Darren Lehrich, Analyst, Deutsche Bank Research

Okay. Good morning, everybody. We're going to get started here. I'm Darren Lehrich. I lead DB's healthcare providers team and we're really happy to have HealthSouth here joining us at the conference. For this particular session, we're going to be doing a fireside chat, if you will. So I'll be leading the discussion a bit and certainly welcome your questions as we move throughout. So I'm not going to end with Q&A. Really, it's just going to be a continuous discussion. I really encourage you to raise your hand and get the mic in and ask questions.

So I'm going to introduce the Company and with us today, Jay Grinney, President and CEO; and Doug Coltharp, he's the Executive Vice President and Chief Financial Officer. Many of you know Mary Ann Arico here in the front representing IR. And so with those introductions, I'm going to just get us started here with a little bit of a discussion around operations and we'll shift around a bit this morning, but Jay, I guess just to get the conversation started from a fundamental perspective, one of the more striking things to me over the past five years or so has been the consistency of HealthSouth's volume growth and not just in absolute terms but in relative terms.

I think in the first quarter, your same-store discharges were about 400 basis points above industry and they've been running at about that level in terms of differential over the past year or so. So maybe, Jay, just help us think through what's driving that and how you think that's going to be sustainable.

Jay Grinney, President and Chief Executive Officer

Okay. And for those of you here and those of you that may be dialing in, we do have what we refer to as our Investor Reference Book, a copy of which is available here and also online and I may be from time to time referencing that just to help you get oriented in. If you go to page 12 in the Investor Reference Book, you'll get a sense of what Darren was talking about in terms of what the difference has been in our market share gains and growth versus the rest of the industry.

And as Darren pointed out, we have consistently outperformed the rest of the inpatient rehabilitation industry. I think that the reason for that is or the reasons actually are several. First and foremost, this is all we do. Our business is exclusively providing inpatient rehabilitative care to patients who need that care. Typically, those requiring rehabilitative services are those having some kind of impairment, be it neurological or orthopedic, oftentimes complicated with medical conditions that impair their ability to function independently. So that means that they -- because of their illness or illnesses, most often that's illnesses, they are unable to care for themselves or unable to bath themselves, to feed themselves, to ambulate without assistance. They are in a very dependent state. Many of our patients are stroke patients or neurological patients.

So our focus has always been on providing care to those patients and to implementing best practices around clinical protocols, around staffing protocols, that will optimize the outcome for that patient, in contrast to our competitors, most of which are small departments or units of acute care hospitals. So you -- on the one hand, in a given market, you have HealthSouth with a anywhere from a 40 to 80-bed hospital, specializing in nothing but inpatient rehabilitative services with a wide range of expertise, a huge focus on neurological and stroke, all of the latest technology, all of the latest equipment and in many cases a disease-specific certification from Joint Commission.

As a sidebar, our hospitals all look for Joint Commission certification in stroke care. We have 92 of our 102 hospitals have that certification and those 92 hospitals represent 80% of all stroke certifications in the United States by the Joint Commission. So you can get an appreciation that the focus on what we do and the fact that it's exclusive then differentiates us from a quality standpoint and an outcome standpoint and I start with that, because that really is at the core we believe of what's driving that consistent volume growth. There's clearly a demographic element that is lifting all boats as the over 65 population increases. That rate of growth is now in the 3% plus range, driven by this baby boom cohort that is becoming Medicare eligible and then -- so that's lifting all the boats.

We think we differentiate ourselves from a quality standpoint, but then we have also looked to standardize the approach that we take in assessing potential patients, identifying whether or not they are a candidate for inpatient rehabilitation, linking in the admitting physician and then bringing that patient into our hospital, standardizing that approach so that the referring hospital -- and 95% of our patients come from an acute care hospital, the referring hospital has a decision very quickly from HealthSouth as to whether or not we can accept that patient because the motivation at the hospital level, acute care hospital level is once they've decided that patient needs to be discharged and discharged to rehab, they need to get them out as fast as possible in order to open that bed up for the new patient. So it's a lot of different issue -- factors, Darren, but I think that at the core of what makes our market share gains I think impressive but also sustainable is the fact that we really do have this as our core mission. Most of our competitors have it as an ancillary service, not a core service.

Darren Lehrich, Analyst, Deutsche Bank Research

That's great. And just keying into the market share topic, I know you gave us the quarterly rundown of how your overall growth is compared to industry but just given the metric you just cited, the 80% of accreditation for the stroke accreditation, what do you think your overall growth rate has been in the stroke category in market share terms? I know you're not at 80% but how has that fared?

Jay Grinney, President and Chief Executive Officer

I don't -- we don't have data sources that would allow us to see what our market share is of stroke. I know that if you go back, say, five years, six years, that stroke was in the top three discharge categories that we treated, but it certainly has grown very consistently over the last five years. And for those of you who may not be familiar with inpatient rehabilitation regulations, there's a rule out there, a Medicare rule called the 60% rule that mandates that 60% of all patients must come from one of 13 qualifying conditions and stroke care is one of those qualifying conditions. That regulation went into effect in 2004. It got phased in and the threshold was -- for compliance was set at 60% in 2007.

Prior to 2004, the industry was oriented primarily towards orthopedic care; knee replacement, hip replacements, and other orthopedic conditions; and industry-wide, about a third of all patients going into rehabilitation facilities were orthopedic patients. In our hospitals, that was closer to 18%, 20%. Fast forward to 2013, the knee and hip replacement patients in our hospitals is closer to 7% to 8%. The industry, it's in the 15% range. So, the industry has shifted. We have shifted. I think we have shifted probably a little faster and I think that, that what you see there is probably what you'll get going forward as well.

Darren Lehrich, Analyst, Deutsche Bank Research

Just my last question on the competitive landscape and your market share drivers, when you think about the skilled nursing facility setting, do you think referral sources have lost confidence in their ability to manage patients? And you mentioned the units at general acute care hospitals, but how do you think about skilled nursing and how you're competing there?

Jay Grinney, President and Chief Executive Officer

Well, skilled nursing plays a role for certain patients. There isn't a lot of overlap between what we do and what nursing homes do. And on page 32 of the Investor Reference Book, we highlight some of those differences. And on page 33, we highlight how CMS perceives those differences. The level of care is much more intense. We're licensed as a hospital and have to meet all of the licensure requirements state by state and at the federal level to maintain that hospital status. Nursing homes obviously are licensed quite differently and without reciting all of the differences that are on page 32, clearly, the level of medical care, nursing care, and therapy care is significantly more intense at a rehabilitation hospital than a nursing home.

That being said, there are certain patients -- for example, there are certain, what I would consider, relatively simple or non-intensive knee and hip patients who can be treated in a nursing home. They are being treated in a nursing home not by choice so much as by that regulation that I just mentioned a minute ago, 60%. Many of our physicians would prefer to take and admit the patient into a rehabilitation hospital but

because of the 60% rule and specifically because knees and hips are not considered a qualifying condition, they're really unable to admit into a nursing home. So we don't see nursing homes as being a significant competitor across the full spectrum of our patients, certainly not in terms of stroke and neurological care.

The level of oversight is just so different that we don't see much of a competitive threat there. And I think given the scrutiny in nursing homes and the fact that CMS is coming out and saying, two years ago, they've looked at it and they don't see that there is any benefit to the patient nor to the Medicare Trust Fund to putting patients into skilled nursing facilities instead of going into an inpatient rehabilitation hospital. And they, as you see on page 33, they identify some of the qualitative differences and outcome differences that are obvious for those kinds of different patient populations.

Darren Lehrich, Analyst, Deutsche Bank Research

That's great. Again, if you have a question, feel free to raise your hand. I'm going to shift gears a little bit to Medicare and CMS. Jay is referencing a rule-making on page, slide 33, but we did recently just get a proposed IRF Rule and appears like the overall rate update was in line with most people's expectations. There were some I guess more administrative and technical things in the rule relating to the removal of non-specific codes. How should we be thinking about the proposal in that context and your ability to capture the same types of reimbursement, now that these codes have been taken out?

Jay Grinney, President and Chief Executive Officer

Okay. So on page 30, we've summarized some of those differences and as Darren mentioned and for those of you who may not be familiar with healthcare services, each year, Medicare submits for comment period proposed rules that would then govern the way they would be administering the program vis-a-vis that sector. So acute care hospitals get a proposed rule. We have hospitals get a proposed rule, nursing homes, et cetera. Our proposed rule came out recently. There's a comment period we're preparing our comments and the key changes in the proposed rule are seen on page 30. First is a market basket update that's mandated by law that we get a market basket update unless Congress decides to come in and change that.

You can see that the increase that's being proposed is a 1.8% net market basket update. There are some additional facility-level adjustments; the net-net for HealthSouth is going to be closer to a 2% and that 1.8%, the difference between 1.8% and 2% is really at the facility level, not at the outlier level. And as a sidebar, if you were to go to slide nine, you get an idea of how -- I would say, how the outlier payment methodology is in sore need of adjustment and change, and we'll tackle that another time. But suffice it to say that we don't get any benefit on the outlier payments because our cost structure is very low. There are some hospitals out there that are getting huge, huge premiums for being inefficient and we think that's a huge opportunity for Medicare to look at how they pay hospitals for outliers and adjust that to reflect true severity and not have it be driven just by cost. So it's my little soapbox.

The big changes on the 60% rule, as you can see in the middle box, so just to set the stage, there are 1,307 codes that Medicare currently uses to presumptively or through an algorithm, a computer algorithm, they look at all of the hospitals' discharges and they have an algorithm that has in the numerator 1,307 codes and that is a -- the codes that they have said, if the patient is coded in one of those codes, we Medicare are going to presume that the hospital is compliant with the 60% rule. The proposed rule is to take 331 of those codes out and force the hospitals to then be better at coding the remaining -- or excuse me, putting the patients into one of the remaining codes.

We think that for the most part, that's going to be a change that the industry can accommodate and just to give you an example, some of the codes, the vast majority of them that are being removed, have in the coding the designation, the term unspecified and that typically refers to the extremity; is it a left extremity, is it a right extremity? Is it total or is it partial? And so there are other codes that are specific, that can be used in replacing that generic unspecified and so yes, I think it's just a matter of the industry moving toward being better and more accurate at coding. We've already started that process and we think that that's going to be a relatively straightforward adjustment for us to make. I expect that it will be a straightforward adjustment for the industry to make as well.

One exception is in the arthritis codes, they are taking some of those codes out of the numerator as well. We still think that we can adjust to that within our Company. What we're hearing from the industry is a little more consternation about their ability to do that as well. Having said that, we are concerned that by eliminating those codes from the presumptive, there may be patients with legitimate arthritic -- or arthritis codes who will not be able to have access to a rehabilitation hospital simply because that hospital may be sitting there with the decision to take that arthritis patient and potentially fall below the presumptive testing and in an abundance of caution, that hospital may say no, unfortunately, we're not able to take you and bring you into the -- our facility because if we do, CMS now is going to be coming in and doing a full-scale review of all of the patients and that's time consuming, it's expensive and it's not going to be worth the effort.

We don't think that that's going to be the case in our hospitals. In fact, we've looked at that and we think we can make this adjustment, but we do have an overarching concern for patients' access and it does go back to the initial comment I made about outliers and that is if this rule and if this new twist is designed to try to reduce payments to inpatient rehabilitation providers, CMS is going about it in our opinion the wrong way. They're limiting access and therefore potentially reducing payments to rehabilitation providers.

Our recommendation has been, and we've presented this on the Hill. It doesn't make us particularly popular in our industry, but if you go to page nine and you look at the dollar amount going to rehabilitation providers in the form of outlier payments, you can see that in 2012, I believe it is, yes, so this is the 2013 rate setting file, $204 million went to rehabilitation providers for outlier payments. You go all the way up to the top, 51% went to 113 facilities and we've looked at those 113 facilities and their case mix index is no higher and in many cases is lower than what we have in our hospitals. The difference is their cost structure is significantly higher and so the outlier payment methodology uses a cost-to-charge ratio.

If your costs are exorbitant, you're going to be eligible for outlier payments disproportionately to those who have a low cost structure. So what we're saying to Members of Congress and the CMS is, listen, you guys, you want to look at ways to reduce payments to providers, don't take it and put it on the back of patients and deny access to care for Medicare patients, put the burden on the providers to get their cost in line. And if you do that and you just look at that $204 million, you take that and reduce that by 20%, 25% or 50% and you put that out over ten years, you've got a lot of savings. You apply that same concept to acute care hospitals and other providers that are subject to outlier payments and you can start to see there are huge saving potentials that are out there.

Darren Lehrich, Analyst, Deutsche Bank Research

Yes. Now, it's a fascinating topic around outliers. We've seen that moving before in other industries. So I'm hopeful that CMS is at least hearing your message.

Jay Grinney, President and Chief Executive Officer

They are. It's, I'll tell you that that is a -- it's kind of a third rail. We are persona non grata in our industry for bringing that up, and I know many of my friends and brethren in the acute care world will probably be very concerned that that topic is raised, but the reality is, is it's based on cost and there's not always a correlation between acuity and cost, and those of us in the industry know that and there's got to be a better way to really identify true outliers that are based on really severe cases, not just outliers that tend to cost a lot because the overall cost structure is so inefficient.

Darren Lehrich, Analyst, Deutsche Bank Research

Jay, I want to shift a little bit to development and we've seen your de novo strategy start to hit its stride. I know you're out there with the target of about four per year, but I wanted to ask a couple of things along the lines here. First, just given the fact that your model, your de novo model comes out of the ground with 40 beds and that's somewhat smaller than your overall Company average, it seems like these projects could have higher occupancy rates and therefore, higher margins. How do you see that as a driver of margins as you go forward? And do you think that's the right framework?

Jay Grinney, President and Chief Executive Officer

Well, first of all, you're right. You're absolutely right. When we looked at what the prototype ought to be back in 2006 and 2007, as we were positioning the Company to be a pure-play inpatient rehabilitation company and we knew we would be in a growth mode. We looked at all of our hospitals and we had a wide range as you said and identified the 40-bed as sort of the prototypical most-efficient model. Now, over time, we've certainly looked at that and we have 50-bed models out there frankly in some of the newer hospitals that we're contemplating bringing on stream that will begin as 50-bed hospitals. All of our hospitals, 40 or 50 though, are designed to expand and to add beds very quickly and very efficiently.

So we build the prototype, be it or 40 or 50 with gym, a therapy gym, a kitchen, a back office, ancillary services designed at a larger chassis so that when we do add the incremental beds, we'll be able to do so without having to go back and add some of those core services as well. But that's -- it's clearly the most-efficient model and we do believe that as we go down the road over the next say ten years, we keep adding new hospitals and you can see on page four, we've got I think eight hospitals that are in some form of development, some have already opened up, two most recently. We've got a couple more that are under certificate of need litigation and we hope to get those results pretty quickly, but we do think that the more hospitals we add that are in that 40 to 50, the more it will help us from a margin standpoint.

Darren Lehrich, Analyst, Deutsche Bank Research

And Jay, do you think we'll be on a different pace of M&A? Just the one or two acquisitions that we've seen over the last several years per year. Do you think that changes over the next two years or three years?

Jay Grinney, President and Chief Executive Officer

We update our model on an annual basis. We're not updating that today. What we've said publicly, and on our calls, is that the development pipeline is getting deeper and we are seeing frankly more acute care hospitals that offer inpatient rehabilitation hospital services in their hospital, looking for a partner to help better manage their rehab services going forward and we feel that we've got 30 hospitals today; 32 of our 102 hospitals are in some kind of joint venture affiliation and the next hospital that opens down in Martin, Florida, will be a joint venture with Martin Health. So we do see the possibility of more coming on, but at this point until we get a little bit further down the road, we want to stick with that. You can count on four acquisitions, two -- excuse me, four de novos, two acquisitions or some combination thereof. And at the appropriate time, we may update that, but certainly the development pipeline is getting a little deeper.

Darren Lehrich, Analyst, Deutsche Bank Research

Doug, I don't want you to fall asleep. It's too early for that. So I want to bring you in the conversation a little bit here. I apologize I've been focused a little bit more on Jay, but just shifting gears a little bit to the capital structure, obviously, a pretty successful tender offer and wanted to get your input on how you're thinking about buyback and going forward, how you think about your capital structure overall?

Doug Coltharp, Executive Vice President and Chief Financial Officer

Yes, I think the tender offer for us, which was very successful in our minds, marked a real turning point in how our Company as a whole, and specifically our Board is looking at the allocation of excess free cash flow and also utilizing some of the excess capacity we have in the balance sheet. And as Jay was quick to point out at the time that we launched the tender offer and as he reiterated in our first quarter earnings call, which was after the completion of the tender offer, it was not intended to be a once and done type of transaction. If we look at the way that the capital structure is set right now and if we look at the free cash flow that the Company is generating, we believe we are in the enviable position of being able to have our cake and eat it too.

We can fund for the foreseeable future all of the high-quality growth opportunities that we believe we will be presented within the IRF space and still have excess cash flow that can be utilized to enhance returns to our shareholders through various forms of distribution and what we've said previously, and will confirm

again today is that all forms of those distribution are under consideration. So, we will certainly evaluate the efficacy and appropriateness of incremental share repurchases, whether those be in the form of tender offers or open market repurchases and we're contemplating whether or not it will make sense for us to engage in any dividend payments, whether those be kind of periodic special-type dividends with the initiation of a regular dividend.

Jay Grinney, President and Chief Executive Officer

And Darren, I would just say to echo what Doug said, if you look on page 46, that's what we use to help articulate what our business outlook is and what the different elements of the strategy are for the Company. Prior to 2013, that very top line, that shareholder distribution element did not exist. And as we turned the corner and as Doug said, through our discussions with the Board, we've now been able to articulate that this is an ongoing component and will be an active component of our strategy and the use of that free cash flow.

Doug Coltharp, Executive Vice President and Chief Financial Officer

I do want to say that I think one of the things that you should not anticipate from us is that we would go out and lever the balance sheet up significantly, even recognizing how advantageous the debt capital markets are right now to make a large distribution. So anything that would be in the category of a leveraged recapitalization, I would classify as highly unlikely for us. We like the flexibility that we've created in the balance sheet. We think there are going to be opportunities to enhance the acquisition pipeline down the road and we just think that given the uncertainty that's out there that we enhance our ability to be able to respond to any environment, if we keep the leverage at an appropriate level.

Darren Lehrich, Analyst, Deutsche Bank Research

Yes, now, I think that's clear and there's clearly opportunities to reprice some of your debt. It seems like 7% and 8% was a good outcome just a few years ago. We're in a different environment clearly. I guess just one last thing on this topic is given that the tax settlement and the state of your NOL, which is over $1 billion in gross value, does that change at all your thinking about the next one to two years just given the tax shield that you have?

Jay Grinney, President and Chief Executive Officer

No. What Darren is referring to for those of you who may not have seen this, the day before we announced our first quarter earnings, we actually reached a settlement agreement with the IRS on a residual tax claim that dated back to 2008 in prior years and that settlement resulted in us adding $260 million in gross federal NOL to a balance of $970 million that already existed at the end of the year. You can do your own estimate as to what our taxable income will be in the years ahead to determine the number of years that that will allow us to basically go without paying significant cash taxes.

Our current estimate is that we'll pay about $8 million to $12 million in cash taxes per annum. And in making that calculation, one assumption that I would provide you is that we think it's fair to use an effective tax rate of 38% to 40%. That is a very important and valuable asset for us. I don't think it necessarily changes our strategy in terms of thinking, well, do we want to do something to accelerate the utilization of that NOL by perhaps monetizing the real estate, or something like that. It isn't enough of a catalyst to do some kind of game-changing transaction there as well, particularly because those federal NOLs are not subject to any kind of expiry date. So we will -- it's just a matter of time, we will continue to generate net income and again depending on your forecast for how that net income rose over time, it's going to allow us to fully utilize the NOL over the next several years.

Darren Lehrich, Analyst, Deutsche Bank Research

Just in the time remaining, one last question we're asking companies that are in planning phases for their health plans and putting the other benefit packages for 2014. Curious just to get your thoughts briefly on

take rates in the Company and how you think that might change in 2014 and whether there's any bigger benefit plan design changes that you're looking at?

Jay Grinney, President and Chief Executive Officer

We're not looking at any significant benefit plan design change. What we have done over the last couple of years is to introduce increasingly attractive alternatives from a wellness standpoint, both from an incentive standpoint, incentivizing our folks to be tested and those who have some kind of chronic disease to maintain their compliance with their program that would be appropriate for that condition. We think we've got a pretty good benefit program. We don't see any changes. We don't also expect that there are going to be a lot of new employees who are signing up and we're just now beginning the negotiations and identifying who we're going to use as the third party.

Darren Lehrich, Analyst, Deutsche Bank Research

Great. That's all we have for time. Want to thank Jay and Doug for joining us and everybody here.

Jay Grinney, President and Chief Executive Officer

Thank you.