Gary Lieberman, Analyst, Wells Fargo Securities LLC

Good morning, everybody. Welcome to day two of the Wells Fargo Healthcare Conference. I'm Gary Lieberman, Wells Fargo's healthcare facilities analyst. We're very happy to have HealthSouth this morning. With us from the company, we have Jay Grinney, the CEO. I have a number of questions for Jay. If anyone in the audience has a question, please put your hand up, and we will get a microphone over to you. Alternatively, you are welcome to text me questions. We'll put the – the instructions are up on the screen if you want to text me a question. So with that, I will get started. So, Jay, maybe talk a little bit about how the sequestration cuts have impacted you. Has it been as expected, or is there anything out of the ordinary?

Jay Grinney, President and Chief Executive Officer

Nothing out of the ordinary, it's pretty much as we expected. As we reported on our first quarter call, we did see a modest impact in the first quarter for patients who were admitted in March, but discharged in April. And then that really was not as we had originally envisioned, but then certainly everything beyond that is very consistent with what our expectations have been.

Gary Lieberman, Analyst, Wells Fargo Securities LLC

Okay. A lot of the discussions centered on cost of care comparisons across different settings. Can you talk a little bit – you've talked in the past about how inpatient rehab facilities stack up versus some of the other post-acute facilities.

Jay Grinney, President and Chief Executive Officer

Yeah. I think one thing that we – maybe just make sure we're all on the same page, when we talk about – when I talk about cost of coverage for rehab or SNF; I'm referring to the payment by the Medicare program, not what does it actually costs to provide the care. I think on the latter, we do an outstanding job of providing high-quality care on a cost-effective basis considerably less than our peer group in the IRF industry.

In terms of comparing the cost of care, the superficial way that's been done in the past is to look simply at the cost per day. And you'll hear oftentimes the skilled nursing industry saying that they are a less expensive alternative because they're being paid by Medicare an average of $450 to $550 a day, and rehab facilities get paid between $1,000 and $1,100 a day. And so on a per-day basis, there's no question. There's a cost differential to the program.

What's interesting though is that CMS is beginning to look at things more from an episodic standpoint. They just recently issued a huge trove of data that we have a third-party going in and analyzing. And some of the preliminary results that we're seeing from that analysis indicates that, in some states where we have a huge presence, Texas is an example, Florida is an example, other states where we have a modest presence, say, California, Tennessee.

On a cost basis, spending for rehab patients is actually less than what Medicare is spending on SNF patients for the same kind of diagnosis and the same kind of underlying medical condition. So this whole notion that there – that SNFs are a lower-cost alternative, I think, is becoming more sophisticated. And instead of looking simply at the per-day difference, people are starting to look at things like, how many re-admissions occur from SNFs versus IRFs? How long does a patient stay in? How many of those patients go directly to home? And so it's really now looking at the value of SNF versus IRFs. And we're very excited about this and we're going to continue that analysis to get a better handle on exactly what those – that benefit is.

But I think that that then speaks to the whole question of site-neutral payments and that there are a lot of people concerned that that, if and when it gets implemented, would automatically mean that IRFs would be

disadvantaged. Well, if we're seeing today that in those – some of those key states that IRF spending by Medicare is actually less than what they're spending – what Medicare is spending for the same kind of patients going into a nursing home, and if you then say there's going to be some sort of site-neutral payment implemented in those – for those patients, it's not inconceivable that the payment would actually be either neutral or slightly beneficial for a rehab especially if they're splitting the difference. And not so good for nursing home providers.

Gary Lieberman, Analyst, Wells Fargo Securities LLC

Okay. Any questions from anyone in the audience? Just talk a little bit about the proposed changes to the 60% rule and the code list and what, if any, implications there might be for HealthSouth?

Jay Grinney, President and Chief Executive Officer

Sure. And by the way, we have – I hope everybody has got a copy of this. We do this on a quarterly basis. It's our investor reference book. We have copies here for the audience members. It's also online. We update it after each quarter, and it provides, I think, a very good amount of information to understand the company. And what I'm going to do now is refer to page 30 of that book just to make it easy for us to talk about this.

So the proposed rule for rehab providers basically had three components: the update, which is pretty straightforward for our company. It's going to net out to be just under 2%. 1.99% is what we're expecting that per unit pricing to go up. There's going to be some new quality reporting measures. We don't have any problems getting ourselves ready for that.

The question that Gary asked is on the 60% rule presumptive methodology code list update. Just as a way of a background, we have what's called the 60% rule that all rehab providers have to abide by. And that rule states that 60% of all patients have to come from 1 of 13 qualifying conditions. You can find those qualifying conditions on page 29.

What Medicare has done and will continue to do is to assess each IRF's compliance with that 60% rule through one of two means. The most frequently used, and the first method of assessing, is called the presumptive methodology. And so they have today about 1,400 different codes that they put in an algorithm. And if your patient, or if an IRF's patients, are coded in one of those 1,400 codes and as they run their test, if the resulting analysis indicates that more than 60% of those patients are in those codes, you are presumptively assumed to meet that 60% threshold.

If for some reason you don't meet that, that doesn't mean that you're undesignated as a rehab provider, the local fiscal intermediary, or MAC, as they're now called, will go in and will do a case-by-case review to determine whether or not you meet that 60% threshold. So the rule – the proposed rule, as you can see in that middle bucket, is to reduce or to take out 331 of those 1,307 codes, so about 25% they're just going to take out. And so that's no longer going to be used in that presumptive testing.

There's a good number of those codes, the vast majority of them, that when you go in and you actually look at the way the code is designated, the term unspecified is in that specific code. And what CMS is saying and, frankly, we think this makes a lot of sense, is that there are additional codes that can be used that would change and remove the word unspecified and replace it with lower-left extremity, upper-right extremity. And just to be a little more specific as to, is the impairment related to both legs, both arms, one side, the other side. And so that change, I think, is going to be pretty easy for the industry to accommodate.

The more challenging one, I think, for the industry, is going to be taking out certain arthritis codes. And those are – if you go back to page 29, that would be number 10, osteoarthritis, the rheumatoid arthritis. And you can see it's after a less intensive setting. And so, going forward, I think providers are going to have to be more diligent going into the acute care record, or having evidence that those less-intensive settings have in fact been exhausted before the patient gets admitted into the rehabilitation setting.

So we're already starting that process of educating our coders, getting that more specific code. We think that this is going to be a change that, if it goes through, we will be able to accommodate. We suspect that there are going to be some rehabilitation providers that might struggle a little bit with this.

The bigger concern, I think, just from a policy standpoint, is that there are going to be arthritis patients, we believe, who will not get rehabilitative care simply because the rehabilitation provider may be concerned that they're too close to that 60% threshold. By putting the patient in, they may presumptively fall below that 60%, and then they're at risk of some medical director coming in from the fiscal intermediary and going through case by case by case. And then you run into the situation where the FI medical director says, no, this patient should be treated in a SNF. And the rehab doctor says, no here's all the reasons why it should be treated in a rehabilitation facility. And then what happens is that those then go into an adjudicated process that takes a long time. And I think a lot of rehab providers are going to just say that's expensive. That's cumbersome. There's no way of knowing how that – what the outcome is going to be. So, to be safe, we're just not going to treat that arthritis patient.

And so then that arthritis patient is going to have to go into another setting, and there are going to be some of those patients who really need to be in a rehabilitation hospital. They simply won't get it. And that's our biggest concern is that the access to the needed care may be compromised.

Gary Lieberman, Analyst, Wells Fargo Securities LLC

Okay. I'm not sure if you had a chance to listen to the hearings on Friday on post-acute, but if you did or heard anything, what were your thoughts...?

Jay Grinney, President and Chief Executive Officer

Yeah. We have a full-time Senior Vice President for Government Relations, Public Policy and Legislation. He's based in Washington, fabulous resource. He is a tremendous asset to the company, a fellow by the name of Justin Hunter. He attended that hearing, and one of the takeaways that we had that was actually encouraging was that there were a lot of questions about the 60% rule because in President Obama's fiscal year 2014 budget, he is proposing that that threshold be reset from 60% back to 75%. And there's some information, I'm not going to bore you with it, but there – if you go into this investor reference book, there's a history on the 60% rule. And it'll give you a little bit more information on that, in fact, that starts on page 28.

So the takeaway that we got that we found encouraging was that there were a lot of questions from members, from committee members about this in questioning both Mark Miller and Jonathan Blum who were there testifying about why do we really need to change this. And in response to those questions, both Mr. Miller and Mr. Blum characterized this rule as clunky. It was crude, which in our mind and I think in the minds of some of the members, really begs a question, well, if it's clunky and crude, why are we doing it? Simply because it's there? I mean, that's really unacceptable to just acknowledge that something is crude and blunt and sort of better than nothing.

And so we kind of walked away from that hearing, thinking that the efforts to reset the threshold from 60% to 75% is going to be a bit of an uphill battle because of the clunkiness and crudeness of it. But also if you go back, and you see on page 28, Congress set the threshold at 60%. It originally was at 75%. But Congress set it at 60% back in 2007, and there were 240 original co-sponsors on that bill in the House, and 61 in the Senate. So it wasn't the small little effort. It was a huge bipartisan effort. Congress pushing back saying, wait a minute, 60% threshold is more than sufficient especially for something that's clunky and crude to limit patient access to rehabilitative care.

Gary Lieberman, Analyst, Wells Fargo Securities LLC

Okay. Earlier this year, HealthSouth completed its tender offer. What do you expect to do with your excess cash now that that's completed?

Jay Grinney, President and Chief Executive Officer

There are a lot of levers that we can pull, and if you look on page 57, we've outlined where the priorities for investing that cash flow are. We're going to continue to grow the business and have a very good development pipeline. We feel very good about that development pipeline. It includes both de novos, acquisitions, joint ventures. We do have the opportunity to repay – to prepay some of our outstanding debt. On page 61, you can see we have the ability to redeem 10% of the 2018s and 2022s. We did that last year in October. We can do that once every 12 months. We haven't made any decision yet as to whether or not we will do that, but that's an opportunity for us to take out some of that expensive debt at 103%.

We do have some hospitals that are leased where the leases are running out, and we have the opportunity to go in and to buy out those leases, take control of the asset, and we will be doing that this year. We've already talked about that publicly. And then we have the opportunity to continue to look at share buyback and dividends either recurring, special, and then to the extent that the preferred are available, look at trying to take those out as well. So we've got a lot of different levers that we can pull.

I think the thing for shareholders to appreciate is that prior to 2013, the company's focus was really two-fold: get the balance sheet to be as strong as it possibly could be; and get that leverage ratio down below three times, which we did last year. And the second was to invest the free cash flow of the company into growing the company.

In 2013, we've really, in a sense, moved into a new era where the size of that cash that we're generating is sufficient for us to now consider and execute strategies that go beyond growing the business. We're not foregoing that growth – those growth opportunities at all. In fact, we're going to continue to invest and to grow the business. But the reality is that we're just generating a lot of cash and we have tremendous liquidity. Our leverage ratio today is still below three times. We've got a lot of capacity on the revolver. And we have the ability to then look at these other value-creating strategies that returns capital to the shareholders.

Gary Lieberman, Analyst, Wells Fargo Securities LLC

Talk a little bit about the impact of healthcare reform that you think it's going to have on the business.

Jay Grinney, President and Chief Executive Officer

On our business, the impact is frankly going to be more on our benefit cost. We don't know what that's going to be. But as we all know, previously, employers could offer the plan and employees would either opt in or not, depending on where they stood and their family and what their personal preferences were going to be. 2014, everybody has to come in and then you've got to opt out if you want – if you don't want to have covered by the company.

So we've got pretty good participation now. We don't know what the impact is going to be yet. We're in the process right now of going through an RFP process. We've got insured product for our employees, so we're talking to our existing benefits company, it's Blue Cross Blue Shield of Alabama, and we're looking to go out and talk to other companies just to see what the market might give us in terms of better pricing, better product, all right, it's going to have an impact there.

On our volumes, it's probably not going to have much of an impact. If it does, it'll be upside, frankly, we're not as – we're not going to be benefited the way acute care hospitals are because we don't have any bad debts. Right now, our bad debts are 1.2% of our total net revenues. If you look at the acute care hospitals is closer to 10% to 15% and the benefit for them is going to be a portion of that gets rolled over. And now they're going to be – there's going to be some sort of coverage for those patients.

That benefit really isn't going to be there for us. We may pick up some to be able to provide care for patients who we can't today because Medicaid, in many states, doesn't cover inpatient rehabilitation. Going

into the exchanges, it will be a covered service. So we may get some additional volumes, but we have not – we're not building our business model on that. If we get that, it'll be great. It'll be additional services that we can provide.

Gary Lieberman, Analyst, Wells Fargo Securities LLC

Okay. Any questions from anyone in the audience? HealthSouth has done a great job of growing their admissions faster than the overall industry. Can you talk a little bit about some of the factors that allows you to do that?

Jay Grinney, President and Chief Executive Officer

Yeah. I think one of the – the most important factor is that, this is all we do. I mean, when Mark Tarr, who's our Chief Operating Officer and he's here today, he and the regional presidents, the hospital CEOs and the hospital teams, wake up each and every day, all they do is focus on inpatient rehabilitative care, providing the best care that is achievable, making sure we're investing in the right technology and the right equipment to serve the patients' needs. And that's in sharp contrast to many of our competitors, most of whom are acute care hospital units or departments. So they're basically 20-bed, 15-bed units that are in a wing of an acute care hospital. They're able to meet some of the limited demands of their patients in that acute care hospital, but they don't have the ability to offer the wide range of services that a specialty provider can, such as HealthSouth.

And if you then look at what is actually occurring in the marketplace, many of our competitors, especially some of the larger systems, admit and treat only those patients who are on that list that I mentioned earlier of compliant cases.

So if you think about the potential universe of patients, there are many out there that are not on that list, but they do meet the medical necessity criteria as set forward by CMS, and we take – for every six patients that come in that are compliant, we take four patients that are not on that list, but they meet medical necessity. Well, there are some systems out there that, all they're doing is taking the compliant cases. And in some instances, those decisions are being made at a central level, and that just – that makes, at the local level, for a less responsive effort to bring patients in and to provide that care in a timely manner.

So I think it's a combination. This is all we do. And because of that, we are able to take patients who are more medically ill and provide that care and get them home, whereas a less sophisticated provider, perhaps one that is – doesn't have the same depth and doesn't have the same clinical depth, are not able to take those patients. And so those are the patients that we end up taking.

QUESTION AND ANSWER SECTION

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Okay. Questions here?

<Q>: [indiscernible]

<A – Jay Grinney – HealthSouth Corp.>: I would not agree with that decade.

<Q>: [indiscernible]

<A – Jay Grinney – HealthSouth Corp.>: It's a fact of life. We don't really bring that into our strategy discussion per se. What we do is, we obviously model when that might expire and when we would become a cash taxpayer above that $8 million to $10 million that we're paying today.

So we incorporate it into our thinking, but we don't develop strategies around trying to maximize the NOL because, frankly – and when I say that by – there's nothing that we're – we don't have a specific track that

says, here's our NOL strategy. Strategy is really grow the company, return value to the shareholders, and then the NOLs will sort of be exhausted at some point in the future and then – on the other side of that.

But even with that, all of the decisions that we're making today in terms of share buyback, in terms of growth, possibly looking at the preferred, possibly looking at dividends, regular or special, all understand that NOL is a finite asset and yet it's providing some nice shielding today. But at some point that's not going to be there. But the company is still going to be able to grow, the cash is going to be very sufficient to meet all of the objectives that we set forward on that previous stage that I talked about.

And just in terms of your question on the acquisitions, we have been very disciplined, but the tender, I think, indicates where we think the best acquisition opportunities are today. We look around in our neighborhood, our post-acute neighborhood, and there's really nobody else that we would rather invest and buy than HealthSouth, nobody. So people say, why aren't you out there buying? Well, we are. We're buying the best company in the post-acute space, and that's HealthSouth.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: On that note, maybe could you talk about other verticals within post-acute and if HealthSouth would ever consider moving into SNFs or home health or...

<A – Jay Grinney – HealthSouth Corp.>: I think, as we look longer term, and I'm always a little reluctant to go down this path because my definition of longer term is 5 to 10 years, and I know there's – everybody here is just long only, and you've got exactly the same time horizon. There may be a few of you that are looking at this quarter or maybe this year. But when I look at long term, I'm looking at five years and beyond, not within the next five years, five years and beyond.

In that kind of environment, I believe there is some chance. It's not a foregone conclusion – other people think it's a foregone conclusion, I don't, that a good part of the Medicare reimbursement will be in some kind of bundled or accountable care organization configuration, and I think some portion of it will be. I don't believe that it's going to be 100% by any stretch.

In that kind of environment, providers, especially post-acute providers, who can offer a wider range of services, I think, will be better advantaged. Our thinking is, we don't need any more facilities because in that accountable care organization environment, and this was talked – mentioned at the post-acute hearing on Friday, a lot of those regulations that exist today that's silo, IRF and SNF and LTAC and home care, all – a lot of those are going to go away. They don't – if Medicare – they exist today only to determine how a provider is going to be paid. That's the only purpose that they exist – for which they exist.

Well in an ACO environment, Medicare doesn't care. They're just going to put one check down into the ACO and say, we're going to monitor your quality and make sure that you guys are not compromising care. And in that kind of environment, without any of those silo regulations, we don't need any more facilities. What we would need to have, to supplement what we do in the facilities, would be a home care capability that would then offer the full continuum of care for the patients requiring post-acute care. And we – that's what makes sense for us.

Now, there are some saying, why aren't you doing that today? Why aren't you looking at home care today? We are, but we're – as we look at home care today, we see a lot of headwinds. We see the rebasing next year. We still got a lot of scrutiny in Washington on home care and overutilization and gaming the system. I think there's a lot more shakeout in home care to occur. And we'd rather be on the other side of that shakeout and maybe have to pay just a little bit more, with a lot less risk, than taking the risk today and screwing up basically what we've created, which is a very strong company and a very strong balance sheet, lot of growth in our core business. And there's nothing that says that we have to do that today, because the industry is moving so quickly into this risk-sharing kind of payment system.

Now, longer term, again, five years out and beyond, yeah, maybe that becomes something that is essential. When we look at home care, we'll be looking at that on a regional basis, not a national. It makes no sense for us to go and look at an Amedisys or a Gentiva or LECG where – or Almost Family. They have – their footprint does not coincide with ours. So why would we want to buy home care in Minnesota when we don't

have any hospitals there? And if we're going to build that continuum out, now we've got to go up to Minnesota and build a bunch of hospitals to supplement the home care. It would be much – we think, a much smarter thing to look at our existing portfolio, build out where we know there's a need for inpatient rehabilitative care and then, through regional or market-specific acquisitions, buy that home care capability over time. But again, that is not anything that we're looking to do in the near term.

Gary Lieberman, Analyst, Wells Fargo Securities LLC

Okay. Unfortunately, we're out of time. So thanks very much for being here today, Jay.

Jay Grinney, President and Chief Executive Officer

All right. Thank you, Gary. Appreciate it.