Darren Perkin Lehrich, Analyst, Deutsche Bank Securities, Inc.

Okay. Good morning. I'm Darren Lehrich. I lead Deutsche Bank's Healthcare Providers team and want to welcome you to day two of our conference. Presenting in this first slot here is HealthSouth Corporation. They are the leading provider of inpatient rehabilitative services in the U.S. And presenting from the company will be Jay Grinney. He's President and CEO; and also Doug Coltharp, the Chief Financial Officer. And we want to welcome HealthSouth to our conference, coming off of a great first quarter. And I know you've got an abbreviated presentation, so we'll get into Q&A real quick here.

I also just want to remind you, for those who were here yesterday, we do have an app and the instructions for the app should be on the table. It's yorn.com/hc and you can post your Q&A if you're listening by webcast, and I'll facilitate some of your questions up at the podium when we get to that point. So with that, thank you.

Jay Grinney, President and Chief Executive Officer

Thank you, Darren, and good morning, everyone. The standard forward-looking statements, which I'm sure you're all very familiar with. As Darren mentioned, HealthSouth is the largest provider of inpatient rehabilitative care services in the country. We have the pleasure of treating patients who are discharged from acute care hospitals with a range of different neurological and orthopedic conditions. Most of the patients we treat are elderly, so most of our patients tend to be Medicare enrollees. About 80% of our revenues come from Medicare.

Now, if you look at our footprint in the country, obviously, we have a big presence in the Northeast down through Florida, across the Southeast into Texas, a couple of hospitals in California. And as you can see on the left-hand side of the slide, we're in a pretty active growth mode, building new hospitals in new markets.

And we have a certificate of need that's been approved. Construction is underway in a hospital in Ocala. This Thursday we're going down -- tomorrow, we're going down to Stuart, Florida, for a groundbreaking with Martin Health. It's a joint venture hospital in Martin County, Florida. We also have land and are beginning the development on hospitals in South Denver, Southwest Phoenix. We have two certificates of need that are in the latter stages of being litigated; one in Williamson County, Tennessee, the other in Middletown, Delaware. We expect favorable, ultimate rulings in both of those and should get those by year-end and we'll begin construction on those hospitals as well.

Today we have about 8% of all inpatient rehabilitation facilities in the country. There are about 1,150 IRFs or inpatient rehabilitation facilities in the United States. We own and operate 8%. Our hospitals tend to be larger by a fair degree, and so you can see that in terms of bed size, our market share is considerably larger than just our number of IRFs. And then more importantly, we treat more patients in those facilities -- in our facilities than do our competitors. So not only do we have larger hospitals, but we have a greater volume in those hospitals. And so, if you look at it from a patient served perspective, about one out of every five patients receiving inpatient rehabilitative care in the United States gets that care in one of the HealthSouth hospitals.

As Darren mentioned, we're coming off a great start to 2012. Discharge volumes were up 6%. It is clearly an advantage to the extra day with the leap year, but even taking that out which takes about 1 percentage point or 100 basis points out, we're up 5% approximately year over year; on a same-store basis, we're up about 4%.

Revenues were driven by not only that strong discharge volume but we also had pricing, about 2% overall. Some of that came from a Medicare update that we received last year of about 1.6%. The balance then came from the managed care pricing that has over the last several years and we expect over the next subsequent years to be somewhere in that 3% to 5% range. This year, it was just a little bit north of 3.5%. It may come down a little bit over the next year or two, but we think that 3% to 5% is the right range to be thinking about our managed care pricing going forward.

EBITDA grew at 8%. That was driven by very strong continued disciplined expense management and leveraging that operating platform as we brought in new patients. And as you see, earnings per share were $0.40. I will note for you that in Q1 of 2011 we had a $0.27 per share one-time benefit, resulting from income tax recoveries for tax years 2007 and 2008. So you see if we back out that $0.27 one-time benefit last year, EPS was up about 33% year over year.

I think the real story, as we see it anyway, for HealthSouth is the fact that we generate a significant amount of free cash flow, $243 million last year, and we have multiple avenues for investing that free cash flow for the benefit of our shareholders.

Historically, that focus had been on strengthening the balance sheet, reducing our leverage. We have achieved that. Our leverage at the end of Q1 was 2.7 times and that contrasts with over 6 times at the end of 2007. So, we've taken a lot of steps to bring that leverage down to strengthen the balance sheet. We think that that's important, especially going into the next several years which we anticipate will be somewhat challenging for all healthcare providers as deficit reduction initiatives kick in, new deficit reduction initiatives are introduced, healthcare providers are all going to have to do more with less. And we think those companies that have strong balance sheets, low amount of leverage, flexible capital structure will be those who will be successful.

In the interim, we're going to be looking to redirect that free cash flow first and foremost to growth. We've got a great platform upon which we can add new hospitals. We also in many of our markets are running up against capacity limits. We're able to then add beds, typically five, 10 beds at a pop and are able to then stay ahead of that demand curve that is growing at about 2% to 2.5%. If you think about the underlying demand for our services, it's demographic driven. It's driven by the fact that this baby boom cohort is aging. The older we get as a population, the more we access the services offered by HealthSouth and more people have strokes, hip fractures, suffer from chronic neurological conditions that impair their ability to function independently in their community.

So we've got an inherent demand about 2%, 2.5%, and we're meeting that -- exceeding that actually as we continue to take market share. We are able to stay out ahead of that through the addition of new beds to keep up with that demand. And then we're entering new markets through what we refer to as our de novo strategy, our brand new hospital construction strategy. I mentioned just a minute ago some of the new hospitals that we're developing. As we look forward over the next several years, we see at least four new hospitals opening up each year.

So as we think about future growth, not only do we have the organic growth that will be available to us and that we'll continue to take market share, we also have the opportunity to enter new markets, provide services to patients and communities where there is an inadequate supply of inpatient rehabilitative beds.

Although we don't have any specific numbers for the acquisitions here because it really is opportunistic and obviously transaction driven, requiring a willing seller, a willing buyer, agreed upon price and terms, but we are targeting at least two acquisitions. These are freestanding rehabilitation hospitals or if there is a unit that might be available in one of our markets, to acquire the unit, consolidate the business then into the freestanding hospital that we own and operate.

Beyond that, we have other avenues that are available to us. We did purchase some of the convertible preferred shares earlier in the quarter. We do have $125 million authorization for that and we will pursue those on a very opportunistic basis.

So in summary, as we look at HealthSouth, we think we are uniquely positioned to be successful in what I believe is going to be a fairly challenging health care environment. As I mentioned, we have inherent demand for our services, growing at about 2% to 2.5%. The conditions that we treat tend to be non-discretionary. People don't choose to have a stroke, they don't choose to fall and break their hip, they don't choose to have a debilitating neurological condition. Those conditions typically occur with age. As they're treated on an acute basis, we receive the patients directly from the acute care hospital, admitted by a

physician. And then those patients are cared for under the supervision of a physician and in collaboration with a professional team at our hospital.

We do have, as I mentioned, the number one position in our industry. The next largest aggregation of inpatient rehabilitation facilities is about six or seven. We have a couple -- there are a couple of smaller, private equity-backed companies in our space. Most of them have a combination of inpatient rehabilitation hospitals and long-term acute care hospitals and the biggest aggregation is about seven IRFs with eight to 10 LTACs. So you see, we've got 99 hospitals. You go down to the next single -- largest single competitor is going to be much, much smaller. So we're in a very fragmented industry and we think that our scale and size gives us significant advantages, especially on the cost side.

And that cost effectiveness is something that we are very proud of. We know that we provide high-quality care. As we looked at our cost per discharge relative to the rest of the industry, we're also very proud of the fact that we can provide that high-quality care at significantly less cost to the Medicare program and to private insurance companies.

Another feature of our portfolio that I think is important to note is that we own and operate most of our hospitals. We have some that are leased, but we own a good percentage of those hospitals. So we have not mortgaged our assets, we haven't mortgaged our future. We're not saddled with escalating lease payments that some of our competitors are going to be challenged with over the next several years. And I think that gives us a lot of flexibility and more importantly, a lot of control over those assets for the foreseeable future.

Talk about the financial strength, not only have we demonstrated the ability to earn EBITDA growth, EPS growth, free cash flow growth, we've also been very protective of the balance sheet, getting our leverage to a level that gives us a lot of flexibility, a lot of headroom as we go into the next several years of challenges. And those, I think, attributes also give us the opportunity to grow. As I mentioned, the growth is not only in existing markets through continued market share gains and fueling that then in with bed additions, but also the opportunity to enter new markets and to serve new populations that historically had been underserved.

Longer term, and this truly is a longer-term view, we will look for opportunistic growth in other complementary post-acute services. To be very candid, that is not something that is on the radar in 2012, that is not something that is on the radar in 2013, and we would only pursue those once we get regulatory clarity from Washington, not only in terms of what the pricing environment is going to look like but additionally, what type of regulatory constraints that are in there in the industry today might be relaxed.

So with that, that concludes my presentation and we'll move -- move into Q&A.

Darren Perkin Lehrich, Analyst, Deutsche Bank Securities, Inc.

Great. Thanks, Jay. So, we've got about 20 minutes in the room here for Q&A and I guess that means that I don't have to abide by the one question and one follow-up rule that Mary Ann imposes.

QUESTION AND ANSWER SECTION

Q – Darren Lehrich – Deutsche Bank Securities, Inc.: So, I guess I'll kick off here and please feel free to raise your hand if you want the mic for a question.

I wanted to start off with just the expansion piece and we went through a period of time a couple of years ago where you were opportunistically able to buy some physician-owned hospitals. I think there were a couple of those situations in Texas perhaps. I'm just curious to get your perspective on where you think the one-off type acquisition opportunities are at this point in time in terms of the expansionary work plans that you have.

A – Jay Grinney – HealthSouth Corp.: Okay. And before I answer, I do want to introduce Mary Ann Arico who is our Chief Investor Relations Officer and we do have an investor reference book. We update it quarterly. We have copies of that for you. We also have a subset of this reference book that are handouts for the slides that we presented today. And then Doug Coltharp is our Chief Financial Officer and we're very delighted to have both of them here as well.

In terms of the growth opportunities, we see most of those occurring through the acquisition of existing units within the acute care hospital and then consolidating that business into our freestanding hospital.

Just by way of reference, I mentioned earlier there are 1,150 inpatient rehabilitation facilities nationwide. 930, roughly, are actual departments or units that are embedded inside of acute care hospitals, hence the fragmented nature of the industry. And so what we're seeing as we progress with our growth strategies and de novos we can control, we can identify the market, we do the research, we can take the risk. The risks that we've taken in the past have all paid off handsomely, so we feel very confident in our ability to assess market opportunities.

Acquisition is a little bit more challenging because, as I said, we have to get a negotiated agreement with the seller, but what we're seeing are -- or is an emerging awareness by many of the acute care hospital operators that the world is going to get less friendly rather than more friendly. We're in the second year of paying for the Affordable Care Act or Obamacare. Next year, we have the third year, so there's going to be some kind of compounding effect of lower Medicare reimbursement. On top of that, next year, we're going to see the effect of sequestration hitting all healthcare providers. So you've got a double whammy on the Medicare side.

Many of the acute care hospitals also are seeing their reimbursement on the managed care side being driven downward. Three years ago, four years ago, managed care pricing on the acute care side would be 5%, 7%, 8%. Now, you're hearing that that pricing may be 3%, 4%, 5%. So, the rate pressures in the industry for the acute care hospitals are causing some acute care hospitals, particularly those that are looking forward to say, gosh, we can't be all things to all people the way we once were. There's just not enough revenue in the system to be able to do that. And they're saying, we've got heart programs, we've got surgery programs, we may want to expand our oncology program, our orthopedic program, all core businesses.

On top of that, many of the acute cares have loss leaders in their emergency room, in obstetrics, and they are thinking through how many loss leaders can we have. I mean, so there are other post-acute services that have been offered by acute care hospitals that frankly they're choosing to get out of that business. And if there's going to be an investment, what we're seeing is more of an investment in the outpatient side.

So that's kind of the backdrop and why we believe that there are going to be opportunities to go into markets where we have a presence, acquire a unit, maybe even joint venture that unit, consolidate that business into our hospital, still be able to provide that service then for the hospital and the physicians that practice at that hospital.

Q – Darren Lehrich – Deutsche Bank Securities, Inc.: That's great. And just on the de novos, I've almost lost count, I think we are at eight in the pipeline, if that number's still right. But I guess the real question about the de novos is you've picked up the pace a bit now that you've got a bit of clarity following last summer's events. Is there anything in the model that -- how you look at these projects that's changed over the last couple years as you've put more of them into the ground?

A – Jay Grinney – HealthSouth Corp.: No, I think that we certainly have learned as we have brought these hospitals online. We always do a look-back to see what the actual operation -- operational performance looks like relative to the pro forma. And frankly, it's really not a wide range of big surprises.

I think that one thing that we've realized is that the startup actually can be a little bit quicker than what we pro forma. We've been, I think, a little bit conservative in how quickly we can bring patients into our hospitals. Some of that is going to be driven by if we have an existing hospital in that market. Great

example is Cypress, Texas. We had three hospitals in the Houston market, there was familiarity with HealthSouth services, we knew the physicians, we opened that hospital, and we were able to fill those beds very quickly. Other markets where we were a new entrant, it may have taken a little bit longer, but not as long as what we had originally envisioned.

Demographics, we still look at the same population characteristics. Obviously, the number of people in that market over the age of 65, the growth rate of that over-65 population cohort is very important to us. We look at things like how many patients are being discharged from the acute care hospitals with conditions that would require rehabilitative services and then we go deeper and say, how many of those patients are ending up in a rehabilitation hospital or a facility, how many are going into nursing homes.

And so, that gives us an opportunity to look at potential upside that may not be apparent if you just looked at the configuration of who's providing that service today. So it's a -- it really is an opportunity to get in and take market share. But we've been very pleased. In fact, if we -- in this -- in the reference book that we have, if you go back to Page 67, it will give you a picture of the last six hospitals that we opened. And you can see there are two things that we're demonstrating here. One is what the ramp-up in average daily census is, how fast do these hospitals get to the company average of about 67%. But more importantly, what's the range for these hospitals to achieve sustained, positive EBITDA. And as you look on this, and you can certainly check this out later, somewhere between three and eight months these hospitals are up and generating sustained, positive EBITDA from that point on.

Q – Darren Lehrich – Deutsche Bank Securities, Inc.: So just on that point...

A – Jay Grinney – HealthSouth Corp.: And you do have a question...

Q – Darren Lehrich – Deutsche Bank Securities, Inc.: Oh, great. Good. Thank you.

Q - Unknown Participant: One small one. You had mentioned the overall challenging environment and then Medicare cuts that you had mentioned. Are you clear on what would happen if the Supreme Court would strike down part or all of Affordable Care Act, what would happen specifically in IRFs, or as a segway in the acute world that then would affect all of these potential acquisitions you would want to do from acute folks that have issues?

A – Jay Grinney – HealthSouth Corp.: Yes, I think that the -- if the mandate is thrown out but the balance of the Affordable Care Act is maintained, in my opinion, for most providers -- and I will go out and say with the exception of HealthSouth, and I'll explain that in just a minute, most providers will find that to be the worst possible scenario. And the reason I say that is because the mandate was the -- the thing they were looking for, the acute care hospitals were looking for to take care of the uncompensated care. So the Affordable Care Act is really not healthcare reform, its health insurance reform. And the whole purpose was to take as many of the uninsured, 50 million people who are uninsured, and bring them into some kind of program where there are resources behind them to pay for the care when they needed the care.

And so the acute care hospitals, I think, were sort of backed into a corner where they had to support the Affordable Care Act and they did that with the notion that, okay, I'm taking 10 years of cuts on my Medicare reimbursement, but I'm going to pick up revenue for that 15%, 16%, 17% of my business that today I'm providing for free. And so that tradeoff volume per pricing was the tradeoff that was given to the acute care industry. So if the mandate goes and there's not a requirement that individuals have insurance, the risk is the uninsured burden for acute care hospitals remains and they're still having to pay for everything else. And so to me, that would be -- for an acute care hospital, I would think that that would be a very bad scenario.

So what does that mean for us? I think that what that means is it puts additional pressure on the acute care hospitals who own inpatient rehabilitation facilities. They may want to monetize that asset, they may want to joint venture that, offload some of the risk of providing that care. So then let's go and say what happens if the mandate goes and the balance of the bill goes. We're back up squares -- square one circa 2008. There will be, in my opinion, some very shortsighted euphoria because those 10 years of cuts will be abolished,

they're going away. And so everybody's thinking great, I don't have to deal with the IPAB (Independent Payment Advisory Board), I don't have to deal with these exchanges, I've got -- my payments have been restored.

Problem is people in Washington are going to say, right, all of the savings that was built into the baseline budget for the Affordable Care Act, they also go away. And so now, when you're looking at the net debt ceiling debate and the breaching of that debt ceiling which is going to happen sometime in the next 12 months, we don't know if it's going to be the end of this year or first part of next, but it's going to happen. And when that happens, deficit reduction discussions will take place that I personally believe will make what happened in August of 2011 seem like just a warm-up, because now we're dealing -- in that scenario, we're dealing with no savings from health care that just made that deficit that much worse.

So in a short-term basis, what happens? Congress, whatever the new Congress is going to be is going to have to take some action. Do they do it in 2013 to be effective in 2014? Who knows? That would be pretty fast for our congress. Or do they work on it 2013, 2014 to be in -- to be ready in 2015?

If -- again, if the Affordable Care Act is gone, they're starting at square zero. And so, short term, what we would envision would be more Draconian Medicare cuts and again, that puts us back in a scenario where if the rest of the industry is being pressured on the rate side, they're not going to be able -- our competitors, that fragmented delivery system may not be able to continue to provide all services to all people. That gives us an opportunity to come in and to acquire or joint venture.

And so, it's really one of the -- I'm glad you asked the question because it's -- to me, it's one of the most important things all of our healthcare providers are facing and we -- we didn't anticipate that we were going to be in Obamacare and deficit reduction initiatives and debt ceiling. We -- there's no way we predicted that. But back in 2006 and 2007, we knew at some point the industry was going to be under a lot of rate pressure and those that have low leverage, flexible balance sheets are going to do fine because the demand is there. The pressure is going to come if you're highly leveraged, if you don't have that flexibility. You're going to cut off capital because your interest obligations are so great.

Maybe more than you wanted to know, but that's -- that's how we look at it.

Q – Darren Lehrich – Deutsche Bank Securities, Inc.: Another question out there. I wanted to ask just a little bit about the discharge growth which had been quite strong for a string of quarters here. And I guess the question is, as you think about the normalized level of growth and coming off of the fairly robust numbers that we've seen, what is it that knocks you back down to that level of growth? Is there something from a -- just a capacity standpoint that you hit? Is there something environmental just in the marketplace that causes that to slow down? Anything that you can help us think through the -- and put into context the rates of growth that we've seen in recent past versus what the longer-term projections are.

A – Jay Grinney – HealthSouth Corp.: Yes, I think that the growth first and foremost has been driven, I believe, by the fact that we can demonstrate to those individuals who refer patients to us, physicians and increasingly to acute care hospitals, case managers. They're really the two primary decision makers and then they need the consent and obviously, the endorsement of the patient. But we can demonstrate to them and do with data on every single patient the ability of our caregivers to improve the functioning capabilities of our patients. And that's really what we do.

We measure ourselves by how successful we are at taking a patient that may be unable to walk, unable to swallow, unable to bathe themselves, unable to have certain cognitive capabilities upon admission, and what is their status upon discharge. And that improvement is called the FIM gain, Function of Independent Measure gain. And that's standardized across all rehabilitation providers. We take that data and we collate that, present a report to the physicians that allows the physicians to see and the case managers to see the kind of progress that's made patient by patient. So we build up that credibility. So that drives the organic growth. And we believe that that will continue to drive organic growth.

The other thing is the underlying demand, 2% to 2.5%. In many of our markets, we're -- we have over-65 cohort growth of 3% and 3.5%. So that gives us the ability -- if we just rise with the tide, which we're not obviously content doing, we should get some of that growth, just that 3%, 3.5% in those markets.

The constraints would be -- would include the inability to keep up with the demand in existing hospitals. We've not run into that because we have a pretty thorough review every other week of all the hospitals that we have in our system, what their occupancy levels are, what that trend has been so that we're out ahead of the bed addition program. There are two hospitals that we have that will be maxed out where we don't have an open -- solution today. And both of those are certificate of need dependent. So we've pursued those. One is actually being contested right now and was not one of them that I mentioned earlier.

So I think that the ability to continue to grow is certainly there, but at some point we get into the whole issue of big numbers, the -- you have to climb over a bigger and bigger base. But that's why we've got the de novos. And being able to add those, it's new store on day one, but after a year and one day, those are now same store. And typically they're not at or near capacity, so they keep providing additional growth.

And then the last thing I would say is, on those hospitals, we also get an additional kicker by bringing on additional beds when they do meet capacity. So we opened a new hospital down in Petersburg, Virginia, I think five years ago, brand new hospital, 40 beds. We've already added beds to that hospital because we maxed out capacity and we were able to do that on a very, very attractive marginal basis.

Q – Darren Lehrich – Deutsche Bank Securities, Inc.: That's great. I just have one last question briefly. Short run, we've got readmission rules coming in the latter part of this year for acute care hospitals. Do you think that will have any incremental benefit to your discharges or the referral that come out of hospitals? Do you think it really changes much at all?

A – Jay Grinney – HealthSouth Corp.: It's not going to hurt. That's for sure. The initial conditions are not those that we typically treat. Most of them are cardiology and cardiac based and congestive heart failure is on that. So we don't treat a lot of patients, but we treat some with those kinds of conditions. Where I think it's going to help us longer term is, it will -- or it has started I should say, the broader view of patient care that looks at that care from an episodic basis, not a discrete basis.

So in the past, I know that a lot of the case managers in the acute care hospitals have really just focused on getting the patient that's in that ICU bed or in the general med-surg bed out. They need that bed vacant so that next patient can come in or they need that patient out so that they can maximize their profitability if that is a Medicare patient.

And so in the past, we've had to go up against case managers who were saying, I need a decision and I need it right now. In the future, they're going to be saying, let's make the decision from the perspective of who can ensure that this patient will not come back and cause me a penalty or cause my hospital to suffer financial penalty for Medicare. So I don't think it's going to hurt. I definitely don't think it's going to hurt. I think that there will be some advantage. It's really kind of hard to predict what it will do, but I think it will be a little bit of a tailwind.

Darren Perkin Lehrich, Analyst, Deutsche Bank Securities, Inc.

That's all the time we have. So, I just want to thank HealthSouth again for being here and thank you all. Have a good day.

Jay Grinney, President and Chief Executive Officer

Thank you.