Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Okay. I think we're going to go ahead and get started. Good afternoon, everyone. I'm Whit Mayo, the Senior Healthcare Facilities Analyst at Robert Baird. It's my pleasure this afternoon to have the management team from HealthSouth.

Representing the company today is Jay Grinney, the Chief Executive Officer, and Doug Coltharp, the Chief Financial Officer. Jay is going to spend I think a couple of minutes giving a high-level overview of the organization for those who may be new to the company and story. And then we'll get right into Q&A if anyone has any questions, please feel free to raise your hand at any point in time. And there are headsets available for everyone that you can hear very well out of.

So with that, Jay.

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Jay Grinney, President, Chief Executive Officer & Director

Great. Thank you, Whit. In addition to Doug and me, we also have Mary Ann Arico, who is our Chief Investor Relations Officer. She has copies of the investor reference book for you here in the audience. For those of you who may be dialing in, you can find that on our website, go to the Investor Reference section and you can see a copy which we update by the way every quarter.

So what I thought I would do, just take a minute or two to orient those who may not know about HealthSouth to our company. We are the largest provider of in-patient rehabilitative services in this country. We have 103 hospitals. In addition to those, in-patient rehabilitation hospital services, we also have a number of out-patient satellite clinics providing physical therapy, occupational therapy for patients on an outpatient setting. And then about two dozen hospital-based home care providers that are providing care for patients discharged from our hospital, who then need some follow on care in their home.

As you can see from the bottom of the slide, from a market share standpoint, the number of facilities that we operate is about 9% of all of the inpatient rehabilitation facilities nationwide. Our hospitals tend to be larger as characterized by the fact that we own and operate 19% of the beds, and as a result of that size, we continue to gain market share and currently serve 21% of all patients being – excuse me, patients requiring rehabilitative services in this country. So you think about the HealthSouth, one out of every five patients who receives inpatient rehabilitative care in the United States gets that care at a HealthSouth Hospital, and that's without any presence in the state of New York, as I think most of you know, there is a prohibition against for-profit providers in the state, unless all of the shareholders are also residents of the state and we only currently have two hospitals in California. So two of the most populous states we have no presence, a minor presence we're going to be obviously growing our presence as you see on this map with the addition of – in California with the addition of the hospital in Modesto.

The patients that we treat are all discharged from an acute care hospital. They're admitted by a physician. They are then under the care of a rehabilitative specialist in our hospitals in collaboration with nurses, physical therapists, occupational therapists, and speech therapists. The purpose of their care is to get them from a state of relative dependence by virtue of their illness to a point where they can function independently and resume their lives with their families and their communities and their loved ones. As you can see in the bottom right-hand portion of the slide, most of the patients we treat have some kind of neurological condition, stroke, chronic neurology, neuropathy, I should say and then a host of orthopedic conditions.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Great. I thought I would probably just start off by getting some of the Medicare government questions out of the way so we can move on to kind of your key strategic initiatives underway. We've got doc fix coming up. We've got the debt ceiling, and there has been a lot of discussion around post acute care reforms. So I am just going to kind of throw that out as one big topic and maybe Jay if you could cut that in different ways, and sort of how do you see HealthSouth's exposure to some of these events and how this evolution of the post acute care system may unfold?

Jay Grinney, President, Chief Executive Officer & Director

Okay. So we look at the events in Washington, and we think of it in sort of three buckets. First is will there be anything in a budget that would impact inpatient rehabilitation providers? I think we all recognize time has essentially run out in finalizing a budget, especially given the distractions – the very serious distractions that are occurring in the Middle East. So, everyone is now focusing on a continuing resolution, getting that passed between now and the end of this month, whether it's short-term in duration or longer-term in duration I don't think really matters in the big picture, it is going to be in lieu of a budget that may or may not have included provisions specific to inpatient rehabilitation. So that bucket we feel does not contain any significant specific risk in-patient rehabilitation.

The second bucket that we look at is when the debt ceiling is breached, will there be a showdown in the federal government. Will there be an attempt to create some kind of grand bargain that would include major reforms to Medicare and if so, would there be anything specific in that grand bargain that would be unique to inpatient rehabilitation. Our sense is that the likelihood of a grand bargain is going down pretty precipitously. We don't feel based on the intelligence that we have and the people we have on the ground and Washington that that is anything that is imminent, that there is a plan that's going to be unveiled that will balance the budget over a longer period of time and allow the debt ceiling to be raised without any controversy.

So the final bucket is going to be the doc picks and then the question is will it be a large doc picks or comprehensive doc picks. I think CBO scored that at about $150 billion, which is a big reduction from where it was two years ago. There is some incentive in Washington to grab that number and try to use that as a fix, but then the question is where you're going to pay for it.

So traditionally what we're hearing or historically what we're hearing was the doc picks would occur within the context of a grand bargain. Now with the grand bargain is questionable is that major doc picks also questionable, we think it is, and so I think what we're going to be faced with is a short-term fix and we don't believe that inpatient rehabilitation providers are going to be disproportionately affected in part because we're only a $7 billion segment for Medicare. We represent 1.2% of total Medicare spending, and that percentage has been very consistent for the last 5 years. So it's not like inpatient rehabilitation spending is out of control. It's a runaway issue. It needs to be addressed, and it's going to be a means for pain for an ultimate doc picks.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Got it. And maybe that as a segue into just the broader concept of post acute care reform and it's – there's been a lot of energy devoted towards this topic and we are probably years and years and years away from any of this manifesting itself into real payment reform. But how do you see inpatient rehab inside of bundling and site-neutral payments and how would you assign risk factors to that in the next 5 years?

Jay Grinney, President, Chief Executive Officer & Director

Well. I think on the site-neutral, that issue has been out there for quite a while and it's – it's a very complicated issue as evidenced by a report that RTI submitted last year after being requested to look at that and to try to come up with a site-neutral payment methodology. And somewhere maybe Doug, you can help me find the page, page 31 of the – that's Mary Ann – Mary Ann Arico, gives you an overview of the site-neutral payment discussion and what prompted this the RTI report that came out last year, that basically said this is really complicated it's going to take a long time to develop a methodology that can be tested. And so, we feel that in that 5-year timeframe, the risk for this is pretty low. Conceptually though, I will say, we don't see site-neutral payments being automatically negative for inpatient rehabilitation. In part because we do believe that a site-neutral payment would include things like incorporating readmission rates into the site-neutral payment, taking into consideration that there are requirements that we have as an inpatient rehabilitation hospital that nursing homes do not have to abide by, for example 24-hour, seven-day-a-week nursing care, three hours of therapy per day for every patient. Those requirements do not exist for nursing homes.

So, presumably in a site-neutral payment system, those cost differences would also be waived. And so in that kind of environment, we feel very comfortable that our outcomes would be vastly superior to those that would be achieved in the nursing home setting. So, when we talk about site-neutral, I don't want anybody to think that that's automatically a negative for inpatient rehabilitation providers, in part because as you know we cannot treat the number of knee and hip replacement patients today that we would like to.

And in a site-neutral payment system, the limitation that we are under today, where we can only treat a narrow range of knee and hip replacement patients should go away because the payor, Medicare should be totally indifferent to where that setting – where that patient receives the care. They should be only focused on the outcome and the quality of that care. So, the site-neutral is not I think an issue that we're seeing, materializing over the next couple of years in that 5-year timeframe.

Bundling yes, there are going to be pilots of bundling projects. We've participated or signed up to participate in some whether or not we'll ultimately end up participating I think is to be seen depending on what the criteria are et cetera. But as we all know, it takes a couple of years to pilot. It then takes some time to evaluate the results of the pilot and then to take the next step of either modifying the pilot and testing it again or determining whether or not there is something there to be rolled out across the entire industry. So, within a context of 5 years, do we see huge changes, the answer is no. In the context of 5 years, do we see a continued evolution of post-acute reform, yes.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Great. Maybe shift topics a little bit just to your top line trends and your volumes. When you look at HealthSouth's results over the past, really 3 years to 4 years since we've seen, I guess some stabilization in the payment system, the company has successfully grown same-store discharges in the low to mid-single digits, quarter in, quarter out for years now. Can you maybe decompose some of the factors you think that's driving that demand for your service and your volumes or the market share and maybe some of the characteristics that make inpatient rehabilitative care a little bit less inelastic of a service than maybe some other subsectors that a lot of us follow.

Jay Grinney, President, Chief Executive Officer & Director

Okay. So, first as you can see in this – in our reference book, 80% of our patients are Medicare patients and it's not because we are going out and saying that's all we want to treat. It's more a function of the kind of care offered in a rehabilitative hospital – rehabilitation hospital is care provided for conditions where patients are impaired and their ability to care for themselves has been diminished. That typically happens as a result of either trauma to a lesser degree or to a much greater degree because of strokes, because of

chronic neurological conditions, because of hip fractures, all of which the elderly are more susceptible to than are the younger population. So, as we look at the demand profile for inpatient rehabilitative care, we look at what is the projected growth rate of the over 65 population? And that number is 3%. So there is a 3% CAGR sort of demand component of our business. That is something that we take a lot of comfort in that from a long-term perspective, there is a very nice growth profile for inpatient rehabilitative services and there is a demand for those services that will grow.

And then as you think about that cohort living longer, there is an even additional component to that demand. But the question about, well, why are we outperforming the rest of the industry? I think is, first starts with the fact that this is all we do. If you look at the rest of the industry about 900 of the 1,130 some inpatient rehabilitation providers, are departments or units of acute care hospitals. They are not the core business of that acute care hospital. They are an ancillary business, and oftentimes a very small component of that acute care hospitals' operations. They treat fewer patients, they don't have the technology that we are able to offer, we establish clinical pathways through a comprehensive network of physicians, 103 hospitals, therapists, nurses that allow us, we believe to be on the leading edge of taking care of patients with inpatient rehabilitative needs. So, at the core of our volume growth has been the ability to demonstrate to physicians, patients, their loved ones that the care at HealthSouth hospitals is going to be superior and is going to be meeting the needs of that individual patient. We then supplement that superior product if you will with a standardized sales and marketing program that allows our marketing liaisons to meet with physicians to assess the patient, to determine on a very quick turnaround basis, whether or not we are able to take care of that patient and then to facilitate the patient coming in.

Once the patient is in our hospitals, we then have a standardized care management program that will shepherd that patient through until they are discharged and focused on the discharge status of each and every patient. So, there is no one single sort of magic bullet that we have that allows us to be successful in taking market share. It's a combination of having first and foremost, great hospitals with superior outcomes that we can demonstrate to physicians, we can achieve standardized sales and marketing program and then an approach to getting the patient to a point where they're independent and then discharged to the right setting so that they can continue their progress.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Great. And for maybe those in the audience that did not see the press release, you have filed an 8-K indicating that third quarter volumes to-date have been....

Jay Grinney, President, Chief Executive Officer & Director

Very solid.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Very solid, yes. Okay. On those same lines is the organic growth. I do want to before moving on to a different topic, talk about the investments that you're making into your technology, your IT systems. You're not being reimbursed, like the acute care industry is for complying with high tech and meaningful use. You are spending significant capital towards this area. Can you talk about the return that you expect to get there and really why make the decision to do this and how you think this will, I think really position HealthSouth over the next 2 to 3 years as hospitals are – move in this direction as well?

Jay Grinney, President, Chief Executive Officer & Director

Yes, we have information in the investor reference book on the pages 76 through 81 for those of you who want to get some additional information, actually through 79. So, as Whit said, we're making the investment in Electronic Medical Records system, not because we're incentivized to do so through high tech, but because we believe it will position our hospitals to be responsive to whatever new world order our industry is evolving to. Whatever that new world order looks like from a reimbursement standpoint, is it risk sharing, is it not, do we have narrow networks or broad networks, one thing that we do believe is going to be important is to have that transferability – that electronic transferability of information among provides, and we want to make sure that we're able to do that and receive information. We think it will facilitate our admission process. We think it will facilitate our referrals from acute care hospitals. If we are able to take that information electronically and assess the patient and be able to respond very quickly, we think that there is – there are patient care values to the EMR. We think it will help reduce medication errors. We think it will help improve the coordination of care today in the medical record, a single medical record. The therapist who may be charting that record in the therapy charting room is taking us – taking the record away from the nurse, who is looking for the medication information that she needs and so we think by having it all electronically based, some of those inefficiencies are going to go away.

And then, frankly on the labor side, a lot of our nurses, a lot of our therapists, particularly those who are just coming out of programs, are coming out of programs where they've been on in electronic medical record and they step into our hospital and they say oh my god, you guys are still paper charting, I mean this is the dark ages where – when are you going to become part of the 21st century and get on an EMR, and so there are a lot of reasons why we are doing it. It is expensive. We've made the commitment to do it, we're not looking for any – don't expect that we're going to get any kind of reimbursement from the federal government, but we think it's the right thing to do long term. I don't think it's going to really bring any value to us in the next 2 to 3 years. I think it will bring tremendous value to us in the next 10 years – 5 years to 10 years.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Got it. Okay. And maybe talk about your staffing, what the market looks like in terms of therapists, what your wage inflation trends have been, you've been able to I think manage that fairly well even in light of the sequester, but maybe give us a glimpse into sort of that expense item?

Jay Grinney, President, Chief Executive Officer & Director

So it's about 50%, 48% of our total net revenues go to salary wages and benefits. And we're seeing the about a 2% to 2.5% per year uptick in the labor cost and we've been able to manage to that range over the last several years without having a negative impact on turnover, our turnover at the therapy level is quite below national averages. It's about 8%, the national average is 15% to 18%, our RN turnover is about the same as the national average and we're looking at improving that through a number of different initiatives. But so the wage rate inflation is going to be somewhere in that 2% to 2.5% range.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Got you. You've had a number of initiatives underway also to drive efficiencies, productivity through the entire organization, where there was team works, you continue to see a lot of improvement on EPOB as a statistic. Can you maybe talk about some of the initiatives that underpin the margin improvement and leverage you've been able to capture on SWB?

Jay Grinney, President, Chief Executive Officer & Director

I'll talk about SWB and then I'll ask Doug to talk about some of the other initiatives outside of labor. Labor has really been – the improvements that we've seen there has really been by virtue of bringing on incremental patients, and doing that in a very marginally profitable way. So every new dollar of revenue derived from a new patient, we're not adding – having to add a new dollar of revenue – new dollar of expense in salaries and benefits. So we have – we made the decision several years ago, we're not going to try to cut our way through expenses to profitability, we're going to focus on growing our way through to profitability by bringing on new patients, making sure the services that we offer are high quality and not look for layoffs or squeezing the labor force, but looking for ways to bring more patients in and then being very disciplined as we add patients to meet that demand.

Douglas E. Coltharp, Chief Financial Officer & Executive Vice President

I think once you move beyond the labor component of our cost structure there, leads to three other opportunities for increased operating leverage. One of those is through supply chain optimization. We've been making some strides there recently, particularly in the areas of food service and pharmaceuticals, but there are other areas of that spend that we're looking to address. It's not a huge opportunity, but it's an important incremental one nonetheless.

The second relates to our occupancy cost and unlike any of our peers in the post-acute provider space we own the very substantial majority of our real estate, we currently own about 70% of our properties. Out of the third of our – or less than 30% of our properties that are leased we're also taking steps where options exist to convert those to own properties. And in fact we had five purchase options embedded in leases that became exercisable this year, it's our anticipation that we will consummate all five of those purchases, that's a spend of roughly $100 million to $110 million potentially.

When you move beyond this year, the opportunities to do that fall off, so that we think we'll have the ability to do perhaps one hospital a year in the ensuing years at a cost of $15 million to $20 million. The fact that we have such a large percentage of our real estate owned, gives us two benefits with regard to operating leverage. The first is, it's a fixed cost and therefore as we drive same-store sales or we do capacity expansions at those facilities, we're generating a higher margin on flow through and related to it being a fixed cost when it's not under a lease, it's not subject to the types of automatic escalators that exist in virtually all of the operating lease arrangements that we've been a party to.

And then the final opportunity for operating leverage is just the expenses related to our corporate office. We have the ability to add a lot of operating capacity out in the – our network of hospitals without adding really any incremental cost to our corporate office.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Great. We've only got a few minutes left. But I wanted to shift topics to capital deployments since we've started discussing the lease buy ups. Can you maybe rank and file the priorities for capital at this point, talk about the environment for joint venturing with non-profit hospitals, outright acquisitions, de novos and any other opportunities that you see.

Jay Grinney, President, Chief Executive Officer & Director

Sure. If you turn to page 57 you can see how we look at the use of our free cash flow and first and foremost, we want to continue to grow the business. We think there are opportunities through building new hospitals either alone or in partnership with acute care hospitals and joint venturing there we have operations.

We've targeted four per year, and we think that that's the right number going forward that we'd be able to bring online. We also think that there are going to be some acquisition opportunities out there, those are fewer and far between, a little more difficult to pin down because it does require negotiations with the seller in agreeing on price and terms, but we've targeted about two per year there. We think that there is also an additional opportunity to add beds at our existing hospitals, somewhere in the 80 to 100 bed range. So if you look at what we think we could do on an annual basis somewhere in that 300 new beds through a combination of adding beds at existing facilities, building new hospitals in new markets, or acquiring facilities either in our existing markets and consolidating or going and entering new markets through that acquisition. So that that's priority one. Priority two is looking at our debt structure. We think we've paid down as much as we need to. Our leverage is now a little less than 2.5 times. We do have the opportunity to call 10% of the 2018 and 2022 notes. We did that last year. We'll have another opportunity to do that again this fall.

And then finally, we've added a new element to our business plan in 2013, and we've executed on that element twice. One is through the share buyback that we did earlier this year. We bought back 9.5% of our outstanding shares and then the initiation of a regular quarterly dividend, which will be paid out in October. So, we have a – we generate a lot of free cash flow, and fortunately, we have a lot of alternatives for how we can invest that free cash flow.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Great. Any questions from the audience at this point. Maybe one last final one and we've got open enrollment starting next month, Jay, and because you have such a Medicare heavy business, most investors don't associate HealthSouth with seeing any benefit from the rollout of the Affordable Care Act. Do you have thoughts about how newly insured covered lives could impact your business one way or the other?

Jay Grinney, President, Chief Executive Officer & Director

We're not anticipating a big pickup quite frankly. And it's more a reflection of the kinds of illnesses that require inpatient rehabilitative care. And the affordable care act is really going after those people, primarily from 20 to 40 the young and the uninsured and trying to bring them on to the – on to the enrollment ranks. So there aren't a lot of – there isn't a lot of trauma, there isn't a lot of conditions that we would typically see in our hospitals. Might there be some at the margin some in incremental patient volumes, possibly, we're not building that into any of our models. We're certainly going to be looking for those patients; we hope to be able to treat those patients. But, we think it's going to be a modest tailwind.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Well great. Well, we are out of time. Jay.

Jay Grinney, President, Chief Executive Officer & Director

Okay. Great. Thank you, Whit. Thank you.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Thank you so much.

Jay Grinney, President, Chief Executive Officer & Director

Thank you everyone.