John Skrobe, Barclays Capital, Inc.

Welcome everybody to the HealthSouth investor presentation. Appreciate everybody's attendance. Today from HealthSouth, we have Doug Coltharp, who is the EVP and Chief Financial Officer. And we also have Ed Fay, who is the company's Treasurer.

And with that I'll hand it over to Doug.

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

Thank you, John, and good afternoon, everyone. A couple of weeks ago we had the privilege of also attending and speaking at the Barclays Capital Equity Conference down in Miami and that conference immediately proceeded the start of the NCAA tournament. And I am a graduate of Lehigh University in Bethlehem, Pennsylvania, and Lehigh miraculously had managed to win the Patriot Conference Tournament and proceed in a relatively rare berth in the NCAA tournament. So I advised the group at that time if they were not yet finished selecting their brackets, they needed to choose Lehigh over Duke and got a hearty round of laughter out of the room, so who is laughing now?

So with that as an opening first, I would like to direct you to our Reg FD Disclosure and remind everyone that this covers items such as our non-GAAP financial measures as well as our forward-looking statements.

This first slide presents an overview of our company for those of you who may not be very familiar with HealthSouth. And as you can see from the bottom of the page, we are the largest owner and operator of in-patient rehabilitation hospitals in the United States. And the key word there is hospitals because we do provide rehabilitation services sometimes you will hear about other venues where rehab maybe provided at skilled nursing facility or nursing home. The central difference is that this is all that we do and that each one of our facilities is licensed as a hospital.

Being licensed as a hospital means that there are certain areas of care criteria that we are required to meet such as 24 hour, seven day a week nursing coverage and a requirement that our patients see a physician at least three times during the week face-to-face, and also that our patients are capable of receiving and will benefit from at least three hours of therapy five days a week. And that is multidisciplined therapy that includes occupational, speech, and physical therapy.

As you can see from the map that is depicted up here, we have 99 freestanding in-patient hospitals predominantly located along the eastern coast, but with a nice presence in Texas as well. Each one of our in-patient hospitals offers outpatient therapy as well. And in addition to the hospital based outpatient services, we also have 26 satellite outpatient clinics. And in addition to that, we have 25 hospital based home health agencies again really intended to provide a continuum of care for the patients that have passed through our in-patient facility.

We are by far the largest player in the country in terms of market share. You see some market share statistics provided at the bottom of this page. Notably we have about 18% of the licensed rehab beds that are out there and we see about 23% of the patients flowing through an in-patient rehabilitation hospital. In 2010 that translated into roughly 118,000 patients discharged.

In terms of types of conditions that we treat, recognize that we are largely focused on Medicare. The average age of our patients is 72 years old, almost 95% of our patients come to us directly from an acute care facility, so they have experienced some type of incidents that had landed them in an acute care facility. They spent three to five days there becoming medically stable. They are not quite ready to come home. And if they meet the medical necessity criteria, they could then transfer to one of our facilities. The top two conditions that we treat are neurological disorders and stroke, and together, those two conditions makeup about 35% of our patient base.

Our market share has been driven not only by capacity additions in terms of new hospitals either acquired or de novo and expanding our existing hospitals, but importantly, we have consistently exceeded the industry with regard to same store growth. And you see that depicted on the graphs on this particular chart. The red bars represent HealthSouth performance over the relevant periods here and the blue bars are one measure of industry performance called UDS.

Now, UDS comprises a little bit more than 60% of the in-patient rehab industry and that 60% does include HealthSouth. And I think that's important to note because although you see that we are consistently exceeding the industry average, the red bar is larger than the blue bar, it may look as you move from left to right on the left hand side of this page that the gap is narrowing, but recognize, because we are the largest player in the industry and the largest participant in the UDS database as we lift performance, it lifts the performance for the entire industry measure here as well.

Importantly, as we've been able to grow our quantity of patients served and increased our market share it's not been at the sacrifice of quality. We are fortunate that our healthcare segment in-patient rehab is one of the few that has a readily acceptable measure of outcome. And the measure that we point to most frequently in in-patient rehabilitation is what's called the FIM Gain.

FIM is an acronym that's stand for Functional Independence Measurement. And each patient admitted to an in-patient rehabilitation hospital be it one of ours or one of our competitors, is administered a battery of 18 tests of everyday living activities and they are given a score when they are admitted to our facility. The same tests of activities of daily living are applied to that patient when they are getting ready for discharge. And the delta between the entry score and score prior to departure is called the FIM Gain.

The graph at the bottom of this page, the green bars represent HealthSouth and the blue bars represent the industry average again comprised of UDS. And you can see that on a very, very consistent basis, we exceed the industry average for quality outcomes by a fairly wide margin.

We've been focused over the last several years on improving our financial position, really highlighted by a reduction in leverage. And as the graph on the left hand side of this page demonstrates, at the end of 2007, our leverage as measured by funded debt-to-EBITDA was as high as 6.7 times. We stated that we had a long-term goal of being able to or pulling that measure below three times.

We had initially thought that we would hopefully achieve that objective by the end of fiscal year 2012. We were able to exceed that goal and actually achieved a financial leverage below three times at the end of the third quarter of 2011, and ended fiscal year 2011 with a leverage ratio of 2.7 times. That was facilitated by $73 million reduction of debt in the fourth quarter of 2011, and for the full year of 2011, we actually reduced our funded debt by $257 million, while posting a double-digit increase in EBITDA.

The reduction in debt carries with it a reduction in required debt service, and that's been one of the factors that has fueled our growth in free cash flow, shown on the right hand side of this chart. This company is a strong and consistent generator of free cash flow, and in 2011, we generated $243 million of free cash flow.

The reduction in debt has also been accompanied by a restructuring in our debt capital and the current composition of our debt capital is represented by the bar graph shown in the middle of this page. I think that it's characterized by a number of important features. One is, we don't face any significant maturities until 2016. And in 2016, it's our bank facilities that come due.

One of our bank facilities is a $500 million revolving credit facility and we have ample unfunded availability under that facility. Beyond the bank facility, you see that our debt profile is represented by well spaced, manageable maturities of senior notes. Those notes are attractively priced and carry very flexible covenants. We have very little in the way of required principal amortization and we have substantial flexibility to prepay debt should we choose to lower the leverage profile even further and/or engage in some opportunistic refinancing activities.

Another key component of our balance sheet strategy is our ownership position in our real estate. And this stands in stark contrast to many of our peers in the post acute facility based provider space. Of our 99 in-patient rehabilitation hospitals, we own either the building and/or the land and the building on approximately – not on approximately, but on 64 of those facilities. Now, that creates two significant advantages for us.

One is, it gives us substantial control over our real estate portfolio. And if an ultimate outcome out of healthcare reform is accountable care organizations or a reconfiguration of the delivery system, it's going to allow us to be more nimble in potentially reconfiguring our own set of services and the buildings under which we operate on a market-by-market basis.

The second advantage is that most of the leases in place for healthcare providers and most of those are now provided by the large publicly traded healthcare REITs, contain automatic escalators in the rent provision, to the extent that we have a much higher percentage of owned facilities than do our peers, our exposure to any of those types of annual escalators is much lower than it is for the peer group. And that's an important consideration in what is likely to be a difficult reimbursement environment for the foreseeable future.

Let's talk for just a couple of minutes about how we look at the business evolving over the next three years beginning with this year particularly in light of those challenges in the reimbursement environment. So at the top of this page, we talk about the de-leveraging activities that I referenced earlier. Again, we now look at our debt and say that the leverage ratio is below the target we had previously established and we feel very good about the composition of our debt capital. Having said that because of the risk that continues to exist in the reimbursement environment, it is very likely that you will see us continue to operate at a leverage profile similar to or below that at which we are currently operating.

Moving into the green bars on this chart, we believe that we continue to have very compelling and attractive growth opportunities within our core business. We think there are opportunities to continue to grow our same store sales that will include and be augmented by the addition of beds at certain of our existing hospitals where occupancy levels justify those. And we will continue to add new freestanding hospitals to our portfolio via de novo activity and we are going to actually be ramping that activity up over the next several years. This year we will only see one de novo open. That new facility will come on board in December of this year. But beginning in 2013, we would expect that for the next several years, we will be able to open up four to five de novos a year.

And we will continue to seek acquisition opportunities of other freestanding hospitals. Those are a little bit hard to come by because we are in such a highly fragmented industry or perhaps the more prevalent opportunity will be consolidating units out of existing acute care facilities. So the focus on growth is going to be very much on reinvestment in our existing IRFs space.

I mentioned previously that one of the outcomes of healthcare reform could be some reconfiguration on delivery system. So you hear terms thrown out there like accountable care organization and/or bundled payments. And those could cause us to alter our thinking about the appropriateness of being able to deliver a broader spectrum of post-acute services on a market-by-market basis. And ultimately altering our thinking in that manner could cause us to think that maybe we want to pursue acquisitions of a service that either we're not into a big way like home health or another type of service offering.

Right now we feel and we think that this will continue to persist for the foreseeable future that there is too much uncertainty regarding the reimbursement environment for any of the other segments of post-acute care for us to be focused on an acquisition strategy outside of the IRF business.

Down at the bottom of this page it's important to note that we can continue to invest in operating enhancements for our business designed to continue to allow us to post those very high quality outcomes and to do so in a very cost effective manner. We enjoy because of our scale and because of the efficiency of our operations, very significant cost advantages over the balance of the industry.

One of the initiatives that we are pursuing beginning in 2012, it was piloted successfully in 2011, is the rollout of a new state-of-the-art clinical information system across all of our hospitals. It will take about five years to rollout across our entire hospital base. We are anticipating that we'll have the system implemented in about 12 hospitals during 2012. The pilot phase covered two hospitals in 2011.

The scale of this undertaking should not be underestimated and it is one that based on the size of our presence and the size of our market share, HealthSouth can undertake this initiative when our peers really aren't in a position to do so. Many of our peers, again if you look at the composition of the industry, are in-patient rehab units that are located within acute care facility. To the extent they adopt a clinical information system at all it's likely to be some watered down version of the system within acute care system that houses that IRF is already using. And it's not a great fit.

We have a custom-designed system specifically made for rehab that was built by Cerner, one of the leading software providers to the healthcare provider community. So again this is going to be rolled out across our facilities over about a five year period. The cost of the roll out, you will see in our financials in two places.

One is, it's going to increase our operating expenses a little bit. We've estimated this year we'll see about $4 million in incremental operating expenses related to the roll out activity. And then also it's going to increase our maintenance CapEx. Although we expect many, many benefits to flow from the implementation of the system, we're treating it as a maintenance CapEx item nonetheless.

I mentioned previously that we are generating significant high levels of free cash flow. And heretofore, the decision about where to spend our free cash flow has been pretty easy. We were over levered and we needed to improve the level and the composition of our debt capital.

We really accomplished our objectives with regard to the debt capital structure in 2011 both by removing the very highly priced 10.75% senior notes, there were $500 million of those that had been part of our capital structure for a number of years and then reducing the overall level of leverage to that 2.7 times that existed at the end of 2011 that I referenced previously. That allows us to think about a broader use of free cash flow on a go forward basis.

And certainly, our top three choices are investing in the compelling growth opportunities within the core IRF space, those items that I mentioned to you previously, where we can get bed expansion opportunities because the occupancy levels justify in existing hospitals, great return, low risk, we're going to take every one of those we can get. The ramp up in the de novo strategy continuing to be on the prowl for the opportunity to acquire other high quality IRF hospitals and/or to do unit consolidations.

We think that even with the array of high-quality growth opportunities that are out there for us in the IRF space, we will have excess free cash flow beyond that. How will that free cash flow be deployed? Right now, we are still working through that framework, but it's likely to be deployed towards a return-of or return-on capital to our various capital providers. It could take the form of further debt reduction. The convertible preferred is certainly on the table. And at the end of the third quarter of last year, we did announce that our Board had approved $125 million share repurchase authorization. We also had previously disclosed that through the fourth quarter of 2009, there had not been any activity under that program.

I want to spend just a couple of minutes elaborating on the reimbursement environment that I touched on earlier. As you know the Budget Control Act, that was signed into law in August of last year created then a special committee of Congress that deliberated in the fall and was supposed to present a set of alternatives for deficit reduction for Congress to give a thumbs up to or thumbs down to in the December timeframe.

Well, that special committee deliberation failed and they never presented an alternative solution to Congress. And as a result, sequestration has become a law and will take effect on January 1, 2013. Now what sequestration means to us is essentially the equivalent of a 2% tax on our Medicare revenues beginning in calendar year 2013. We have estimated that the impact on us unmitigated would be about $32 million. That's a revenue number and here an EBITDA number as well because it's unmitigated.

We also believe that regardless of the outcome of this fall's elections there is going to be continued focus on budget deficit reductions and that in all likelihood part of those discussions are going to look back to the Medicare provider community and seek conditional cuts.

This chart explains why we do not believe we should or will be targeted for any kind of disproportional cuts. The top of this chart shows the percentage of total Medicare spending on post acute services that has made up of in-patient rehab. And I'm sorry actually the top part of this chart is Medicare spending on in-patient rehab as a percent of the total Medicare budget. And you can see that it has come down by roughly a third as a percentage of the Medicare budget over the course of the last decade.

Now tie this then together with the line graph on the bottom part of the chart and there spending in in-patient rehab is represented by the red line that is the second from the bottom. Many times when you hear about efforts for Medicare spending reduction, you'll hear the phrase bending the cost curve. Look at the cost curve for in-patient rehab; it has been bending. What this also demonstrates is that nominal dollar spending, so never mind what the rate of increase is relative to another rate of increase, nominal dollar spending in the total in-patient rehab sector has been relatively constant over the last decade. Compare that to the very rapid increase represented by skilled nursing facilities and home health, and I think it demonstrates that the greater opportunity and the greater necessity for cuts in the provider community lies outside of in-patient rehabilitation.

I also want to use this slide to demonstrate that this isn't our first rodeo. We've been through difficult reimbursement environments before and you don't have to look to the very distant past to find an analogous situation. During 2008, as part of the trade-off for the final settlement on the 60% room, in-patient rehab facilities were faced not with the pricing freeze, but with a pricing rollback and then an 18 month pricing freeze that also coincided with the deepest economic recession this country has faced since The Great Depression in the 1920s and 1930s.

What happened to HealthSouth during that period in the ensuing quarters, we've substantially increased our EBITDA represented by the green bar charts here. And how did we do that? We did it a number of ways, but the most substantial thing that we did was consistently increase our discharge volume. It's those market share gains that we've talked about at the outset of the presentation. And if you look at the fragmented nature of our business, it's our belief that if there are more reimbursement reductions coming to our sector, we are going to be better positioned to weather that storm than our peers because of our capitalization, because of our cost efficiency etcetera. And the combination of our superior quality outcomes and that financial strength will allow us to garner further market share in that kind of environment.

And I want to use this slide just to kind of wrap things up before we open things up for question, this really highlights why we feel that HealthSouth has developed a very strong and sustainable business model. I've talked a little bit about some of the attractive things that we see within our industry, but we do believe that we operate within a very attractive sector of healthcare.

We have very favorable demographics. If you think about the average age of our patient, again being 72 and think about the aging of the Baby Boomers, this is a segment of the population that is growing faster than the national average.

Many, if not a very high percentage of the maladies that we treat, are non-discretionary in nature. I mentioned at the outset of our presentation that together neurological disorders and strokes make up about 35% of our patient base. You can't choose to differ one of those conditions. If you experience one of those conditions, you're going to need to seek services and you're going to come to a facility like ours. And the business is highly fragmented beneath us.

We have the industry-leading position that I mentioned before that allows us to invest in things like the clinical information system, which our peers really don't have the ability to do because they don't have

sufficient scale. We are by far the most cost effective player in the business. That's a function not only of our scale, but also of the very focused initiatives that we've put in place in area such as labor management.

I talked about the strength of our balance sheet that flows from our real estate portfolio. And our overall financial strength that is characterized not only by the strong free cash flow, the relatively low leverage level, but recognize also that because of the very substantial NOL carry forwards that we have, our expectation is that we'll paying off – we'll be paying only $7 million or $10 million in cash taxes for the next several years at a minimum.

And then finally, we believe that we continue to be faced with an array of high quality growth opportunities within our core IRF space, which means that we don't have to go out and engage in bed perform types of acquisitions, in a new service that we may be unfamiliar with taking on a high degree of financial leverage and taking on with that a high level of integration risk. We can continue to grow our revenues and grow our EBITDA by taking market share and by building additional capacity in our core IRF space.

And with that I'll entertain questions if there are any.

QUESTION AND ANSWER SECTION

<Q>: On the topic of sequestration, what are your lobbyists telling you in terms of how the current state of play recognizing that all eyes are on the election, but I think there has been some talk about what's ultimately going to happen with sequestration and also what you might be hearing on that?

<A – Douglas Coltharp – HealthSouth Corp.>: Our expectation right now is that almost regardless of the outcome of the election, sequestration will take place. It's – if you think about it, nothing is going to get done that changes that or alters that in any way during the course of this year because of the pending election. Whether the existing regime stays in place or a new one comes into place, or whatever changes are made in the two houses of Congress, it's going to be difficult for them to do anything prior to the January 1 deadline when sequestration kicks in. So they're probably going to let that take place and then the real budget deficit reduction discussions will take place through 2013.

Our best guess right now is that there will be incremental reforms coming out of those budget deficit reductions, but that the easiest thing, again regardless of who is in power, the easiest thing will be to layer those on top of sequestration. That pain is already out there, you don't have to argue about that with anybody else rather than repealing sequestration and putting in place another set of reductions.

I think one of the wild cards out there is, can you leave it in place for Medicare, which seems to work okay and repeal it for defense. And that's more I think a political issue than a legal issue, but one that may have some bearing. Any incremental questions?

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

Well, great. Thank you all for your time and attention.