HealthSouth
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Erin Blum: Okay. We're going to get started with the next presentation. It's HealthSouth. We're very pleased to have Ed Fay and Andy Price with us. Thank you. Go ahead.

Ed Fay: Thank you, Erin. Thanks for having us here. I am joined here by Andy Price. He's our chief accounting officer. So, let's just first take a second here to acknowledge this disclaimer about forward-looking statements.

HealthSouth Corporation, for those of you who are not familiar with us, we are focused primarily on the inpatient rehabilitation segment of post-acute care. As you can see on this slide with a map of our facilities, HealthSouth, look at the table at the bottom -- HealthSouth does comprise 9% of all the IRFs in the country. IRF is an acronym, it's inpatient rehabilitation facility. Our IRFs tend to be larger than those of most of the rest of the industry, and so those 9% of the facilities translate into 19% of all the hospital beds and about 21% of all the patients served in inpatient.

We also do have some home health and some outpatient, and that is -- really, that business functions as an adjunct to our inpatient rehabilitation. We're servicing primarily the same patients we saw on the inpatient side.

We are fairly well diversified. We are spread out across 21 states, and we're in Puerto Rico at two facilities there as well. We have been adding to our franchise over the last few years. We've been building new hospitals, acquiring facilities.

During 2013, we built two new facilities, one in Littleton, Colorado, as well as one in Stuart, Florida. And then we acquired the Walton Rehabilitation Center in Augusta, Georgia. And we're going to add more hospitals to our franchise during 2014. We're developing two 50-bed hospitals, one of them will be in Newnan, Georgia. That's our second entry into that state, as well as one in Altamonte Springs, which is near Orlando. And then we're going to be opening a 34-bed hospital in Middletown, Delaware. All of these hospitals will be opening very late during 2014.

So, just a little bit of background about what we do. Our hospitals serve a fairly well defined subset of the patients, of all those outpatients who are being discharged from the acute care hospitals. The patients who are not well enough that they can go home but who could benefit from an intensive therapy regimen can come to our facility and stay typically about two weeks. And while they are there, they will be getting, as I said, an intensive

therapy on a multidisciplinary basis three hours a day, some combination of physical therapy, occupational therapy, as well as speech/language pathology.

And coming through a stay at a HealthSouth hospital, the intention is to spend those two weeks with us to heal and get better with around-the-clock nursing care, as well as regular physician visits. And while we're working on the therapy side of things and helping that patient regain his independence, regain his strength so that he can go home, return to the community and go about living a healthy, independent lifestyle once again.

Our facilities, if you look at the box in the upper right corner of this slide, you can see that our facilities do strive to offer a very high standard of care. The Joint Commission has a program whereby we can be certified in a variety of clinical conditions for the kinds of care that we can provide there, and we have 96 hospitals that have received such disease-specific certifications. That is 96 out of our total population of 103 hospitals.

So, I mentioned that our patient criteria fairly well defined. If you look at this chart here on the left side of slide 5, you can see that we have listed here the most frequent clinical conditions that we see in our facilities. The Medicare request here is that 60% of all the patients that we treat be found to have been diagnosed with at least one of 13 specific diagnoses in order to be what we call a compliant case in our facility. The typical case types are strokes, neurological disorders, certain orthopedic conditions, brain injuries and so on. And most of those would constitute a compliant admission into our facility.

Also note the chart on the bottom right of this page here. The projected population growth, this is as per the Medicare Trustees' Report, and you can see that the Medicare population is projected to grow at a somewhat higher pace here, now that we're seeing the first cohort of the Baby Boomers beginning to reach that 65-year-old threshold. And so we're going to be seeing a 3% compound annual growth rate on that population over the next several years. That is very important to us when you consider the clinical conditions that we are servicing, neurological conditions, strokes, things of this sort, hip fractures. This tends to be afflictions that are borne disproportionately by the elderly, so we do have a fair amount of Medicare concentration in our hospitals. Approximately 80% of all the patients we see are Medicare patients.

The franchise today is comprised of 6,800 hospital beds. You can see the franchise is fairly evenly distributed between Certificate of Need states and non-CON states. The Certificate of Need, those are state licensures that limit the number of providers in certain segments of healthcare, and so we're evenly distributed between those CON and non-CON states.

One of the things that we think on specifically or importantly on a credit basis that is very important for our portfolio of hospitals, that we actually own the vast majority of our real estate. Sale-leaseback arrangements are not uncommon in the post-acute segment, and in particular for a smaller company, a startup company, the amount of capital it might take to open a new facility -- let's say if we were opening a 40-bed hospital, it might be, say, a $20

million to $22 million investment. That would be a substantial barrier to entry. There are a lot of providers in this space who don't find themselves with the amounts of capital that we have, and so they'll enter into a sale-leaseback arrangements in order to finance a lot of that upfront capital.

We find those arrangements to be burdensome. We find them to be expensive. We don't rule them out in all cases, but we have been able to avoid them. And we actually own the buildings at least in the vast majority of the instances of our hospitals. We own 75 of our buildings. We're only in 28 lease arrangements for our facilities.

During 2013, we were able to buy our way out of four lease arrangements that were coming up for either their expiry or a purchase option date. We exercised those options and in addition, there was one facility in western Massachusetts where the lease expired and we chose, because of the condition of the facility, the age of the facility, we chose to build a new hospital in its place. So, when we've had the opportunity, we have looked very hard at the possibility of just exiting a lease arrangement and owning our property. We think it gives us a lot more strategic flexibility and it keeps us out of a relatively expensive layer of capital with escalators embedded in it as well.

We've been working very diligently at improving the strength of our balance sheet over the last several years. You can see where we were coming from at the end of 2009. By this time, in 2009, in fact, we were well on our way to repositioning the credit profile of the Company. But even at that time we were still 4.6 times levered. We've been able to bring that leverage down almost to two turns since that point in time. That's been done both through EBITDA growth as well as some debt prepayments and repayments that we've gone through.

During 2013, because we had already reached a long-term target that we had established of getting to three times, we got there during 2011. During 2013, we took advantage of the opportunity to return some capital to our shareholders. We did a tender offer for $233 million of our stock in the first quarter.

In the third quarter of last year we announced an inaugural dividend of $0.18 per share per quarter. And then in the fourth quarter we entered into an exchange transaction. We have a preferred stock issuance that's been outstanding since 2006, and we were able to do an exchange transaction whereby we took out a significant fraction of it in exchange for a new note, a subnote, $320 million convertible subnote in place of the preferred.

The free cash flow generation of the Company has really been one of the strong points of the story over the last several years. You can see this chart on the right-hand side of the slide here we're looking at now, slide 7. And you can see that the growth has been fairly substantial. We put up $331 million of adjusted free cash flow during 2013. That cash flow growth has been coming really through strong EBITDA performance as well as gradually reducing debt servicing costs that we've been experiencing over the last several years.

And, also, we are benefiting from a net operating loss. We've had the net operating loss, I was saying, for several years, but we are still enjoying the benefits of that. We paid $7 million or $7.5 million of cash taxes during 2013, and we still have some more of that to run.

So, on this slide here we can see a snapshot of our liquidity profile, and this really complements the free cash flow story fairly nicely. You can see we had $65 million of cash on the balance sheet and, importantly, we had a revolving credit facility, $600 million revolving credit facility. Most of that was undrawn as of the end of the year. So, we have ample liquidity.

And then in the bottom right-hand corner of this slide we do have our credit ratings. You can see that we are now at BB on both sides. We've gotten there gradually over time as the rating agencies have come to appreciate the strength of the cash flow as well as the gradually improving leverage profile of the Company.

This slide here is a depiction of the debt instruments as they come up for maturity. And the first thing that is noteworthy here, as we stand here in early 2014, is that the Company has no material maturities between now and 2018. In 2018, our credit agreement as it is currently structured, that would mature. We also have a senior note which will mature in October of that year.

Now, that note, that 7.25% note will become callable later this year, and then right behind it is an [8.8%] note that is maturing in 2020. It will be callable in February of next year. And then if you look at the right-most chart, that orange stack, is the convertible subnote I mentioned earlier. That note, which pays a 2% coupon, has an ultimate maturity date of 2043. And, again, it replaced a note -- it replaced, I should say, preferred stock, which itself was perpetual. Some of that preferred stock is still outstanding.

What we found attractive about the exchange transaction was that we were able to move into a note here that pays a pretax 2% coupon and come out of a preferred instrument, which is paying a 6.5% after-tax dividend. So, it's a fairly expensive piece of capital that we've had on our books since 2006, and we're pleased to be unburdened of a significant portion of that instrument.

On this chart here we're just showing what we think the priorities for HealthSouth need to be over the next several years. First of all, we do believe that we can grow our EBITDA somewhere between 4% and 8% over the next several years. The leverage ratio that we had targeted to get to below three times, we are there now. We would anticipate keeping that there even while we do look for opportunities to return some capital to shareholders. As I mentioned, we have a regular dividend now. We'll continue looking at share repurchase transactions and, of course, the three times is a guideline here. It's not a hard and fast, and if we saw the right opportunity we would be willing to take that higher for some period of time.

We're going to be growing organically and within the same stores that we currently operate through bed expansions. We would expect to also open some new facilities. I mentioned some of those at the outset. And then we'll also be acquiring some hospitals as well as we go. Some of those opportunities will likely be joint venture opportunities. We do have 31 joint ventures that we are operating currently, so entering into new joint venture arrangements would be something that would not be new for us. We did enter into a joint venture arrangement in Stuart, Florida last year. That hospital I mentioned was a joint venture with the Martin Health System.

And, of course, we will continue to focus on these key operational initiatives. We have been developing new TeamWorks programs. We did one a couple of years ago that focused on care management. We're going to look at rolling out, designing one and implementing one. TeamWorks is the word -- let me just stop to just mention TeamWorks is a term we use internally for any of our best practices initiatives that are going to be impacting our hospitals. We have a particular TeamWorks initiative we are looking at implementing that will be focused on the patient experience.

I'll also note we are implementing a clinical information system. We're well underway with that. We have that system transitioned and installed now in 36 of our facilities. We anticipate that we will be converting 20 more hospitals this year to that system and that will continue on for the next several years until we're fully integrated on that system.

And then, of course, we'll continue to focus on all of those quality initiatives that will continue to provide outstanding care for the patients in our facilities. We look at ACOs and bundling, we think, well, we don't necessarily think that that is the reimbursement environment of the future, but we do focus on a high quality of care and we maintain a very cost-effective business model. And so long as in a more integrated reimbursement landscape where those things are appreciated, as well as where you have a clinical IT system that allows the sharing of data across providers, we think we're going to be well positioned for any adaptations there.

This slide is just showing the priorities for how we anticipate investing our free cash flow. I mentioned capacity expansions, bed expansions. We'll be continuing on with those during 2014 and we'll invest somewhere between $25 million and $35 million on those. In addition, we'll be designing and developing those new hospitals I mentioned, and so we'll spend a total of $80 million to $110 million on those discretionary projects that is not inclusive of any acquisitions that may be affected during the year.

We have one more opportunity to purchase a leased property that is going to cost us somewhere between $15 million and $20 million. And, of course, we've also projected the annualization of the quarterly dividend that we're paying out.

So, just to pull it all together here, we think that HealthSouth is particularly well positioned given the favorable demographic trends in the industry, in which it is a leader. We are going to capitalize and continue to capitalize on our industry-leading position by making use of our leverage across not just the cost side of things, where we focus significantly on our labor management, supply chain, other hospital expenses, G&A, and also leveraging those internal best practices that I mentioned in all of our TeamWorks initiatives.

We have a real estate portfolio that we think is a strategic asset because we do own such a significant fraction of it that we're not burdened by expensive leases. And the Company's financial position is very strong. The cash flows are strong. The balance sheet is strong. We have ample liquidity, no maturities that are coming up immediately upon us. The leverage is within our target range, and we would anticipate that we can continue to both pursue our development initiatives, our clinical initiatives, the installation of our clinical information system, hopefully returning some capital to shareholders as we go along the way here, and then most importantly, continue to provide outstanding clinical and therapeutic care to all the patients in our hospitals.

Erin Blum: Thank you. I'll start off with some questions and then I'll open to the audience. So, first, just to start with a broad, general question is thinking about your 2014 outlook, what do you see as the major swing factors that will determine whether you achieve that or even whether you end up raising that guidance and do better than that?

Ed Fay: We feel well positioned heading into 2014. I think that we offered guidance at the beginning of the year. Some people suggested that it was conservative, but really we had a very strong 2013. We have a few new hospitals we brought on, but we don't have a whole lot of significant new growth that we would anticipate during 2014 from development. Because, as I mentioned, all those other hospitals that we're going to be developing, they won't have a material effect on 2014 because of the late date at which they're going to start.

We would like some clarity around the reimbursement environment. The only really clouds on the horizon right now that we're looking at, or that we're really focused on in the near term are the possibilities around a doc fix and is there going to be any changes there? We don't have any particular reason to think that inpatient would be specifically looked at there, but it's possible that providers will be asked to pay for some sort of a fix.

There has been talk that there is going to be a big fix. People were suggesting that when Senator Baucus was stepping down from the Finance Committee that some people wanted to put together something more comprehensive, maybe as long as a 10-year fix. They started walking back to a five-year fix. We're not hearing as much talk along those lines right now, so we think that there has to be something done, because the current SGR fix only reaches out to the end of March. So, something will have to be done for the balance of 2014, but we're not sure what's exactly going to be in that, and we're really not expecting it to be a multi-year fix at this point. We're not hearing things along those lines. Andy, do you have anything else you want to --

Andy Price: The only thing I would add is that our 2013 earnings did include a one-time insurance adjustment, so that would need to be normalized out. And we're anniversaring sequestration in the first quarter of 2014, which is another $7 million or so of EBITDA headwind.

Erin Blum: Okay. And as I think about volume growth, thinking for the industry overall versus bed growth for the industry overall, again, do you think bed growth has kept pace with demand, or is there some opportunity for further bed growth out there?

Ed Fay: Sometimes Med-Pac looks at these things and they do it on a national basis. It's really going to be a market-by-market analysis, so that's why we've opened new facilities where we saw an opportunity to do that, because we believe that there was not a sufficient number of beds in a given market. There are still opportunities like that, which is why we're building a hospital right now in Newnan, Georgia. Georgia is a CON state, so it's not always easy to effect a transaction like this, where we can apply for and obtain that CON.

The same could be said about Florida. We have been successful. We opened a hospital in Ocala, Florida in 2012, and I mentioned Stuart, and then this one. So, this is a third hospital in recent years that we've been able to obtain the CON and opened a hospital there.

There are certainly markets where there continues to be opportunities to open a new facility or potentially look at places where there are beds and maybe the hospital -- I should say the market is not necessarily under-bedded, but the beds themselves are under-utilized. Perhaps they are embedded in an acute care hospital and the focus is about all the priorities that the administration in acute care hospital might be focused on. Inpatient rehabilitation can become something of an afterthought, and so there are instances where you could find a market that really has a much greater need for inpatient rehabilitation than is actually being capitalized upon because it's simply not a focus.

Erin Blum:Okay. And so how would you rate hospital interest level in continuing to own these types of post-acute assets? Have they increased, decreased over the last few years, do you think?

Ed Fay: Every hospital is different, and there are reasons why some hospitals might be interested in having a discussion about either selling a unit that they have or potentially entering into a joint venture. Some of them might say we're cash constrained, this unit is really not bringing us the financial value that it otherwise could, or they could -- so, they might decide that they want to sell it. Or they might decide we still want to stay in that business, we think that rehabilitation is core to the mission that we have as a not-for-profit provider in this market. And so they may choose to joint venture, and we find that the discussions can go either direction with regard to that.

Whether they -- I think we're having more discussions along those lines today and yet -- and clearly the motivations in part are the pricing environment. We've seen the Affordable Care Act, which had certain care cuts embedded in it, along with sequestration. And some of these inpatient rehab facilities were struggling to make money even before these cuts were being implemented. And as people start to think, okay, sequestration is kind of becoming a part of the environment now, just financially they're finding more reasons to start looking at opportunities to partner.

But we're also able to demonstrate to them clinical outcomes that are superior to the industry norms, and so that along with the clinical information system, we're bringing our best practices. Therapists really enjoy working in a HealthSouth facility, so I think we're able to bring a range of benefits to a potential joint venture and/or seller in a market who still takes a very highly vested interest in the quality of the care that is going to be taking place in that market.

Erin Blum: And so if a hospital takes the decision that we want to either sell or JV our inpatient rehab beds and they call HealthSouth, do you hope that they want to sell it or do you prefer to do a JV?

Ed Fay: Free market would be different. It really depends on who the provider is and how are they positioned within the market, and do they themselves have an excellent clinical reputation? Are they servicing the types of patients that would typically find their way into an inpatient rehabilitation facility? So, it would really depend -- as I said before, I think everything in healthcare in the provider space is market-by-market-by-market. There are certainly some markets where we would prefer to be an outright owner, but there are several instances where we're very pleased to be joint venture partners, or we would be pleased to be a joint venture partner in the new market as well.

Erin Blum: Okay. And then on the question side, is there a certain target, valuation multiple that you shoot for? How do you think about valuations?

Ed Fay: We have really three criteria that we look at when we're modeling a transaction, and it's typically not an easy EBITDA, the reason being that it's very hard to get to what the EBITDA is. If you're looking at a unit, it's operating within an acute care hospital, and they might have a contribution margin but they don't have a full income statement.

Now, we've looked at enough. We actually have a fairly good idea. And, of course, we also know when we look at a market, we have a fairly good idea given these sorts of patients that we see in the acute care hospital, we believe the demand for inpatient services should be of a certain size or a certain amount. And then the rest of it really becomes something on the cost side, something that we're very good at. We would know with a fair degree of confidence exactly what the potential value is of that.

So, when we are designing our own models, what we're looking for is an IRR, and we'll model it out and we'll look for an IRR. And I think we've called out in our reference book that on a pre-tax basis we'll look for, say, a 15% IRR, and we're looking for NPV-positive. We also talk about a cash payback, which is looking at the cash that we would be earning, the kinds of returns we would earn over a five-year horizon and comparing that to, say ,the total value of the investment.

We are making a transition. We are looking a little bit more now at return on invested capital when we're doing those metrics, so we're looking at a couple different ways to think about the balance sheet and getting the right efficiency out of that.

Erin Blum: Does anybody in the audience have anything that they want to ask? Yes?

Unidentified Participant: You had talked about the short-term doc fix and there could be some provider penalties. Were you referring to providers specifically or post-acute care providers generally, or all service providers?

Ed Fay: We don't see any reason that IRFs would be singled out in any sort of a specific way. We're thinking in the broadest sense that it could be providers more generally. But we're really -- we don't know. We have no information that suggests that there is any particular plan for how to finance it. In fact, it's obviously precisely where some of the discussions started to break down with regard to some sort of a more comprehensive solution, whether it's a 10-year fix, which had been scored by the CDO as being $138 billion for the first five years of that 10-year period, which was scored as a $60 billion cost. And it was precisely around this whole question, how is it going to be paid for if we're going to look for this comprehensive or this longer term solution to the SGR problem? That's where those discussions really started to struggle.

I think that that's likely to be a scenario that's going to develop here again, but just that we know we have a date coming up. We know it's the end of March, and so it's possible that in any of a variety of ways, I suppose, providers could be impacted. Because people might look in part for providers to make up the difference on whatever it is that they have to fund, which I think might be $5 billion, if I remember the CDO report correctly, over the balance of the year.

Unidentified Participant: Okay, thanks. And then just talking about -- you talked a lot with Erin about the JVs, the IRF JVs, can you talk about M&A for other complementary service areas, whether it's home health or other post-acute segments, and how you think about that? I mean, you kind of referred to some semblance of integration with the acute care space, but if you can just also secondarily talk to integrated care, post-acute, first M&A and then integrated care?

Ed Fay: So, on the M&A front, we have looked at the possibility of acquiring other businesses and segments outside of inpatient rehabilitation. At the same time that we've been looking at

them, some of them became under significant pressure on the reimbursement front. And as much, particularly, say, with home health, some of the scrutiny was really around utilization and the appropriate use of home health.

We actually see the compelling logic of having home health as part of the continuum of care upon discharge from an inpatient rehabilitation facility, because frequently enough your therapy and your recovery is not completed yet. And so we actually do have 25 agencies where we are providing home health services as an adjunct to what's happening in our facilities. Post-discharge we're continuing our services of those patients.

So, it is possible that we would look at the logic there of that connection and we would choose to invest further in that. It's not today something that we are really focused on. We are not looking here early in 2014 and saying we need to start making a change.

We need to start purchasing assets within other segments of post-acute and building out this continuum of care. Partly because what I had said earlier about the whole ACO and bundling and these initiatives which are -- although it's been out there as a point of discussion for some period of time, it's still early in terms of determining where is the value that's being created from some of these models? Particularly we think about with the pioneer ACOs, where the results that were published last year appear to be fairly ambiguous.

There are certain bundling initiatives out there, but what the economic value is that's been achieved, and I'm speaking of the value, say, from the perspective not just of the provider but also from Medicare's perspective, what kind of value are they seeing? We're not really seeing that there is a whole lot there that is tangible. And so we remain agnostic as to the pace at which the reimbursement environment might become more integrated, and yet we continue to make sure that our investments are focused on quality and are focused on efficiency.

And the TeamWorks initiatives that we're putting place, the clinical information system that we're installing, that these things are aligned with the concept of a more integrated payment system, where we can share data with other providers, where we can demonstrate that we are costing the Medicare system less on a per-discharge basis. We provide that. That's actually in the appendix of the slides that we are showing here.

All of these things we are doing because, well, one, we think these are the right things to do, these are the right investments for us to make. And, secondly, we do believe that these dovetail nicely with these concepts of a more integrated payment environment.

Unidentified Participant: Okay, thanks. So, we can presume that at this point in time you haven't entered into any kind of capitation type of situation with acute care, PBOs, etc.?

Ed Fay: We have -- in a couple of instances we have actually participated, began participating in ACOs, in a couple of bundling initiatives, but the actual results there are not really material.

Erin Blum: Okay. I'm going to shift gears a little bit, and we have a few minutes left, to the financial side. On your slide 4, I think priorities for free cash flow, I think you called it a debt repayment for 2014, you showed NA. So, you still have another bite at the 103 call on one of the bonds and $45 million drawn on the revolver. So, should I take that NA as a to be determined or a zero?

Ed Fay: Right. NA does not mean zero. So, there -- acquisitions, like we said, it's excluded, not because it's a zero, but because we're not calling out a number right now. I mentioned we have two notes that are becoming callable within the next 12 months. One of them will be callable in October of this year. Today, if you look at the coupon, it's a 7.25 note, and clearly HealthSouth could print a new note of similar duration and the coupon would be lower. So, I think that the math and I think the coupon savings is sufficient that you would look at the, we'll call them the friction costs of the call premium you would pay as underwriting fees on the new note. All of that and you would still say this is going to be an [NPD] positive, this is a cash flow positive transaction. So, I think it makes sense for us to be thinking about those things. We have no specific plan right now whereby we're saying we're going to call that note.

Erin Blum: Okay. And then last chance for the audience. Okay, so --

Unidentified Participant: Erin, can I -- sorry. In terms of exit opportunities or strategic M&A for HealthSouth possibly as a target, do you view the business model of your Company as LBOable?

Ed Fay: I think that's a question you'd have to ask someone on the other side. Why would it not be, I guess I would ask. There are strong cash flows in our Company. Today the leverage is low. The profile of the Company is strong. There is positive growth there, so -- but we are not looking at anything like an LBO right now.

Erin Blum: Okay, we'll leave it there. Thank you very much for coming. We really appreciate having you here.