Toby King, Managing Director, Citigroup

Good morning. I'm Toby King, in the healthcare investment banking group at Citi and I'm very excited to have HealthSouth with us today, specifically Doug Coltharp, Executive Vice President and Chief Financial Officer, and Ed Fay, Senior Vice President and Treasurer. This is the team that over the last 2.5 years executed a pretty material restructuring of the company's balance sheet, lowered costs, extended maturities, increased flexibility and really teed the company up for the next phase of growth.

We're excited to hear from them today. We have a brief presentation that we're going to walk through, that Doug and Ed are walking through, and then we'll turn it over to Q&A at that time. Doug?

Doug Coltharp, Executive Vice President and Chief Financial Officer

Thank you, Toby, and thank you all for your consideration this morning. We're going to take you through just about five or six slides to give you a quick update on the company and where we are on a quarter-to-date basis. And then we'll spend most of our time opening it up to your questions.

For those of you who aren't overly familiar with HealthSouth, we are the largest owner and operator of inpatient rehabilitation hospitals in the country. We've got 99 facilities. The next largest aggregation of inpatient rehabilitation hospitals within any single company is about 12. Our hospitals are across 27 states. You can see the geographic dispersion here with more of a concentration in areas like Texas and the Southeast. And from a market share perspective we operate about eight percent of the inpatient rehabilitation facilities that are out there in the country because on average our facilities are larger and more productive. We have an even larger market share when measured by the number of beds that are out there and by the number of patients served as well. And in terms of the types of patients that we serve, a little bit more than 20 percent of our patients are those who are suffering from a chronic neurological disorder and about another 17 percent are those who are recovering from stroke.

A couple of comments on the quarter as we cross over the midway point. Nothing really too surprising here. As we had discussed on our third quarter earnings call, we experienced what we think was an anomaly with regard to an increased length of stay with the patients who were in-house at the end of September, the end of our third quarter, which rolled some discharges into October. As a result, for the month of October we saw very strong discharge growth. As we look at November and December, because of the holidays those tend to be the most difficult months for us to predict from a discharge perspective and unlike each of the previous two years we don't have as much of a tailwind in the fourth quarter provided by new hospitals coming on board.

We did have two hospitals located in New Jersey, one in Tinton Falls and one in Toms River, that were impacted by Sandy. They recovered very quickly and as a result we don't anticipate any material impact on our fourth quarter earnings from the storm.

As we had announced in September, it was part of a refinancing that we'll talk about in just a moment, we did exercise a ten percent call option that we had on our 2018 and 2022 senior notes. That call option was actually consummated in October. That became a third quarter event. That was a cash use of roughly $65 million and it will result in a loss on extinguishment of debt of roughly $2.7 million that'll be in our fourth quarter.

Other comments on the quarter: Really all of the growth initiatives that we have previously discussed remain on track. Most significantly in terms of the near-term is over the next couple of weeks here we'll be bringing on board a new 40 bed hospital that was a de novo project for us located in Ocala, Florida and we're excited about that.

This slide shows where we currently sit in terms of our debt maturity profile. As I think everyone in this room probably knows, in September like a lot of other companies that are out there we took advantage of the very favorable conditions in the high yield market and issued $275 million in new senior unsecured notes

with a 2024 maturity and a 5.75 percent coupon. We used a portion of the proceeds to fund that call option on the 2018s and the 2022s that I referenced just a moment ago and then really replenished all of our capacity under our $600 million revolving credit facility with the exception of a small amount that was reserved for some letters of credit. And what you can see then is a debt capital structure that really provides us with a lot of flexibility as we continue to face a period of uncertainty with regard to reimbursement risk. On the front end, a lot of liquidity. We've got some cash on hand. We also have this very substantial capacity under our $600 million revolver, which isn't due until 2017. And then we've got relatively comparable sized layered maturities of senior notes that extend predominantly in two year increments thereafter.

A couple of comments regarding free cash flow: First, before we get to free cash flow, be aware that as we had anticipated and planned for we have had an increase this year in our maintenance capital expenditures. Whereas over the last couple of years we had run at kind of a $40 to $50 million range, this year we're running at $75 to $80 million and that's a range that will probably be fairly constant over the next couple of years and the increase is really attributable to two factors: One, this year we began the rollout across all of our hospitals of a new clinical information system. This is basically our equivalent of an electronic medical record. Recognize that unlike the acute care hospitals we are not eligible for any high tech reimbursement from the government. This is all on our gamble. The costs to roll that out are roughly $1 million to $1.5 million per hospital and we're doing it over a five year period, roughly 20 hospitals a year. That kind of puts you in this with roughly 80 percent of the costs being capitalized and the balance being expensed this adds about $25 million to maintenance capex on an annual basis.

The other component of the increase is that our 99 hospitals are of a very wide range in terms of the age of the facilities. We want to make sure that we continue to keep all of those in a very high quality condition. You'll see us doing a very substantial refurbishment of two to three of those per annum.

When we then get beyond the maintenance capex and look at free cash flow, our first priority is looking at compelling growth opportunities within the core IRFS space and we've got at least three different levels where we can do that. The highest and best use of our cash is for what we call bed expansions and that's adding additional beds in existing hospitals. And I say that that's the highest and best use because the risk adjusted returns are the highest and that's because we're making that investment when the demand for those services has already been well established and we're able to leverage the infrastructure that we already have in place in that market.

We're doing -- it'll fluctuate a number but we're looking to add about 80 to 100 beds to our existing hospital base. That's off of a base of roughly 6,500 to 6,600 beds on a per annum basis. The cost for doing so is about $20 to $25 million. The considerations that we have when we get ready to do a bed expansion are we're obviously monitoring the occupancy rates at those hospitals and we also have to look at the physical configuration of the plant and whether or not there are any licensing restrictions or CON restrictions that we have to go through on the front end.

Next, we look at acquisitions and really there are two types of acquisitions. First is across the country there are roughly 250 freestanding inpatient rehabilitation hospitals. Now we've got 99 of those and as I mentioned at the outset they get pretty dispersed thereafter. But we do occasionally get opportunities to buy a freestanding rehabilitation hospital. We made an announcement on one of these acquisitions very recently and that is the Walton facility in Augusta, Georgia. This will be our first entry into Georgia. We're very excited about that. That is a very well regarded hospital. We're looking forward to taking that facility over. We anticipate that that transaction will close in the first quarter of 2013.

We also from time to time get an opportunity to consolidate a unit out of an acute care hospital into an existing HealthSouth rehabilitation hospital and we announced a transaction of this nature back in the summer of this year, I believe it was in June, in San Antonio. Our RIOSA Hospital is a large 108 bed facility located in downtown San Antonio. One of the major acute care providers, the Cristus Health System, chose to exit that business, really convert more of the space to operating rooms, traditional med-surg type services. We paid them to basically exit that business and the hope is of course the volume that was channeling into their facility now comes our way.

And then in addition to the acquisition opportunity we do have the ability to engage in de novo growth. I mentioned previously the Ocala facility, which will be coming on board in a couple of weeks. We have two de novos that will come on board in 2013, another one in Florida, in Stuart, Florida that is a JV with the Martin Healthcare System and then we also have one in Littleton, Colorado, which is a suburb of Denver. We're excited about both of those opportunities.

When we move beyond that to the extent that we still have free cash flow, we'll look at whether or not there are opportunities to further reduce debt and whether that's warranted. I'll tell you right now we feel good about both the composition of our debt capital structure, as I reviewed earlier, and we feel good about the leverage that we're operating at as well. I wouldn't suggest that that's a large priority.

And we have in the past exercised some opportunities where they exist in our hospital leases to convert those into owned properties, either because there's a purchase option in the lease or because we're reaching the expiry of the lease and we choose to either buy that facility or build a new hospital in that market. On that last point, we do have a current example there. In Ludlow, Massachusetts, we've been operating in a leased facility. The hospital is a very productive hospital. It's more than 100 years old. The lease expires in two years. We've started construction on a replacement hospital that we will own in that market that's also a great new development in a community like Ludlow that doesn't have a lot of other engines of economic growth.

We've got more of those options. We've got about 15 in total over the next five years. Some of those, when we exercise a lease purchase option, just lead to a renegotiation of a lease on more favorable terms. In other instances we will actually consummate the acquisition of that property. And recognize that as we sit today we own about two-thirds of our real estate. We believe that that carries two advantages in the days ahead. One is, firstly, all leases are subject to annual escalations in the occupancy costs and those march on whether or not you're getting increases in Medicare reimbursement. Obviously we're not subject to that on our own properties. The second is we've got just a lot more flexibility about how we manage our real estate portfolio. To the extent that there are changes in the configuration of the delivery network on a local basis and we want to put an emphasis on one market at the expense of another market, we've got more flexibility to manage that plan.

And then last slide, I've gone a little bit longer than I had said I would on the frontend in the way of an introduction, but this is a slide that we use to just kind of tie together why it is that we feel we're excited about the opportunities moving forward, even with the uncertainty that exists out there and believe that our business is particularly well capitalized to seize on those opportunities. And I really just want to spend the last couple of minutes here talking about the first bullet point that appears on this slide, which is the attractiveness of the sector. And I'll get back to that chart that we had at the beginning that talked about the types of patients we serve.

Well, yes, it's true if you include Medicare Advantage we're about 75 to 80 percent Medicare and that's because the average age of the patient that we serve is 72. But the maladies that we treat are not going away. And as the demographic cohort that we serve continues to grow and for the next ten years it's going to grow larger than the national average because of the aging of the Baby Boomers and increasing life expectancy, you're going to have more patients experiencing those maladies that are going to require treatment. And this is not a business that is subject at all to technological obsolescence, not on the frontend in terms of there haven't been any pills invented that are going to make you not suffer a stroke or some of the neurological disorders. There are things that you can do in your lifestyle that potentially lessen the risk of those. But as the population ages the incidence of those maladies is going to continue to increase. And then once they do occur, there isn't any technology that can treat those patients other than that which is applied through the therapists and nurses who are the primary employees in our facility. We feel very good about the runway that is afforded in terms of the continued growth in the need for our services.

With those comments, Toby, I'll turn it over to you or we'll open it up for questions.

Toby King, Managing Director, Citigroup

Maybe I'll just ask a couple to get the ball rolling here. On the other side of the election last week it now looks that healthcare reform is going to move forward. As you think about what that could mean in the post-acute world, I would suspect that will result in some sort of closer coordination of care, potentially some sort of bundling and therefore emphasize the right care in the right setting at the right cost. How is HealthSouth do you think positioned for the changes that are going to happen?

Doug Coltharp, Executive Vice President and Chief Financial Officer

A couple things. First, with regard to the Affordable Care Act itself there's not a lot in the Affordable Care Act that has a very significant impact on our sector, on inpatient rehabilitation services. The primary thing within the Affordable Care Act is that it does set the market basket update. It says that there will be one through 2019 and then the productivity adjustments and then the incremental reductions that were mandated in the first couple of years. Those are not overly significant considerations for us. Because our patient base was already Medicare eligible the mandated increase in coverage really doesn't do a lot to change the demand for our services.

We do have sequestration which we believe will take effect in January, 2013 and we are not anticipating that it will be deferred or repealed, at least as it relates to Medicare providers. We're anticipating that that will take place. As we have disclosed previously, the impact to us is about $32 to $34 million in revenue because that's a pricing reduction that falls through to the EBITDA line. Having said that we did take one offsetting action and that is we are on a merit increase cycle for most of our employees that would take place on October 1, 2012 and extend it to October 1st of next year. This year, we elected to forego any merit increases and instead pay those employees a one-time bonus in December of this year. You'll see a larger salary, wages and benefit expense in Q4 of this year than we would have otherwise experienced but that results in about a $10 million savings as we move into 2013. The net impact is in that $22 to $24 million range.

Moving now directly to Toby's question in terms of what do we see in terms of changes in the delivery care network, I think I failed to mention on that asset when I was describing our business, but out of our 99 hospitals roughly a third of those are already operated in a joint venture with one of the acute care hospitals in our market. That gives us great insight as to what might be happening with regard to formations of ACOs or other similar models to really address patient care on an episode basis versus these more narrow segments that we've been dealing with to date.

We will tell you that from our perspective there hasn't been a lot of momentum behind those initiatives to date. With the election settled we would expect that to begin to accelerate. We are in conversations with all of the acute care hospitals, either that we have JV relationships with or who are simply significant referral sources to us because in all of our hospitals 95 percent of our patients come to us from an acute care facility.

As a post-acute provider, we're really not in a position to drive those networks. They've got to be driven by the acute care providers. But we do believe that we're very well-positioned to play as a participant and a big part of that is that we, if you could look at our data and this is contained in the Investor Reference Book which we just updated this week and which is available on our website, and we consistently produce amongst the highest quality outcomes in the industry and we do it on the most cost effective basis. When you start thinking now about acute care providers wanting to line up partners to handle an episode of care and do it in a way that ensures that there aren't readmissions back into the acute care facility but also make sure that the dollars that are provided to cover that episode of care cover the cost and also provide a reasonable profit margin, we think we're going to be a prime candidate.

Toby King, Managing Director, Citigroup

We talked a lot about de novo strategies. Can you help us kind of frame the opportunity? How much white space is there out there for de novos? Have you done the analysis to identify markets? Is there a laundry list of places you would like to go over the next three or so years? And how big of an opportunity is that really to grow the business?

Doug Coltharp, Executive Vice President and Chief Financial Officer

I'm going to ask Ed to take this one. In addition to his responsibilities in Treasury, Ed's group runs our business analytics area and one of the major things that they do is spending time identifying potentially good markets for us to move into.

Ed Fay, Senior Vice President and Treasurer

First of all, we do believe that there's going to be an opportunity to keep a stable pipeline of de novos developing. If you look at our map that we have back in slide number three, you'll see that we've actually got three under development right now, one that we're going to be opening up in December in Ocala, Florida. We have a joint venture arrangement in Martin County, Florida with the Martin Health System and then another that's going to be opening in Littleton, Colorado. Those ones are already under development.

In addition, we do have CONs pending. We've actually secured the CONs, one in the State of Delaware, one adjacent to our joint venture facility that we have in Nashville with Vanderbilt. This one will be in Williamson County. We do have other transactions in the pipeline currently that are pending some CON settlements. Beyond that, we still see more opportunities to develop new de novos, either in CON markets or in non-CON markets.

Furthermore, we still believe that the -- back to the original question about the Affordable Care Act and about some changes there, obviously acute care hospitals are already feeling pressure. They're feeling margin constraints and you know that there's a lot of, particularly in the not for profit sector there's been a lot of transactions, either mergers with those systems or with they're doing mergers into a for profit system. We see that as being still opportunistic for us in terms of growth opportunities, doing new joint venture arrangements with them or possibly just buying their unit and starting a new freestanding facility. And then finally, we could be even doing in market consolidations of the nature that Doug mentioned earlier in San Antonio where a not for profit provider there decided to exit the business and we were able to buy that and basically consolidate that business into our existing facility. We still think that the pipeline there will be stable and we see opportunity for de novo and acquisitions into the future.

Toby King, Managing Director, Citigroup

Maybe one more and then we'll turn it over to the audience. If you look back over the last three or so years, the entire provider universe has really struggled to produce any organic growth. HealthSouth has consistently done better than the provider universe broadly. What would you attribute that to and how do you think about the opportunity going forward to just drive organic top line growth?

Doug Coltharp, Executive Vice President and Chief Financial Officer

It's an excellent point. If you look and we've got a slide in the Investor Reference Book somewhere here, but over about the last ten years Medicare spending in the IRFS segment has been relatively flat from a nominal dollar perspective and as a result it's actually declined as a percentage of the overall Medicare spend. It's been just north of $6 billion and again that's about 75 percent of the revenues for all IRFS providers out there. The growth has been muted for the industry as a whole and yet HealthSouth has been able to experience very nice and very consistent quarter-over-quarter and year-over-year increases in both revenue and discharge volume, which obviously means we're taking market share. And we're taking market share by opening up new facilities and expanding the availability of this service in markets that were

previously underserved and we're also taking market share away from less efficient providers of these services.

We do believe that there's still some runway to go there. Also contained in our Investor Reference Book you'll see a number of different ways where we look at segmenting the margin, the profit margin for IRFS providers and we cut it by size and we cut it by nonprofit versus for profit; we cut it by freestanding versus acute care facilities. Recognize that we operate at a very nice EBITDA margin. We're north of 20 percent. But particularly when you start looking at the providers that are housed within an acute care hospital, their segment margins are low to single mid-digits. Some of that is a scale issue.

Those are going to be much smaller units and it's very difficult to get the labor productivity in one of those smaller units. They don't have the aggregation of facilities we have so they don't have the ability to leverage the corporate infrastructure and then also things come into play like supply chain management, again where there are scale opportunities. And they simply don't have the ability to climb the same learning curve that we have with regard to treatment protocols that makes us more efficient at treating these patients.

As a result, we think that if there is a more difficult reimbursement environment ahead of us it's going to force a lot of these acute care providers to make hard choices about whether or not they want to continue to be in that business. And this is going to be coupled with what should be an increase in traditional med-surg patients that flows from the mandated coverage in the Affordable Care Act. When that happens, there'll be certain of those units that we choose to buy because they were a profitable business and we'll consolidate that into one of our freestanding hospitals or that capacity will exit the industry. And again, we think that that'll be a benefit to us.

We do think that overall we would see expenditures in this segment growing a little bit faster over the next several years because of the increase in population but that we think we have opportunities beyond that to continue to take market share.

Toby King, Managing Director, Citigroup

Maybe I'll turn it open to the group here to ask questions directly. Since we have a few more minutes maybe I'll ask one more. You mentioned on your last slide here cost effectiveness is one of the business fundamentals. What would you want to highlight in terms of cost initiatives that you guys have underway to continue to drive expense control?

Doug Coltharp, Executive Vice President and Chief Financial Officer

I think the most significant area of emphasis for us over the last several years has been around labor management. There the most significant development was technology enabled. We have a proprietary software product called Beacon which is our labor scheduling system. And there are some slides that show you what kind of the Beacon screens look like contained in the Investor Reference Book. I encourage you to take a look at those.

But what it's done over the last several years is it now provides our hospital CEOs and the corporate office with real time data around all of the key labor metrics on a hospital by hospital basis. It's put our hospitals in a much better position to set staffing levels in accordance with the ADC on really a daily basis.

Now to contrast that, we've gone -- now we're at real time and that's been in place for the last couple of years. Prior to that, those reports were lagging by as much as a week. We were constantly playing catch-up. And when you think about that, the information was lagging by a week, our length of stay is 13 or 14 days. The patients stay with us about 14 days. We were well behind the curve. And now it has really allowed us to hone in on labor productivity.

I think we've also had some nice pickups. Supplies are a much smaller portion of our business than you'd find in an acute care facility for instance. But we've added some real sophistication both in terms of the personnel and the systems that we have in our supply chain and one of the initiatives that we've had in

place over the last couple of years was to take the drugs that do get used in our facilities and drive those towards the generic counterparts and that's allowed us to see anywhere from flat to slight decreases in drug costs whereas as a whole the industry tends to be rising at kind of an annual five to eight percent clip.

Ed, anything else coming to mind?

Ed Fay, Senior Vice President and Treasurer

Supply chain is obviously a very key part of the cost initiative and some of it is not just moving toward generics but obviously pharmaceutical companies are interested in holding on to their share and so we also can get savings on the name brand drugs. Then if the physicians have a preference, then they can stick with that. They don't have to move to the generic. But we've been able to leverage our scale and get better contracts with the name brands and we're getting savings there without moving to the generics.

Doug Coltharp, Executive Vice President and Chief Financial Officer

Two other things I'd point to real quickly there, I mentioned previously the fact that we own about two-thirds of our real estate. We're not subject to those annual increases in occupancy costs and yet we're increasing volume and getting pricing increases, which means we're getting increased leverage against the occupancy costs in our hospitals. And second is we have a very efficient corporate office and we're not adding to the cost of our corporate office when we add new hospitals or when we do bed expansions and so forth. That's staying relatively fixed. That's, again, a smaller factor but we're increasing leverage off of the G&A spend as well.

Toby King, Managing Director, Citigroup

Last chance for questions from the audience. I guess that means you've done a great job with the presentation.

Doug Coltharp, Executive Vice President and Chief Financial Officer

Thank you all for your attention today.

Toby King, Managing Director, Citigroup

Thanks for being here.