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CONFERENCE CALL PARTICIPANTS

John Ransom *Raymond James - Analyst*

PRESENTATION

John Ransom - *Raymond James - Analyst*

Good afternoon. I'm John Ransom. I'm most pleased to introduce the management team of HealthSouth. In my opinion, this should be a textbook study for a well-executed corporate turnaround. And I think the thing to think about now is the company is well out of the woods and is transitioning into a growth phase, and I think they're doing that against the backdrop of probably a more complex and less clear regulatory situation for post-acute. And we would expect over time the company to be more offensive with its capital development and also perhaps even extend its footprint beyond its legacy inpatient rehab business where I think the EBITDA is up about 60% off the base.

So with that, I turn it over to Jay Grinney. Thanks.

Jay Grinney - *HealthSouth Corporation - President and CEO*

Great. Thank you, John. Good afternoon, everyone.

So for those of you who are -- may not be familiar with HealthSouth, we are the largest provider of inpatient rehabilitative care in the United States. For those of you who may not be entirely comfortable or familiar with health care terms, post-acute is the area that we play in. Post-acute services are services that are provided to patients once they are discharged from an acute care hospital. They've maybe been in the hospital because they've had a stroke, they've fallen, they've fractured their hip, they've had their hip surgically repaired, and then they need some follow-on care in a hospital setting, and that hospital setting would be ours. So we're called inpatient rehabilitation facilities. We go by the acronym IRF -- I-R-F -- and you'll hear me refer to that throughout the presentation today.

We're in 28 states. We've got 2 hospitals in Puerto Rico. And as you can see from the bottom right-hand portion of this slide, most of the patients that we treat in our hospitals have some kind of neurological condition. Either they've got -- they've had a stroke, they are rendered incapable of caring for themselves living independently, or they've had some kind of chronic neurological condition that renders them in the same condition. We take those patients. They stay with us on average for about 2 weeks. And at the end of that time, our goal is to discharge as many of those patients to their home as possible. We discharge about 80%-plus of all patients directly into their home setting. The footprint that you see is pretty much what we've had from a legacy standpoint over -- although over the last several years, as John mentioned, we started to invest our free cash flow into growing this portfolio within patient rehabilitation facilities. I think perhaps the most important part of this slide is right here. As you can see, we own an operate about 9% of all IRFs in the country, and for those of you not familiar with the industry, it is a highly-fragmented industry. There are about 1,132 inpatient rehabilitation facilities. Several hundred of those are free-standing, as our hospitals are, but the vast majority -- about 940 -- of those inpatient rehabilitation facilities are departments or units of acute care hospitals. And so that provides a backdrop for the industry in terms of number of IRFs. We own and operate about 9%. Our hospitals tend to be larger. So we have 19% of the beds, and then if you look at in terms of market share, we've got about 21% of all patients served in an IRF in this country get served at a HealthSouth hospital, which we think is pretty significant, given the fact that we don't have any presence in New York, we don't have any in the metro area of Chicago, and we don't have any in the metro area of Los Angeles -- the three largest concentrations of population in this country. So we're very proud of the fact that we have that market-leading position. We're very proud of the quality of care that our nurses, our therapists provide to the patients each and every day.

And as I mentioned a minute ago, we are looking to expand. This year, we -- in 2013, we opened and acquired Walton Rehabilitation Hospital over in Augusta, Georgia; opened a 40-bed hospital in Colorado; a joint venture hospital down in Stuart, Florida. We have 3 projects that are underway

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right now -- 4 if you count the one in Modesto. That's still going through the permitting process. Probably won't be open until some time in 2015. But we have 3 hospitals that will be online by the end of this year. A fourth hospital in Franklin, Tennessee, could conceivably begin construction this year if we get a favorable ruling on a certificate of need that we have been granted but that has been challenged.

One of the things we're most proud about HealthSouth is the financial position we're in today. As you can see, we were several years ago highly-leveraged. If you go back to 2007, 2006, we were 5.7 times leveraged. We've taken that down pretty dramatically over the last couple years. That's been really where we have put the focus of our free cash flow deployment. We looked at repaying debt, repositioning our balance sheet and creating a very, very strong foundation upon which we could then grow. And we have been very successful at that if you look at some of the key metrics that we look at. We've been able to treat more and more patients every year. The compounded annual growth rate in discharges is 4.5%. The underlying demand for inpatient rehabilitative care is about 2%, growing at about 2% per year -- is projected to increase as the aging baby boom population expands into Medicare eligibility. And so we look at the demand profile for inpatient rehabilitative services and we look out over the next 5, 10, 20 years and we think that demand profile is going to present a very strong tailwind for our company and for the demand for inpatient rehabilitative services.

We've been able to get slight pricing increases from Medicare. 80% of our business are Medicare patients. So we've been getting about a 2%-per-year on average increase from Medicare, driving top line to about 6% -- just under 6.5% per year growth rate. We're able to leverage our cost structure pretty dramatically. So we can bring those new patients on on a very profitable basis marginally, and you can see that that has resulted in very strong EBITDA growth. The thing that we're the most proud of, though, is the growth in our adjusted free cash flow. Of all the metrics that we look at internal to the company, that's the metric that we really zero in on more than any other. And, in fact, if you were to go back to -- I believe it was 2007 -- the amount of free cash flow we were generating was $7 million. And we've grown that to $331 million over a very short period of time.

So as we think about the story of HealthSouth, and as you think about the story of HealthSouth, we would suggest that you would really want to focus on what do we do with that free cash flow and what does that mean for you as a shareholder.

Just to put that into perspective -- so if you start with the EBITDA and you start thinking about, okay, what do we have to take into consideration before we can start looking at the amount of adjusted free cash flow. We've got this slide for you to give you some idea of what some of the deductions are going to be. Interest expense -- about $100 million per year. We've been tracking $95 million a year. Cash payments for taxes -- somewhere in the $10 million to $15 million working capital. Pretty broad range, but it -- as you can see, it does fluctuate pretty dramatically. Maintenance CapEx this year -- scheduled to be somewhere in the $90-million to $100-million range. Last year, we had thought it was going to be around $85 million. We would have been very close to that but for the timing of some capital expenditures that we purchased in 2013. We were invoiced for that but we didn't pay it on a cash basis until early January. And then the result of an exchange that we initiated last year where we exchanged some convertible equity for convertible debt and, in the process, we were able to significantly reduce our cash preferred dividend payments. And you can see that the impact is pretty dramatic. If you look at the net benefit of the convertible preferred exchange into convertible debt, it was about a $10-million pickup for HealthSouth.

So what do we do with it? What are the options that we have available to us? And we've laid it out -- for those of you in this -- in the conference today, we do have an Investor Reference Book. We update this on a quarterly basis and you'll be able to see some of these slides in that. We also have a handout of the presentation.

So the first thing that we focus on is can we grow our core business. Can we expand the portfolio of inpatient rehabilitation facilities and meet the demand that we know is there, and that is, as I mentioned a minute ago, growing at a -- somewhere in that 2% to 3% range for the foreseeable future. And as we look at our portfolio and as we look at that demand out there, we conclude yes, indeed, we can continue to meet that. And that is a very logical way for us to invest that free cash flow.

First thing that we look at are existing hospitals in our existing markets and those that are getting to the point where they're maximizing their capacity. They just can't take any more patients. They're full more than they're not. They will have the need for new beds at some point in time. And we have targeted about 80 beds per year. We anticipate that the ability to expand our existing hospitals -- our same-store hospitals -- by about 80 beds per year is what we forecast for the next several years.

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As a reference point, when we add a brand new hospital -- whenever we go out and we build a de novo hospital, they tend to be 40-bed hospitals. So another way of thinking about our bed capacity capabilities is that we're adding two new de novos just by adding beds to our existing facilities. We find that that is the most logical way to invest that free cash flow. It's the highest return, we know the markets, we know the referring physicians, we know the demographics, we have a track record and we're able to bring these new beds on very seamlessly and very effortlessly.

The next thing we look to do is to add new inpatient rehabilitation facilities in markets where we don't have a presence. So there a couple ways of doing that. One is going out and looking at markets where there is a demand with little supply of inpatient rehabilitation beds. We assess that market. We look at the overall population. We look at the over-65 population. We look at growth rates in both of those segments. We look at other rehabilitation providers in that market, be it other IRFs or other skilled nursing facilities that may be saying that they can provide care and are in fact providing limited care for some of the patients that can be treated in a -- better treated in an IRF. We look at then the regulatory environment. Does it require a certificate of need? Does it not? And then we will then determine whether or not in -- if it makes sense for us to make an investment in that market to put the capital to work to build the portfolio.

This is some of the metrics for a 40-bed de novo. We have seen in a couple of markets where the demand profile is such that we're moving to a 50-bed hospital, but most of those that we've added, as you can see here, are 40-bed with 2 -- Altamonte Springs, a suburb here in Orlando; Newnan, Georgia -- that are under construction right now where the demand is such that we're going to start with a 50-bed. And then the hospital out in Modesto, California, is also going to be a 50-bed. So you can see, historically, we've built them at 40 beds. Most of the hospitals that we've opened over the last several years have had some kind of bed expansion already, so within a 1 or 2-year period of time, we're at full capacity and we're adding. So I think we might have been a little conservative in some of the forecasting and we're moving now to consider 50-bed models in addition to the 40-bed.

One of the things that we do is we build all of our hospitals in such a way that we can add that new capacity very, very quickly. So the backbone of the hospital -- in terms of the therapy space, in terms of the back office, in terms of dietary and all the support services -- are originally built and designed to handle more than the original 40 or 50 beds. And that gives us the ability to then generate significantly higher returns with each new bed addition because all we have to do is add the beds and we can do that very quickly. Typical 40-bed hospital -- somewhere in the $18-million to $20-million -- $22-million range. You can see the breakdown in terms of construction, land and equipment. One thing that I would note is that that does include a clinical information system. We have an electronic clinical information system in all of our new hospitals, and we are installing that clinical information system in 40 -- excuse me -- 20 of our existing hospitals each year. So by 2017, we'll have all 103 hospitals on a fully-functioning electronic clinical information system.

In terms of just startup costs, somewhere between $500,000 and $1 million per unit is what you should expect, and that's pretty much what we've seen over the last several years. Part of it is a function of the fact that we have to treat 30 patients with no revenue before we're able to get licensed and certified by the Medicare program.

So if you throw all this together, you're looking at a 15% minimum IRR. From a cash payback basis, we're looking at somewhere in the 5 to 7 years, and that's for de novos.

So just to give you -- I know this is kind of a busy trend -- busy slide -- excuse me -- but you can see the last several hospitals that we've added, and the black dots show where it's sustained positive EBITDA and then the line graph shows you where they are with respect to their occupancy during the first 12 months of operations. So you can see that virtually every single one of these facilities becomes EBITDA-positive in the first 6 months, and they reach the overall company average occupancy level, which is just under 70%, in a very, very short period of time. So these have been very successful for us and we're very proud of the fact that every single one of those hospitals has hit the ground running. The one that's the exception right here is Littleton, Colorado, and we've had -- we had some initial problems getting on to all of the managed care contracts. We thought it would take somewhere between 1 and 3 months to do that. It's taking us a little bit longer, but that hospital is back on track and we're very confident that it will be an outstanding hospital for us.

So that's one way of deploying that cash -- is to build new hospitals in new markets and to have those new hospitals meet a demand that is not being met. Another is to go into an existing market and to acquire either a unit from an acute care hospital, take that unit, bring it into an existing HealthSouth hospital, or potentially to take that unit and to convert it into a freestanding hospital. You can see again we're targeting a 15% IRR.

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Cash payback is a little bit quicker, and that's primarily a function of the fact that you're buying into existing revenue flows, existing cash flows, existing EBITDA, and it's much easier for us to turn it around -- turn a broken hospital around than it is to start something from the ground up.

We have a lot of things that we bring to the table when we acquire a new rehabilitation hospital. Probably the one thing that really differentiates us is we have an internal process that Teamworks. Teamworks is really nothing more than our way of identifying best practices in the company, standardizing those best practices and then implementing those best practices across the entire portfolio. We've done that with sales and marketing, we've done that with care management, and we're going to be looking at patient experience in 2014. And what we've found is that by identifying and tapping into those best practices, we're able to see some really significant improvement, particularly in those facilities that may be at the lower end of that distribution of performance. We also have some outstanding management tools that we've developed over the last several years that give our operators real-time capability in managing their expenses -- anything from supplies to equipment, but most importantly, to labor. That is 50% of our revenues -- 48% of our revenues go to labor, and so we've put a lot of time and attention in focusing on the labor tools that are available to our managers. Talked about the electronic medical records system. We also bring a significant amount of clinical expertise to these hospitals. Since this is all we do -- when we wake up in the morning, that's all we think about is providing superior quality inpatient rehabilitative services. So all of our physician efforts, all of our nursing efforts, all of our therapy efforts are designed at establishing leading protocols for providing inpatient rehabilitative care and then, again, promulgating that -- those best practices across all hospitals.

You can see we've really divided it into two kinds of acquisitions. One would be where we buy a unit. So all of these were units that were in another hospital -- in an acute care hospital. We acquired that unit, brought the patients over to our hospital. The acute care hospital would sign a non-compete, would get out of the business and we would then consolidate the inpatient rehabilitative services in that market. We also have been out there looking at free-standing hospitals to acquire, and you can see over the last several years we've acquired 5 -- including the most recent one in Augusta -- and in every single instance, within a very short period of time we've taken the facility that was underperforming and bringing it through our sales and marketing, through our clinical protocols, through our operational protocols -- bring those hospitals up to the HealthSouth standard.

So this is kind of a busy slide, but it just shows you the relative contributions of both the same-store and de novo hospitals and acquisitions to the sustained volume growth over the last several years. The thing to really focus on starting at the macro level -- if you take that overall average growth rate, that's about 4.5% per year. For the last several years, we've been able to grow the number of new patients treated in our hospitals by about 4.5% per year. In terms of the breakdown between same-store and new-store, obviously after 12 months new-store goes into same-store. So you've got that dynamic at play. But about two-thirds of that volume growth is coming out of the new stores and about one-third is coming from new stores. And as we look out over the next several years, we're -- we feel pretty confident that we'll be able to add somewhere in that 4 to 6 new hospitals per year to be able to continue this significantly above-average discharge growth.

So that's kind of where we put our focus initially is if we've got $1 of excess of free cash flow, we're going to put it into growing our existing portfolio. And again, the main reason for that is the demand profile for inpatient rehabilitative care we believe is a very, very strong tailwind that will carry us for many years to come. We then look for opportunities to reduce debt. Our leverage, as you saw, is right now about 2.8 times. We think a reasonable target is 3 times or less. Since we're already there -- and you'll see in the handout that we have for you -- our maturity profile is such that we don't have any near-term maturities. We do have some 2018 notes that will be callable this fall. Obviously we'll look at whether or not it makes sense to call them or to do something with those. But we don't see any near-term need to pay down the debt. We feel like our balance sheet is in very, very good shape. We do have some properties that are leased. About a third of our hospitals are under some kind of long-term lease arrangement. We have the opportunity to buy out several of those. We did 4 last year; we're going to look to do 1 this year. And that's really strictly a function of what the lease terms call for. If we could tomorrow buy them all out, we would, to give us control of those assets, but the reality is we have limited opportunities over the next several years -- 1 this year and maybe 2 additional properties that we can take out over the next 3 years or so.

So it really then puts us down into this last component of our free cash flow strategy, and that's returning cash to shareholders. We weren't in a position to do that prior to 2013. We started last year telling shareholders that they could expect some type of distribution if we had cash at the end of the year. We also told our shareholders that we would not be afraid to use some of the capacity in the balance sheet if it made sense to do just that. And so as you can see here, we did buy back about -- we bought back $234 million of common last year. We initiated a dividend. And then, as I mentioned before, we did exchange some of our convertible preferred stock for convertible preferred debt. So we are very comfortable

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with this approach. We don't feel any compelling reason today where we have to go out and expand beyond our current footprint, but as we look at the evolving delivery system, we know that we need to be at least open to that and we need to be preparing ourselves for how that delivery system may change.

So we're of the opinion that the movement towards ACOs, to bundled payments and the like, to coordinated care, may occur but if it does occur, it's going to be occurring at a very slow pace. It's going to be more evolutionary than revolutionary. Our belief is some of the initial results from pioneer ACOs and other ACO have been very mixed. Not everybody's saving money. Those that are are not saving as much as what it cost them to put these ACOs in place. So I think the jury is still out on whether or not that will indeed be the model for Medicare payments going forward, but we want to be prepared. We want to make sure that we have a clinical information system in place in all of our hospitals so we have that connectivity, we can get clinical information and we can be seamless in the receipt and care of that patient. Where it makes sense, we want to have a joint venture arrangement within a large acute care hospital. A third of our hospitals already have that arrangement. So if any of these large systems decide that they want to get into some kind of accountable care organization, we're already joined at the hip with them as their rehabilitation provider. We do like owning all of our assets -- the physical plants. That gives us a lot of flexibility going forward. Obviously we want to make sure that the cash flow and the balance sheet remain strong. Most importantly, we want to continue to provide high-quality care and be able to demonstrate that to potential partners and to participate, as we are right now, in some initial bundling and ACO development.

And as I said, although we have no compelling need to expand into other services today, if and when we do, it will be in the post-acute arena. So as I said before, that's either going to be home care, long-term acute care, hospice or potentially skilled nursing. The two services that make the most sense to us, frankly, would be either long-term acute care or home care, but there's a lot of regulatory uncertainty over both of those segments and continues to be over both of those segments. So we want to be very cautious as we think about expanding. We see, again, no reason to go out and diversify just for diversification purposes. If you as a shareholder want to diversify, you can buy us and then you can buy whatever diversified company you want. You can diversify in your portfolio, and I suspect many of you do. We would be looking at potential acquisitions if we saw (a) the delivery system moving at a faster pace to some kind of coordinated care where it made sense for us to offer a broader range of post-acute services, and (b) if the regulatory environment got such that we felt comfortable moving into those adjacent services and with the risks that are attendant with those services.

So just in summary, we think we've got a pretty strong company, a pretty compelling business model. We are in a very attractive sector of health care that's growing at about 3% per year. We are the market-leading provider in that space. We have the number-one position not only in terms of patients served, but also in terms of outcomes and cost effectiveness. We own most of our assets. We're buying those that we can. We have a very strong balance sheet. We don't have any near-term maturities. We're generating a lot of free cash flow. We have multiple avenues for investing that free cash flow. And then we have very compelling opportunities to expand in our core business -- inpatient rehabilitation -- but also, opportunistically and under the right circumstances, we have the ability to move into other complimentary post-acute services.

So that concludes the presentation. I think we are right out of time and we'll now move -- we'll move to the breakout.

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