of this page: 23% of all patients on a national basis, and roughly 18% of licensed beds.

Our network of inpatient rehab facilities include 99 freestanding hospitals, 29 of those are operated in joint ventures with acute care providers. Each one of our hospitals provides outpatient services as well. And supplementing that, we have 26 outpatient satellite clinics and also 25 hospital-based home health agencies. Our network covers 27 states and Puerto Rico. We employ about 22,000 folks.

In terms of the types of maladies we treat, the two most common conditions are stroke and neurological disorders. Together, those two categories comprise about 35% of the patients that we serve. And approximately 95% of the patients who are admitted to one of our facilities come to us from an acute care facility.

Last week, we issued an 8-K and provided some commentary on the first quarter. We acknowledged that through January and February, our volume growth was tracking with expectations. We provided full year guidance on volume growth expectations in our Q4 2011 conference call, which was done in February and suggested that we're looking for 2.5% to 3.5% discharge volume growth for the full year.

In Q1, we reminded everyone that we're up against a pretty stiff comp from last year; last year in the first quarter, our discharge volume grew 7.8%.

And just a couple of comments on EBITDA comparables for the first quarter as well. Last year in the first quarter, we received a $1.5 million EBITDA benefit in the form of a provider tax credit, and we won't expect that to replicate this year. And then this year, we're proceeding with the roll out of a new clinical information system, which will add about $1.4 million to the expense base that wasn't present in the first quarter of last year. So as you think about your own expectation for EBITDA growth in the first quarter, just remember that there is roughly this $3 million hill to climb.

And then really just kind of wrapping it up, I want to point out some of the things that we think are key takeaways regarding HealthSouth's business model and our position in the industry. It begins with the fact that we operate in what we think is a very attractive sector of healthcare, and we say that really for two primary reasons. The first is, the demographics are very much in our favor. The average age of the patient that we treat is 72. I mentioned the types of ailments that we treat before; strokes, neurological disorders et cetera.

If you look at what's happening demographically, the underlying demographic for our patients is growing between 2% and 2.5%, and we believe that, that demographic in many of the markets in which we operate a hospital is growing even faster. The baby boom cohort is moving into that age category. They're going to continue to experience these types of maladies, so the demand characteristics appear to be very favorable for the foreseeable future.

The second is that the business is just highly fragmented beneath us. I cited some of our market share statistics previously. We do have the industry-leading position. And we are, by far, the most cost-effective provider in the business. We can point to some slides later on that show kind of the average margin for us. We're able to take that cost-effective position and actually translate that into a lower cost per Medicare discharge than our peers do.

We think that one of the other components of our overall business model that's an important advantage is the ownership position that we have in our real estate. Unlike a lot of other facility-based providers in the post acute sector, we've adopted a philosophy of owning a very substantial portion of our real estate. Out of those 99 free standing inpatient hospitals, we own the land and/or the land of the building on 64, so roughly two-thirds.

We have a very strong financial position. Focus of the company over the last several years has been on de-levering the balance sheet. We had set an objective of bringing the leverage, as measured by funded-debt to EBITDA, to below three times. We did that well ahead of schedule and actually ended fiscal year 2011 with that ratio at 2.7 times. We think that's a very appropriate place to be and that provides us with a lot of flexibility as important as the composition of our debt capital. We have a lot of flexibility in our debt arrangements and face no significant maturities prior to 2016.

We are also a very substantial generator of free cash flow. Our adjusted free cash flow for 2011 was $243 million. We benefit at least impart in our adjusted free cash flow from the fact that we have a very substantial federal NOL and, therefore, pay roughly just $7 million to $10 million in cash taxes on an annual basis.

And we believe that we are faced with numerous good growth opportunities, in terms of bed expansions at our existing facilities, de novo facilities, we're now targeting opening four to five de novos per annum and also acquisition opportunities, either of other freestanding IRFs or by consolidating units from acute care hospitals into one of our existing facilities.

So with that is an overview. Adam?

Adam Todd Feinstein, Analyst, Barclays Capital, Inc.

All right, very good. Squeezed a lot in a short period of time, good. So maybe as a the starting point, maybe just talk a little bit about what you're anticipating on the regulatory front over the next few years?

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer

We believe that we've got pretty good visibility into what the reimbursement environment is going to look like for 2012 and 2013. Obviously, the Medicare pricing for the first three quarters of this year is already baked in; that went into effect at October 1 of 2011. And that translates for us into a net increase of about 1.6%. That pricing will remain in effect until October 1 of this year. We don't know what the market basket update will be for the fourth quarter, but our current assumption is that it'll be roughly similar to what it was this year.

We don't think anything will happen during the course of this year to change that, largely owing to the fact that it's an election year, and we all see what is happening in terms of the give and take with Congress and the administration right now. Almost regardless of the outcome from the election, we believe that sequestration will be in place for 2013. And to remind you, that's a 2% impact to whatever our Medicare revenues would otherwise have been in 2013.

Now, a lot of folks have taken the assumption that you're just going to take our 2012 Medicare revenues and haircut that by 2%, but that's not the case, because we do believe that there will be a net pricing increase that will occur on October 1 of this year from Medicare and then the 2% sequestration, which starts on January 1 will be an offset to that. That's the environment that we would think we'll be in for the next two years.

Beyond that, it's really anybody's guess. We believe, as I think, probably everybody in this room that, again, regardless of the outcome of the election, there's going to be a need for very dramatic action against the budget deficit. And you can't really address the budget deficit in any meaningful way without going after Medicare.

Now, we think that there are a lot of structural changes that can and should be made to Medicare that really won't have a very significant impact on us. As an example, the much talked about increase in the eligibility age, our average patient is 72, so raising the eligibility age to 67 doesn't have much of an impact and means testing as well. It's also the case that roughly 30% of Medicare expenditures are spent in the end of life care. Those heroic gestures that are made to try to save someone, typically a very elderly patient who is entering their last days.

That's not really a sector of Medicare that impacts our facility. Because by virtue of qualifying for admission to one of our facilities from an acute care facility, the expectation is that over about a two week period that patient is going to be well enough to go home again.

Having said all of that, and I guess trying to bring it to a summation, even though there is not great visibility beyond 2013, we are bracing ourselves for further reimbursement reductions. Ultimately, we believe that will impact our peers in the industry much more than it will impact us, and we're optimistic that we'll be able to respond to that with further market share gains.

Adam Todd Feinstein, Analyst, Barclays Capital, Inc.

Great. All right. And then, I guess, we talked about this earlier in terms of, company is now a growth company, and having a very strong balance sheet gives you have lot of opportunity in terms of future growth opportunities. So maybe talk a little bit about, I guess, opening new sites relative to doing

acquisitions, and just how you're thinking about the opportunity and maybe just reiterate some of the comments you've made in the past on that.

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer

Sure. So our top priority for the development of free cash flow for the foreseeable future is to invest as much as we can in good growth opportunities in our core in-patient rehabilitation space. And it really takes three primary forms. The first, the lowest risk, highest return of capital opportunity we have is when we achieve a certain occupancy level at one of our hospitals and have the physical ability to add incremental beds.

Obviously the demand is already there. The hospitals are already established. We're leveraging a big portion of our fixed cost base, so we will take all of those opportunities that we can. They are limited predominantly by the level of occupancy on facility-by-facility basis, in certain cases by the physical configuration of the building and in about half of our states by a CON process.

Having said that, we've been successful at adding about 80 to 100 beds per year to our base; and I think that's a good assumption on a go forward basis. That would translate into a CapEx requirement of about $20 million to $25 million a year.

We also are pursuing a strategy of an accelerated de novo growth. We've had very good success with the about half a dozen de novos that we've been able to operate or open over the last several years. We're looking to ramp that up to somewhere between four and six new units a year, beginning in 2013. In most cases what we're doing there is starting with a 40 bed all-private room facility. It's important to note that it's all-private rooms, because that allows us to get to a higher level of overall occupancy before we hit capacity constraints, and the reason for that is simply because we don't encounter gender compatibility or infection control issues in an all-private room facility.

We are specifically designing those facilities, both in terms of acquiring enough land on the front end and the modular composition of the de novos, so that they can be turbo-charged with bed additions typically in 10 bed increments down the road. So what you will hopefully see out of our de novo activity is, facility gets opened, takes about six months or so to achieve its run rate of occupancy. In about three years, it's consistently above that 90% level, so it qualifies for a bed expansion; go about another two years and we add another 10 beds and the return gets turbo-charged in that manner.

And then the third component of the growth strategy is acquisition opportunities. So we benefit from this very large market share in terms of 23% of the patients and 18% of licensed beds; that's the good news. The bad news is there aren't a lot of significant acquisition opportunities in this space. Again, we have 99 freestanding hospitals. The next largest aggregation within any company is eight, and then the numbers drop off pretty rapidly thereafter. So there aren't big pools of IRFs that we can go out and combine into single transaction. It's a very, very fragmented business.

And in fact, the lion's share of the facilities that are out there, out of roughly 1,150 or so IRFs across the country, about 920 or 930 are actually units within acute care facilities. That's where the bigger acquisition opportunity lies.

Interestingly enough, historically, we would often find that those units that were housed within a not-for-profit hospital. The operators of those hospitals were sometimes reluctant to think about entering into a partnership with us or removing that capability from their acute care facility, even though that IRF within their hospital was operating at a low level of profitability and frequently ran at pretty unproductive census level, and it was part of their overall mission to be all things to all people in the communities in which they served.

The combination of a few difficult years on the endowment front, reimbursement cuts and volume decreases experienced by the acute care players and potentially augmented by the coverage mandate that

is forthcoming is causing many of those non-for-profits to think differently about the allocation of space and the administration of services within their markets.

So we've started to see a lot more inbound calls wanting to explore opportunities, where we can purchase a unit, essentially purchase the license beds, and then enter into a non-compete with an acute care player in a market where we operate in existing facility. That's also, we're very high return of capital, and we're optimistic that we'll see more opportunities to do that in the days ahead.

Adam Todd Feinstein, Analyst, Barclays Capital, Inc.

Okay, great. Maybe just talk a little bit about, I guess, volume growth that, clearly you guys have mentioned in opening comments, you guys have shown very impressive volume growth. And I guess a lot of that's been taking market share, but maybe just talk a little bit about, as you think about volume growth opportunities and, once again, is there still more market share to gain in your key markets?

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer

Sure. Mary Ann, if we can go to the comparative comp gains, so as Adam mentioned...

Mary Ann Arico, Chief Investor Relations Officer

Slide 11.

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer

Slide 11, okay.

Mary Ann Arico, Chief Investor Relations Officer

In the reference book.

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer

Yeah, so in the reference book, if you are – and I was supposed to tell those who are participating by webcast, on the front end, that the reference book, which contains all of our slides that was recently updated, better late than never, Mary Ann. It can be found by the red link on the investor relations portion of our website.

So if you are participating by webcast and are looking at that document right now, we're on slide 11, and this really shows the history we've had on gaining market share. So if you are on the left hand side of this chart, the blue bars represent one of the two industry measures that are out there, UDS. UDS contains about two-thirds of the industry. And note that it does include HealthSouth in that industry bar as well, and the red bar is then our – the comparative number for discharge growth for HealthSouth.

And you can see that very consistently over time, we have been outperforming the industry in terms of discharge growth. Because the aggregate industry has been relatively flat, that tells you that we are in fact picking up market share from the competitors.

Now several of our folks who we've talked to before about that have looked, as this chart goes from left to right and said, well, the gap is diminishing. You're not outperforming by as much. That is partially attributable to our own success. Because we are included in the blue bar and we are the red bar, the more market share gains that we have, the harder it is to differentiate ourselves from the pack, because we make up a bigger piece of that piece.

We continue to believe that the very high quality outcomes that we're producing and also other competitive advantages such as the fact that we are able to roll out a state-of-the-art clinical information system across all of our hospitals, an investment that our peers are unlikely to be able to make anytime soon, are going to continue to position us with the acute care players, with the physicians in a manner that allows for incremental market share growth.

Adam Todd Feinstein, Analyst, Barclays Capital, Inc.

Okay, all right. And maybe when one thinks about it, the balance sheet and leverage now is significantly lower than where it was, but – and obviously, you talked about how you would look to deploy capital. But do you think the balance sheet is possibly under-levered currently. I mean, how are you thinking about kind of a target leverage, I guess, longer term and then relative to the current leverage?

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer

So, again just as a reminder, we ended 2011 with the funded debt to EBITDA 2.7 times; that was inside of our original target of three times. We look not only at the total level of leverage, but the composition of the debt capital is also very important to us and Mary, what slide is this.

Mary Ann Arico, Chief Investor Relations Officer

55.

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer

So for those on the webcast, slide 55 gives you a depiction of our debt capital structure and importantly what you see is that we face no maturities of any consequence until 2016 when our bank facility will mature. And then you've got evenly layered maturities well spaced beyond that, so that gives us a lot of flexibility. When we look at both the level of debt and the composition of debt, we certainly don't feel any need to further delever right now.

With regard to the ability to potentially increase the leverage, certainly a lot of other facility-based providers in the acute space and in the post acute space, feel comfortable running at higher levels of leverage.

I think, again, because we really feel like we've only got good clarity on the reimbursement environment for the next two years, we're unlikely to take the leverage back up until we get more clarity on what's on that back-end. And we're doing that not necessarily or not, because we're operating out of fear in terms of our ability to weather additional reimbursement cuts, but because we want to be opportunistic.

Again, if further reimbursement cuts come, as a result of deficit reduction activities, we strongly believe it's going to impact the rest of the industry much more severely than it's going to impact us and we think that's going to lead to increased opportunities to gain market share via acquisition and opening up new facilities and we want the balance sheet flexibility to be able to seize that opportunity.

Adam Todd Feinstein, Analyst, Barclays Capital, Inc.

All right. And I guess, we've got a couple of minutes left here. So big theme obviously within the healthcare is healthcare reform and the potential for bundling and everything else, and we had a good conservation about this last night. So maybe just – maybe if you could just go through your views there in terms of, what – I guess how you guys are thinking about it, and how you're thinking about in terms of the changing landscape, I guess, for post acute care?

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer

So, I think the two most talked about elements of that reform are payment bundling and accountable care organizations. And right now, there just isn't a lot of clarity about ultimately what those will look like. When you start with either one of those, I think, one of the advantages – we have a number of advantages going in. I think one of the advantages that we have is that, as I mentioned on the front-end, 29 of our 99 facilities are already operated as joint ventures with acute care partners. So we're already accustomed to partnering upstream with the acute care players.

We have been monitoring, particularly that network of joint venture partners to see if anybody is going to take an initial step and participate in one of the ACO pilots. If they choose to do so, we will do so alongside them, we haven't seen any takers yet.

Another advantage when we think about ACOs, is the installation of this Clinical Information System, what that's going to do in terms of our ability to communicate with the acute care providers, I think it's going to be a significant advantage over other post- acute providers of services.

And then our national network of facilities and the high outcomes and cost-effective way in which we produce those high outcomes, all I think set us up well for life, in an accountable care organization. We just don't know what it's going to look like and we don't know over what timeframe it comes together.

So the emphasis is going to be on continuing to do what we do very well, doing it in a cost-effective manner, forming partnerships with acute care players where we can, monitoring the environment and looking to be close to the leading edge, but certainly not on the bleeding edge.

I think the same holds true for payment bundling. As we talked about last night at dinner, CMS acknowledged – or excuse me, Medpac acknowledged last week that there is just a lot of decisions that need to be made about how ultimately any kind of payment bundling needs to be structured.

As fundamentalists, who do you include in the bundle? Is it just the acute care facility? Is it the acute care facility and the doctor? Is it the acute care facility, the doctor and the post-acute provider? And what do you do about readmissions? And, really, until you make some basic decisions about that, it's hard to suggest what direction bundling ultimately goes into. So there again wait and see.

Adam Todd Feinstein, Analyst, Barclays Capital, Inc.

All right. Well, very good. Well, to stay on schedule we'll end there and we got our breakout in the Crown Conch Room. So thank you, Doug, and I enjoyed that and we look forward to having more questions in the Q&A.

Douglas E. Coltharp, Executive Vice President & Chief Financial Officer

Great. Thank you, all.