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Citi 2012 North American Credit Conference
New York City | November 14, 2012

Doug Coltharp, Executive Vice President and Chief Financial Officer

Forward-Looking Statements

The information contained in this presentation includes certain estimates, projections and other forward-looking information that reflect our current outlook, views and plans with respect to future events, including legislative and regulatory developments, strategy, capital expenditures, development activities, dividend strategies, repurchase of securities, effective tax rates, financial performance, and business model. These estimates, projections and other forward-looking information are based on assumptions that HealthSouth believes, as of the date hereof, are reasonable. Inevitably, there will be differences between such estimates and actual events or results, and those differences may be material.

There can be no assurance that any estimates, projections or forward-looking information will be realized.

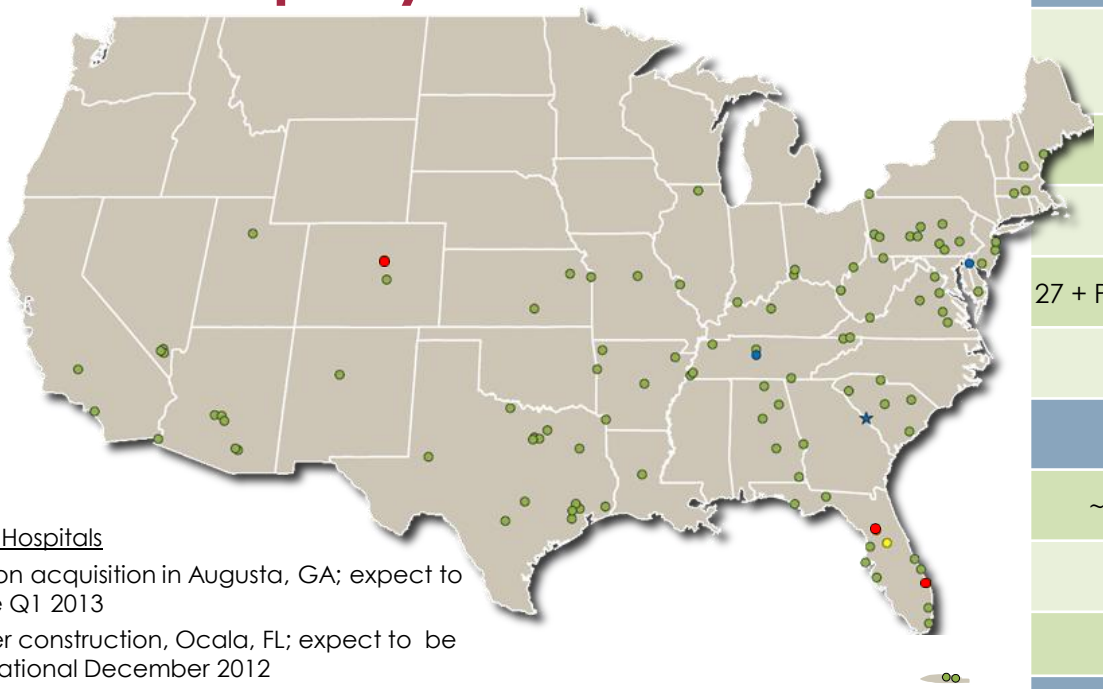
All such estimates, projections and forward-looking information speak only as of the date hereof. HealthSouth undertakes no duty to publicly update or revise the information contained herein.

You are cautioned not to place undue reliance on the estimates, projections and other forward-looking information in this presentation as they are based on current expectations and general assumptions and are subject to various risks, uncertainties and other factors, including those set forth in the Form 10-K for the year ended December 31, 2011, our Form 10-Q for the quarters ended March 31, 2012, June 30, 2012, and September 30, 2012, and in other documents we previously filed with the SEC, many of which are beyond our control, that may cause actual results to differ materially from the views, beliefs and estimates expressed herein.

Note Regarding Presentation of Non-GAAP Financial Measures

The following presentation includes certain "non-GAAP financial measures" as defined in Regulation G under the Securities Exchange Act of 1934. Schedules are attached that reconcile the non-GAAP financial measures included in the following presentation to the most directly comparable financial measures calculated and presented in accordance with Generally Accepted Accounting Principles in the United States. Our Form 8-K, dated November 13, 2012, provides further explanation and disclosure regarding our use of non-GAAP financial measures and should be read in conjunction with these supplemental slides.

Our Company



New Hospitals

- ★ Walton acquisition in Augusta, GA; expect to close Q1 2013
- Under construction, Ocala, FL; expect to be operational December 2012
- Under construction, Stuart, FL; expect to be operational Q2 2013
- Under construction, Littleton, CO; expect to be operational Q2 2013
- CON approved for 50-bed hospital in Orlando, FL; expect to be operational 2nd half of 2014
- CON approved for Middletown, DE; being contested
- CON approved for Williamson Co, TN; being contested

Portfolio – As of September 30, 2012

99	Inpatient Rehabilitation Hospitals ("IRF") • 29 operate as JV's with Acute Care Hospitals
26	Outpatient Rehabilitation Satellite Clinics
25	Hospital-Based Home Health Agencies
27 + Puerto Rico	Number of States
~ 22,500	Employees

Key Statistics – Trailing 4 Quarters

~ $2.1 Billion	Revenue
122,225	Inpatient Discharges
907,105	Outpatient Visits

Patients Served

Most Common Conditions (Q3 2012):

1. Neurological	21.2%
2. Stroke	16.1%
3. Other orthopedic conditions	9.4%
4. Fracture of the lower extremity	9.3%
5. Debility	8.9%

Marketshare

~ 8% of IRFs (Total in U.S. = 1,152)

~ 18% of Licensed Beds

~ 23% of Patients Served

Largest Owner and Operator of Inpatient Rehabilitation Hospitals in the U.S.

Q4 2012 Observations & Considerations (as of Nov 13, 2012)

Volume:

- As anticipated, October 2012 discharge growth was positively impacted by an increased length of stay at the end of September which rolled discharges into October.
- Discharge growth in November and December (holiday season) is always difficult to predict.

Storm Sandy:

- The bulk of the storm-related disruption was limited to two hospitals (Toms River and Tinton Falls hospitals in NJ). We do not expect the storm to have a material effect on HealthSouth's Q4 2012 earnings.

Balance Sheet:

- Redeemed 10% of the 2018 and 2022 Senior Notes
  - Approx. $65 million debt reduction
  - Q4 2012 will include an approx. $2.7 million loss on early extinguishment of debt

Q4 2012 Observations & Considerations (as of Nov 13, 2012)(cont.)

Growth:

- Continued construction on a replacement hospital for HealthSouth Rehabilitation Hospital of Western Massachusetts (53-bed)
  - This hospital will be owned and will replace an existing leased facility.
- Completed construction of a new 40–bed hospital in Ocala, FL
  - Expect to begin treating patients in December
- Continued development and construction of hospitals in:
  - Stuart, FL (34-bed)
  - Littleton, CO (40-bed)

Debt Maturity Profile

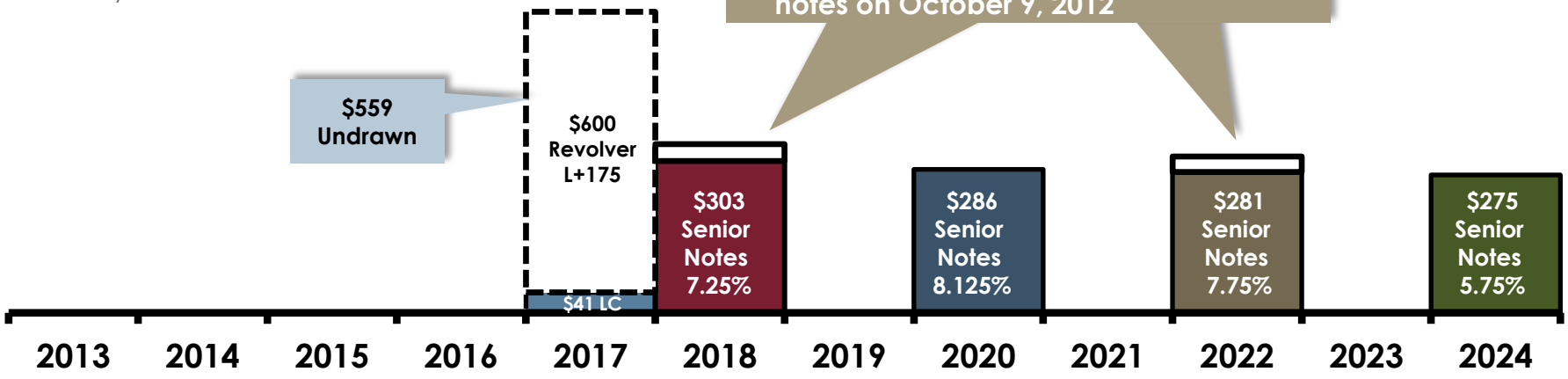
HealthSouth is now positioned with a lower-cost, flexible capital structure…

- Additional debt pre-payment opportunities and flexible covenants (1)
- No near-term maturities and well-spaced debt maturities
- Limited exposure to higher interest rates

Pro forma September 30, 2012 (2)

($ in millions)

- 10% of the outstanding principal is currently callable per annum at 103%.
- Redeemed 10% of the 2018 and 2022 notes on October 9, 2012



(1) The credit agreement has a $200 million restricted payment basket for debt repayment and stock repurchases, which is subject to an annual grower basket equal to 50% of excess cash flow plus certain other amounts including net cash proceeds from certain equity issuances.

(2) Does not include $342.2 million of convertible perpetual preferred stock and capital leases and other note payables.

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Priorities for Reinvesting Free Cash Flows

Priorities

Growth

(millions)

Growth in core business	2012 Assumptions	9 Months 2012	2011
Bed expansions (80 - 100 beds)	$20 to $25	$14.5	$12.5
De novo hospitals (complete Ocala; start 4 others)	$50 to $70	$28.8	$15.6
Acquisitions (target 2/year) - Free standing IRFS - Hospital Unit	TBD	$3.1	$6.5
	$70 to $95, excluding acquisitions	$46.4	$34.6

Alternate Opportunities

Debt Reduction

	9 Months 2012	2011
Debt pay down, net	-	$256.6
Purchase leased properties [1]	$9.4	$28.6

Shareholder Distribution

Convertible preferred stock repurchase ($125 million market repurchases)	$46.5	-
Common share repurchase ($125 million authorization)	-	-
Cash dividends (one time or regular)	-	-
	$55.9	$285.2

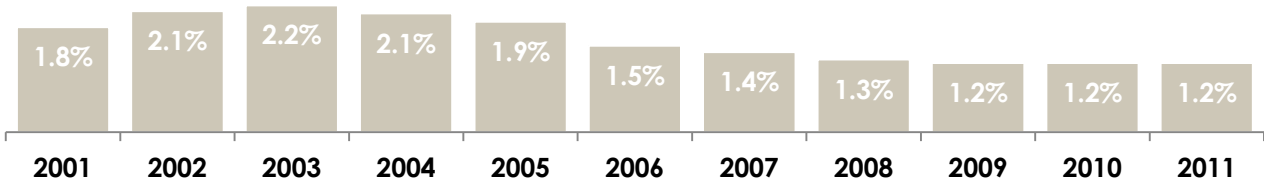
(1) 2012 includes the purchase of the real estate (previously subject to an operating lease) associated with our joint venture hospital in Fayetteville, AR for approx. $15 million, half of which was reimbursed to us by our joint venture partner through a capital contribution; also includes an initial investment for a replacement hospital for our currently leased hospital in Ludlow, MA.

Strong and Sustainable Business Fundamentals

Attractive Healthcare Sector	• Favorable demographic trends • Nondiscretionary nature of many conditions treated in IRFs • Highly fragmented industry
Industry Leading Position	• #1 market share: above industry same-store growth and margins • Consistent achievement of high-quality, cost-effective care • Roll-out of state-of-the-art clinical information system
Cost-Effectiveness	• Focused labor management • Continued improvements in supply chain • Significant operating leverage of G&A expense
Real Estate Portfolio	• Portfolio of strategically located, well-designed physical assets • 99 IRFs [1]; 65 owned and 34 long-term, real estate leases • Relatively low maintenance capex requirements
Financial Strength	• Strong balance sheet; ample liquidity, no near-term maturities • Minimal cash income tax expense ($8 - $12 million / year) attributable to NOLs • Substantial free cash flow generation
Growth Opportunities	• Located in Medicare growth markets • Flexible, accelerated de novo strategy • Hospital acquisitions and unit consolidations

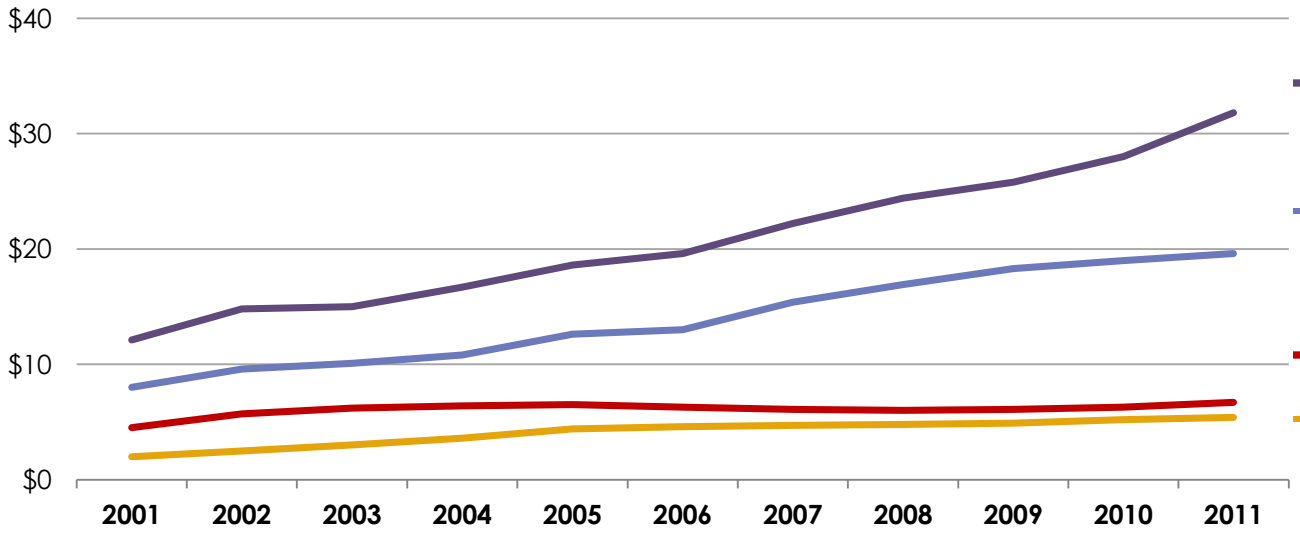
(1) Inclusive of nonconsolidated entities

Medicare Spending on Post-Acute Services



Inpatient rehabilitation spending (% of total Medicare spending)

Total Medicare Spending on Post-Acute Services **$63.5 billion** in 2011



Post-Acute Settings	2010 Medicare Margin	Projected 2012 Medicare Margins
Skilled nursing facilities	18.5%	>14%
Home health agencies	19.4%	13.7%
Inpatient rehabilitation hospitals	8.8%	8.0%
Long-term acute care hospitals	6.4%	4.8%

Note: These numbers are program spending only and do not include beneficiary copayments.
Sources: Center for Medicare & Medicaid Services, Medicare Trustees Report May 2012 – Page 6, MedPAC Data Book, June 2012 – page 118, MedPAC Report to Congress, Medicare Payment Policy, March 2012 – pages 184,193, 225, 227, 248, 251, 271, and 272.

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Our Cost-Effectiveness

Total Inpatient Rehabilitation Facilities (IRFs): 1,139

		Avg. Beds per IRF	Avg. Medicare Discharges per IRF [2]	Avg. Est. Total Payment per Discharge for FY 2013	Average Est. Total Cost per Discharge for FY 2011
HLS [1] =	97	67	896	$17,301	$12,371
Free-standing (Non-HLS) =	135	52	597	$18,603	$16,251
Hospital Units =	907	23	231	$18,249	$18,857
Total	1,139	30	331	$18,106	$16,805

HealthSouth "costs" Medicare less per patient, on average.

HealthSouth differentiates itself by providing superior quality care at a lower cost.

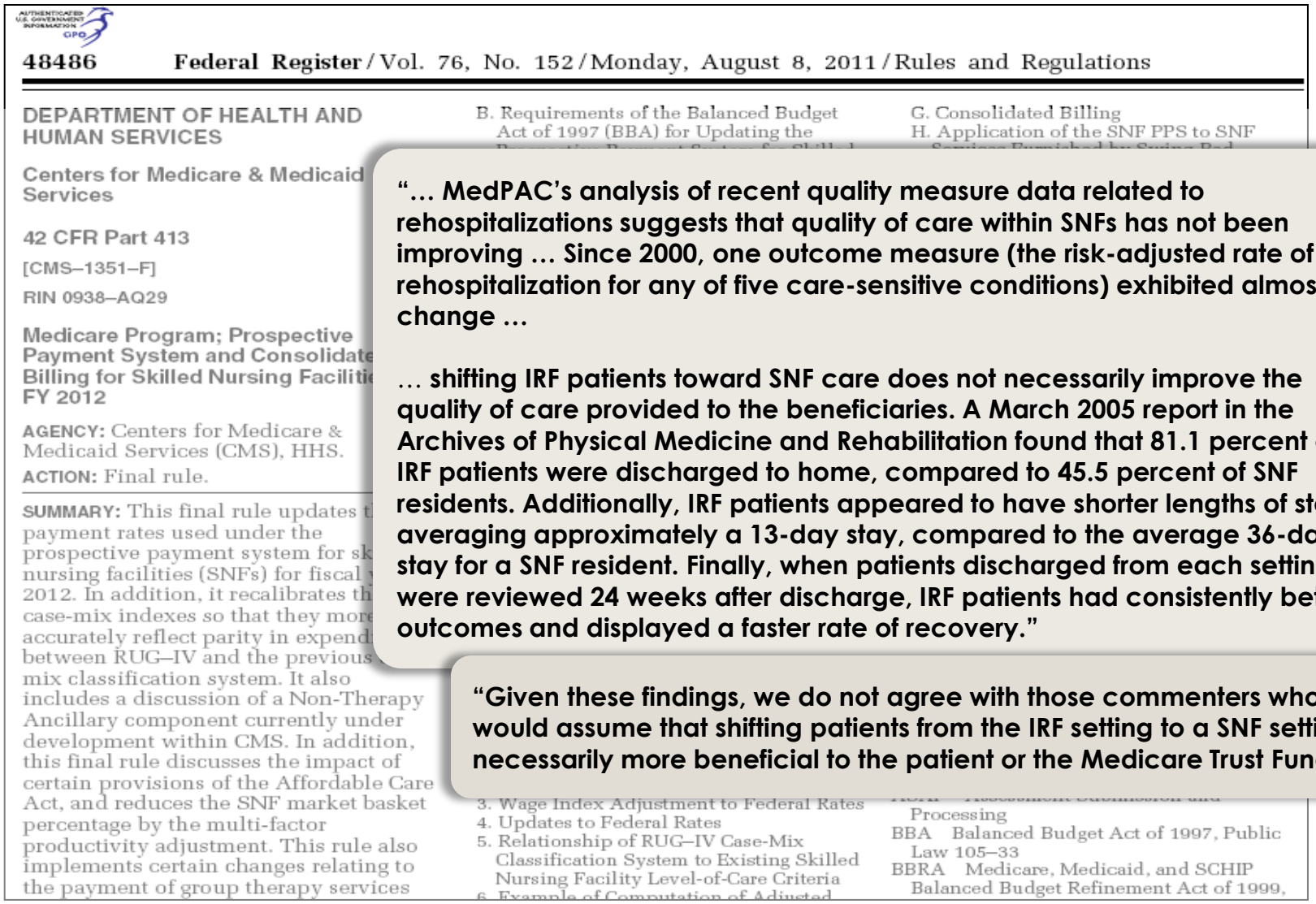
- ✓ Standardized clinical protocols
- ✓Supply chain efficiencies
- ✓Sophisticated management information systems

(1) The 97 for HLS does not include HealthSouth Rehabilitation Hospital of Cypress, TX, which opened in October 2011, or HealthSouth Rehabilitation Hospital at Drake, which opened in December 2011.

(2) In 2011, HealthSouth averaged 1,233 total Medicare and non-Medicare discharges per hospital in its 96 consolidated hospitals.

Source: Medicare Report to Congress, Medicare Payment Policy, March 2012 – page 239 and 240, FY 2013 CMS Rate Setting File

CMS: Inpatient Rehabilitation vs. Skilled Nursing



48486 Federal Register / Vol. 76, No. 152 / Monday, August 8, 2011 / Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

[CMS–1351–F]

RIN 0938–AQ29

Medicare Program; Prospective Payment System and Consolidate Billing for Skilled Nursing Facilitie FY 2012

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule updates t payment rates used under the prospective payment system for sk nursing facilities (SNFs) for fiscal 2012. In addition, it recalibrates th case-mix indexes so that they more accurately reflect parity in expend between RUG–IV and the previous mix classification system. It also includes a discussion of a Non-Therapy Ancillary component currently under development within CMS. In addition, this final rule discusses the impact of certain provisions of the Affordable Care Act, and reduces the SNF market basket percentage by the multi-factor productivity adjustment. This rule also implements certain changes relating to the payment of group therapy services

B. Requirements of the Balanced Budget Act of 1997 (BBA) for Updating the

G. Consolidated Billing

H. Application of the SNF PPS to SNF

3. Wage Index Adjustment to Federal Rates
4. Updates to Federal Rates
5. Relationship of RUG–IV Case-Mix Classification System to Existing Skilled Nursing Facility Level-of-Care Criteria

Processing

BBA Balanced Budget Act of 1997, Public Law 105–33

BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999,

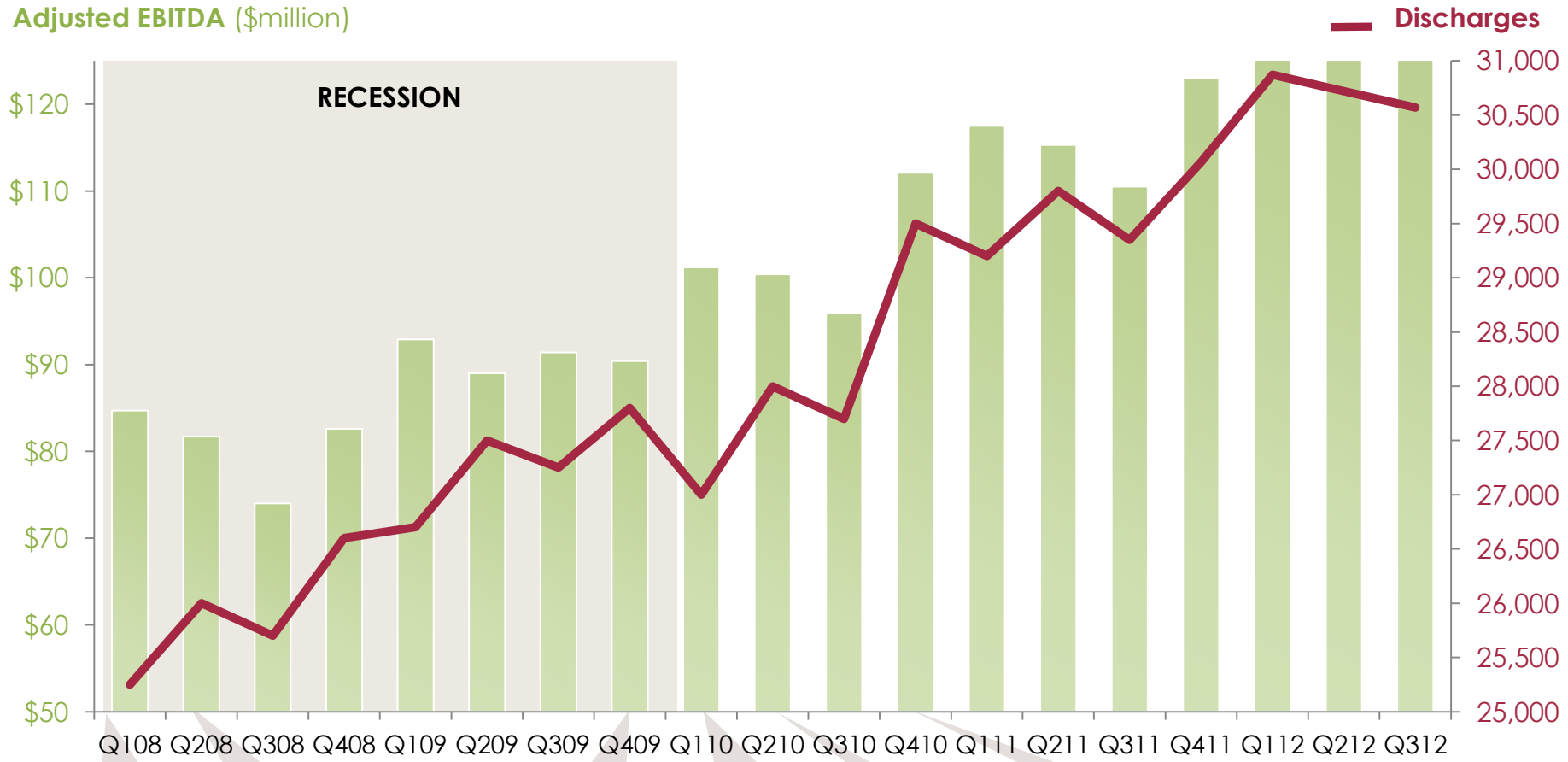
"… MedPAC's analysis of recent quality measure data related to rehospitalizations suggests that quality of care within SNFs has not been improving … Since 2000, one outcome measure (the risk-adjusted rate of rehospitalization for any of five care-sensitive conditions) exhibited almost no change …

… shifting IRF patients toward SNF care does not necessarily improve the quality of care provided to the beneficiaries. A March 2005 report in the Archives of Physical Medicine and Rehabilitation found that 81.1 percent of IRF patients were discharged to home, compared to 45.5 percent of SNF residents. Additionally, IRF patients appeared to have shorter lengths of stay, averaging approximately a 13-day stay, compared to the average 36-day stay for a SNF resident. Finally, when patients discharged from each setting were reviewed 24 weeks after discharge, IRF patients had consistently better outcomes and displayed a faster rate of recovery."

"Given these findings, we do not agree with those commenters who would assume that shifting patients from the IRF setting to a SNF setting is necessarily more beneficial to the patient or the Medicare Trust Fund."

Source: http://www.gpo.gov/fdsys/pkg/FR-2011-08-08/pdf/2011-19544.pdf

HealthSouth has successfully managed through Medicare payment cuts and an economic recession…



MMSEA (Final Establish-ment of 60% rule)

Medicare Price Rollback & 18 Month Freeze

1st Medicare IRF Price Increase Since 2007

CMS Implements New Coverage Criteria for IRF Admissions

PPACA Signed Into Law

Price Increase: Less PPACA Adjustment

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