PARTICIPANTS

Corporate Participants

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

MANAGEMENT DISCUSSION SECTION

Unverified Participant

[Starts Abruptly] next presentation. With our presentation, we have the management team from HealthSouth Corporation, Doug Coltharp, CFO and Ed Fay, Treasurer. Thank you, guys, for joining us and coming down. I'll turn over the podium to you.

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

Good morning, everyone. Before we get started, just a couple of housekeeping items. Larry, how do I advance this? Let's see if that works. That didn't work. There we go.

First, I'll draw your attention to the cautionary language regarding any forward-looking statements. And then, secondly apart from the slide deck up here, you should each have in front of you, a copy of our investor reference book. If you're not familiar with this document, this is a document that we've assembled that really addresses all of the questions that we typically get in these types of conferences or in our equity conferences from the analyst community regarding our performance, our business strategy, the industry, the regulatory environment, et cetera. We post this to our website, and we update it on a quarterly basis, typically a week or two after we've issued our quarterly earnings documents; a thing many of our investors and potential investors have found very useful.

I'd like to start with just a quick overview of our company. We'll move through a number of slides and then hopefully still have some time for questions at the end. We are the largest owner and operator of freestanding inpatient rehabilitation hospitals in the U.S. We operate a network of 103 hospitals, spanning 28 states and Puerto Rico. We augment that service offering with 25 hospital-based home health agencies and 21 satellite outpatient clinics focused on therapy.

From a market share perspective, we're by far the largest in this segment. We have 9% of the inpatient rehabilitation facilities in the U.S., 19% of the licensed beds and 21% of the patients that are discharged from an inpatient rehabilitation facility. Now the gap between those two latter statistics in the first, talks about the scale of our average facility. Couple of slides further on, you'll see why that's important, but on average, our hospitals are bigger than other freestanding hospitals as well as the units that are housed within acute care facilities.

We've had a very solid performance on the year-to-date basis. This slide reflects some of the key metrics through the third quarter of this year and it really continues a trend that we've exhibited over the past couple of years. The key measure for volume in our business is discharge volume growth. That was up 5.3% through the first three quarters of this year. That drove revenue volume up 5.7% over that same period of time and adjusted EBITDA up 8.5%.

The EPS numbers that are in the bottom right-hand side of this chart have a little bit of noise in them, predominantly based on the fact in the second quarter of this year, we had a very large favorable settlement with the IRS that finds its way through the EPS number. Even adjusting for that, we would have had a very nice increase in EPS on a year-over-year basis through the first three quarters.

A couple of highlights to point out since the end of third quarter, both of which relate to our capital structure, first, last week we completed the optional redemption of 10% of each of our 2018 and 2022 senior notes. That's a transaction that totaled about $58 million and you may recall that we did something very similar in the fourth quarter of last year. Secondly, earlier in November, we completed a series of privately negotiated exchange transactions that allowed us to exchange $257 million of our convertible perpetual preferred stock carrying a 6.5% dividend for some new 2% coupon convertible notes. And that's a transaction that will be in excess of $10 million per annum cash flow accretive to our company.

Let's talk a little bit about our overall business for those of you who may not be as familiar with an inpatient rehabilitation hospital. First, we're very heavily Medicare dependent. About 80% of our revenues, if you include Medicare Advantage, are from Medicare sources. The average age of our patient is 72. Almost 95% of our patients come to us after an episode has landed them in an acute care facility.

If they are admitted to an acute care facility, they typically spend about three to five days to get medically stabilized. The attending physician determines that they no longer require that level of intensive care, but by the same token, they're not ready to return home. If that same physician then determines that they are requiring some post acute care in an inpatient setting, an IRF is one of the potential destinations that they could be sent to.

In order for a patient to be admitted into an inpatient rehabilitation hospital, and this is true for 100% of the patients that might be admitted to our hospital, they have to meet medical necessity criteria as determined by an independent physician. A medical necessity criteria is a bit of a subjective test, but it's where the physician is determining that that patient is able to tolerate and will benefit from the intensive multi-discipline therapy regimen that is administered in an inpatient rehabilitation facility. And that therapy regimen typically includes up to three hours of therapy up to five times a week.

Listed on the left-hand side of this chart, you can see the most common types of cases that we handle. And the top two comprising those 40% of our patient base are neurological and stroke. Now these are obviously very medically complex patients that don't lend themselves well to being treated in less intensive settings. I think what's also telling about this chart is the de-emphasis on kind of the standard orthopedic conditions that were really the bread and butter of the industry, say in the late 1990s or early 2000. So you can see that indicated by the knee and hip replacement number here, which is down at less than 8%.

Unlike many of the other segments in healthcare, there is a national objective standard for measuring the quality of outcome in our industry segment, something that's called FIM Gain. And FIM is an acronym. It stands for Functional Independence Measurement. This is a battery of tests that is administered to each patient upon being admitted into an inpatient rehabilitation facility. And these tests measure the patient's ability to conduct certain activities of daily living. They include things like the ability of the patient to walk unassisted for a certain distance or to use the restroom on their own et cetera.

Patient again is administered that test when they are admitted and given the score. When the patient is being ready for discharge, the same battery of tests are administered. The delta between the two scores is the FIM Gain. This chart compares HealthSouth's average FIM Gain and these are all acuity adjusted against a national database here called the UDS database. HealthSouth is the green bar, UDS database is the blue bar, and you can see in all periods we have exceeded the national database by a very significant margin indicating that we are generating sufficiently better outcomes for the patients admitted to our facilities. And again, this is on an acuity adjusted basis.

Another key differentiator for our company is the cost effectiveness with which we're able to provide this very high quality care. And I know there's a lot of information on this slide. This slide along with many of the others that are included in my presentation today, are included in the investor reference book. Now, again, that's available through our website. But this is a slide that draws data from the MedPAC report and it breaks down our industry into a couple of different buckets. The first characterized by the red bar, those are our freestanding hospitals; the green bar is the residual freestanding inpatient rehabilitation hospitals; and the gray bar is the units that are housed within acute care facilities.

As you move from left to right, again getting back to a point that I made on the very first slide, you can see that on average, our facilities are larger than the peers. Continue to move left to right, you can see that as a result, we tend to have more discharges per facility and our case mix, which is an indication of acuity, is higher. So again, we are treating the more medically complex patients. Now the more telling two statistics on the far right-hand side of this, in spite of the fact that we're treating higher acuity patients, our average cost to treat those patients is lower than the other peer groups. Now how are we able to do that? There's a scale advantage that exists on a per facility level, there's also a scale advantage that exists across the corporate level.

I mentioned previously that we own and operate 103 freestanding hospitals. We believe the next largest aggregation within any one single competitor is 12, and it drops off from there as well, that's for freestanding hospitals. There are some larger aggregations of units within acute care facilities, those numbers are a little bit harder to get at. And again, the scale advantages at a corporate level there are somewhat eroded based on the fact they've got a lot of other things that are going on in those boxes.

And move over to the far hand right, and you see that with our lower cost, we're able to treat these higher acuity patients at an average cost of Medicare that is lower than the other members of our peer group. And that is predominantly based on the fact that as a result of our very efficient cost structure, we get very little in the way of what are called outlier payments. And outlier payments are a mechanism that CMS has used to adjust for unforeseen difficulties in treating a standard patient.

A Medicare patient in an inpatient rehabilitation facility is coded when they're admitted to a facility and based on that coding a fixed payment is going to be due to the provider when that patient is discharged. In certain instances, when unforeseen difficulties are encountered treating that patient and costs exceed that scheduled reimbursement, you're able recoup up to 80% of the incremental cost through an outlier payment mechanism.

Those outlier payments were capped at 5% of total Medicare payments to the industry. We receive – in spite of the fact that we're so large, we receive less than one half of 1% of those payments. And again, it owes back to our very efficient cost structure. We don't have a chart in here, but it is included in our investor reference book. We give the distribution of how the outlier payments are disseminated amongst the various providers. 50% of the outlier payments go to 10% of the providers, which means that, right now, they are being rewarded for being inefficient operators. This is an item that we've brought to the attention of members of Congress as they think about what might be some appropriate and surgical ways to address costs in the Medicare system.

This slide we use to highlight the very substantial improvements that we've made in the overall financial of our company. This only goes back as far as 2008. If we took this back further to 2004 when Jay Grinney, our current CEO, came in the aftermath of the Scrushy fraud, it would be even more impressive. But what you see are a very substantial reduction in balance sheet leverage on the far hand – left side. And that really started initially with cash that was generated from restructuring the business by selling off non-core assets. Some of those proceeds were used for government settles and securities loss settlements and so forth; the balance of it was applied to reduce the debt.

As we moved into about 2008, those settlements were behind us. The company was generating free cash flow but was still too highly levered, so the prioritization of free cash flow was directed towards a reduction in leverage. That leverage has now come into a very acceptable level. We have targeted a leverage profile of less than three times EBITDA. We are pretty substantially below that right now. If you compare that to our peer group, particularly in the post-acute sector, I think you'd find that that is certainly on the low side. Another thing that I think should be factored in when you consider our overall financial leverage profile is that, unlike really anybody else in the post-acute sector, we own 75% of the real estate that we occupy. The reduction in leverage has led, obviously, to a reduction in debt service requirement. And the reduction in debt service requirement, together with a dramatically improving EBITDA, contributes to the very substantial rise in adjusted free cash flow that you see depicted on the right hand side of this page.

This gives you a good picture of the fruits of our labors in terms of repositioning the debt capital structure for the company. So, this shows our debt maturity profile and what we have been focused on over the last several years is not only reducing the overall level of indebtedness, but ensuring that we had the right composition of our debt capital. And what do we mean when we say right composition? It's the right maturity profile. We want to make sure that we're not creating any kind of significant refinancing bubble in a particular one or two-year period.

We obviously look at the cost of the debt. We look at the required amortization. We look at the ability to make optional prepayments; and then finally, the restrictive and financial covenants. We've made great strides there. I think it's important to note that the first maturity that we face, the far left-hand side of this graph, is not until 2018 and that's our revolving credit facility. Beyond that, you see relatively evenly sized maturities of senior notes ranging from about $250 million to about $280 million.

We are now in a position where we are generating substantial amounts of free cash flow. And with the de-levering of the company accomplished, it allows us to think about how we can direct that free cash flow to more productive mode. And the first priority we have for free cash flow is to invest in capacity expansions in our core IRF business. Fortunately, we have multiple levers with which to do that. The lever that we will always pull first when it is available to us is to add beds to existing facilities. This is typically done when the occupancy level of that facility dictates that typically by being north of 80% on a consistent basis, the demand for incremental services exist in that market.

Most of our facilities have the ability to space a physical configuration for us to expand the facilities. When we can do that, we tend to generate very high returns, not unusual for us to see an IRR on this type of project that would be north of 30%. The second lever that we can pull with regard to capacity expansion is at de novo hospitals. Here, we've said we're targeting four de novo hospitals per annum. This won't be exactly evenly spaced on a year-by-year basis. The de novos are spread both between non-CON and CON states. The CON states can have a little bit longer of a gestation period.

On average, our prototypes are averaging 40 to 50 beds, typically, all private rooms and on average the cost to build one of those facilities is going to be $20 million to $25 million. And the third lever that we can pull within capacity expansion is acquisitions and there are really two type of acquisition opportunities that exist here. The one that we believe is currently more prevalent is the ability to consolidate a unit out of an acute care hospital and what we do not do is, we don't go in assume ownership of and then run either because the owners are on a contractual basis or units actually confined within an acute care hospital. We're talking about here where a unit would be purchased out of an acute care hospital and it would be consolidated into either an extant HealthSouth Hospital or would be used as a catalyst for us to develop the de novo and give us a leg up in that market space.

After we have fully exhausted all of the high-quality core growth opportunities that we have in any particular given year, we'll then look at balance sheet items and shareholder return as the next utilization of free cash flow. I mentioned previously that we're very comfortable with our existing financial leverage, it's inside the target that we had previously established and the composition is appropriate. We wouldn't expect to see a lot of activity with regard to free cash flow in this category. Having said that, one of the things that we consider as a leverage reduction is when we convert a leased property into an owned property and we're able to do that either at the termination point of a lease or in a certain number of our leases, we have an interim purchase option.

Last year happened to be a year when we had a large amount of activity around those purchase options. And we purchased four properties that had been under lease arrangement and brought them into the owned category last year. And as you can see the number here, that was an expenditure of roughly $90 million to $100 million that also included some of the expense related to building a new hospital to replace a hospital where the lease had come to its termination.

In terms of opportunities to purchase leased properties going forward, are going to be much more sporadic, and really more like one a year for the next five years. As we look at those opportunities, they typically serve as a catalyst for offers simultaneously engaged in a discussion with the landlord regarding

the potential renegotiation of the lease. And if during those negotiations, we can get an acceptable cap rate, we can get no or at least a reasonable rent escalator clause and we can also ensure the control of the property be it via either a license or CON remits back to us at the conclusion of lease, we may be inclined to stay in the lease arrangement. If those three tests cannot be met, we'll go ahead and exercise the purchase option. And the last category is one that's really emerged as a key focal point in 2013 and that's utilizing excess free cash flow for shareholder distributions.

And there were two very significant moves in this direction in 2013. First, in the first quarter of this year, we tendered for about $232 million, roughly 9.5% of the outstanding amount of our common shares. And then in the third quarter of this year, we initiated our first ever regular quarterly cash dividend. It was done in a relatively modest yield, a little bit over 2% at $0.18 per share per quarter. One was paid in the fourth quarter of this year, and the second payment has been declared and is scheduled for payment in January of 2014.

Two more slides to wrap up. This is a slide that we utilize frequently to look forward on a three-year basis and highlight the key components of our business model. The metrics that we are attempting to drive are in the upper left hand side of this: EBITDA, CAGR and adjusted free cash flow. And I think what's important to take away from this is, as you look down across the various colored bars here, we have multiple levers and we're working on all of these at one time to be able to drive those metrics to within the ranges that we're targeting.

Then, the final slide before we'll open it up for questions; this is kind of how we wrap it all together. It's really the investment thesis of the company. So, it starts with the fact that we believe we're operating in a very attractive healthcare sector. I talked about the scale that we have relative to our competitors, earlier. One of the things that I didn't mention was the very favorable demographic profile of the patients that we serve. Again, I mentioned the average age of our patients is 72 years.

The population segment that we serve is currently growing significantly faster than the national average. And it's being fueled on both ends. On the front-end, the very front-end of the baby-boom cohort is beginning to move north of 65 and the back-end of the segment that we address is being aided by the increase in life expectancy. These patients are going to experience the kind of maladies that land them in our facilities. They've got to receive treatment anywhere. These are not the types of maladies that are subject, unfortunately, anytime in the near term to technological obsolescence.

Cost effectiveness, I pointed out to you, that is something that is a continued focus for our company. We get asked frequently whether or not we believe that there are substantial opportunities for further margin improvement. Our response there is that we are continuously looking for opportunities to improve the margin, but when we're operating in the 23%, 24% EBITDA margin, obviously, the low-lying fruit has been gathered. Nonetheless, we remain very vigilant about cost management.

Real estate portfolio, virtually unprecedented anywhere in the healthcare sector to have a company own 75% of its real estate.

Financial strength, we've hit on a couple of key things. The other thing that I would throw out here that I haven't already touched upon is that at the end of the third quarter, we had a federal NOL balance of about $1 billion remaining, which means we remain a very low cash tax payer. Cash tax is currently running at about $8 million to $12 million per year. And then finally, I hit on the fact that even staying just within our core industry, which is our focus, we have multiple levers that we can pull to add capacity to our core business.

And with that, now, Ed and I would be pleased to accept your questions.

Unverified Participant

Doug, could I just kick one off real quick? Your trends, obviously, on both pricing and volume in particular, on a same-store basis have been, as you were talking earlier, kind of running against the tide of what we're seeing in healthcare services segment broadly. Can you just touch on what – your calls have certainly highlighted this in the past, but can you just – if I was to ask you one, two, three data points, which really underpins that strong same-store direction, if you will, relative to the industry, can you...?

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

Yeah, so, Larry's question, in case anybody didn't hear it, is that our trends, particularly on metrics like same-store volume growth, have seemed to run counter to the volume metrics that have been exhibited over the same period of time by many of the acute care hospital providers. And there is, I think, less correlation between the volume metrics of the acute care hospitals and our volume metrics than you might initially expect when you hear that almost 95% of our patients come to us from an acute care hospital. And it's because we're really dealing with a very small percentage of the overall patients who are discharged from an acute care hospital. In fact, I think something like 3.5% of the patients who go into an acute care facility, ultimately, go into an inpatient post-acute setting and only a percentage of those find their way into an IRF. And, of course, the patients that are in that small segment that we're capturing, are characterized by non-discretionary conditions, don't choose to have a stroke or to experience one of the neurological disorders that we see. And by virtue of the fact that the average age of the patient that we're treating is 72, they're already Medicare eligible.

So, this idea of deferring a treatment because you don't have insurance coverage doesn't really come into play. Is there some discretionary amount that is impacted by fluctuations in the acute facilities? Yes, but it's relatively minor. The other thing that I think has allowed us to drive the volume increase is it gets back to both the – first and foremost, the quality measure that I showed you before and the cost effectiveness, and that is, we are able to demonstrate to the acute care hospitals, we're referring again, almost 95% of our patients that we can treat the more medically complex patients and that we can treat them in a manner that produces high-quality results and lowers re-admission risk, and that's very important to those partners.

Final comment I want to make in this regard and this may be more on the come than it is embedded in the recent historical is, we've talked about in a lot of other settings that I didn't mention today is, unlike really any of our other brethren in the post acute space, we have decided to proactively proceed with the implementation of electronic medical records. Now, many of you may know that the Affordable Care Act mandated that acute care hospitals proceed with a medic – an electronic medical record and they get subsidized for doing so providing they hit certain what are called meaningful use standards. No such requirement and no such subsidization exists in the post-acute sector.

Nonetheless, we determined that it would be the appropriate thing to do for our employees, for our patients and for the acute care hospitals with whom we have relationships to proceed with the implementation of such a system. We are in the – just about to enter the third year of a rollout of a Cerner system that was specially made for us and tailor designed for inpatient rehabilitation hospitals. Today, that is up and running in 37 of our hospitals. We're rolling it out at about 20 hospitals to 25 hospitals a year and now that is implemented, it makes us further the partner of choice with the upstream acute care hospitals.

We may have time for one or two more questions if there are any? Yes, sir.

QUESTION AND ANSWER SECTION

<Q>: [indiscernible] (27:49 – 27:54) your thoughts on the discussion about site-neutral payments and the potential for the Medicare cuts that could impact IRFs versus skilled nursing facilities if they went forward with that proposal?

<A – Doug Coltharp – HealthSouth Corp.>: Sure, very timely question. The question was, could I offer some thoughts on the potential for Medicare reimbursement cuts or changes to patient criteria directed towards the IRFs segment and specific question regarding site-neutral payments which is this concept that somehow reimbursement for certain maladies that could be treated in a skilled nursing facility and an inpatient rehabilitation facility might kind to be merged. I think the first is, regarding site-neutral payments, I won't go into a lengthy discourse here, but CMS would tell you and I think anybody who really has studied the issue in Congress would tell you that it is enormously complex to attempt to address and among other things that would need to be defined would be what specific conditions get set and what's the required treatment of care.

There is a slide in the investor reference that points out the differences between the level of care provided in one of our facilities and a SNF, it starts with the fact that each one of our facilities is licensed as an acute care hospital, and that doesn't happen for SNFs. So, we think there is very little momentum behind there. There is talk in terms of another movement on patient criteria to move the current 60% rule to 75% rule. We think that has very little momentum. We also think that if it is implemented, we'll be in a better position to adjust to it. Currently, on average, we run at about a 75% compliance, not at all hospitals individually, but on average. But we think the biggest impact there was it would be denying care to a sector of the Medicare population that requires it.

There is always – particularly in an environment like this where the budget deficit and the debt ceiling are getting so much discussion, there is always the potential for further entitlement cuts. Medicare would be on that list, providers would have to pony up. And I think in our estimation, it's more likely that it takes the form of some kind of incremental market basket update than anything else.

And I think with that, unfortunately, we're just about out of time, but I appreciate everyone's attention today.

Unverified Participant

Thank you, Doug. Thank you, Ed. Thanks everyone.