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FORM 8-K
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 8-K

CURRENT REPORT

Pursuant To Section 13 or 15(d) of the Securities Exchange Act of 1934

Date of Report (date of earliest event reported): June 13, 2014

HealthSouth Corporation
(Exact name of Registrant as specified in its Charter)

Delaware
(State or Other Jurisdiction of Incorporation)

001-10315	**63-0860407**
(Commission File Number)	(IRS Employer Identification No.)

3660 Grandview Parkway, Suite 200, Birmingham, Alabama 35243
(Address of Principal Executive Offices, Including Zip Code)

(205) 967-7116
(Registrant's Telephone Number, Including Area Code)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communication pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

ITEM 7.01. *Regulation FD Disclosure .*

Updated Investor Reference Book and 2014 Guidance

Subsequent to its earnings release for the first quarter of 2014, HealthSouth Corporation ("HealthSouth" or the "Company") assembled an investor reference book, which was filed as Exhibit 99.1 to the Current Report on Form 8−K on May 12, 2014. As of June 17, 2014, the Company has updated the Investor Reference Book, which is attached to this Current Report on Form 8−K as Exhibit 99.1 (the "Investor Reference Book"), to incorporate the impact of the previously disclosed transaction in which the Company acquired an additional 30% equity interest from UMass Memorial Health Care, its joint venture partner in Fairlawn Rehabilitation Hospital in Worcester, Massachusetts. This transaction increased HealthSouth's ownership interest from 50% to 80% and resulted in a change in accounting for this hospital from the equity method of accounting to a consolidated entity. The Investor Reference Book is available at http://investor.healthsouth.com by clicking on an available link.

Based on its results for the first quarter of 2014 and the additional ownership interest in Fairlawn Rehabilitation Hospital, HealthSouth expects, as of the date hereof, to exceed the high end of its Adjusted EBITDA and earnings per share guidance ranges. As previously reported, these guidance ranges are:

- Adjusted EBITDA of $555 million to $565 million
- Earnings per share from continuing operations attributable to HealthSouth of $1.86 to $1.91

The Company will also provide its initial observations for solid volumes in April and May 2014. As a reminder, discharge growth for the second quarter of 2013 was 6.3% and included new-store growth from the consolidation of St. Vincent Rehabilitation Hospital in Sherwood, Arkansas, the acquisition of Walton Rehabilitation Hospital in Augusta, Georgia, and three de novo hospitals (Ocala, Florida; Littleton, Colorado; and Stuart, Florida).

The Company uses "same-store" comparisons to explain the changes in certain performance metrics and line items within its financial statements. Same-store comparisons are calculated based on hospitals open throughout both the full current periods and throughout the full prior periods presented. These comparisons include the financial results of market consolidation transactions in existing markets, as it is difficult to determine, with precision, the incremental impact of these transactions on the Company's results of operations.

HealthSouth Corporation will participate in the 2014 Wells Fargo Securities Healthcare Conference in Boston on June 17-18, 2014. HealthSouth President and Chief Executive Officer, Jay Grinney, will participate in a fireside chat presentation on Wednesday, June 18 th at 10:40 a.m. ET and reference selected slides included in the Investor Reference Book. The presentation will address, among other things, the Company's strategy and financial performance and discuss industry trends and dynamics. The presentation will be webcast live and will be available at http://investor.healthsouth.com by clicking on an available link.

The information contained herein is being furnished pursuant to Item 7.01 of Form 8-K, "Regulation FD Disclosure." This information shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), or incorporated by reference in any filing under the Securities Act of 1933, as amended, or the Exchange Act, except as shall be expressly set forth by specific reference in such a filing.

Note Regarding Presentation of Non-GAAP Financial Measures

The financial data contained in the Investor Reference Book attached hereto as Exhibit 99.1 includes non-GAAP financial measures, including the Company's leverage ratio and Adjusted EBITDA. The leverage ratio referenced therein is defined as the ratio of consolidated total debt to Adjusted EBITDA for the trailing four quarters. The Company believes its leverage ratio and Adjusted EBITDA are measures of its ability to service its debt and its ability to make capital expenditures. Additionally, the leverage ratio is a standard measurement used by investors to gauge the creditworthiness of an institution. The Company's credit agreement also includes a maximum leverage ratio financial covenant which allows the Company to deduct up to $75 million of cash on hand from consolidated total debt. The Company reconciles Adjusted EBITDA to net income in the Investor Reference Book attached hereto as Exhibit 99.1 and to net cash provided by operating activities in the Investor Reference Book attached hereto as Exhibit 99.1 and below.

The Company uses Adjusted EBITDA on a consolidated basis as a liquidity measure. The Company believes this financial measure on a consolidated basis is important in analyzing its liquidity because it is the key component of certain material covenants contained within the Company's credit agreement, which is discussed in more detail in Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations,* "Liquidity and Capital Resources,"

and Note 8, *Long-term Debt* , to the consolidated financial statements included in its Annual Report on Form 10−K for the year ended December 31, 2013 (the "2013 Form 10−K"). These covenants are material terms of the credit agreement. Noncompliance with these financial covenants under the credit agreement—its interest coverage ratio and its leverage ratio—could result in the Company's lenders requiring the Company to immediately repay all amounts borrowed. If the Company anticipated a potential covenant violation, it would seek relief from its lenders, which would have some cost to the Company, and such relief might not be on terms favorable to those in the Company's existing credit agreement. In addition, if the Company cannot satisfy these financial covenants, it would be prohibited under the credit agreement from engaging in certain activities, such as incurring additional indebtedness, paying common stock dividends, making certain payments, and acquiring and disposing of assets. Consequently, Adjusted EBITDA is critical to the Company's assessment of its liquidity.

In general terms, the credit agreement definition of Adjusted EBITDA, referred to as "Adjusted Consolidated EBITDA" there, allows the Company to add back to consolidated net income interest expense, income taxes, and depreciation and amortization and then add back to consolidated net income (1) all unusual or nonrecurring items reducing consolidated net income (of which only up to $10 million in a year may be cash expenditures), (2) costs and expenses related to refinancing transactions (in years prior to 2012), (3) any losses from discontinued operations and closed locations, (4) costs and expenses, including legal fees and expert witness fees, incurred with respect to litigation associated with stockholder derivative litigation, including the matters related to Ernst & Young LLP and Richard Scrushy discussed in Note 18, *Contingencies and Other Commitments* , to the consolidated financial statements accompanying the 2013 Form 10−K and Note 8, *Contingencies and Other Commitments* , to the condensed consolidated financial statements included in Part I, Item 1, *Financial Statements (Unaudited)* , of the Company's quarterly report on Form 10-Q for the quarterly period ended March 31, 2014 (the "March 2014 Form 10−Q"), and (5) share-based compensation expense. The Company also subtracts from consolidated net income all unusual or nonrecurring items to the extent they increase consolidated net income.

Under the credit agreement, the Adjusted EBITDA calculation does not include net income attributable to noncontrolling interests and includes (1) gain or loss on disposal of assets, (2) professional fees unrelated to the stockholder derivative litigation, and (3) unusual or nonrecurring cash expenditures in excess of $10 million. These items may not be indicative of the Company's ongoing performance, so the Adjusted EBITDA calculation presented here includes adjustments for them.

Adjusted EBITDA is not a measure of financial performance under generally accepted accounting principles in the United States of America ("GAAP"), and the items excluded from Adjusted EBITDA are significant components in understanding and assessing financial performance. Therefore, Adjusted EBITDA should not be considered a substitute for net income or cash flows from operating, investing, or financing activities. Because Adjusted EBITDA is not a measurement determined in accordance with GAAP and is thus susceptible to varying calculations, Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures of other companies. Revenues and expenses are measured in accordance with the policies and procedures described in Note 1, *Summary of Significant Accounting Policies* , to the consolidated financial statements accompanying the 2013 Form 10−K.

The Company also uses adjusted free cash flow as an analytical indicator to assess its performance. Management believes the presentation of adjusted free cash flow provides investors an efficient means by which they can evaluate the Company's capacity to reduce debt, pursue development activities, and return capital to its common stockholders. The calculation of adjusted free cash flow and a reconciliation of net cash provided by operating activities to adjusted free cash flow are included in the Investor Reference Book attached hereto as Exhibit 99.1. This measure is not a defined measure of financial performance under GAAP and should not be considered as an alternative to net cash provided by operating activities. The Company's definition of adjusted free cash flow is limited and does not represent residual cash flows available for discretionary spending. Because this measure is not determined in accordance with GAAP and is susceptible to varying calculations, it may not be comparable to other similarly titled measures presented by other companies. See the consolidated statements of cash flows included in the 2013 Form 10-K and the condensed consolidated statements of cash flows included in the March 2014 Form 10-Q for the GAAP measures of cash flows from operating, investing, and financing activities.

Reconciliation of Net Cash Provided by Operating Activities to Adjusted EBITDA

	Three Months Ended March 31,		Year Ended December 31,				
	2014	2013	2013	2012	2011	2010	2009
				(In Millions)			
Net cash provided by operating activities	$ 107.1	$ 121.4	$ 470.3	$ 411.5	$ 342.7	$ 331.0	$ 406.1
Provision for doubtful accounts	(7.5)	(7.4)	(26.0)	(27.0)	(21.0)	(16.4)	(30.7)
Professional fees—accounting, tax, and legal	1.6	1.4	9.5	16.1	21.0	17.2	8.8
Interest expense and amortization of debt discounts and fees	27.9	24.2	100.4	94.1	119.4	125.6	125.7
UBS Settlement proceeds, gross	—	—	—	—	—	—	(100.0)
Equity in net income of nonconsolidated affiliates	4.3	2.9	11.2	12.7	12.0	10.1	4.6
Net income attributable to noncontrolling interests in continuing operations	(14.8)	(14.6)	(57.8)	(50.9)	(47.0)	(40.9)	(33.3)
Amortization of debt discounts and fees	(3.1)	(1.0)	(5.0)	(3.7)	(4.2)	(6.3)	(6.6)
Distributions from nonconsolidated affiliates	(3.4)	(3.4)	(11.4)	(11.0)	(13.0)	(8.1)	(8.6)
Current portion of income tax expense (benefit)	3.6	1.8	6.3	5.9	0.6	2.9	(7.0)
Change in assets and liabilities	26.9	13.0	48.9	58.1	41.4	5.7	9.1
Net premium paid on bond issuance/redemption	—	—	1.7	1.9	22.8	—	—
Cash used in (provided by) operating activities of discontinued operations	0.2	0.7	1.9	(2.0)	(9.1)	(13.2)	(5.7)
Other	1.3	0.3	1.6	0.2	0.6	2.0	1.3
Adjusted EBITDA	$ 144.1	$ 139.3	$ 551.6	$ 505.9	$ 466.2	$ 409.6	$ 363.7

For the three months ended March 31, 2014, net cash used in investing activities was $67.8 million and resulted primarily from capital expenditures. Net cash used in financing activities during the three months ended March 31, 2014 was $50.7 million and resulted primarily from repurchases of common stock, cash dividends on common stock, and distributions paid to noncontrolling interests of consolidated affiliates.

For the three months ended March 31, 2013, net cash used in investing activities was $47.9 million and resulted primarily from capital expenditures and acquisition activity. Net cash used in financing activities during the three months ended March 31, 2013 was $126.2 million and resulted primarily from repurchases of common stock as part of the tender offer completed in the first quarter of 2013.

For the year ended December 31, 2013, net cash used in investing activities was $226.2 million and resulted primarily from increased capital expenditures and the acquisition of Walton Rehabilitation Hospital. Net cash used in financing activities during the year ended December 31, 2013 was $312.4 million and resulted primarily from repurchases of common stock as part of the tender offer completed in the first quarter of 2013.

For the year ended December 31, 2012, net cash used in investing activities was $178.8 million and resulted primarily from capital expenditures. Net cash used in financing activities during the year ended December 31, 2012 was $130.0 million and resulted primarily from distributions paid to noncontrolling interests of consolidated affiliates, repurchases of 46,645 shares of the Company's convertible perpetual preferred stock, dividends paid on the Company's convertible perpetual preferred stock, and net principal payments on debt offset by capital contributions from consolidated affiliates.

For the year ended December 31, 2011, net cash used in investing activities was $24.6 million and resulted primarily from capital expenditures, net settlement payments related to interest rate swaps, and purchases of restricted investments offset by proceeds from the sale of five long-term acute care hospitals in August 2011. Net cash used in financing activities during the year ended December 31, 2011 was $336.3 million and resulted primarily from net debt payments, including the optional redemption of the Company’s 10.75% Senior Notes due 2016, distributions paid to noncontrolling interests of consolidated affiliates, and dividends paid on the Company’s convertible perpetual preferred stock.

For the year ended December 31, 2010, net cash used in investing activities was $125.9 million and resulted primarily from capital expenditures, net settlement payments related to interest rate swaps, acquisitions of businesses, and net purchases of restricted investments offset by a decrease in restricted cash and proceeds from the sale of the Company’s hospital in Baton Rouge. Net cash used in financing activities during the year ended December 31, 2010 was $237.5 million and resulted primarily from net debt payments, distributions paid to noncontrolling interests of consolidated affiliates, dividends paid on the Company’s convertible perpetual preferred stock, and debt amendment and issuance costs.

For the year ended December 31, 2009, net cash used in investing activities was $133.0 million and resulted primarily from capital expenditures and net settlement payments related to interest rate swaps. Net cash used in financing activities during the year ended December 31, 2009 was $224.3 million and resulted primarily from net debt payments, distributions paid to noncontrolling interests of consolidated affiliates, dividends paid on the Company’s convertible perpetual preferred stock, and debt amendment and issuance costs.

Supreme Court of Alabama Ruling Against HealthSouth in Ernst & Young Arbitration Appeal

On June 13, 2014, the Supreme Court of Alabama affirmed the decision by the Circuit Court of Jefferson County, Alabama denying HealthSouth’s motion to vacate the decision of the American Arbitration Association panel which, on December 18, 2012, dismissed the Company’s claims against Ernst & Young LLP.

This arbitration has its origin in March 2003 when stockholder derivative plaintiffs acting on behalf of HealthSouth filed a lawsuit against Ernst & Young. Ernst & Young served as the Company’s auditor during the period when HealthSouth was a victim of fraudulent and improper accounting practices directed by certain former officers and employees of the Company. The claims against Ernst & Young included, among other things, that from 1996 through 2002, Ernst & Young acted recklessly and with gross negligence and failed to perform reviews and audits of the Company’s financial statements with due professional care as required by law and by its contractual agreements with the Company. This matter was referred to arbitration by Judge Allwin E. Horn, III, Circuit Court Judge, Jefferson County, Alabama, and in August 2006, the Company and the derivative plaintiffs agreed to jointly pursue the claims in arbitration.

“Although we are disappointed with the decision of the Supreme Court of Alabama,” said John Whittington, Executive Vice President and General Counsel of HealthSouth, “we are encouraged by the substance of the concurring opinion which confirms our position that the arbitrators got it all wrong. We are continuing to study the opinion and evaluating our options going forward.”

Forward-Looking Statements

Statements contained in this document and the Investor Reference Book attached hereto as Exhibit 99.1 which are not historical facts, such as those relating to the financial guidance, the business model, and further litigation efforts, are forward-looking statements. In addition, HealthSouth, through its senior management, may from time to time make forward-looking public statements concerning the matters described herein. All such estimates, projections, and forward-looking information speak only as of the date hereof, and HealthSouth undertakes no duty to publicly update or revise such forward-looking information, whether as a result of new information, future events, or otherwise. Such forward-looking statements are necessarily estimates based upon current information, involve a number of risks and uncertainties, and relate to, among other things, future events, HealthSouth's plan to repurchase its debt or equity securities, dividend strategies, effective income tax rates, HealthSouth's business strategy, its financial plans, its future financial performance, its projected business results or model, its projected capital expenditures, and its leverage ratio. Actual events or results may differ materially from those anticipated in these forward-looking statements as a result of a variety of factors. While it is impossible to identify all such factors, factors which could cause actual events or results to differ materially from those estimated by HealthSouth include, but are not limited to, the price of HealthSouth's common or preferred stock as it affects the Company's willingness and ability to repurchase shares and the financial and accounting effects of any repurchases; any adverse outcome of various lawsuits, claims, and legal or regulatory proceedings involving HealthSouth, including its pending DOJ and HHS-OIG investigations; potential disruptions, breaches, or other incidents affecting the proper operation, availability, or security of HealthSouth's information systems; significant changes in HealthSouth's management team; HealthSouth's ability to successfully complete and integrate de novo developments, acquisitions, investments, and joint ventures consistent with its growth strategy; changes, delays in (including in connection with resolution of Medicare payment reviews or appeals), or suspension of reimbursement for HealthSouth's services by governmental or private payors; changes in the regulation of the healthcare industry at either or both of the federal and state levels, including as part of national healthcare reform and deficit reduction; competitive pressures in the healthcare industry and HealthSouth's response thereto; HealthSouth's ability to obtain and retain favorable arrangements with third-party payors; HealthSouth's ability to attract and retain nurses, therapists, and other healthcare professionals in a highly competitive environment with often severe staffing shortages and the impact on HealthSouth's labor expenses from potential union activity and staffing shortages; general conditions in the economy and capital markets; the increase in the costs of defending and insuring against alleged professional liability claims and HealthSouth's ability to predict the estimated costs related to such claims; and other factors which may be identified from time to time in HealthSouth's SEC filings and other public announcements, including HealthSouth's Form 10−K for the year ended December 31, 2013 and Form 10-Q for the quarter ended March 31, 2014.

ITEM 9.01. *Financial Statements and Exhibits.*

(d) Exhibits

99.1 HealthSouth Corporation Investor Reference Book - Post Q1 2014 Earnings Release.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the Registrant has duly caused this Report to be signed on its behalf by the undersigned hereunto duly authorized.

HEALTHSOUTH CORPORATION

By: /s/ JOHN P. WHITTINGTON

Name: John P. Whittington

Title: Executive Vice President, General Counsel and Corporate Secretary

Dated: June 17, 2014

HEALTHSOUTH





INVESTOR REFERENCE BOOK

Post Q1 2014 Earnings Release

Last updated June 17, 2014

Forward-Looking Statements

The information contained in this presentation includes certain estimates, projections and other forward-looking information that reflect our current outlook, views and plans with respect to future events, including legislative and regulatory developments, strategy, capital expenditures, development activities, dividend strategies, repurchases of securities, effective tax rates, financial performance, and business model. These estimates, projections and other forward-looking information are based on assumptions that HealthSouth believes, as of the date hereof, are reasonable. Inevitably, there will be differences between such estimates and actual events or results, and those differences may be material.

There can be no assurance that any estimates, projections or forward-looking information will be realized.

All such estimates, projections and forward-looking information speak only as of the date hereof. HealthSouth undertakes no duty to publicly update or revise the information contained herein.

You are cautioned not to place undue reliance on the estimates, projections and other forward-looking information in this presentation as they are based on current expectations and general assumptions and are subject to various risks, uncertainties and other factors, including those set forth in the Form 10-K for the year ended December 31, 2013, the Form 10-Q for the quarter ended March 31, 2014, and in other documents we previously filed with the SEC, many of which are beyond our control, that may cause actual events or results to differ materially from the views, beliefs and estimates expressed herein.

Note Regarding Presentation of Non-GAAP Financial Measures

The following presentation includes certain "non-GAAP financial measures" as defined in Regulation G under the Securities Exchange Act of 1934. Schedules are attached that reconcile the non-GAAP financial measures included in the following presentation to the most directly comparable financial measures calculated and presented in accordance with Generally Accepted Accounting Principles in the United States. Our Form 8-K, dated June 17, 2014 to which the following supplemental slides are attached as Exhibit 99.1, provides further explanation and disclosure regarding our use of non-GAAP financial measures and should be read in conjunction with these supplemental slides.

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Our Company



New Hospitals

- ★ Littleton, CO; 40-bed hospital; began accepting patients May 15, 2013
- ★ Stuart, FL; 34-bed hospital; began accepting patients June 5, 2013
- ○ Under construction; 50-bed hospital in Altamonte Springs, FL; expect to be operational Q4 2014
- ○ Under construction; 50-bed hospital in Newnan, GA; expect to be operational Q4 2014
- ○ Under construction; 34-bed hospital in Middletown, DE; expect to be operational Q4 2014
- ○ Johnson City, TN; 26-bed hospital; expect to finalize by year-end 2014.
- ○ Purchased land for 50-bed hospital in Modesto, CA; expect to be operational in Q4 2015
- ● CON approved for 40-bed hospital in Franklin, TN; under appeal

Marketshare

~ 9% of IRFs (Total in U.S. = 1,134)

~ 19% of Licensed Beds

~ 21% of Patients Served

Portfolio – As of March 31, 2014

103	Inpatient Rehabilitation Hospitals ("IRF") • 31 operate as JV's with Acute Care Hospitals
17	Outpatient Rehabilitation Satellite Clinics
25	Hospital-Based Home Health Agencies
28 + Puerto Rico	Number of States
~ 23,700	Employees

Key Statistics-Trailing 4 Quarters

~ $2.3 Billion	Revenue
130,747	Inpatient Discharges
788,330	Outpatient Visits

Patients Served

Most Common Conditions (Q1 2014):

1. Neurological	25.0%
2. Stroke	16.7%
3. Fracture of the lower extremity	9.2%
4. Other orthopedic conditions	9.0%
5. Brain injury	8.3%

Our Hospitals

96 of our hospitals hold one or more disease-specific certifications from The Joint Commission's Disease-Specific Care Certification Program. (1)







Major Services

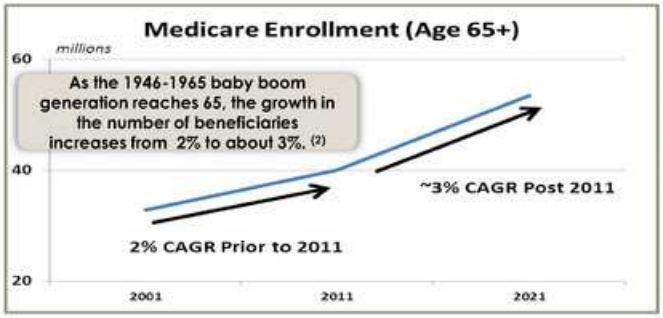
- **Rehabilitation Physicians:** manage and treat medical needs of patients
- **Rehabilitation Nurses:** oversee treatment programs of patients
- **Physical Therapists:** address physical function, mobility, safety
- **Occupational Therapists:** promote independence and re-integration
- **Speech-Language Therapists:** treat communication and swallowing disorders
- **Case Managers:** coordinate care plan with physician, caregivers and family
- **Post-discharge services:** outpatient therapy and home health

(1) Under this program, Joint Commission accredited organizations, like our hospitals, may seek certification for chronic diseases or conditions such as brain injury or stroke rehabilitation by complying with Joint Commission standards, effectively using evidence-based clinical practice guidelines to manage and optimize patient care, and using an organized approach to performance measurement and evaluation of clinical outcomes. Obtaining such certifications demonstrates our commitment to excellence in providing disease-specific care.

Our Patients

Average Age of a HealthSouth Patient:
- **All patients = 72**
- **Medicare FFS = 76**

Census Data [1] - Population Growth by Age			
	5 Year CAGR		
Age	**2015 -2020**	**2020-2025**	**2025-2030**
65 to 69 years	2.4%	2.1%	0.1%
70 to 74 years	5.2%	2.5%	2.1%
75 to 79 years	4.3%	5.3%	2.6%
80 to 84 years	2.2%	4.5%	5.5%
85 to 89 years	0.3%	2.5%	4.8%
Total 65 to 89	**3.3%**	**3.1%**	**2.3%**



Referral Sources:

93%	Acute Care Hospitals
6%	Physician Offices/Home
1%	Skilled Nursing Facilities

Most Common Conditions (Q1 2014):

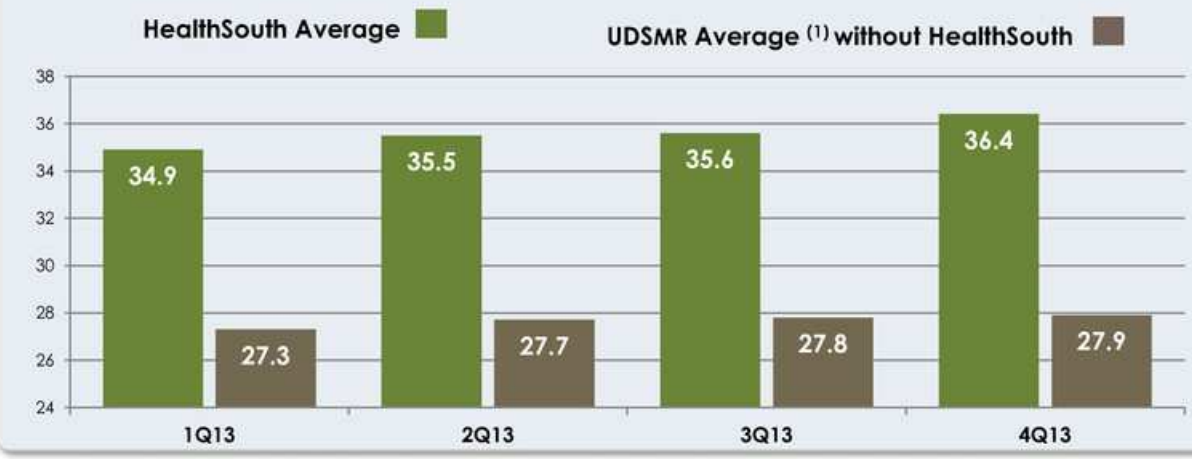
1.	Neurological	25.0%
2.	Stroke	16.7%
3.	Fracture of the lower extremity	9.2%
4.	Other orthopedic conditions	9.0%
5.	Brain injury	8.3%
6.	Debility	7.9%
7.	Knee/Hip replacement	6.8%
8.	Major multiple trauma	4.0%
9.	Cardiac	3.6%
10.	All other	9.5%

Admission to an IRF:
- Physicians and acute care hospital case managers are key decision makers.
- All IRF patients must meet reasonable and necessary criteria and must be admitted by a physician.
- All IRF patients must be medically stable and have potential to tolerate three hours of therapy per day (minimum).
- IRF patients receive 24-hour, 7 days a week nursing care.
- Average length of stay ~13.4 days

(1) Source: www.census.gov/population/projections/files/summary/NP2012-T12.xls
(2) Center of Medicare & Medicaid Services, Medicare Trustee's Report May 2013 – pages 10 and 22

HEALTHSOUTH

Our Quality



FIM® Gain (2) is based on the change from admission to discharge of an 18 point assessment.

- **Inpatient rehabilitation hospitals evaluate all patients at admission and upon discharge to determine their functional status.**
  - FIM® is the tool for measuring functional independence.
- **The difference between the FIM® scores at admission and upon discharge is called the "FIM® Gain."**
  - The greater the FIM® Gain, the greater the patient's level of independence, the better the patient outcome.

Source: UDSMR Database

(1) Beginning in Q1 2014, we will report quality outcomes without HealthSouth included in the UDSMR Average. As a result, we will be reporting one quarter in arrears. The UDS average is the risk adjusted average of a patient mix pulled from the UDS nation that is similar to the HealthSouth actual patient mix. Cases are placed into CMGs by admitting impairment code, functional status at admission, and sometimes age.

(2) FIM® instrument is a trademark of Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc.

Our Cost-Effectiveness

Total Inpatient Rehabilitation Facilities (IRFs): 1,134

		Avg. Beds per IRF	Avg. Medicare Discharges per IRF [2]	Case Mix Index [3]	Avg. Est. Total Cost per Discharge for FY 2014	Avg. Est. Total Payment per Discharge for FY 2014
HLS [1] =	99	68	918	1.23	$12,194	$17,979
Free-Standing (Non-HLS)=	136	52	621	1.20	$16,102	$18,971
Hospital Units =	899	23	231	1.14	$18,925	$18,847
Total	1,134	30	338	1.18	$16,704	$18,668

- The Avg. Est. Total Payment per Discharge has not been reduced by 2% for sequestration [4]
- Medicare pays HealthSouth less per discharge, on average, and HealthSouth treats a higher acuity patient.
- **HealthSouth differentiates itself by:**
  - ✓ "Best Practices" clinical protocols
  - ✓ Supply chain efficiencies
  - ✓ Sophisticated management information systems
  - ✓ Economies of scale

(1) The 99 for HLS does not include HealthSouth Rehabilitation Hospital of Ocala, FL (opened December 2012), HealthSouth Rehabilitation Hospital of Littleton, CO (opened May 2013), or HealthSouth Rehabilitation Hospital at Martin Health in Stuart, FL (opened June 2013). Walton Rehabilitation Hospital is included in "Freestanding (Non-HLS)."

(2) In 2013, HealthSouth averaged 1,287 total Medicare and non-Medicare discharges per hospital in its 101 consolidated hospitals.

(3) Case Mix Index (CMI) from the rate-setting file presented above are adjusted for short-stay transfer cases. HealthSouth's unadjusted CMI for 2013 was 1.34 versus 1.29 for the industry as measured by UDSMR, a data gathering and analysis organization for the rehabilitation industry; represents ~70% of the industry, including HealthSouth sites.

(4) The Budget Control Act of 2011 included a reduction of up to 2% to Medicare payments for all providers that began on April 1, 2013 (as modified by H.R. 8). The reduction was made from whatever level of payment would otherwise have been provided under Medicare law and regulation.

Source: FY 2014 CMS Final Rule Rate Setting File (see slide 9) and Medicare Report to Congress, Medicare Payment Policy, March 2013 – pages 221 and 223

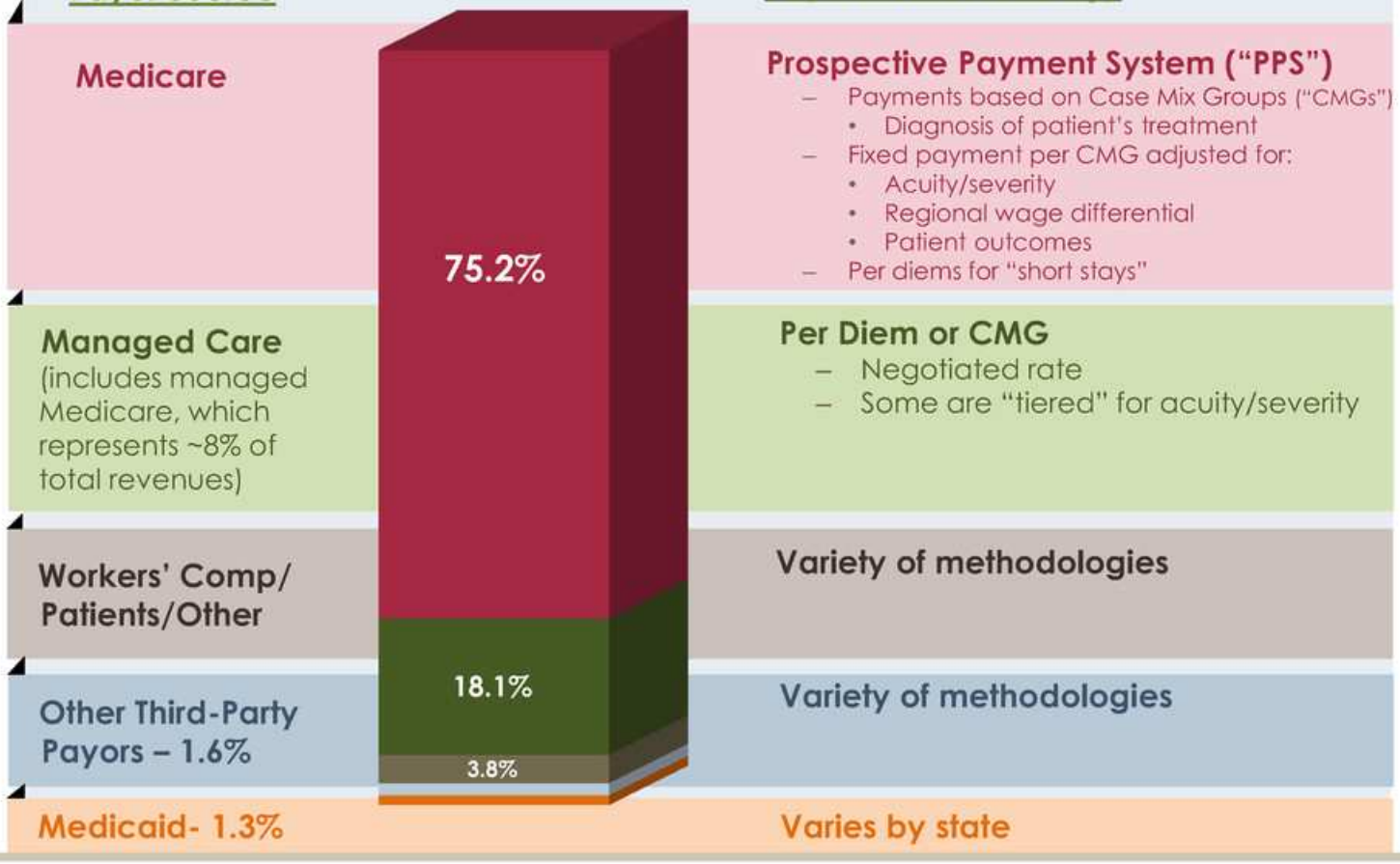
CMS Fiscal Year 2014 IRF Final Rule Rate Setting File Analysis

Notes:

(1) All data provided was filtered and compiled from the Centers for Medicare and Medicaid Services (CMS) Fiscal Year 2014 IRF Final Rule rate setting file found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html. The data presented was developed entirely by CMS and is based on its definitions which are different in form and substance from the criteria HealthSouth uses for external reporting purposes. Because CMS does not provide its detailed methodology, HealthSouth is not able to reconstruct the CMS projections or the calculation.

(2) The CMS file contains data for each of the 1,134 inpatient rehabilitation facilities used to estimate the policy updates for the FY 2014 IRF-PPS Final Rule. Most of the data represents historical information from the CMS fiscal year 2012 period and does not reflect the same HealthSouth hospitals in operation today. The data presented was separated into three categories: Freestanding, Units, and HealthSouth. HealthSouth is a subset of Freestanding and the Total.

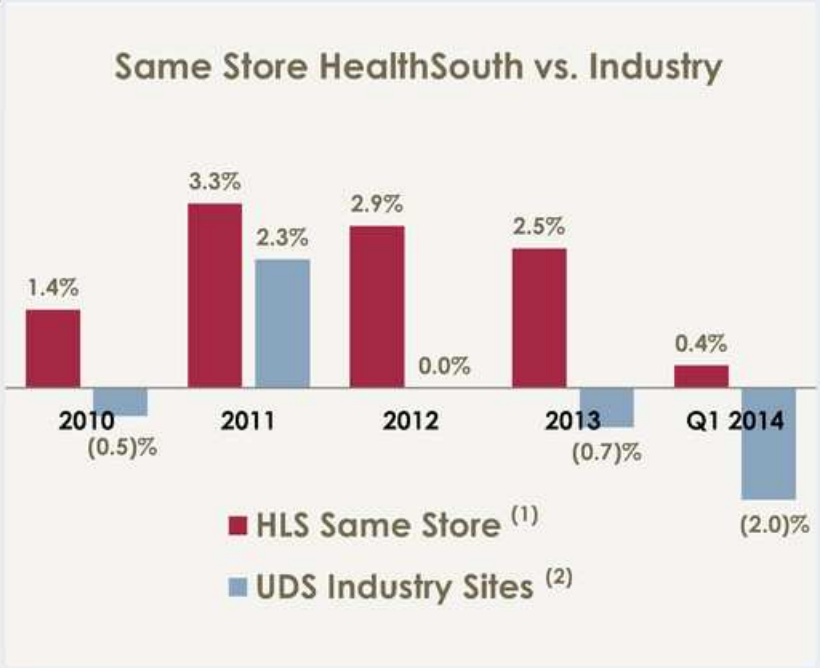
Our Payors (Q1 2014)



HEALTHSOUTH

Our Discharge Growth vs. Industry

HealthSouth's volume growth has outpaced competitors'



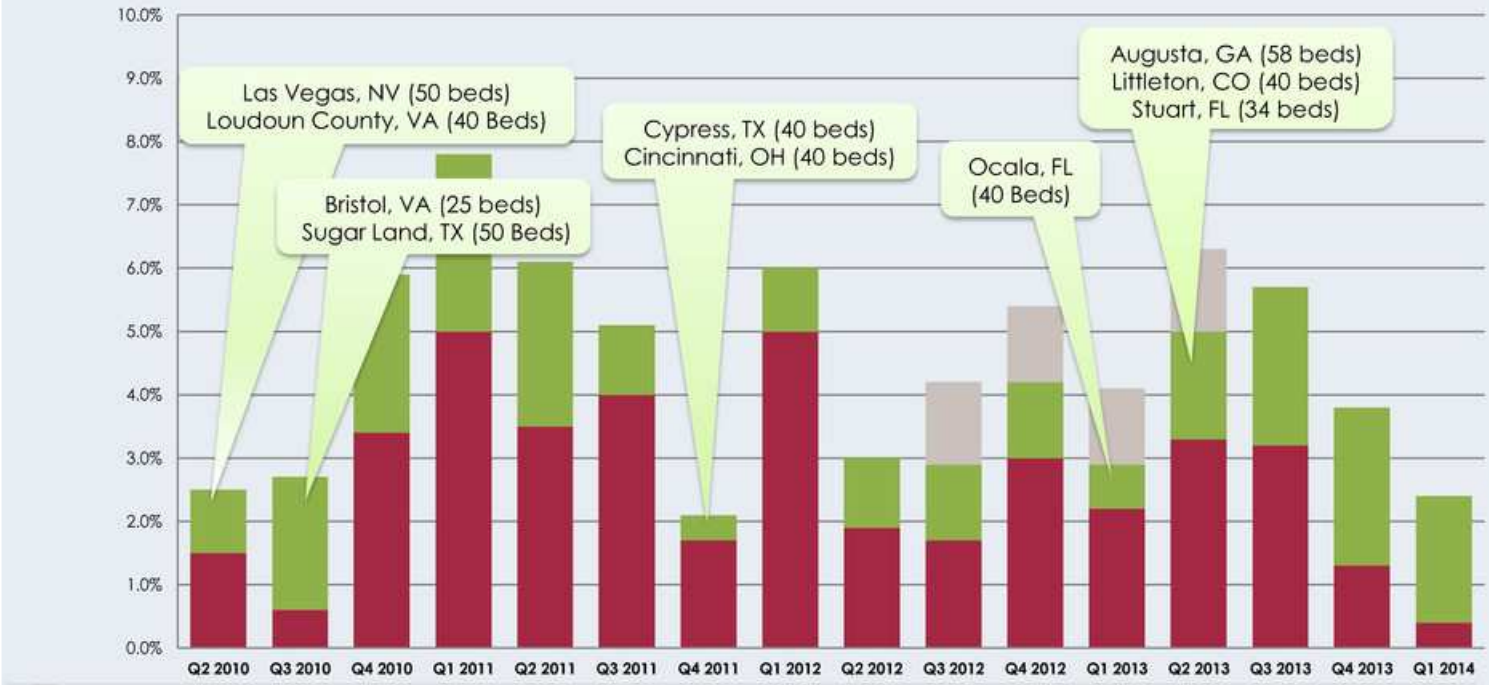
- Medicare Enrollment (Age 65+) is growing at approx. 3% per year.
- TeamWorks = standardized and enhanced sales & marketing
- Bed additions to existing facilities will enhance organic growth.
  - 68 beds added in 2013
  - 95 beds added in 2012

(1) Includes consolidated HealthSouth inpatient rehabilitation hospitals classified as same store during that time period. That number was 97 for the three months ended March 31, 2014.
(2) Data provided by UDSMR, a data gathering and analysis organization for the rehabilitation industry; represents ~70% of industry, including HealthSouth sites classified as same store prior to 2011.

HEALTHSOUTH

Our New Store/Same Store Growth (con't)

HealthSouth's volume growth is driven by bed expansions and new IRFs.



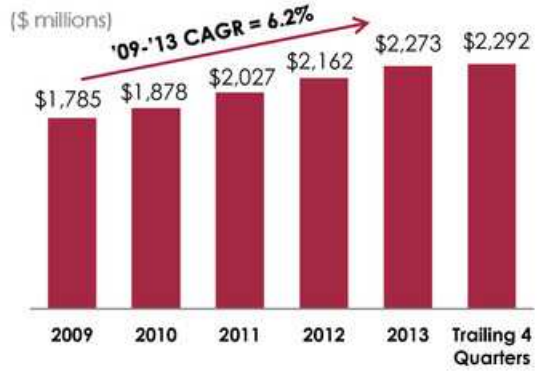
	Q2 2010	Q3 2010	Q4 2010	Q1 2011	Q2 2011	Q3 2011	Q4 2011	Q1 2012	Q2 2012	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014
St.Vincent's [1]										1.3%	1.2%	1.2%	1.3%			
New Store	1.0%	2.1%	2.5%	2.8%	2.6%	1.1%	0.4%	1.0%	1.1%	1.2%	1.2%	0.7%	1.7%	2.5%	2.5%	2.0%
Same Store	1.5%	0.6%	3.4%	5.0%	3.5%	4.0%	1.7%	5.0%	1.9%	1.7%	3.0%	2.2%	3.3%	3.2%	1.3%	0.4%
Total by Qtr.	2.5%	2.7%	5.9%	7.8%	6.1%	5.1%	2.1%	6.0%	3.0%	4.2%	5.4%	4.1%	6.3%	5.7%	3.8%	2.4%
Total by Year			3.1%				5.2%				4.6%				5.0%	

(1) In Q3 2012, HealthSouth amended the joint venture agreement related to St. Vincent Rehabilitation Hospital in Sherwood, AR which resulted in a change in accounting for this hospital from the equity method of accounting to a consolidated entity. Moved to same store in Q3 2013.

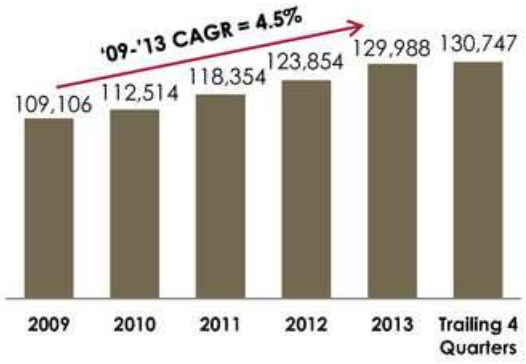
HEALTHSOUTH

Our Track Record

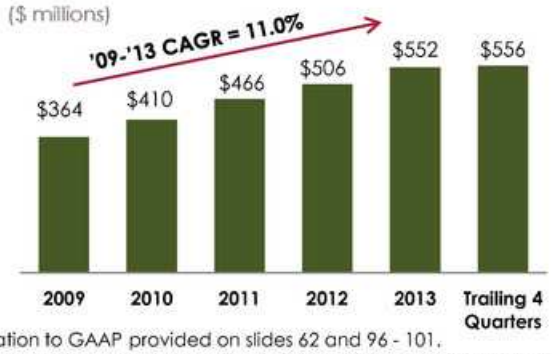
Revenue



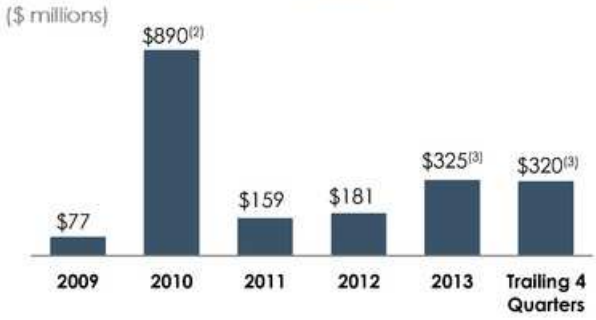
Discharge Volume



Adjusted EBITDA (1)



Income from Continuing Operations Attributable to HealthSouth

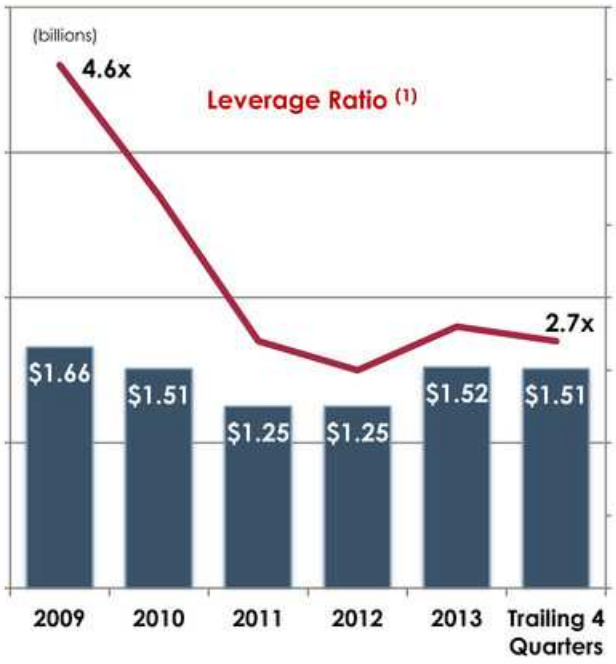


(1) Reconciliation to GAAP provided on slides 62 and 96 - 101.
(2) 2010 includes an income tax benefit of ~$741 million primarily due to the reversal of a substantial portion of the valuation allowance against deferred tax assets.
(3) Includes an approx. $115 million benefit related to a settlement with the IRS

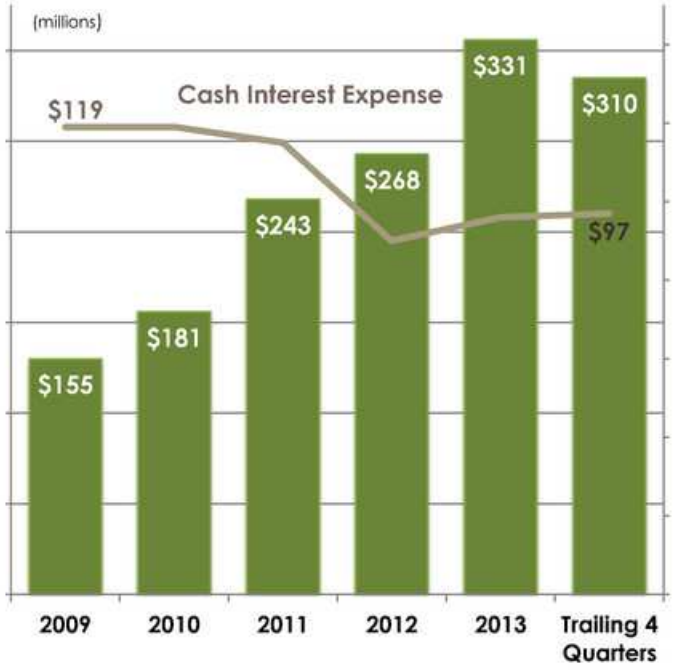
HEALTHSOUTH

Our Track Record (con't)

Total Debt



Adjusted Free Cash Flow (2)

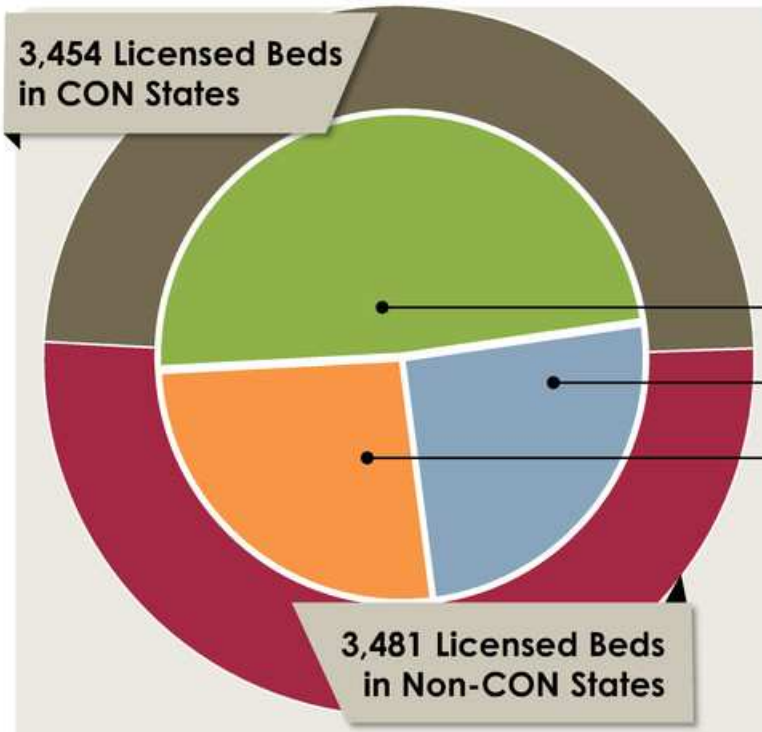


(1) Based on 2009 and trailing 4 quarters Adjusted EBITDA of $363.7 and $556.4 million, respectively; reconciliation to GAAP provided on slides 62 and 96-101.

(2) Reconciliation to GAAP provided on slide 61.

HEALTHSOUTH

Our Assets
103 [1] Inpatient Rehabilitation Hospitals: 6,935 Licensed Beds[2]



HealthSouth has the option to purchase two leased properties in the next five years (2016 and 2018).

50 Own Building and Land

26 Own Building Only

27 Lease Building and Land

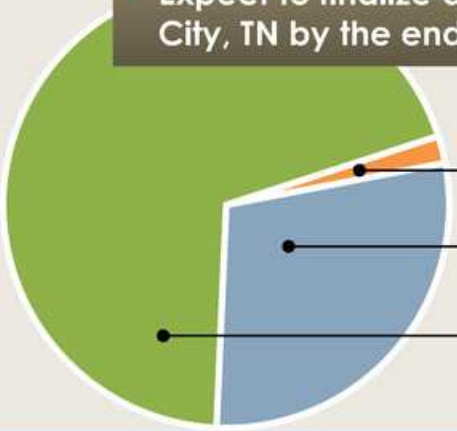
A Certificate of Need (CON) is a legal document required in many states and some federal jurisdictions before proposed acquisitions, expansions, or creations of facilities are allowed.

(1) 1 of the 103 HealthSouth hospitals is nonconsolidated. For that hospital, we own the building only.
(2) Excludes 41 licensed beds at the nonconsolidated hospital

HEALTHSOUTH

Our Joint Venture Partnerships

- HealthSouth's management of IRF joint ventures began in 1991.
- HealthSouth's joint venture partners own equity that ranges from 2.5% to 50%.
- Expect to finalize a joint venture with Mountain States Alliance in Johnson City, TN by the end of 2014



1 Equity Method Joint Ventures

30 Consolidated Joint Venture Hospitals

72 Consolidated 100% Ownership

31 joint venture hospitals in place include major healthcare systems :

- Barnes-Jewish
- University of Virginia Medical Center
- Vanderbilt University
- Geisinger Health System
- Martin Health System
- Monmouth Medical Center (Barnabas Health)
- Yuma Regional Medical Center
- Rockford Health System

Our Preparation for Shifts to Coordinated Care Delivery Models

- Evolutionary rather than revolutionary
- Strong balance sheet and free cash flow enhance flexibility

31 joint venture hospitals with acute care systems already in place (examples include):
- Barnes-Jewish
- University of Virginia Medical Center
- Vanderbilt University

Strong balance sheet and free cash flow:
- No significant debt maturities prior to 2018
- Relatively low financial leverage
- Ample liquidity under revolving credit facility
- Consistently strong free cash flow

Installing clinical information systems (CIS) in all HealthSouth hospitals:
- 41 installations completed as of March 31, 2014
- Cerner custom system capable of interfaces with all major acute care EMR systems
- Participating in Health Information Exchanges (HIE)

High-quality, cost-effective provider:
- FIM® gains consistently exceed industry results
- Scale and operating leverage contribute to low cost per discharge (1)
- On average, Medicare pays HealthSouth less per discharge although HealthSouth treats a higher acuity patient. (1)

Flexibility in managing physical plant:
- 102 HealthSouth IRF's are free-standing
- 76 HealthSouth IRF's are owned vs. leased

Participation in new delivery models:
- Exploring ACO participation in several markets
- Participating in bundled payment pilots

(1) See slide 8.

Our Strong and Sustainable Business Fundamentals

Attractive Healthcare Sector	• Favorable demographic trends • Nondiscretionary nature of many conditions treated in IRFs • Highly fragmented industry
Industry Leading Position	• #1 market share: above industry same-store growth and margins • Consistent achievement of high-quality, cost-effective care • Rollout of state-of-the-art clinical information system
Cost-Effectiveness	• Focused labor management • Continued improvements in supply chain • Significant operating leverage of G&A and occupancy expenses
Real Estate Portfolio	• Portfolio of strategically located, well-designed physical assets • 103 IRFs [1]; 76 owned and 27 long-term, real estate leases • Option to purchase additional leased properties
Financial Strength	• Strong balance sheet; ample liquidity, no near-term maturities • Minimal cash income tax expense ($10 - $15 million in 2014) • Substantial free cash flow generation; $0.18 per share quarterly cash dividend on common stock • Approx. $224 million common stock repurchase authorization remaining as of March 31, 2014
Growth Opportunities	• Bed expansion at existing hospitals • Flexible de novo strategy • Flexible IRF acquisition and unit consolidation strategy • Ability to pursue other post-acute sectors opportunistically

(1) Inclusive of one nonconsolidated entity

Industry Structure

Overall Healthcare Spending

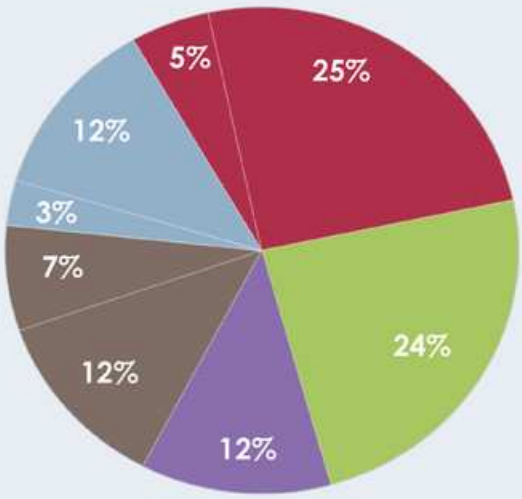
National Healthcare Spending: $2,793.4 billion



Source: Center for Medicare & Medicaid Services, National Health Expenditure Data for calendar year 2012 – Table 2

Medicare 2012 Spending = $565.9 Billion (1)

$6.7B (1%)
Inpatient Rehabilitation Hospitals
(Included in Inpatient Hospitals)



$ 28.0B $139.7B	Skilled Nursing Inpatient Hospital (2)	Medicare Part A
$ 69.6B $ 39.1B	Physician Payments Outpatient Hospital	Medicare Part B
$ 18.6B $ 68.2B	Home Health Other Services (3)	Medicare Parts A&B
$136.2B	Medicare Managed Care	Medicare Part C
$ 66.5B	Outpatient Rx	Medicare Part D

(1) Percentages are based upon total Medicare spending of $565.9 billion (does not include administrative expenses), Center of Medicare & Medicaid Services, Medicare Trustee's Report May 2013 – page 10

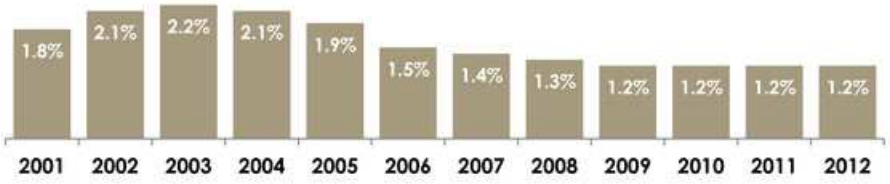
(2) Inpatient Hospital includes spending for acute care hospitals along with, inpatient rehabilitation and long-term care hospital services; in 2012, Medicare spent $6.7 and $5.5 billion, respectively, for these services (MedPAC Report to Congress, Medicare Payment Policy, March 2014 – Pages 244 and 263).

(3) Other Services reflects spending for hospice; in 2012, Medicare spent $15.1 billion for hospice services. (MedPAC Report to Congress, Medicare Payment Policy, March 2014 – Page 299). Other Services also reflects spending for various other outpatient services.

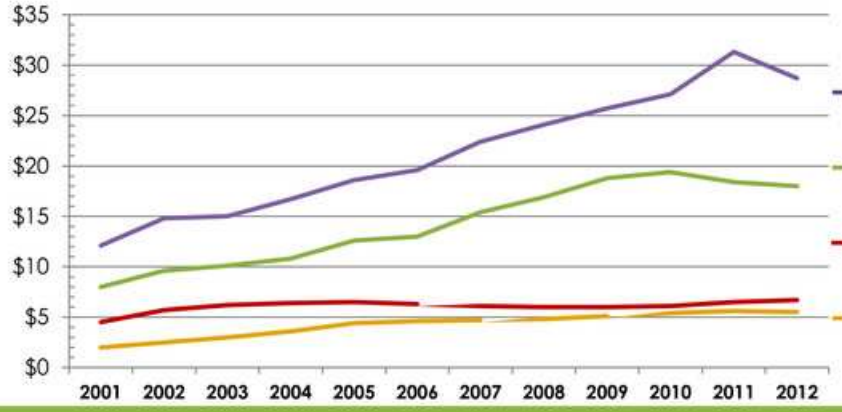
Continuum of Healthcare Services



Medicare Spending on Post-Acute Services



Total Medicare Spending on Post-Acute Services approx. **$58.9 billion** in 2012



Post-Acute Settings	2012 Medicare Margin	Projected 2014 Medicare Margin
Skilled nursing facilities	13.8%	12.0%
Home health agencies	14.4%	12.6%
Inpatient rehabilitation hospitals	11.1%	11.8%
Long-term acute care hospitals	7.1%	6.5%

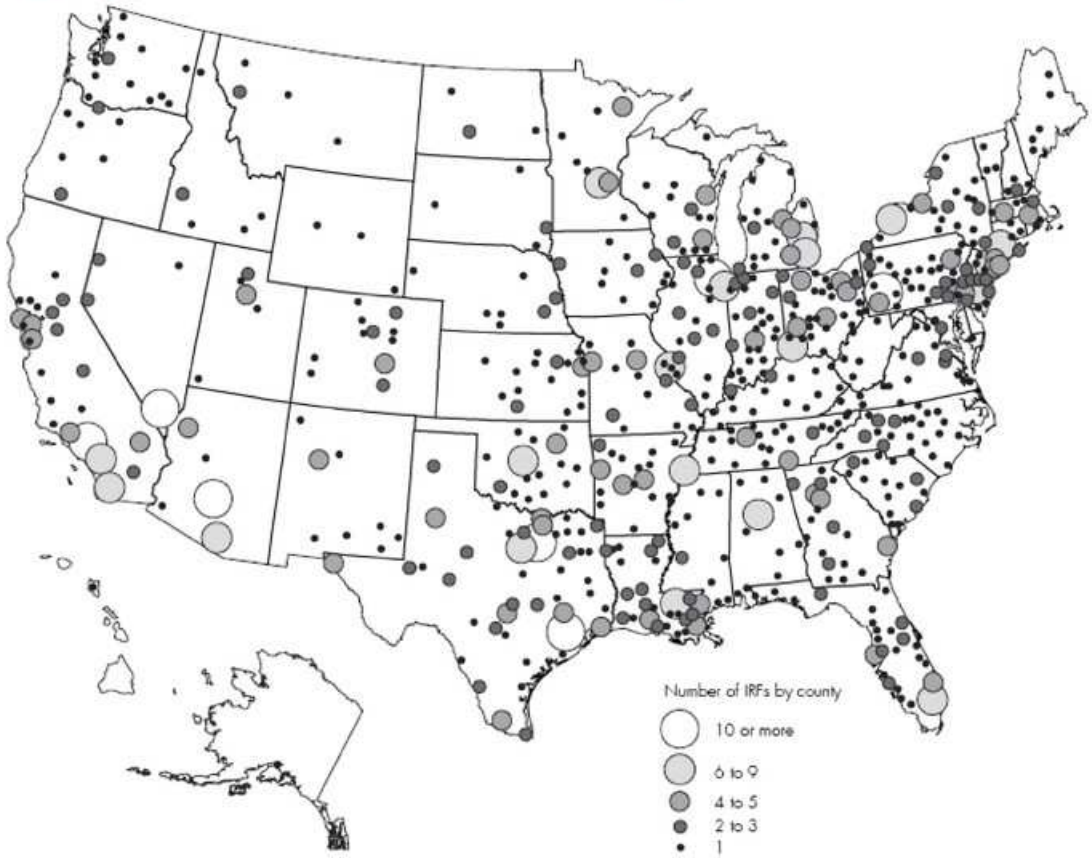
Projected 2014 Medicare margins do not reflect the effect of 2% sequestration (1). For example, taking sequestration into account, the projected inpatient rehabilitation margin for 2014 would be approx. 10.0%.

Sources: Center for Medicare & Medicaid Services, Medicare Trustees Report May 2013 – Page 10, MedPAC Testimony to Subcommittee on Health Committee on Ways and Means U.S. House of Representatives – Page 3; MedPAC Report to Congress, Medicare Payment Policy, March 2014 – Pages 181, 197, 203, 213, 226, 227, 241, 256, 257, 263, 277, and 279.

(1) The Budget Control Act of 2011 included a reduction of up to 2% to Medicare payments for all providers that began on April 1, 2013 (as modified by H.R. 8). The reduction was made from whatever level of payment would otherwise have been provided under Medicare law and regulation.

HEALTHSOUTH

Geographic Distribution of IRFs, 2012



Source: MedPAC Report to Congress, Medicare Payment Policy, March 2014 – page 243

Supply of IRFs remained stable in 2012

Type of IRF	2004	2005	2006	2008	2010	2011	2012	Average Annual Change 2004-2008	Average Annual Change 2008-2011
All IRFs	1,221	1,235	1,225	1,202	1,179	1,165	1,166	-0.4%	-1.0%
Urban	1,024	1,027	1,018	1,001	981	972	973	-0.6	-1.0
Rural	197	208	207	201	198	193	193	0.5	-1.3
Freestanding	217	217	217	221	233	234	239	0.5	1.9
Hospital based	1,004	1,018	1,008	981	946	931	927	-0.6	-1.7
Nonprofit	768	768	758	738	729	711	698	-1.0	-1.2
For profit	292	305	299	291	294	294	307	-0.1	0.3
Government	161	162	168	173	156	158	157	1.8	-3.0

Note: IRF (inpatient rehabilitation facility). For all years, the rural/urban breakdown is by Core-Based Statistical Area (CBSA) definition. For 2012, the ownership of four facilities is unknown.

Source: MedPAC Report to Congress, Medicare Payment Policy, March 2014 – page 247

Inpatient Rehabilitation Sector Margins

Type of IRF	Share of Medicare discharges 2012	Margins						
		2004	2006	2008	2009	2010	2011	2012
All IRFs	100%	16.7%	12.4%	9.3%	8.4%	8.7%	9.8%	11.1%
Urban	91.2	17.0	12.6	9.5	8.6	9.0	10.2	11.4
Rural	8.8	13.9	10.6	7.2	5.9	5.6	6.1	7.3
Freestanding	45.3	24.7	17.5	18.1	20.5	21.3	22.9	23.8
Hospital based	54.7	12.2	9.6	3.8	0.2	-0.4	-0.1	0.8
Nonprofit	46.9	12.8	10.7	5.3	2.3	2.1	2.6	2.1
For profit	45.8	24.4	16.3	16.8	19.0	19.6	21.0	22.9
Government	7.3	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Number of beds								
1 to 10	2.5	3.4	-3.8	-4.8	-11.6	-10.0	-6.8	-7.8
11 to 21	19.0	9.6	7.0	0.5	-2.7	-3.2	-3.3	-1.9
22 to 59	42.3	16.1	12.4	8.3	6.5	6.9	8.0	9.3
60 or more	36.2	22.6	17.5	16.9	18.3	18.4	19.4	20.9

Note: IRF (Inpatient rehabilitation facility), N/A (not applicable). Government-owned facilities operate in a different financial context from other facilities, so their margins are not necessarily comparable. Their margins are not presented separately here, although they are included in the margins for other groups (e.g., all IRFs), where applicable.

Source: MedPAC analysis of Medicare cost report data from CMS. Medicare Report to Congress, Medicare Payment Policy Report, March 2014 - page 256

Inpatient Rehabilitation Standardized Comparison of Costs

Type of IRF	Mean Adjusted Cost Per Discharge
All IRFs	$15,738
Hospital based	16,592
Freestanding	12,469
Nonprofit	15,824
For profit	14,858
Government	17,644
Urban	15,349
Rural	17,747
Number of beds	
1 to 10	17,653
11 to 21	16,462
22 to 59	15,524
60 or more	12,953

Mean adjusted costs per discharge are lower for freestanding IRFs and larger facilities, 2012

High margins among both hospital-based and freestanding IRFs in the low-cost quartile of standardized costs, 2012

Characteristic	Quartile: Low Cost	Quartile: High Cost
Number of IRFs	271	271
Percent:		
Hospital based	45.80%	93.70%
Freestanding	54.2	6.3
Nonprofit	38	63.1
For profit	59.4	18.5
Government	2.6	18.5
Urban	94.5	69
Rural	5.5	31
Median Medicare Margin:		
All	26.40%	-25.50%
Hospital based	21.8	-25.7
Freestanding	29.2	-20.4
Median:		
Number of beds	42	17
Occupancy rate	69%	52%
Case-mix index	1.26	1.20
Median costs per discharge:		
All	$10,929	$19,671
Hospital based	11,542	19,608
Freestanding	10,488	20,143*

Note: IRF (Inpatient rehabilitation facility). Costs per discharge are standardized for the wage index, case mix, and outliers. Government-owned facilities operate in a different financial context from other facilities, so costs are not necessarily comparable. *Reflects small cell size (17 facilities).

Source: MedPAC analysis of 2012 standard analytical file and Medicare cost report data from CMS. Medicare Report to Congress, Medicare Payment Policy Report, March 2014 – page 255

Readmission Rates

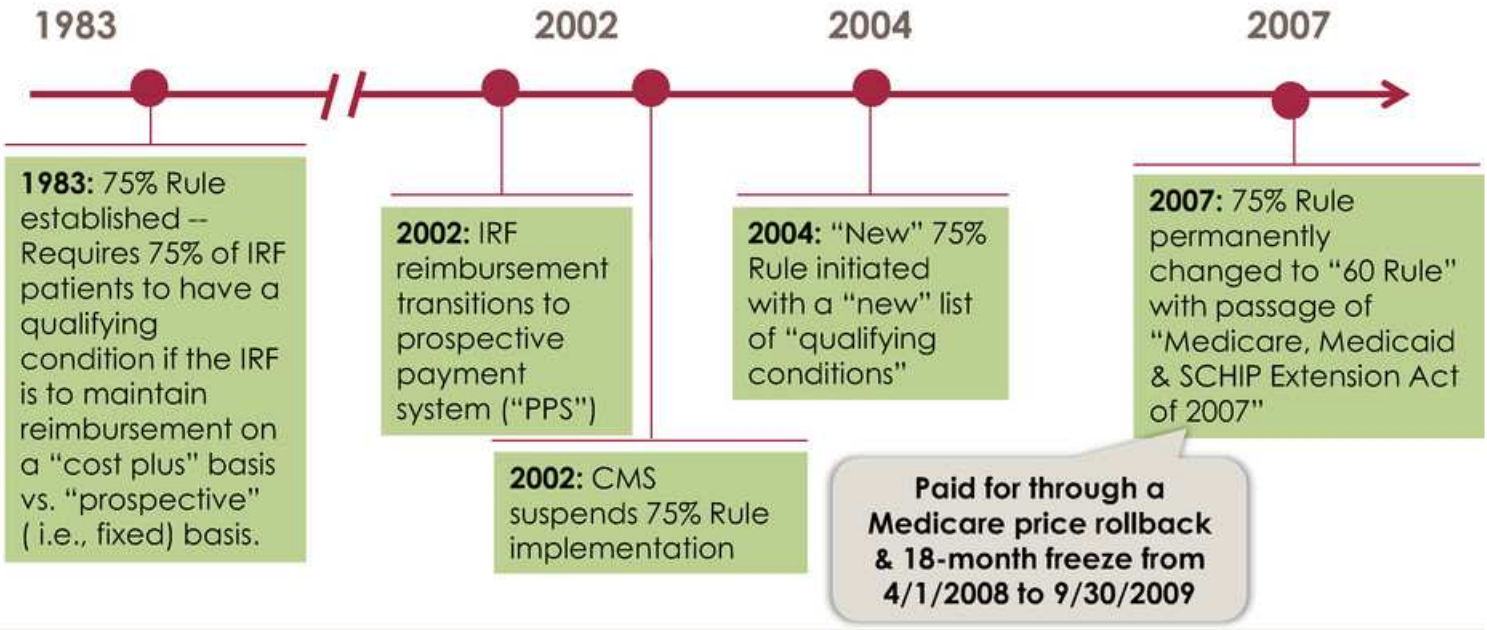
Post-Acute Care ("PAC") Setting	Percent Discharged from Hospital to PAC Setting	Percent Rehospitalized after Using PAC Setting	Percent Died in PAC Setting
Skilled Nursing Facility	17.3%	22.0%	5.4%
Home Health	16.0%	18.1%	0.8%
Long-Term Care Hospital	1.0%	10.0%	15.5%
Inpatient Rehabilitation	3.2%	9.4%	0.4%
Inpatient Psychiatric	0.5%	8.7%	0.4%
Hospice	2.1%	4.5%	82.2%
TOTAL	40.0%	18.0%	6.2%

Note: Use of home health care and hospice is based on care that starts within three days of discharge. Other PAC care starts within one day of discharge. Home health use includes episodes that overlap an inpatient stay.

Source: MedPAC Data Book, Healthcare Spending and the Medicare program, June 2008 – Chart 9-3

"60% Rule": Medicare Regulation for Rehabilitation Hospitals

The 60% Rule requires at least 60% of all patients admitted must have at least one medical diagnosis or functional impairment from a list of 13 compliant conditions (a.k.a "compliant conditions" or "CMS-13").



Inpatient Rehabilitation Hospital (IRF): Qualifying Conditions

Original Qualifying Conditions

1. Stroke
2. Brain injury
3. Amputation
4. Spinal cord
5. Fracture of the femur
6. Neurological disorder
7. Multiple trauma
8. Congenital deformity
9. Burns
10. Polyarthritis (includes "joint replacement")

Became

New Qualifying Conditions

1. Stroke
2. Brain injury
3. Amputation
4. Spinal cord
5. Fracture of the femur
6. Neurological disorder
7. Multiple trauma
8. Congenital deformity
9. Burns
10. Osteoarthritis (after less intensive setting)
11. Rheumatoid arthritis (after less intensive setting)
12. Joint replacement
    - Bilateral
    - Age ≥ 85
    - Body mass index > 50
13. Systemic vasculidities (after less intensive setting)

% Lower extremity joint replacement	2006	2008	2011	2012	2013
HealthSouth	**14.6%**	**10.9%**	**8.4%**	**8.2%**	**7.6%**
UDS Industry minus HealthSouth	**17.5%**	**13.6%**	**11.4%**	**10.8%**	**9.6%**

Alternative to "Re-Setting" "60% Rule" to "75% Rule": Cap IRF Outlier Payments @ 10%

More Efficient Less

Hospital Deciles	# of Hospitals			Total Outlier Payments				Avg Outlier Payment per Discharge		
	HLS	Non-HLS	Total	HLS	Non-HLS	Total	%	HLS	Non-HLS	Total
90-100	-	114	114	$ -	$ 112,760,917	$ 112,760,917	52.6%	N/A	$ 2,087	$ 2,087
80-90	-	113	113	$ -	$ 38,619,910	$ 38,619,910	18.0%	N/A	$ 1,261	$ 1,261
70-80	1	112	113	$ 175,926	$ 22,618,402	$ 22,794,328	10.6%	$ 247	$ 753	$ 741
60-70	-	113	113	$ -	$ 15,464,443	$ 15,464,443	7.2%	N/A	$ 496	$ 496
50-60	4	110	114	$ 383,221	$ 10,036,359	$ 10,419,580	4.9%	$ 85	$ 354	$ 316
40-50	12	102	114	$ 736,581	$ 6,143,198	$ 6,879,779	3.2%	$ 53	$ 231	$ 170
30-40	9	104	113	$ 319,164	$ 3,876,213	$ 4,195,377	2.0%	$ 37	$ 155	$ 124
20-30	24	89	113	$ 440,264	$ 1,775,232	$ 2,215,496	1.0%	$ 20	$ 76	$ 49
10-20	19	94	113	$ 156,417	$ 775,867	$ 932,284	0.4%	$ 9	$ 34	$ 24
0-10	30	84	114	$ 24,985	$ 59,408	$ 84,393	0.1%	$ 1	$ 3	$ 2
Totals	99	1,035	1,134	$ 2,236,558	$ 212,129,949	$ 214,366,507	100.0%			

Outlier observations:

- 10% of IRFs receive 53% of the outlier payments; None are HealthSouth.
- HealthSouth receives approx. 1% of the IRF outlier payments despite treating approx. 24% of the Medicare patients/discharges.
- As a result of outlier payments, CMS pays HealthSouth approx. $702 less per discharge than other providers.
- Capping IRF outlier payments at 10% could save Medicare approx. $600 million over 10 years.

Source: FY 2014 CMS Final Rule Rate Setting File (see slide 9)

IRF-PPS Fiscal Year 2015 Proposed Rule: Key Provisions

Update to Payment Rates

The proposed rule:

- Would implement a **net 2.1%** market basket **increase**
  - 2.7% market basket increase
  - (20 bps) Affordable Care Act reduction
  - (40 bps) Affordable Care Act productivity reduction
- Freezes the update to the IRF facility-level rural, low-income patient and teaching status adjustments at FY 2014 levels
- Updates the outlier threshold
- Also proposes a new data collection requirement that will capture the minutes of therapy by specialty. CMS plans to use this data to potentially support future rule making in this area.

60 Percent Rule – Update to Presumptive Methodology Code List

- CMS proposes revisions to the list of codes it uses to presumptively test compliance with the 60% Rule.
  - The proposed rule eliminates an additional 10 post-amputation ICD-9-CM codes used for presumptive testing starting October 1, 2014.
- ICD-10-CM cross walk from ICD-9-CM proposed (effective no earlier than October 1, 2015).

New Quality Reporting

CMS proposes:

- Changes to IRF patient assessment instrument ("PAI")
- FY 2017 two new quality measures: Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus Bacteremia Outcome Measure and Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection Outcome Measure
- To begin validation audits to ensure completeness and accuracy of submitted quality data.

HealthSouth Observations

Pricing:

- Net pricing impact to HealthSouth expected to be approx. +2.2% for FY 2015 before sequestration (1)
- Because of its efficient cost structure, HealthSouth receives very few outlier payments despite higher acuity patients (see slide 31).

Coding:

- Post-amputation cases represent approx. 0.5% of HealthSouth's Medicare discharges
- ICD-10-CM cross walk - A thorough clinical evaluation will need to be completed before submitting comments on the rule.

Quality:

- HealthSouth will supplement existing quality reporting systems to meet the new requirements.

(1) The Budget Control Act of 2011 included a reduction of up to 2% to Medicare payments for all providers that began on April 1, 2013 (as modified by H.R. 8). The reduction was made from whatever level of payment would otherwise have been provided under Medicare law and regulation. This automatic reduction, known as "sequestration," anniversaried April 1, 2014.
Source: http://ofr.gov/(S(z30ikq54j5qye1ox5hjkmnr2))/OFRUpload/OFRData/2014-10321_PI.pdf

Post Acute Payment Reform – IMPACT Act of 2014

For Immediate Release
March 18, 2014

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The United States Senate
COMMITTEE on FINANCE
Ron Wyden, Chairman Orrin G. Hatch, Ranking Member

Bipartisan, Bicameral Effort Underway to Advance Medicare Post-Acute Reform

Senate Finance and House Way and Means Committees Release Draft Legislation

Washington, DC - Today, Senate Finance Committee Chairman Ron Wyden (D-OR) and Ranking Member Orrin Hatch (R-UT), along with Ways and Means Committee Chairman Dave Camp (R-MI) and Ranking Member Sandy Levin (D-MI) released a discussion draft titled, *Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act of 2014)*. The *IMPACT Act of 2014* takes a crucial step toward the modernization of Medicare payments to post-acute care (PAC) providers and a more accountable, quality-driven PAC benefit. The draft can serve as the core building block for future Medicare PAC reforms.

Without comparable information across PAC settings, policymakers and providers cannot determine whether patients treated and the care provided in different settings is, in fact, the same or whether one PAC setting is more appropriate. Absent this information, it is difficult to move forward with PAC payment reforms.

The *IMPACT Act of 2014* requires standardized data that will enable Medicare to:

1. Compare quality across PAC settings;
2. Improve hospital and PAC discharge planning; and,
3. Use this information to reform PAC payments (via site neutral or bundled payments or some other reform) while ensuring continued beneficiary access to the most appropriate setting of care.

Take Aways

- ✓ Not a formal bill
- ✓ Reflects current thinking
- ✓ Acknowledges that existing information is not comparable across settings
- ✓ Requires collection of additional quality and clinical data prior to recommending post acute care payment reforms
- ✓ If introduced as a bill, there likely will be revisions.

Source: http://www.finance.senate.gov/newsroom/ranking/release/?id=c0c98f25-db43-45d8-9055-3959a1c6d997
Source: http://waysandmeans.house.gov/uploadedfiles/pac_leg_text_final.pdf

Post-Acute Payment Reform – A Complicated Issue

2005:

- The Deficit Reduction Act of 2005 directed CMS to conduct a study aimed at reforming and harmonizing the disparate methods of paying for services in post-acute settings that could be substituted for one another.
- The study required utilization of a uniform patient assessment instrument.
- CMS contracted with Research Triangle Institute (RTI) to perform the study.

2012:

- RTI released a 353 page report [1].
- IRF patients had:
  - Greatest self-care change (improvement)
  - Greatest change in overall mobility improvement
- Data are preliminary and more research is forthcoming.

Next steps [1]:

- Refinement of existing models
- Additional models predicting discharge destinations, mortality, and length of stay
- Further work in examining resource intensity, costs, and outcomes to better understand and validate preliminary findings
- Further analysis of patient- specific cost of non-therapy ancillary use is needed to understand how their costs vary by patient complexity
- Consideration around the desirability and feasibility of a composite cost measure that combines therapy, non-therapy ancillaries, and fixed costs
- Additional analysis that attempts to link selected outcomes to payment and other incentive structures

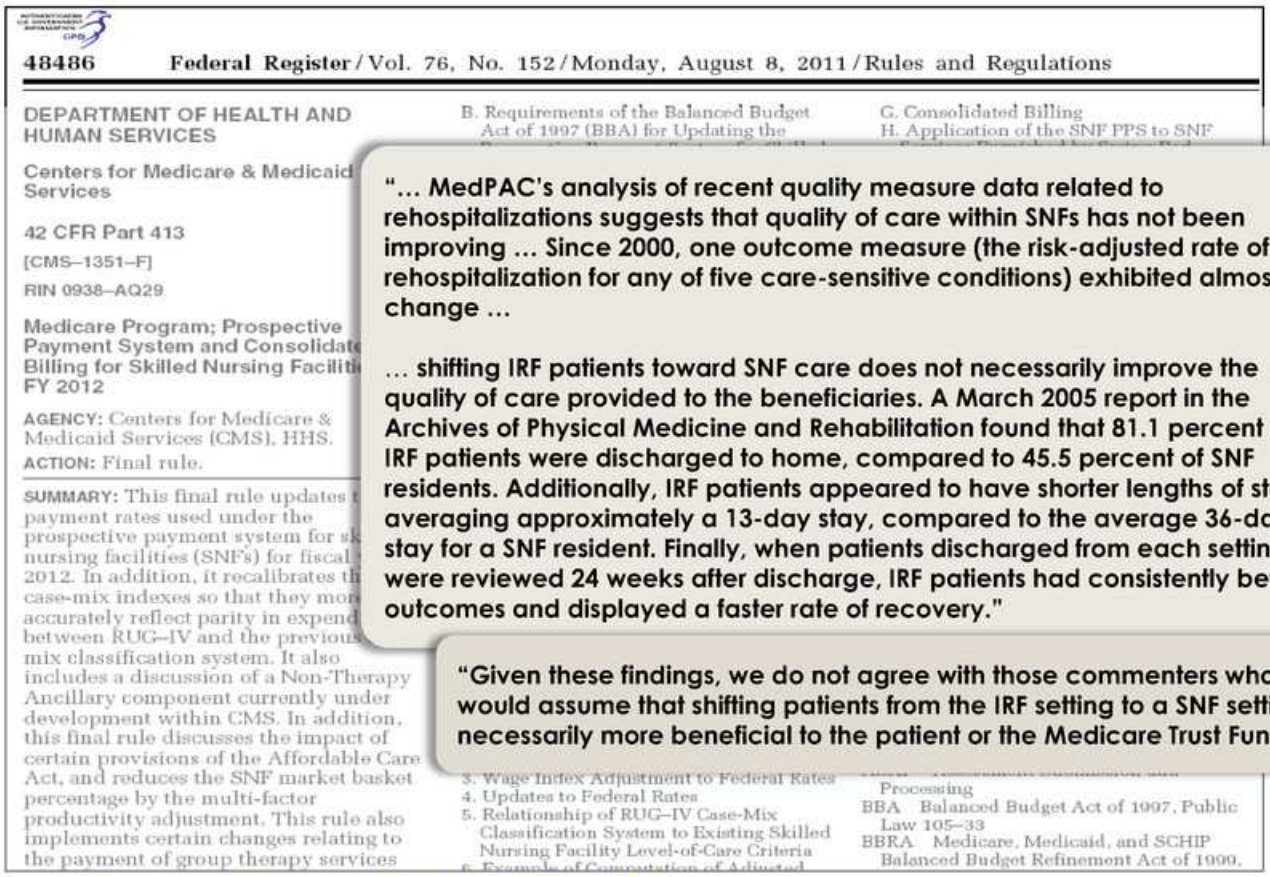
(1) Post-Acute Care Payment Reform Demonstration Report to Congress Supplement—Interim Report, May 2011, RTI International

Different Levels of Services

Rehab Hospital		Nursing Home	
Average length of stay [1]	**= 12.9 days**	**Covered days per admission** [1]	**= 27.4 days**
Discharge to community [1]	**= 69.9%**	**Discharge to community** [1]	**= 30.6%**
Requirements:		**Requirements:**	
Rehab hospitals must also satisfy regulatory/policy requirements for hospitals, including Medicare hospital conditions of participation.		No similar requirement; Nursing homes are regulated as nursing homes only	
All patients must be admitted by a rehab physician.		No similar requirement	
Rehab physicians must re-confirm each admission w/n 24 hours.		No similar requirement	
All patients, regardless of diagnoses/condition, must demonstrate need and receive at least three hours of daily intensive therapy.		No similar requirement	
All patients must see a rehabilitation physician "in person" at least three times weekly.		No similar requirement; some SNF patients may go a week or longer without seeing a physician, and often a non-rehabilitation physician.	
Rehab hospitals required to provide 24 hour, 7 days per week nursing care; many nurses are RNs and rehab nurses.		No similar requirement	
Rehab hospitals are required to use a coordinated interdisciplinary team approach led by a rehab physician; includes a rehab nurse, a case manager, and a licensed therapist from each therapy discipline who must meet weekly to evaluate/discuss each patient's case.		No similar requirement; Nursing homes are not required to provide care on a interdisciplinary basis and are not required to hold regular meetings for each patient.	
Rehab hospitals are required to follow stringent admission/coverage policies and must carefully document justification for each admission; further restricted in number/type of patients (60% Rule)		Nursing homes have comparatively few policies governing the number or types of patients they treat.	

(1) MedPAC, Report to the Congress: Medicare Payment Policy, March 2014 – Pages 189, 244, and 254.

CMS: Inpatient Rehabilitation vs. Skilled Nursing



48486 Federal Register / Vol. 76, No. 152 / Monday, August 8, 2011 / Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

[CMS–1351–F]

RIN 0938–AQ29

Medicare Program; Prospective Payment System and Consolidate Billing for Skilled Nursing Facilit FY 2012

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule updates t payment rates used under the prospective payment system for sk nursing facilities (SNFs) for fiscal 2012. In addition, it recalibrates th case-mix indexes so that they mor accurately reflect parity in expend between RUG–IV and the previous mix classification system. It also includes a discussion of a Non-Therapy Ancillary component currently under development within CMS. In addition, this final rule discusses the impact of certain provisions of the Affordable Care Act, and reduces the SNF market basket percentage by the multi-factor productivity adjustment. This rule also implements certain changes relating to the payment of group therapy services

B. Requirements of the Balanced Budget Act of 1997 (BBA) for Updating the

G. Consolidated Billing

H. Application of the SNF PPS to SNF

3. Wage Index Adjustment to Federal Rates

4. Updates to Federal Rates

5. Relationship of RUG–IV Case-Mix Classification System to Existing Skilled Nursing Facility Level-of-Care Criteria

Processing

BBA Balanced Budget Act of 1997, Public Law 105–33

BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999,

"… MedPAC's analysis of recent quality measure data related to rehospitalizations suggests that quality of care within SNFs has not been improving … Since 2000, one outcome measure (the risk-adjusted rate of rehospitalization for any of five care-sensitive conditions) exhibited almost no change …

… shifting IRF patients toward SNF care does not necessarily improve the quality of care provided to the beneficiaries. A March 2005 report in the Archives of Physical Medicine and Rehabilitation found that 81.1 percent of IRF patients were discharged to home, compared to 45.5 percent of SNF residents. Additionally, IRF patients appeared to have shorter lengths of stay, averaging approximately a 13-day stay, compared to the average 36-day stay for a SNF resident. Finally, when patients discharged from each setting were reviewed 24 weeks after discharge, IRF patients had consistently better outcomes and displayed a faster rate of recovery."

"Given these findings, we do not agree with those commenters who would assume that shifting patients from the IRF setting to a SNF setting is necessarily more beneficial to the patient or the Medicare Trust Fund."

Source: http://www.gpo.gov/fdsys/pkg/FR-2011-08-08/pdf/2011-19544.pdf

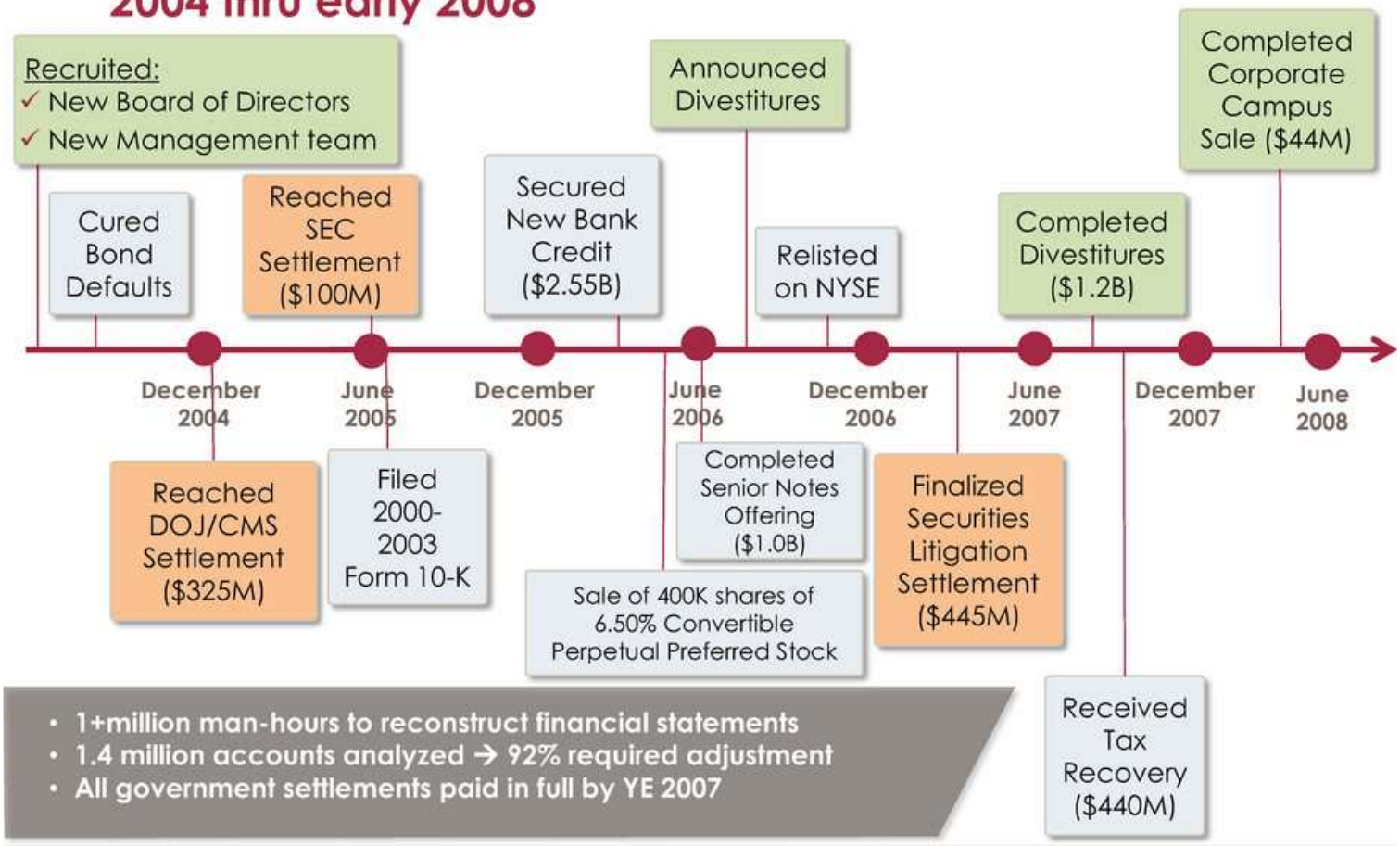
Specific Post-Acute Regulatory Changes

Future Regulatory Risk	Inpatient Rehabilitation Facility	Skilled Nursing Facility	Long-Term Acute Care Hospital	Home Health	Hospice
1. Re-basing payment system	No	Yes: Rebased in FY 2012 (-12.6%)	Starting in FY 2016, LTCHs will be paid "site-neutral payment" rates for certain types of cases; such cases will not be subject to the LTCH >25 day avg. length-of-stay rule	Yes: CY 2012 re-weighted case weights and payment from high therapy to low or no therapy; Further rebasing required as part of PPACA starting in 2014	Yes: Required by PPACA no sooner than October 1, 2013
2. Major outlier payment adjustments	No	No	Yes: implemented short stay outlier change end of 2012	Yes: 10% cap per agency	No
3. Upcoding adjustments	No	No	3.9% payment adjustment for FY 2013; phased in over 3-year period	Yes: -1.32% payment adjustment for CY 2013	No
4. Patient criteria	No: 60% Rule admission criteria already in place	No	Legislation implementing admission criteria being phased in on or after October 2015	No: Patient – physician "face-to-face" encounter & new therapy documentation implemented in 2011	No: Patient – physician "face-to-face" encounter implemented in 2011
5. Healthcare Reform					
• Market basket update reductions	• Known	• Known	• Known	• Known	• Known
• Productivity adjustments	• Began FY 2012	• Began FY 2012	• Began FY 2012	• Begins 2015	• Began FY 2013
• Bundling pilot established	• Began 2013	• Began 2013	• Began 2013	• Began 2013	• N/A
• Independent Payment Advisory Board	• CY 2019	• FY 2015	• CY 2019	• CY 2015	• CY 2019
• New quality reporting requirements	• Being implemented	• Being implemented	• Being implemented	• Being implemented	• Being implemented
• Value based purchasing	• Pilot begins 2016	• Begins FY 2019	• Pilot begins 2016	• Post 2013	• Pilot begins 2016
• Hospital readmission penalties	• Post 2013	• Begins FY 2019	• Post 2013	• N/A	• N/A
6. Other	Changes to ICD-9-CM Codes under Presumptive testing starting for compliance review periods beginning on or after October 1, 2014	Distinct Calendar Days of Therapy captured for therapy payment purposes; Forecast error reduction of 0.5% implemented FY 2014	MMSEA 25% patient threshold relief extended through September 30, 2017	Limits on transfer of ownership	Modified wage index system being phased in over 7-year period beginning in FY 2010
	• Future efforts to address the cost associated with the prevention of the statutory decrease of more than 20% in Medicare physician reimbursement referred to as the "doc-fix" • Extended "Outpatient Therapy Caps" and manual medical review through March 31, 2015, and increased the multiple procedure payment reduction to 50% effective April 2013.				
7. Deficit Reduction	• The Budget Control Act of 2011 includes a reduction of 2% (known as "Sequestration") to Medicare payments for all providers that began on April 1, 2013, (as modified by H.R. 8). The Protecting Access to Medicare Act modified these cuts in FY 2024 by requiring a 4% reduction to Medicare payments during the first half of FY 2024 and no cuts (0%) to Medicare payments during the second half of FY 2024.				

Sources: Healthcare Reform Bill (PPACA, HERA), CMS Regulatory published rules and MMSEA and Pathway for SGR Reform Act of 2013 Protecting Access to Medicare Act of 2014

Historical Perspective

Historical Perspective: Massive Restructuring Effort 2004 thru early 2008

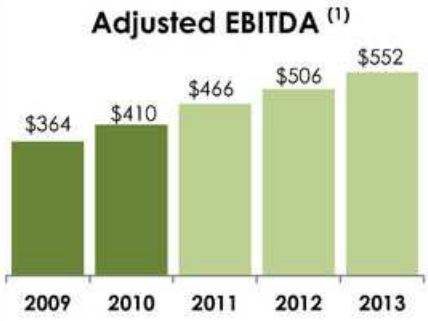


- 1+million man-hours to reconstruct financial statements
- 1.4 million accounts analyzed → 92% required adjustment
- All government settlements paid in full by YE 2007

Historical Perspective

2009: Focused on Debt Reduction with Increased Emphasis on Organic Growth

- **Continued focus on delevering (approx. $151 million in debt repaid)**
- **Focused on organic growth; TeamWorks sustainability module rolled out**
- **Issued 5 million shares for securities litigation settlement (Q3)**
- **Received first Medicare market basket update in 18 months (Q4)**
- **Reinvigorated development efforts (Q4)**



2010: Focused on Debt Reduction with Increased Emphasis on Organic Growth

- **Healthcare reform passed; reduced future market basket updates**
- **Weak acute care referral volumes**
- **Adjusted annual volume growth target to 2.5-3.5%**
- **Development efforts paid off**
  - 2 de novos, 2 IRF acquisitions, 2 unit acquisitions
- **Completed Senior Notes offering with 2018 and 2022 maturities (7.25% and 7.75% coupon, respectively)**
- **Refinanced term loans and revolver (Q4)**
  - Repaid $151.2 million in debt
  - Gained flexibility to repay the 10.75% notes that were due in 2016 and callable beginning in June 2011

(1) Reconciliation to GAAP provided on slides 62 and 97-101.

Historical Perspective

2011: Focused on Accelerating Organic Growth and Deployment of Free Cash Flow

- **Grew volumes 5.2%**
- **Sold five long-term acute care hospitals (LTCHs); closed remaining LTCH**
- **Raised $122 million by reopening 2018 and 2022 Senior Notes**
- **Retired approx. $501 million of 10.75% Senior Notes due 2016**
- **Opened one de novo (Cypress); acquired Drake; received approval for two CONs**
- **Slowed development efforts due to regulatory uncertainty; reinstated development efforts once the BCA [1] outcome was known.**



(1) The Budget Control Act of 2011 included a reduction of up to 2% to Medicare payments for all providers that began on April 1, 2013 (as modified by H.R. 8). The reduction was made from whatever level of payment would otherwise have been provided under Medicare law and regulation.

(2) Reconciliation to GAAP provided on slides 62, 96-99, and 101.

Historical Perspective

2012: Focused on Accelerating Organic Growth and Deployment of Free Cash Flow

- **Established 2012 – 2014 business model** [1]
  - 2.5-3.5% discharge growth; 5-8% Adjusted EBITDA CAGR
  - 12-17% adjusted free cash flow CAGR
- **Purchased 46,645 shares of our convertible perpetual preferred stock for $46.5 million**
- **Upgraded to Ba3 and BB– by Moody's and S&P, respectively**
- **Amended senior secured credit facility**
- **Issued $275 million of 5.75% Senior Notes maturing 2024**
- **Redeemed 10% of the 2018 and 2022 Senior Notes (~$65 million in Q4)**
- **Continued development efforts: one de novo, two unit consolidations**



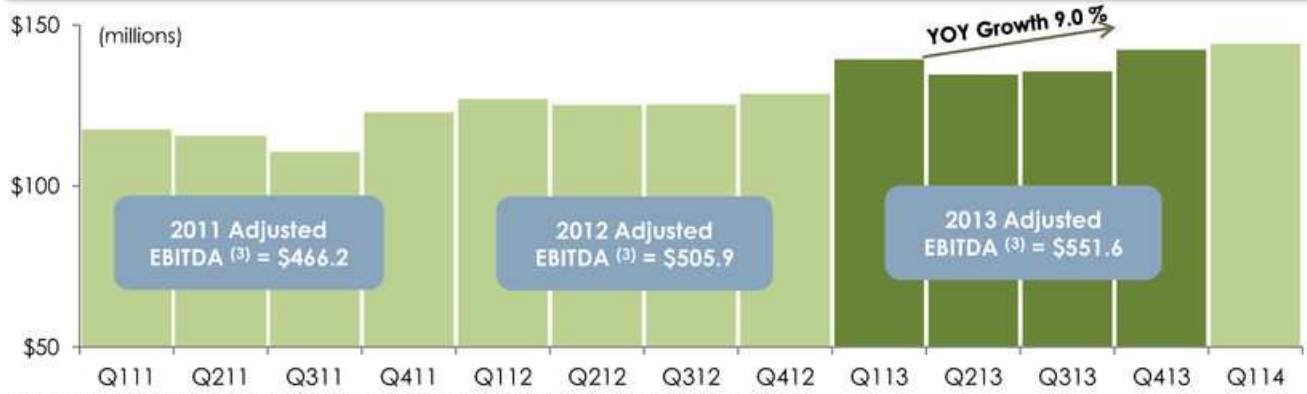
(1) 2014 - 2016 business model on slide 51 supersedes 2012 – 2014 business model.
(2) Reconciliation to GAAP provided on slides 62, 96-99, and 101.

HEALTHSOUTH

Historical Perspective

2013: Focus on Growth and Shareholder Value

- **Established 2013 – 2015 business model [1] (includes sequestration[2])**
  - 2.5-3.5% discharge growth; 4-8% Adjusted EBITDA CAGR;10-14% adjusted free cash flow CAGR
- **Completed tender offer for 9.5% of then-outstanding common shares (Q1)**
- **Entered into agreements with the IRS resulting in increase of gross federal NOL by approx. $283 million**
- **Opened two de novo hospitals (Q2); acquired 58-bed inpatient rehabilitation hospital in Augusta, GA (April 1)**
- **Amended senior secured credit facility, extending maturity date and increasing flexibility (restricted payments)**
- **Initiated quarterly cash dividend of $0.18 per share of common stock**
- **Redeemed 10% of the 2018 and 2022 Senior Notes (~$58 million in Q4)**
- **Exchanged 257,110 shares of Convertible Perpetual Preferred Stock for $320 million of newly issued 2.0% Convertible Senior Subordinated Notes due 2043 (Q4)**



(1) 2014 - 2016 business model on slide 51 supersedes 2013 - 2015 business model.
(2) The Budget Control Act of 2011 included a reduction of up to 2% to Medicare payments for all providers that began on April 1, 2013 (as modified by H.R. 8). The reduction was made from whatever level of payment would otherwise have been provided under Medicare law and regulation.
(3) Reconciliation to GAAP provided on slides 62, 96-99, and 101.

HEALTHSOUTH

Historical Perspective

2014: Focus on Growth and Shareholder Value

- **Established 2014 – 2016 business model**
  - 2.5-3.5% discharge growth; 4-8% Adjusted EBITDA CAGR;
- **Adjusted EBITDA negatively impacted by $8 million for sequestration.**
- **Repurchased $26.3 million of common stock (808,880 shares)**



(1) Reconciliation to GAAP provided on slides 62, 96-99, and 101.

HEALTHSOUTH

HealthSouth has successfully managed through Medicare payment cuts and an economic recession…



HEALTHSOUTH

Revenues & Expenses

Revenues (millions)	Q1 2014	Q4 2013	Q3 2013	Q2 2013	Q1 2013	Q4 2012	Q3 2012	Q2 2012	Q1 2012	Full Year 2013	Full Year 2012	Full Year 2011
Inpatient	$ 558.2	$ 537.5	$ 528.8	$ 527.4	$ 537.1	$ 518.1	$ 498.9	$ 495.0	$ 500.6	$2,130.8	$2,012.6	$1,866.4
Outpatient and other	33.0	34.6	35.2	37.1	35.5	34.8	38.1	38.4	38.0	142.4	149.3	160.5
Consolidated net operating	$ 591.2	$ 572.1	$ 564.0	$ 564.5	$ 572.6	$ 552.9	$ 537.0	$ 533.4	$ 538.6	$2,273.2	$2,161.9	$2,026.9
(Actual Amounts)												
Discharges	32,889	32,906	32,307	32,645	32,130	31,695	30,569	30,719	30,871	129,988	123,854	118,354
Net patient revenue / discharge	$ 16,972	$ 16,334	$ 16,368	$ 16,156	$ 16,716	$ 16,346	$16,320	$ 16,114	$16,216	$ 16,392	$ 16,250	$ 15,770
Expenses (millions)												
Salaries and benefits	$ 286.1	$ 272.0	$ 269.5	$ 273.6	$ 274.6	$ 269.5	$ 262.3	$ 257.4	$ 261.0	$1,089.7	$1,050.2	$ 982.0
Percent of net operating revenues	48.4%	47.5%	47.8%	48.5%	48.0%	48.7%	48.8%	48.3%	48.5%	47.9%	48.6%	48.4%
EPOB (employees per occupied bed) [1]	3.32	3.47	3.48	3.43	3.31	3.46	3.46	3.41	3.34	3.42	3.42	3.47
Hospital-related expenses	$ 121.3	$ 118.4	$ 116.9	$ 117.8	$ 116.4	$ 114.8	$ 111.0	$ 112.6	$ 112.0	$ 469.5	$ 450.4	$ 435.2
(other operating [2], supp., occ.)												
Percent of net operating revenues	20.5%	20.7%	20.7%	20.9%	20.3%	20.8%	20.7%	21.1%	20.8%	20.7%	20.8%	21.5%
General and administrative	$ 23.4	$ 24.8	$ 22.6	$ 23.0	$ 23.9	$ 24.6	$ 23.2	$ 22.1	$ 23.9	$ 94.3	$ 93.8	$ 90.2
(excludes stock-based compensation)												
Percent of net operating revenues	4.0%	4.3%	4.0%	4.1%	4.2%	4.4%	4.3%	4.1%	4.4%	4.1%	4.3%	4.5%
Provision for doubtful accounts	$ 7.5	$ 3.6	$ 8.0	$ 7.0	$ 7.4	$ 7.2	$ 7.0	$ 6.5	$ 6.3	$ 26.0	$ 27.0	$ 21.0
Percent of net operating revenues	1.3%	0.6%	1.4%	1.2%	1.3%	1.3%	1.3%	1.2%	1.2%	1.1%	1.2%	1.0%

(1) Employees per occupied bed, or "EPOB," is calculated by dividing the number of full-time equivalents, including an estimate of full-time equivalents from the utilization of contract labor, by the number of occupied beds during each period. The number of occupied beds is determined by multiplying the number of licensed beds by the Company's occupancy percentage.

(2) Excludes loss on disposal or impairment of assets

Adjusted EBITDA (1)

(Millions)	Q1 2014	Q4 2013	Q3 2013	Q2 2013	Q1 2013	Q4 2012	Q3 2012	Q2 2012	Q1 2012	Full Year 2013	Full Year 2012	Full Year 2011
Net operating revenues	$ 591.2	$ 572.1	$ 564.0	$ 564.5	$ 572.6	$ 552.9	$ 537.0	$ 533.4	$ 538.6	$ 2,273.2	$ 2,161.9	$ 2,026.9
Less: Provision for doubtful accounts	(7.5)	(3.6)	(8.0)	(7.0)	(7.4)	(7.2)	(7.0)	(6.5)	(6.3)	(26.0)	(27.0)	(21.0)
Net operating revenues less provision for doubtful accounts	583.7	568.5	556.0	557.5	565.2	545.7	530.0	526.9	532.3	2,247.2	2,134.9	2,005.9
Operating expenses:												
Salaries and benefits	(286.1)	(272.0)	(269.5)	(273.6)	(274.6)	(269.5)	(262.3)	(257.4)	(261.0)	(1,089.7)	(1,050.2)	(982.0)
Hospital-related expenses:												
Other operating expenses (2)	(83.2)	(80.1)	(79.7)	(79.3)	(78.0)	(76.6)	(75.4)	(74.4)	(73.0)	(317.1)	(299.4)	(284.0)
Supplies	(27.6)	(27.1)	(25.5)	(26.6)	(26.2)	(26.2)	(23.8)	(25.9)	(26.5)	(105.4)	(102.4)	(102.8)
Occupancy costs	(10.5)	(11.2)	(11.7)	(11.9)	(12.2)	(12.0)	(11.8)	(12.3)	(12.5)	(47.0)	(48.6)	(48.4)
	(121.3)	(118.4)	(116.9)	(117.8)	(116.4)	(114.8)	(111.0)	(112.6)	(112.0)	(469.5)	(450.4)	(435.2)
General and administrative expenses (3)	(23.4)	(24.8)	(22.6)	(23.0)	(23.9)	(24.6)	(23.2)	(22.1)	(23.9)	(94.3)	(93.8)	(90.2)
Equity in nonconsolidated affiliates	4.3	3.0	2.0	3.3	2.9	3.0	3.3	3.1	3.3	11.2	12.7	12.0
Other income (4)	1.7	1.3	0.6	1.9	0.7	1.1	1.2	0.4	0.9	4.5	3.6	2.7
Noncontrolling interests (5)	(14.8)	(15.3)	(14.1)	(13.8)	(14.6)	(12.3)	(12.8)	(13.2)	(12.6)	(57.8)	(50.9)	(47.0)
Adjusted EBITDA	**$ 144.1**	**$ 142.3**	**$ 135.5**	**$ 134.5**	**$ 139.3**	**$ 128.6**	**$ 125.2**	**$ 125.1**	**$ 127.0**	**$ 551.6**	**$ 505.9**	**$ 466.2**

(1) Reconciliation to GAAP provided on slides 62, 96-99, and 101.

	Q1 2014	Q4 2013	Q3 2013	Q2 2013	Q1 2013	Q4 2012	Q3 2012	Q2 2012	Q1 2012	Full Year 2013	Full Year 2012	Full Year 2011
In arriving at Adj. EBITDA, the following were excluded:												
(2) Loss on disposal or impairment of assets	$ 1.3	$ 1.6	$ 2.5	$ 1.7	$ 0.1	$ 1.4	$ 1.6	$ 0.6	$ 0.8	$ 5.9	$ 4.4	$ 4.3
(3) Stock-based compensation expense	7.3	5.8	6.2	6.5	6.3	6.0	6.1	5.9	6.1	24.8	24.1	20.3
(4) Gain related to our consolidation of St. Vincent Rehabilitation Hospital	-	-	-	-	-	-	4.9	-	-	-	4.9	-
(5) Noncontrolling interests related to discontinued operations	-	-	-	-	-	-	-	-	-	-	-	(1.1)

Outstanding Share Summary, Warrant Information, Conversion Price

(millions)	Q1 2014	Q1 2013	Weighted Average for the Period Full Year 2013	2012	2011	2010	2009
Basic shares outstanding [1][2][3][4]	87.3	94.0	88.1	94.6	93.3	92.8	88.8
Diluted shares outstanding [1][2][3][4]	100.9	107.1	102.1	108.1	109.2	108.5	103.3

(millions)	End of Period Q1 2014	Q1 2013	FY 2013	FY 2012	FY 2011
Basic shares outstanding [1][2][3]	86.8	86.0	86.8	94.6	93.3
Convertible perpetual preferred stock [4]	0.096	0.353	0.096	0.353	0.400
If converted, equivalent common shares	3.2	11.6	3.2	11.6	13.1
Convertible senior subordinated notes [4]	$320.0	-	$320.0	-	-
If converted, equivalent common shares	8.1	-	8.1	-	-

	Date	Approx. Conversion Rates	Approx. Conversion Price
Convertible perpetual preferred stock	4/2/2014	33.3222	$30.01
Convertible senior subordinated notes	4/2/2014	25.4896	$39.23

(1)(2)(3)(4) – Notes on slide 49

Outstanding Share Summary, Warrant Information, and Conversion Price Notes

(1) The Company purchased 9,119,450 common shares in Q1 2013 through a tender offer at a price of $25.50 per share.

(2) 10 million warrants (pre-October 2006 reverse split) were issued in connection with a January 2004 loan repaid to Credit Suisse First Boston. The warrants expired on January 16, 2014. The holders of these warrants chose both cash and cashless exercises into shares of our common stock. Prior to warrant expiration, 755,323 shares of our common stock were issued upon exercise between September 30, 2013 and January 16, 2014.

(3) The agreement to settle our class action securities litigation received final court approval in January 2007. These shares of common stock and warrants were issued on September 30, 2009. The 5.0 million of common shares are included in the outstanding shares. The warrants to purchase approx. 8.2 million shares of common stock at a strike price of $41.40 (expire January 17, 2017) were not assumed exercised for the dilutive shares outstanding because they were antidilutive in the periods presented.

(4) The difference between the basic and diluted shares outstanding is primarily related to the convertible senior subordinated notes and our convertible perpetual preferred stock (convertible into 8.1 million and 3.2 million common shares, respectively, as of March 31, 2014).

a. On November 18, 2013, the Company closed separate, privately negotiated exchanges in which it issued $320 million of 2.0% Convertible Senior Subordinated Notes due 2043 in exchange for 257,110 shares of the Company's 6.5% Series A Convertible Perpetual Preferred Stock. The Company recorded approx. $249 million as debt and approx. $71 million as equity. The convertible notes are convertible, at the option of the holders, at any time on or prior to the close of business on the business day immediately preceding December 1, 2043 into shares of the Company's common stock at a conversion rate of approx. 25.4896 shares per $1,000 in principal amount, which is equal to a conversion price of approximately $39.23 per share, subject to customary antidilution adjustments. The Company has the right to redeem the convertible notes before December 1, 2018 if the volume weighted average price of the Company's common stock is at least 120% ($47.08) of the conversion price of the convertible notes for a specified period. On or after December 1, 2018, the Company may, at its option, redeem all or any part of the convertible notes. In either case, the redemption price will be equal to 100% of the principal amount of the convertible notes to be redeemed, plus accrued and unpaid interest. As a result of the transaction, the dividend on the convertible perpetual preferred stock was reduced from approx. $5.7 million per quarter to approx. $1.6 million per quarter.

b. The 96,245 shares of preferred stock outstanding after the exchange transaction are convertible at the option of the holder, at any time into shares of common stock at a conversion price of $30.01 per share, which is equal to a conversion rate of approx. 33.3222 shares of common stock per share of preferred stock, subject to a specified adjustment. We may at any time cause the shares of preferred stock to be automatically converted into shares of our common stock at the conversion rate then in effect if the closing price of our common stock for 20 trading days within a period of 30 consecutive trading days ending on the trading day before the date we give the notice of forced conversion exceeds 150% ($45.02) of the conversion price of the preferred stock.

Business Outlook
2014 to 2016
(as of June 17, 2014)

Business Outlook: 2014 to 2016(1)

Business Model
- **Adjusted EBITDA CAGR: 4-8%** (2)
- **Continued strong free cash flow generation**

Potential depletion of the federal NOL during the 2014 to 2016 timeframe will affect Cash Flow CAGR.

Strategy	2013	2014	2015	2016
Shareholder Distributions	$234 million common stock tender; initiated dividends	• **Quarterly cash dividends** • **Opportunistic share repurchases ($26.3 million; 808,880 common shares in Q1 2014)**		
Leverage	**< 3.0x** Debt to Adjusted EBITDA	**< 3.0x Debt to Adjusted EBITDA** (subject to shareholder value-creating opportunities)		
Core Growth	**Bed expansion = 68**	**Same-store Growth** (Includes bed expansions and unit consolidations)		
	New IRF's = 3 Littleton, CO, Stuart, FL, Augusta, GA	**New IRF's** (target of 4-6/year) Altamonte Springs, FL; Newnan, GA; Middletown, DE; Johnson City, TN	**New IRF's** (target of 4-6/year)	
Opportunistic Growth		**Consider opportunistic, disciplined acquisitions** of complementary post-acute services		
Key Operational Initiatives	• **Enhancing outcomes and patient experience**			
	• **Implementing CIS:** Target 20 hospitals/year; Installation complete in 41 hospitals through Q12014; Expect installation at all hospitals by YE2017.			
	• **Positioning for evolving delivery and payment models:** ACO, bundling, etc.			

(1) If legislation affecting Medicare is passed, HealthSouth will evaluate its effect on the Company's business model.
(2) This is a multi-year CAGR; annual results may fall outside the range. Reconciliation to GAAP provided on slides 62, 96, 97, and 101.

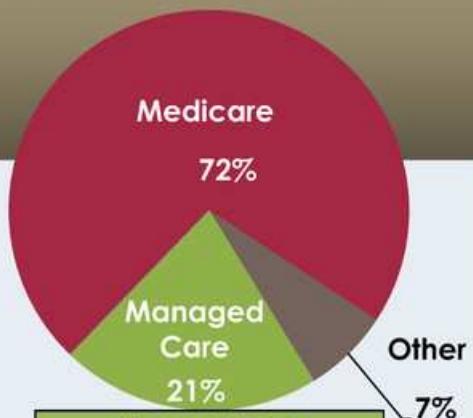
Business Outlook: Revenue Assumptions

Revenue

Volume

- 2.5% to 3.5% annual growth (excludes acquisitions)
- Includes bed expansions, de novos and unit consolidations

Payor Mix by Discharges



Managed Care Expected Price Increases

2014	2015	2016
2-4%	2-4%	2-4%

Medicare Pricing

	FY 2014 [3] Q4 13 - Q3 14	FY 2015 [4] Q4 14 - Q3 15	FY 2016 Q4 15 - Q3 16
Market basket update [1]	2.6%	2.7%	2.9%
Healthcare reform reduction	30 bps	20 bps	20 bps
Healthcare reform productivity adjustment	50 bps	40 bps	~ 100 bps

2% Sequestration [2]

(1) Medicare IRF-PPS Notice for FY 2014, Medicare IRF-PPS Proposed Rule for FY 2015, and management's estimate for FY 2016.
(2) The Budget Control Act of 2011 included a reduction of up to 2% to Medicare payments for all providers that began on April 1, 2013 (as modified by H.R. 8). The reduction was made from whatever level of payment would otherwise have been provided under Medicare law and regulation. This automatic reduction, known as "sequestration," will result in a net year-over-year decrease to our net operating revenues of approx. $9 million in 2014 (anniversaried April 1, 2014).
(3) HealthSouth believes, based on the Medicare IRF-PPS Rule for FY 2014, it should realize a net increase of approx. 1.95% in FY 2014 before sequestration.
(4) HealthSouth believes, based on the Medicare IRF-PPS Proposed Rule for FY 2015, it should realize a net increase of approx. 2.2% in FY 2015 before sequestration.

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Business Outlook: Expense Assumptions

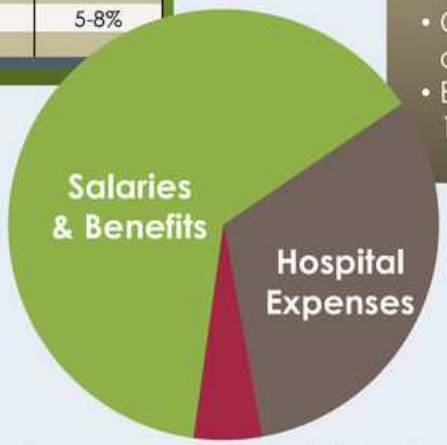
Expense

Salaries & Benefits (1)

	2014	2015	2016
Merit increases	2.0-2.5%	2.0-2.5%	2.0-2.5%
Benefit costs increases	5-8%	5-8%	5-8%

Hospital Expenses

- Other operating expenses and supply costs tracking with inflation
- Occupancy costs declining as a percent of revenue
- Bad debt expense of approx. 1.3% to 1.5 %



General and Administrative

~4% of revenue
(excludes stock-based compensation)

(1) Salaries, Wages and Benefits: ~ 89% Salaries and Wages; ~11% Benefits.

Guidance
(as of June 17, 2014)

2014 Guidance - Adjusted EBITDA[1] (as of June 17, 2014)

Adjusted EBITDA

$555 million to $565 million (exceed high end of range)

Based on results of Q1 2014 and the additional ownership interest in Fairlawn Rehabilitation Hospital, HealthSouth expects its 2014 full-year results to exceed the high end of this guidance range.

Considerations for full-year 2014 [2]:

- ✓ **Revenue growth of 4.0% to 5.0% before sequestration**
  - — Discharge growth between 2.5% and 3.5%
  - — Revenue per discharge growth between 2.0% and 2.3% before sequestration
  - — Lower outpatient revenues
- ✓ **Adjusted EBITDA impact of approx. $8 million (net of noncontrolling interests) for sequestration** (sequestration anniversaried on April, 1 2014)
- ✓ **Increased operating expense of approx. $4 million for continued implementation of CIS and a TeamWorks project to enhance the patient experience**
- ✓ **Bad debt expense of 1.3% to 1.5%**

In addition:

- ✓ **2013 benefited from reductions to self-insurance reserves, including $6.7 million attributable to lowering the Company's statistical confidence level.**

(1) Reconciliation to GAAP provided on slides 62, 96, and101

(2) The considerations have not been updated for the additional ownership interest and consolidation of Fairlawn Rehabilitation Hospital effective June 1, 2014 (see slide 102).

2014 Guidance - EPS (as of June 17, 2014)

Earnings per Share from Continuing Operations Attributable to HealthSouth [1]

$ 1.86 to $ 1.91

Based on results of Q1 2014 and the additional ownership interest in Fairlawn Rehabilitation Hospital, HealthSouth expects its 2014 full-year results to exceed the high end of this guidance range.

Considerations [2]:

- ✓ Higher depreciation and amortization related to recent capital investments.
- ✓ Higher interest expense and amortization of debt discounts and fees related to the exchange of convertible senior subordinated notes for convertible perpetual preferred stock [4]
- ✓ Assumes provision for income tax of approx. 40% (cash taxes expected to be $10 - $15 million for full-year 2014)
- ✓ Basic and diluted share counts reflect Q1 2014 share repurchase activity.

		EPS Guidance [2]	
	Actual	Low	High
(In Millions, Except Per Share Data)	2013	2014	
Adjusted EBITDA	$ 551.6	$ 555	$ 565
Interest expense and amortization of debt discounts and fees	(100.4)	(112)	
Depreciation and amortization	(94.7)	(106)	
Stock-based compensation expense	(24.8)	(25)	
Other, including noncash loss on disposal and impairment of assets	(5.9)	(7)	
	325.8	305	315
Certain Nonrecurring Expenses:			
Government, class action, and related settlements	23.5	-	
Professional fees - accounting, tax, and legal	(9.5)	(7)	
Loss on early extinguishment of debt	(2.4)	-	
Pre-tax income	**337.4**	**298**	**308**
Income tax	(12.7)	(118)	(123)
Income from continuing operations [1]	**324.7**	**180**	**185**
Income allocated to participating securities [3]	(3.4)	(2)	(2)
Convertible perpetual preferred dividends [3]	(21.0)	(6)	(6)
Repurchase of convertible perpetual preferred stock [3]	(71.6)	-	-
After-tax convertible debt interest expense [4]	-	8	8
Basic shares [3]	88.1	87.0	87.0
Diluted shares [4]	102.1	101.2	101.2
Earnings per share [1]	$ 2.59 [3][5]	$ 1.86 [4]	$ 1.91 [4]

(1) Income from continuing operations attributable to HealthSouth
(2) The considerations and EPS Guidance table have not been updated for the additional ownership interest and consolidation of Fairlawn Rehabilitation Hospital effective June 1, 2014 (see slide 102).
(3) The income allocated to participating securities, the convertible perpetual preferred dividends, and the repurchase premium on preferred stock need to be subtracted from income from continuing operations to calculate basic earnings per share.
(4) The interest and amortization related to the convertible senior subordinated notes must be added to income from continuing operations when calculating diluted earnings per share.
(5) Diluted earnings per share are the same as basic earnings per share due to antidilution.

Income Tax Considerations

GAAP Considerations:

- As of 3/31/14, the Company's federal NOL had a gross balance of approx. $866 million.
- The Company has a remaining valuation allowance of approx. $30 million related to state NOLs.

Cash Tax Payments:

- In 2014, the Company expects to pay approx. $10 million to $15 million of income tax, net of refunds. HealthSouth is in the process of determining if this range will need to be revised as a result of the June 1, 2014 increase in ownership interest and consolidation of Fairlawn Rehabilitation Hospital.
- HealthSouth is not currently subject to an annual use limitation ("AUL") under Internal Revenue Code Section 382 ("Section 382"). An "ownership change," as defined by Section 382, could subject the Company to an AUL, which would approximate the value of the Company at the time of the "ownership change" multiplied by the long-term tax exempt rate.

Free Cash Flow

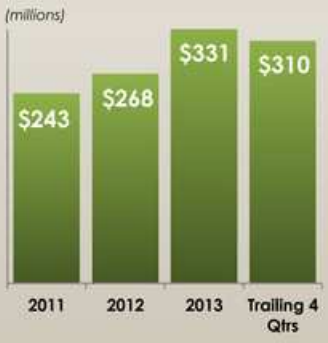
Adjusted Free Cash Flow [1] Considerations

Reflects:

- **Continued investment in the CIS and hospital refresh projects**
- **Timing of maintenance capital expenditures in 2013 and 2014**

Certain Cash Flow Items [2] (millions)	2013 Actual	Q1 2014 Actual	2014 Assumptions
• Cash interest expense [3]	$95.4	$24.8	$100
• Cash payments for taxes, net of refunds [4]	$7.7	$1.4	$10 to $15
• Working capital and other	$19.6	$20.9	$15 to $25
• Maintenance CAPEX [5]	$74.8	$30.2	$90 to $100
• Dividends paid on preferred stock	$23.0	$1.6	$6

Adjusted Free Cash Flow [1]



(1) Reconciliation to GAAP provided on slide 61.
(2) Definition of adjusted free cash flow is net cash provided by operating activities of continuing operations minus capital expenditures for maintenance, dividends paid on preferred stock, distributions to noncontrolling interests, and nonrecurring items. Common stock dividends (approx. $16 million paid in Q4 2013 and approx. $64 million projected for 2014) are not included in the calculation of adjusted free cash flow.
(3) Net of amortization of debt discounts and fees.
(4) HealthSouth is in the process of determining if the 2014 range will need to be revised as a result of the June 1, 2014 increase in ownership interest and consolidation of Fairlawn Rehabilitation Hospital.
(5) 2013 benefited by approx. $12 million for equipment purchases that were invoiced in Q4 2013 and paid in early 2014.

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Priorities for Reinvesting Free Cash Flow

Remains Highest Priority

Growth in Core Business

(millions)

	2013 Actual	Q1 2014 Actual	2014 Assumptions
Bed expansions (target ~ 80 beds/yr) and unit consolidations	$24.9	$3.5	$25 to $35
New IRF's (target 4-6/yr)	55.5	10.5	55 to 75
	$80.4	$14.0	$80 to $110, excluding acquisitions

Objectives Achieved

Debt Reduction

	2013 Actual	Q1 2014 Actual	2014 Assumptions
Debt pay down, net [1]	($264.0)	$ -	N/A
Purchase leased properties	90.3	19.4	$15 to $20

Complements Growth Investments

Shareholder Distribution

Convertible preferred stock repurchase [1]	249.0	-	-
Cash dividends on common stock [2]	15.7	15.8	64
Common stock repurchase (~$224 million authorization remaining as of March 31, 2014) [3]	234.1	26.3	TBD
	$325.1	$61.5	TBD

(1) Issued $320 million of 2.0% Convertible Senior Subordinated Notes due 2043 in exchange for 257,110 shares of the Company's 6.5% Series A Convertible Perpetual Preferred Stock. Excluding fees, no cash was used in the transaction. The Company recorded approx. $249 million as debt and approx. $71 million as equity.
(2) On July 25, 2013, the board of directors approved the initiation of a quarterly cash dividend on our common stock of $0.18 per share.
(3) On February 14, 2014, the board of directors approved an increase in our existing common stock repurchase authorization from $200 million to $250 million. The $234 million reflects the tender offer completed in Q1 2013 for approx. 9.5% of the common shares.

Adjusted Free Cash Flow

Reconciliation of Net Cash Provided by Operating Activities to Adjusted Free Cash Flow

(Millions)	Q1 2014	Q1 2013	Full Year 2013	2012	2011	2010	2009
Net cash provided by operating activities	$ 107.1	$ 121.4	$ 470.3	$ 411.5	$ 342.7	$ 331.0	$ 406.1
Impact of discontinued operations	0.2	0.7	1.9	(2.0)	(9.1)	(13.2)	(5.7)
Net cash provided by operating activities of continuing operations	107.3	122.1	472.2	409.5	333.6	317.8	400.4
Capital expenditures for maintenance [1]	(30.2)	(18.9)	(74.8)	(83.0)	(50.8)	(37.9)	(33.2)
Net settlements on interest rate swaps	-	-	-	-	(10.9)	(44.7)	(42.2)
Dividends paid on convertible perpetual preferred stock	(1.6)	(5.7)	(23.0)	(24.6)	(26.0)	(26.0)	(26.0)
Distributions paid to noncontrolling interests of consolidated affiliates	(12.0)	(13.2)	(46.3)	(49.3)	(44.2)	(34.4)	(32.6)
Non-recurring items:							
UBS Settlement proceeds, less fees to derivative plaintiffs' attorneys	-	-	-	-	-	-	(73.8)
Net premium paid on bond issuance/redemption	-	-	1.7	1.9	22.8	-	-
Cash paid for professional fees - accounting, tax, and legal	1.6	1.4	7.0	16.1	21.0	17.2	15.3
Cash paid for government, class action, and related settlements	-	-	(5.9)	(2.6)	5.7	2.9	11.2
Income tax refunds related to prior periods	-	-	-	-	(7.9)	(13.5)	(63.7)
Adjusted free cash flow	**$ 65.1**	**$ 85.7**	**$ 330.9**	**$ 268.0**	**$ 243.3**	**$ 181.4**	**$ 155.4**
Cash dividends on common stock	**$ 15.8**	-	**$ 15.7**	-	-	-	-

(1) Maintenance capital expenditures are expected to be $90 to $100 million in 2014.

Net Cash Provided by Operating Activities Reconciled to Adjusted EBITDA

	Q1		Full Year				
(Millions)	2014	2013	2013	2012	2011	2010	2009
Net cash provided by operating activities	$ 107.1	$ 121.4	$ 470.3	$ 411.5	$ 342.7	$ 331.0	$ 406.1
Provision for doubtful accounts	(7.5)	(7.4)	(26.0)	(27.0)	(21.0)	(16.4)	(30.7)
Professional fees—accounting, tax, and legal	1.6	1.4	9.5	16.1	21.0	17.2	8.8
Interest expense and amortization of debt discounts and fees	27.9	24.2	100.4	94.1	119.4	125.6	125.7
UBS Settlement proceeds, gross	-	-	-	-	-	-	(100.0)
Equity in net income of nonconsolidated affiliates	4.3	2.9	11.2	12.7	12.0	10.1	4.6
Net income attributable to noncontrolling interests in continuing operations	(14.8)	(14.6)	(57.8)	(50.9)	(47.0)	(40.9)	(33.3)
Amortization of debt discounts and fees	(3.1)	(1.0)	(5.0)	(3.7)	(4.2)	(6.3)	(6.6)
Distributions from nonconsolidated affiliates	(3.4)	(3.4)	(11.4)	(11.0)	(13.0)	(8.1)	(8.6)
Current portion of income tax expense (benefit)	3.6	1.8	6.3	5.9	0.6	2.9	(7.0)
Change in assets and liabilities	26.9	13.0	48.9	58.1	41.4	5.7	9.1
Net premium paid on bond issuance/redemption	-	-	1.7	1.9	22.8	-	-
Cash used in (provided by) operating activities of discontinued operations	0.2	0.7	1.9	(2.0)	(9.1)	(13.2)	(5.7)
Other	1.3	0.3	1.6	0.2	0.6	2.0	1.3
Adjusted EBITDA	$ 144.1	$ 139.3	$ 551.6	$ 505.9	$ 466.2	$ 409.6	$ 363.7

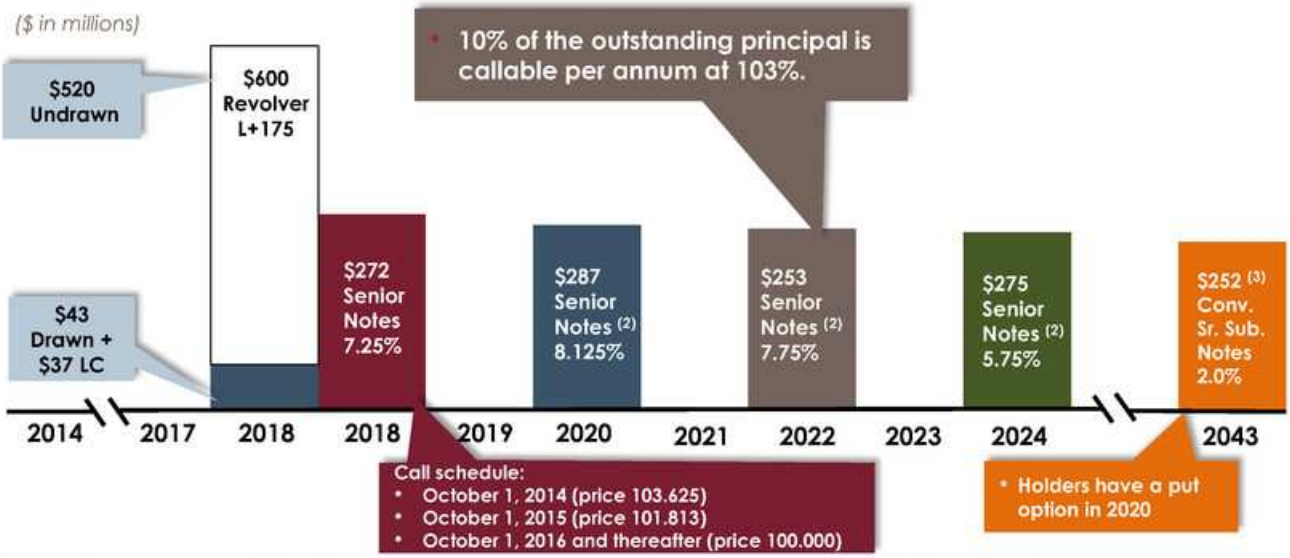
Refinancing and Delevering

Debt Maturity Profile

HealthSouth is positioned with a cost-efficient, flexible capital structure…

- **No near-term maturities and well-spaced debt maturities**
- **Limited exposure to higher interest rates**

March 31, 2014 (1)



(1) Does not include approx. $93 million of convertible perpetual preferred stock, approx. $87 million of capital leases, and approx. $46 million of other note payables.
(2) The 2020, 2022, and 2024 Senior Notes become callable in 2015, 2015, and 2017, respectively.
(3) On November 18, 2013, the Company closed separate, privately negotiated exchange agreements under which it issued $320 million of 2.0% Convertible Senior Subordinated Notes due 2043 in exchange for 257,110 shares of the Company's 6.5% Series A Convertible Perpetual Preferred Stock. The Company recorded approx. $249 million as debt and approx. $71 million as equity. As of 3/31/14, approx. $68 million remains as an unamortized debt discount.

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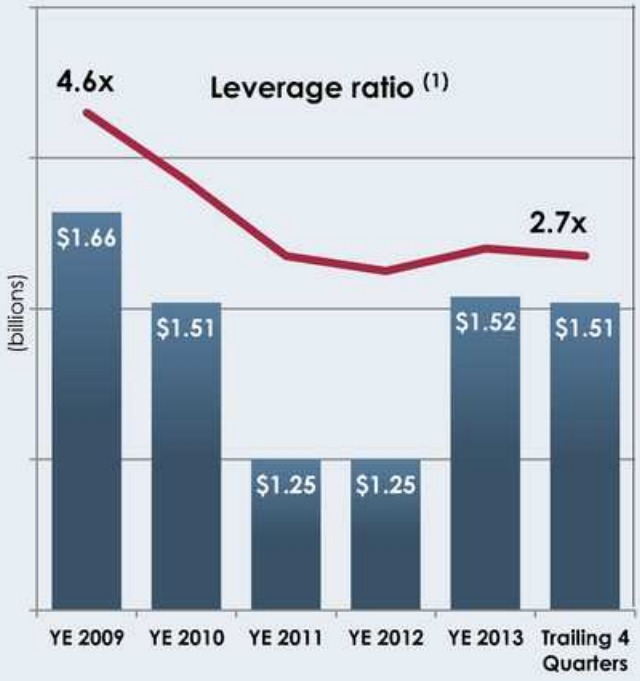
Debt and Liquidity

Debt Outstanding



Liquidity

	March 31, 2014	Dec. 31, 2013
Cash Available	$ 53.1	$ 64.5
Revolver Total Line	$ 600.0	$ 600.0
Less:		
- Draws	(43.0)	(45.0)
- Letters of Credit	(37.3)	(36.5)
Available	$ 519.7	$ 518.5
Total Liquidity	$ 572.8	$ 583.0

Credit Ratings

	S&P	Moodys
Corporate Rating	BB- Stable	Ba3 Stable
Revolver Rating	BB+	Baa3
Senior Notes Rating	BB-	Ba3

(1) Based on 2009 and trailing 4 quarters Adjusted EBITDA of $363.7 million and $556.4 million, respectively; reconciliation to GAAP provided on slides 62 and 96-101.

Debt Schedule

(Millions) Corporate	Credit Rating S&P BB-	Credit Rating Moody Ba3	Mar. 31, 2014	Dec. 31, 2013	Change in Debt vs. YE 2013
Advances under $600 million revolving credit facility, June 2018 - 1 Month LIBOR +175bps	BB+	Baa3	$ 43.0	$ 45.0	(2.0)
Bonds Payable:					
7.25% Senior Notes due 2018	BB-	Ba3	272.4	272.4	-
8.125% Senior Notes due 2020	BB-	Ba3	286.7	286.6	0.1
7.75% Senior Notes due 2022	BB-	Ba3	252.5	252.5	-
5.75% Senior Notes due 2024	BB-	Ba3	275.0	275.0	-
2.00% Convertible Senior Subordinated Notes due 2043 (1)			251.6	249.5	2.1
Other notes payable			46.3	47.6	(1.3)
Capital lease obligations			87.3	88.9	(1.6)
Long-term debt			**$ 1,514.8**	**$ 1,517.5**	**$ (2.7)**
Debt to Adjusted EBITDA (2)			**2.7x**	**2.8x**	

(1) On November 18, 2013, the Company closed separate, privately negotiated exchange agreements under which it issued $320 million of 2.0% Convertible Senior Subordinated Notes due 2043 in exchange for 257,110 shares of the Company's 6.5% Series A Convertible Perpetual Preferred Stock. The Company recorded approx. $249 million as debt and approx. $71 million as equity. As of 3/31/14, approx. $68 million remains as an unamortized debt discount.

(2) Based on 4 Qtr. trailing and 2013 Adjusted EBITDA of $556.4 million and $551.6 million, respectively; reconciliation to GAAP provided on slides 62, 96, 97, and 101.

Credit Agreement Key Covenants (1)

All Transactions are subject to no defaults under covenants and pro forma leverage of less than 4.5x and interest coverage of at least 2.75x

Transaction	Limitations
Acquisitions	No additional limitations
Unsecured debt issuance	No additional limitations
Restricted payments: Common stock or debt purchases; common stock dividends	Unlimited up to pro forma senior secured leverage ratio of 1.5x. • If greater than 1.5x, subject to an aggregate restricted payments basket (2), which was greater than $200 million at the end of Q1 2014.
Restricted payments: Preferred stock purchase	Unlimited up to pro forma leverage ratio of 3.0x.

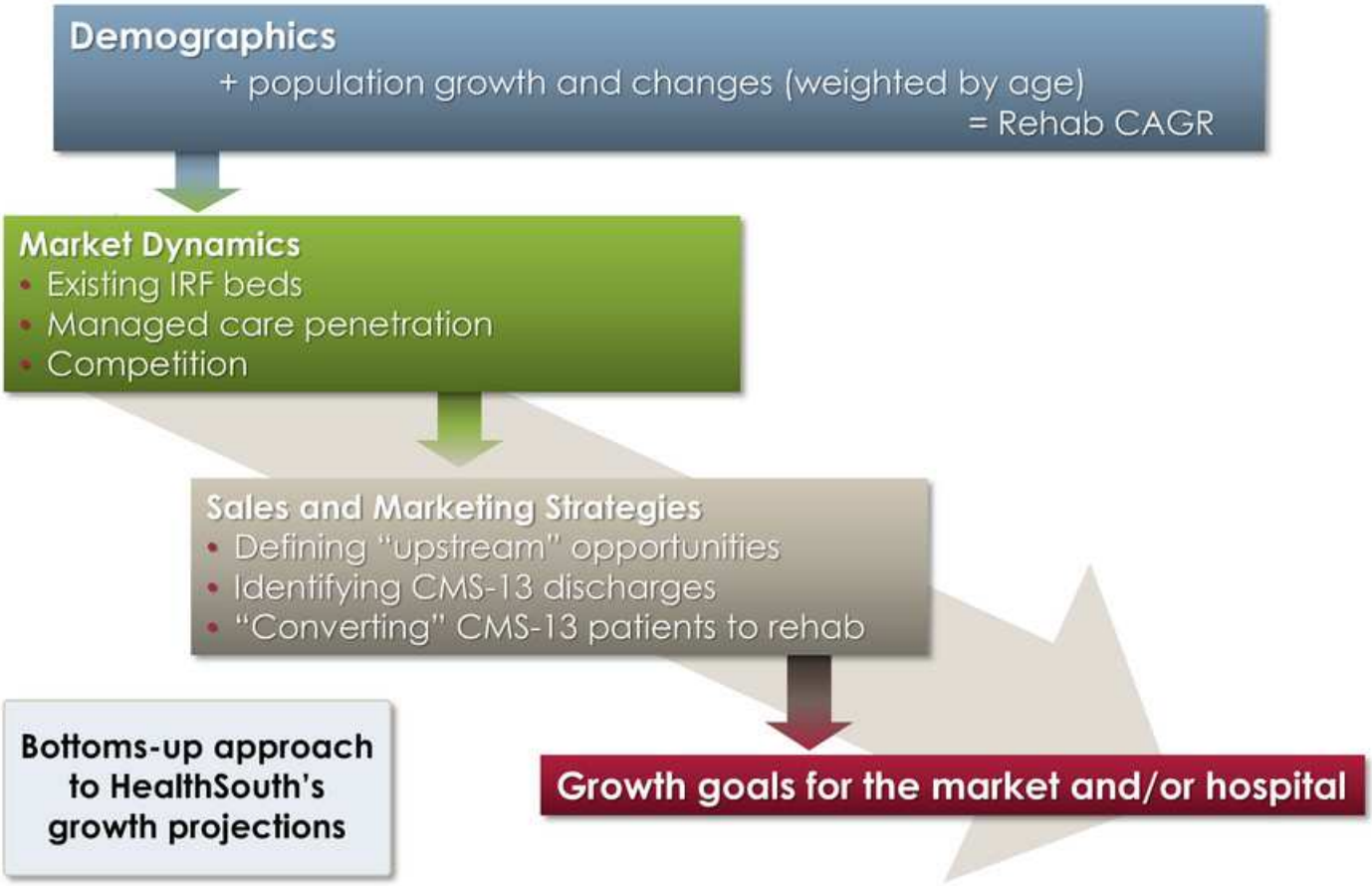
The pro forma senior secured debt leverage ratio per the credit agreement using trailing twelve-month Adjusted EBITDA at the end of Q1 2014 was less than 0.5x.

(1) Amendment to the credit agreement was filed as Exhibit 10.1 to Form 10-Q on July 30, 2013. Full agreement filed as Exhibit 10.2 to Form 10-Q on August 4, 2011. Senior unsecured note indentures include a restricted payments basket which generally builds yearly by 50% of the net income from continuing operations. The bond indenture restricted payments basket at the end of Q1 2014 was approx. $500 million.

(2) The maximum amount limitations above are subject to increase by a "grower" basket equal to 50% of excess cash flow plus certain other amounts including net cash proceeds from certain equity issuances.

Growth

Organic Growth: A Strategic Framework



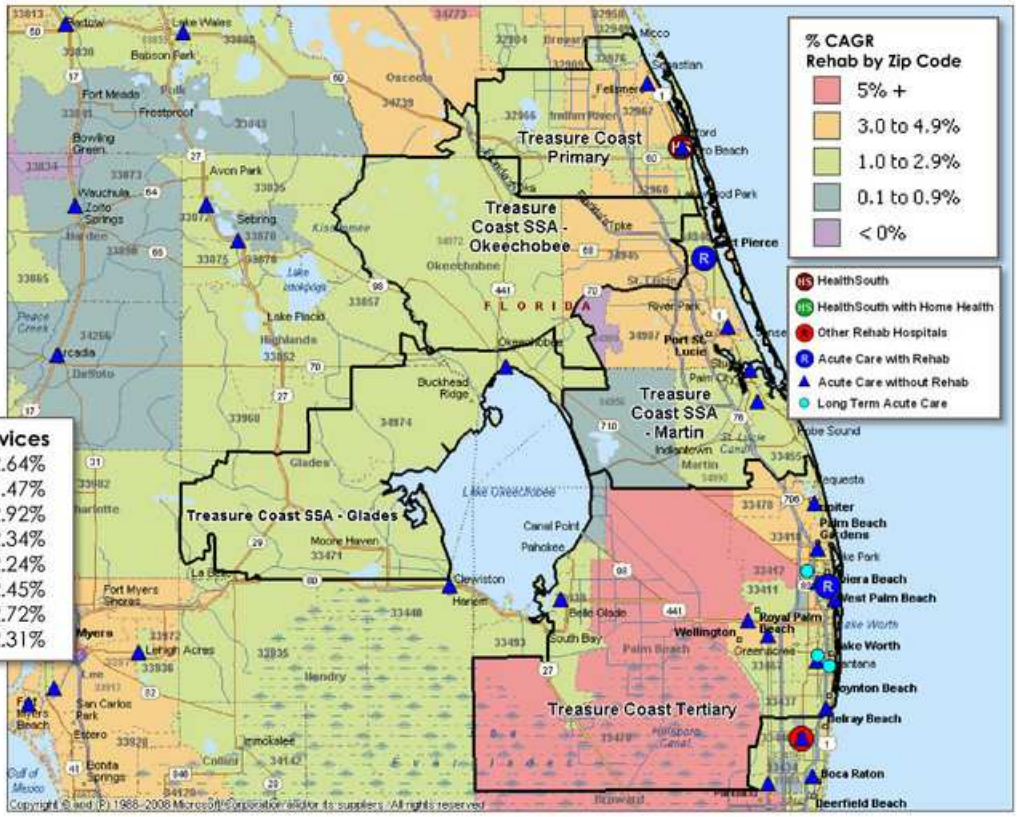
Organic Growth: Compounded Annual Growth Rate (CAGR) [1]

Weighted for Rehab Services [1] [2]

Organic Growth

- Demographic changes
- Population growth

% CAGR Weighted for Rehab Services	
Treasure Coast Primary	2.64%
Treasure Coast SSA – Glades	1.47%
Treasure Coast SSA – Martin	2.92%
Okeechobee	2.34%
Treasure Coast Tertiary	2.24%
Combined	2.45%
State of Florida	2.72%
USA	2.31%



[1] Numbers in map are for illustrative purposes only and do not represent actual results.
[2] "Weighted for Rehab Services" - methodology weights growth in rehab age groups higher.

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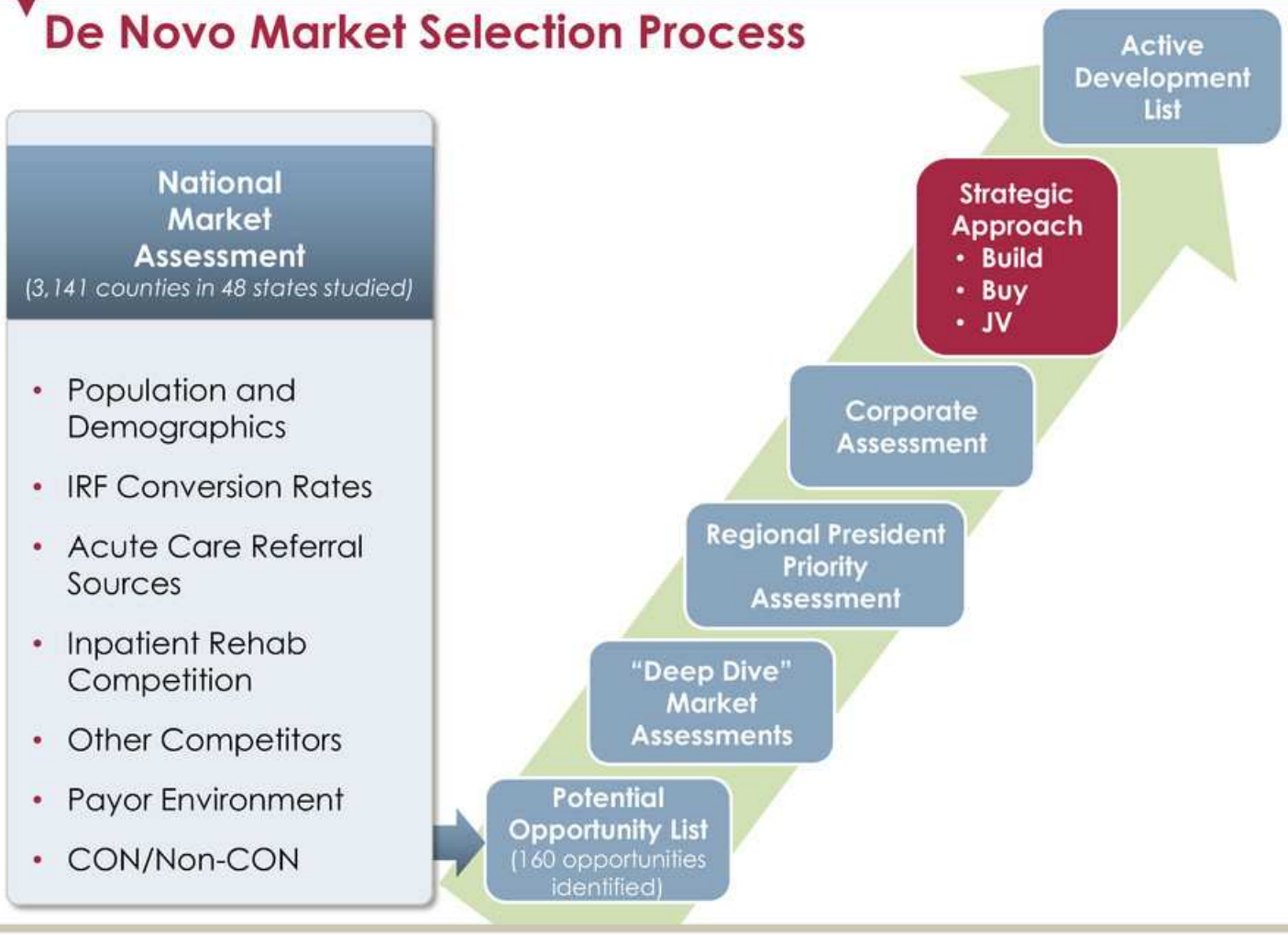
De Novo Market Selection Process



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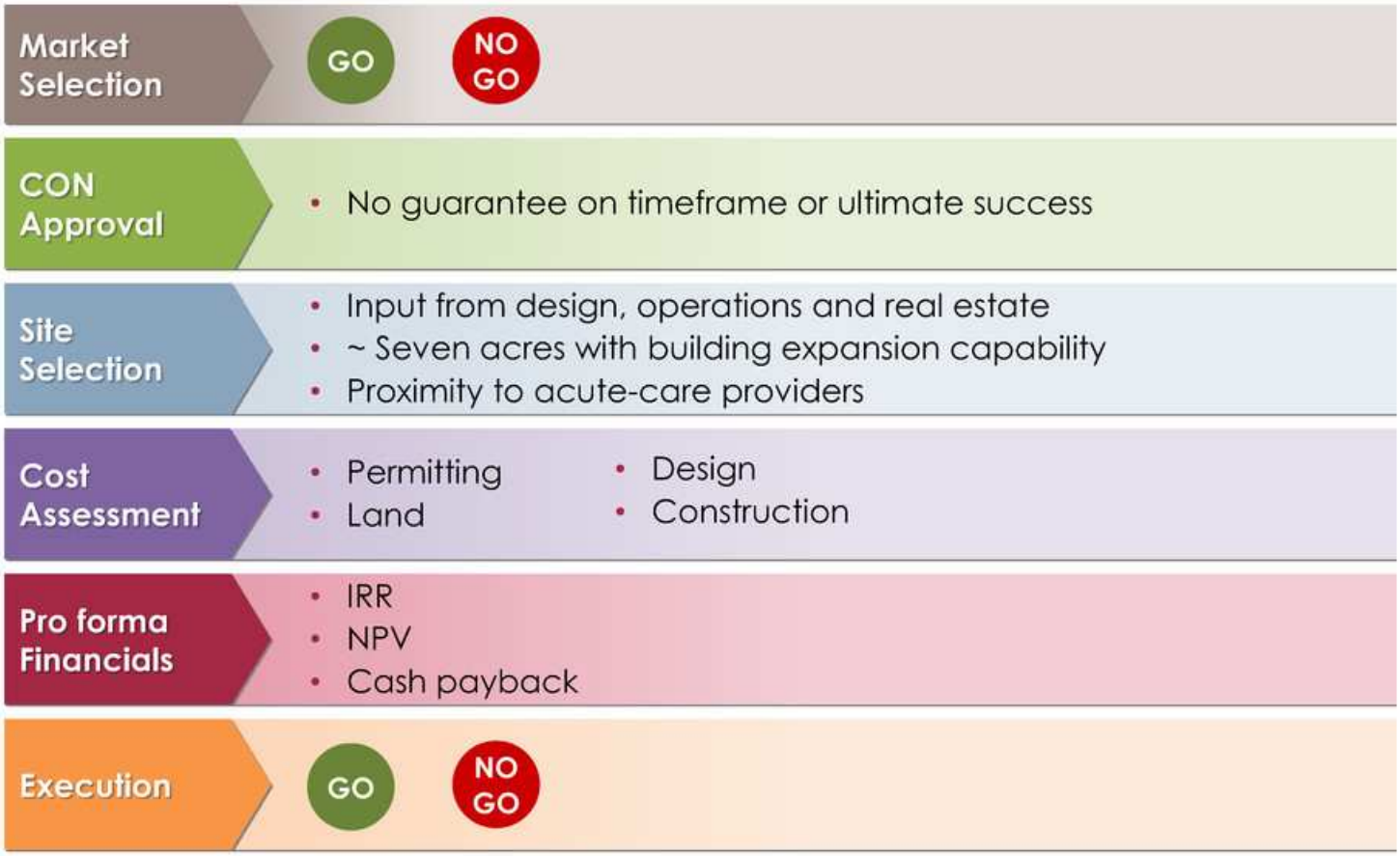
De Novo Evaluation Process



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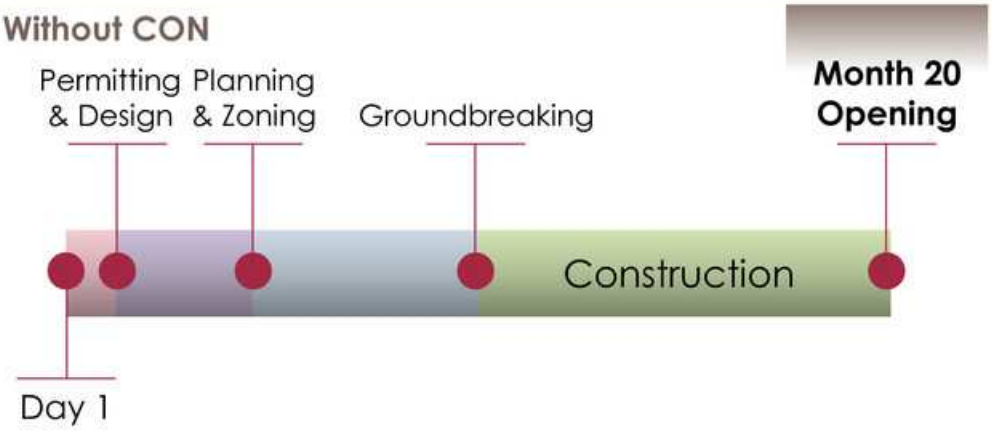
Illustrative De Novo Timeline

With CON



Without CON



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Portfolio Growth: De Novo (40-50 beds) Assumptions and Timing

All projects have minimum IRR target of 15% (pre-tax).

Investment Considerations

- Cash Payback [1] = 5 to 7 years
- Inclusive of CON costs (where applicable)
- Includes cost of CIS installation
- May be structured as a joint venture

- Prototype includes all private rooms
- A minimum of 30 patients treated for zero revenue (Medicare certification)
- Core infrastructure of building anticipates future expansion; potential to enhance returns with future bed expansion

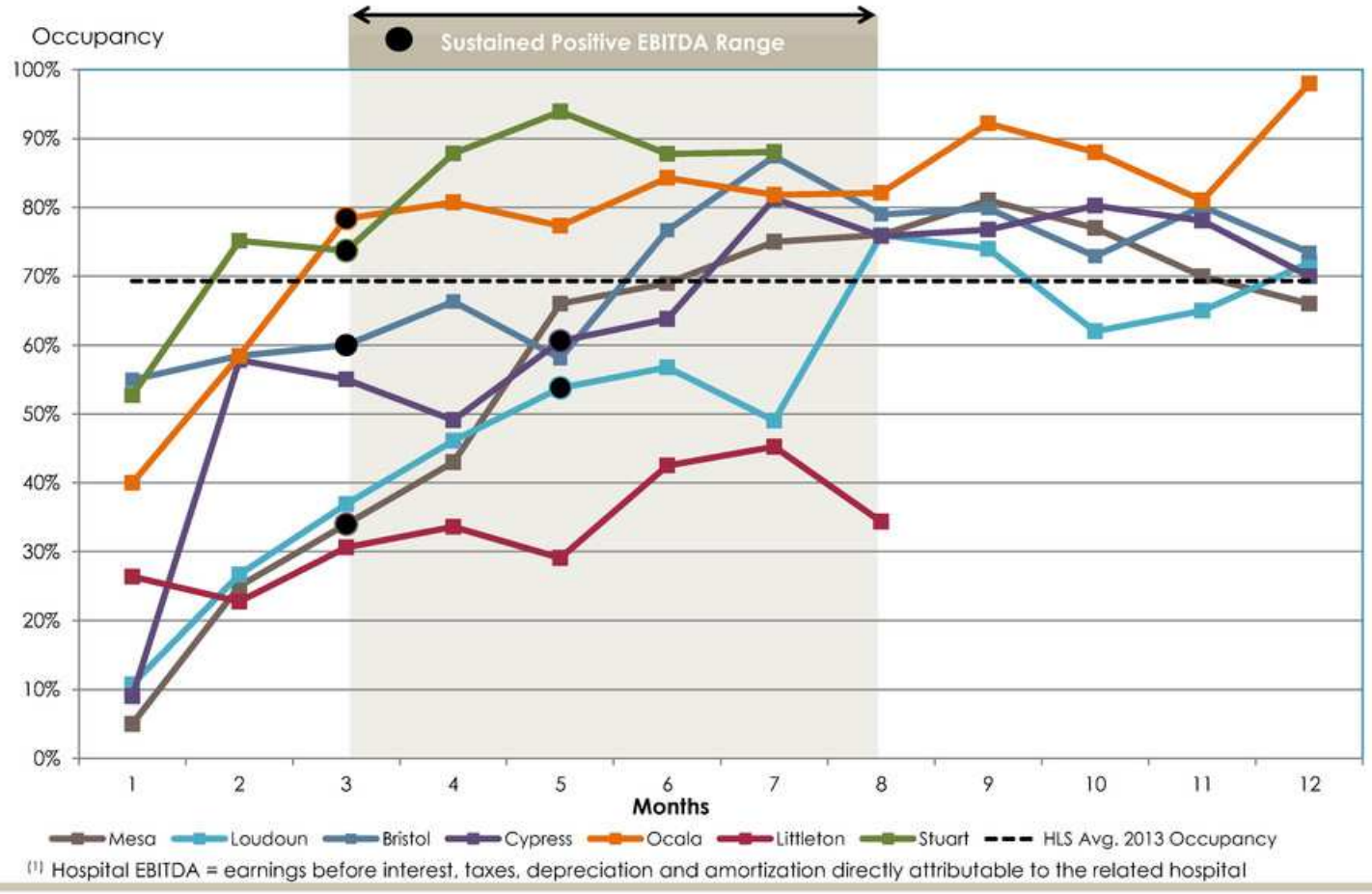
Capital Cost (millions)	Low	High
Construction, design, permitting, etc.	$15	$17
Land	2	3
Equipment (including CIS)	3	4
	$20	$24

Pre-Opening Expenses [3] (thousands)	Low	High
Operating	$325	$550
Salaries, wages, benefits	375	650
	$700	$1,200

Operational Date	Location [2]	Beds
Q4 2015	Modesto, CA	50
Q4 2014	Middletown, DE	34
Q4 2014	Newnan, GA	50
Q4 2014	Altamonte Springs, FL	50
Q2 2013	Littleton, CO	40
Q2 2013	Stuart, FL	34
Q4 2012	Ocala, FL	40
Q4 2011	Cypress, TX	40
Q3 2010	Bristol,VA	25
Q2 2010	Loudoun County, VA	40
Q3 2009	Mesa, AZ	40

(1) Future cash payback periods may increase when the Company exhausts its NOLs (slide 57).
(2) Does not include Franklin, TN; CON award is under appeal
(3) Pre-opening expenses include expenses for training new employees on the clinical information system, which vary based on the timing of the first admission.

De Novo Occupancy and EBITDA[1] Trends



[1] Hospital EBITDA = earnings before interest, taxes, depreciation and amortization directly attributable to the related hospital

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Portfolio Growth: Acquisition Assumptions, Timing and Performance

All projects have minimum IRR target of 15% (pre-tax).

Acquisition Assumptions

Investment Considerations	Value Added
• Price varies depending on size, market, and physical asset • Cash Payback [1] = 4 to 6 years • May be structured as a joint venture • Clinical information system is additive to the purchase price	• TeamWorks approach to sales/marketing • Labor management tools and best practices • Clinical expertise • Clinical technology and programming • Supply chain efficiency • Medical leadership and clinical advisory boards

Unit/Equity Acquisitions

Location	Beds	Date Acquired
Worcester, MA [2]	110	Q2 2014
San Antonio, TX	34	Q3 2012
Ft. Smith, AR	30	Q3 2010
Little Rock, AR	23	Q1 2010
Altoona, PA	18	Q4 2009
Arlington, TX	30	Q3 2008

IRF Acquisition

Location	Date Acquired	Acquired Census	One Year Later Census
Johnson City, TN [3]	Q4 2014	TBD	TBD
Augusta, GA	Q2 2013	31	40 [4]
Cincinnati, OH	Q4 2011	0	27
Sugar Land, TX	Q3 2010	26	35
Las Vegas, NV	Q2 2010	16	35
Vineland, NJ	Q3 2008	26	31

(1) Future cash payback periods may increase when the Company exhausts its NOLs (slide 57).
(2) Worcester, MA is an increase in equity and consolidation of Fairlawn Rehabilitation Hospital effective June 1, 2014.
(3) Expect to finalize by year-end 2014
(4) Census for Q1 2014

Potential Expansion: Post-Acute Care Services



Medicare Spending (billions)	$5.5	$15.1	$6.7	$28.7	$18.0
# of Discharges	140,463	1,270,000	373,000	2,396,548	3,400,000
Length of Stay	26.2	88 days	12.9	<100 days	N/A
# of Providers	420	3,720	1,166	14,938	12,311
Facility Ownership Mix	For-Profit (77%) Non-Profit (19%) Gov't (4%)	For-Profit (59%) Non-Profit (35%) Other (6%)	For-Profit (26%) Non-Profit (60%) Gov't (14%)	For-Profit (70%) Non-Profit (25%) Gov't (5%)	For-Profit (88%) Non-Profit (12%)
Hospital vs. Free-standing	Free-standing (62%) Hospital Based (38%)	Free-standing (71%) Hospital Based (15%) Home Based or SNF (14%)	Free-standing (20%) Hospital Based (80%)	Free-standing (95%) Hospital Based (5%)	N/A
Rural vs. Urban	Urban (94%) Rural (6%)	Urban (71%) Rural (29%)	Urban (83%) Rural (17%)	Urban (70%) Rural (30%)	Urban (83%) Rural (17%)

(1) For information on HealthSouth's hospital portfolio, see slide 4.

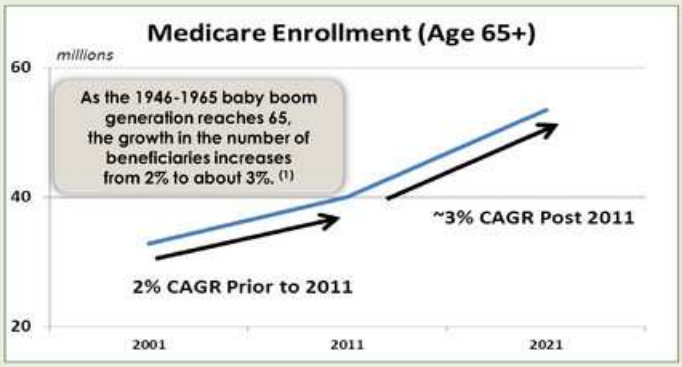
Sources: Medpac Data Book, March 2014 – pages 185, 218, 226, 244, 247, 272, 273, 299 and 307, Medpac Payment Policy, March 2012 – page 266

Summary: Multiple Avenues Available for Sustained Growth

- **The Company continues to have excellent organic growth opportunities, including bed expansions and unit consolidations.**
  - Nondiscretionary nature of many conditions served
  - Track record of consistent market share gains
- **Organic growth will be complemented with new IRFs (target 4 to 6 per year)**
  - De novos and IRF acquisitions will allow entry into, and growth in, new markets.
  - Proven track record of success
- **Longer-term consideration of opportunistic acquisitions of complementary post-acute services predicated on:**
  - Regulatory clarity
  - Purchase price and terms and conditions

The IRF patient population is experiencing favorable long-term demographic trends:

- Aging of baby boomer generation
- Increased average life expectancy
- Low threat of technological obsolescence

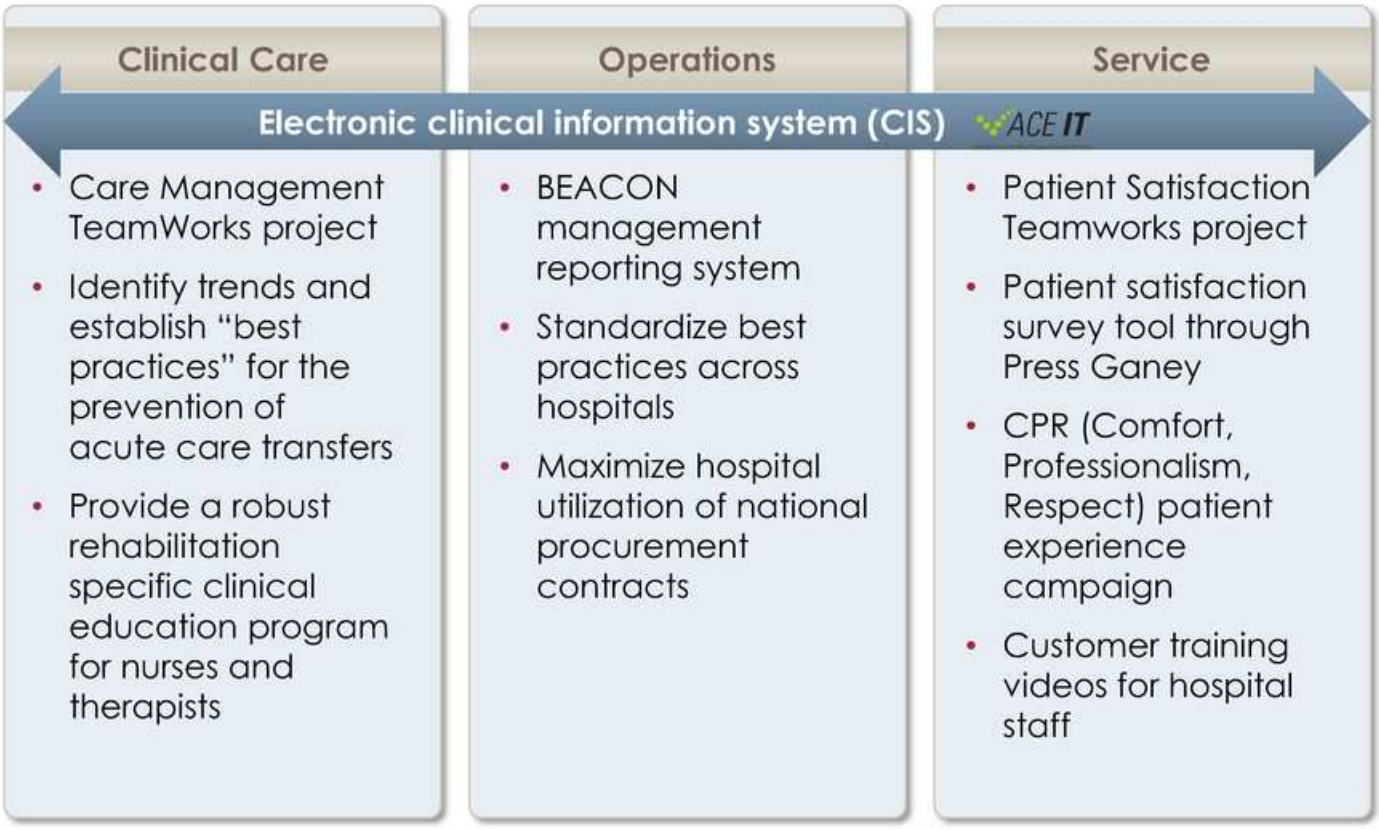


(1) Center of Medicare & Medicaid Services, Medicare Trustee's Report May 2013 – pages 10 and 22

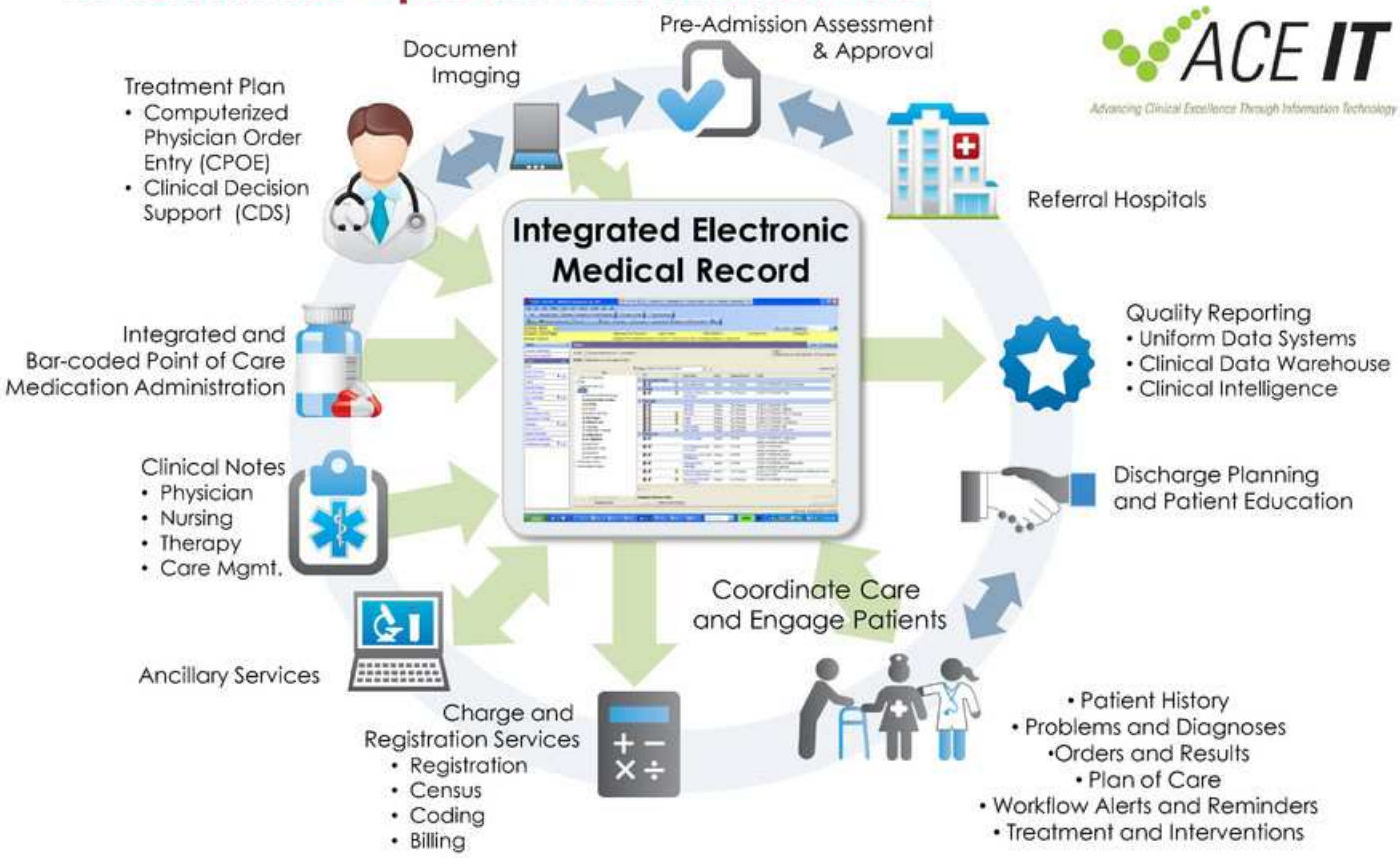
Operational Initiatives

Operational Strategy

Excellence in …



CIS Standardization Improves Patient Safety and Streamlines Operational Efficiencies



CIS Benefits and Value Proposition

ACE IT
Advancing Clinical Excellence Through Information Technology

Patient Safety

- Automated medication administration at the point of care
- Clinical data repository (reporting and outcomes)
- Real time patient condition awareness
- Rule driven identification of preventable adverse medical events

Operational Efficiencies

- Streamline sales and marketing process
- Clinical charge capture efficiency
- Real time awareness of therapy intensity (higher intensity associated with better outcomes)
- Enterprise standardized clinical documentation and coding processes
- Workflow management, patient/resource scheduling

Cost-Effectiveness

- Stage setter for interoperability with referral sources and health information exchanges
- Patient-centered care is a key competitive differentiator and impacts patient choice.

CIS Timeline

ACE IT
Advancing Clinical Excellence Through Information Technology

2014 - 2017	• Complete installation in remaining hospitals and acquired hospitals • Install ACE IT in all de novo HealthSouth hospitals • April 29, 2014 – installation now complete in **46** of our **103** inpatient rehabilitation hospitals
2013	• Installed ACE IT in 18 existing hospitals • Installed ACE IT in de novos located in Littleton, CO and Stuart, FL • Installation completed in **36** of **103** inpatient rehabilitation hospitals
2012	• Installed ACE IT in 12 existing hospitals • Installed ACE IT in de novo located in Ocala, FL
2011	• Signed contract with Cerner for Company-wide implementation starting in 2012 • Installed ACE IT in existing HealthSouth hospital (Valley of the Sun) • Installed ACE IT in HealthSouth Rehabilitation Hospital of Cypress, TX
2010	• Installed ACE IT in HealthSouth Rehabilitation Hospital of Northern VA hospital
2009	• Pilot project kickoff in August; designated "ACE IT" • Core team assembled; pilot hospitals identified • Cerner selected for pilot
2008	• Restarted evaluation of three potential vendors
2006 - 2007	• CIS project put on hold due to financial constraints, divestitures, and delevering • Initial vendor evaluations in 2006
2005	• Initial request for proposal sent to six vendors; six vendors responded; three finalists were chosen

CIS Cost

- **No incentive payments (i.e. "HITECH") for inpatient rehabilitation hospitals** (1)
  - Only acute care hospitals are eligible
- **Installation cost will vary by hospital depending on items such as size and physical plan.**
  - Installation cost expected to be in a range of $1 million to $1.5 million per hospital.
  - Approx. 70% of the initial spend will be capital expense and the remainder will be operating expense.
- **Projected/estimated costs:**

($ millions)	2013 Actual	2014 Estimate	2015 Estimate	2016 Estimate
No. of hospitals installed	20	20	20	20
Operating expenses	~$12	~$13	~$15	~$16
CAPEX	~$21	~$18	~$22	~$17

(1) The American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) provides incentive payments to eligible professionals, eligible hospitals, and critical access hospitals participating in Medicare and Medicaid programs that adopt and successfully demonstrate "meaningful use" of certified electronic health record technology.

TeamWorks: Care Management

2012 was the first full year of "Care Management" implementation.



Goals

- Improve operational effectiveness, patient satisfaction, and quality outcomes
- Engage interdisciplinary teams
- Reduce:
  - Complication rates
  - Cost per case
  - Payor denials
- Increase:
  - Quality outcomes
  - Patient involvement in care decisions
- Standardize "Care Management" staffing (added approx. one clinical resource per hospital)

CPR: Comfort, Professionalism, Respect

CPR is an in-house course designed to train all employees to realize that even minor encounters between staff and patients can have a memorable impact on the patient's entire experience.

COMFORT
PROFESSIONALISM
RESPECT
CPR
GETTING TO THE HEART OF THE PATIENT EXPERIENCE

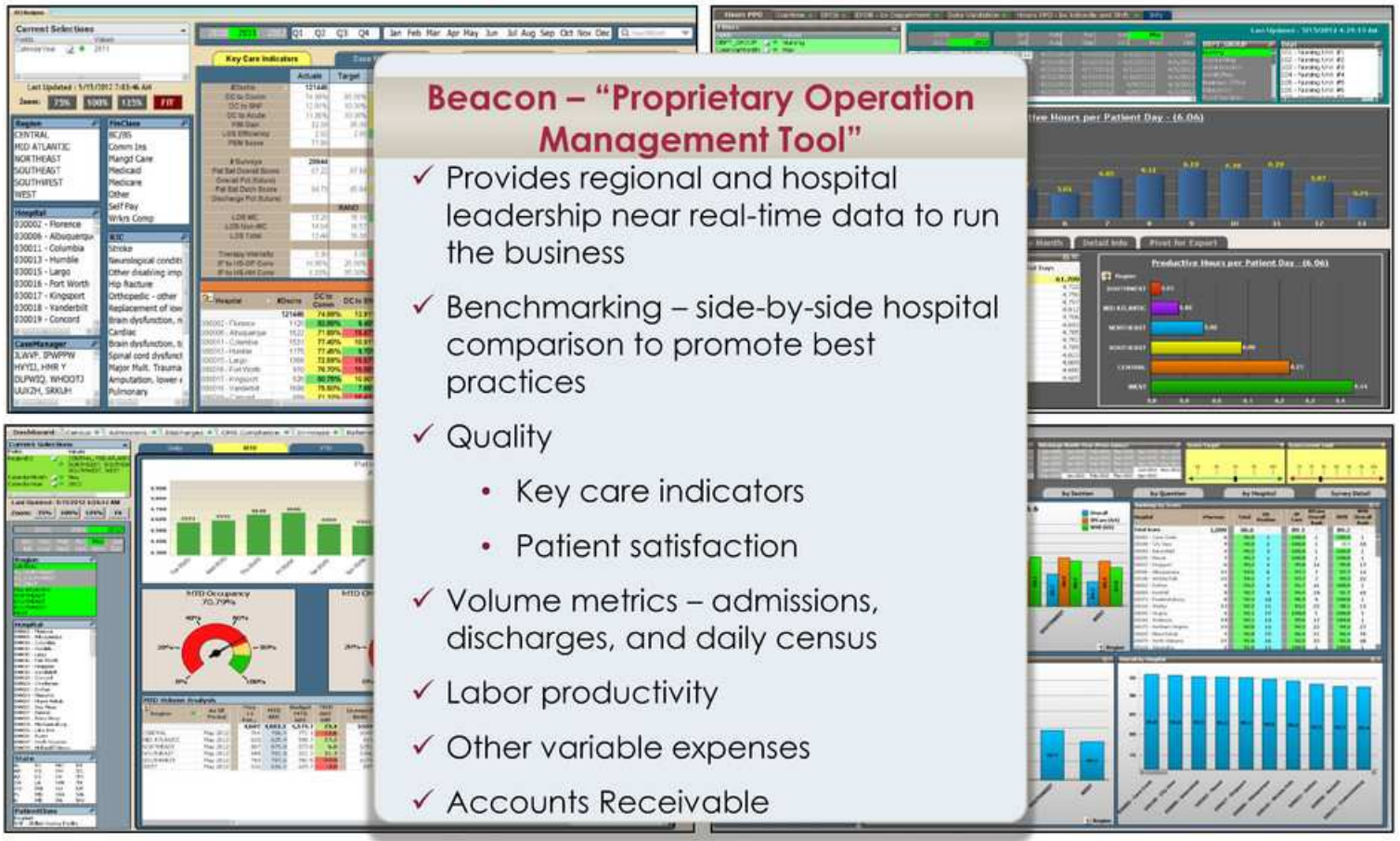
- All employees trained in the CPR campaign.
- Hospital-based trained facilitators will work directly with employees.
- A series of short videos is used to depict common scenarios of patient/staff situations.
- Facilitator training is highly interactive, encouraging discussions among staff.

Ultimate goal is to improve employee-to-patient interactions, leading to:

- Improved patient satisfaction scores
- Reduced patient complaints
- More satisfied employees


BEACON
HEALTHSOUTH MANAGEMENT REPORTING
volume
revenue
costs
quality
patients
labor
workforce

BEACON: Management Reporting (1)

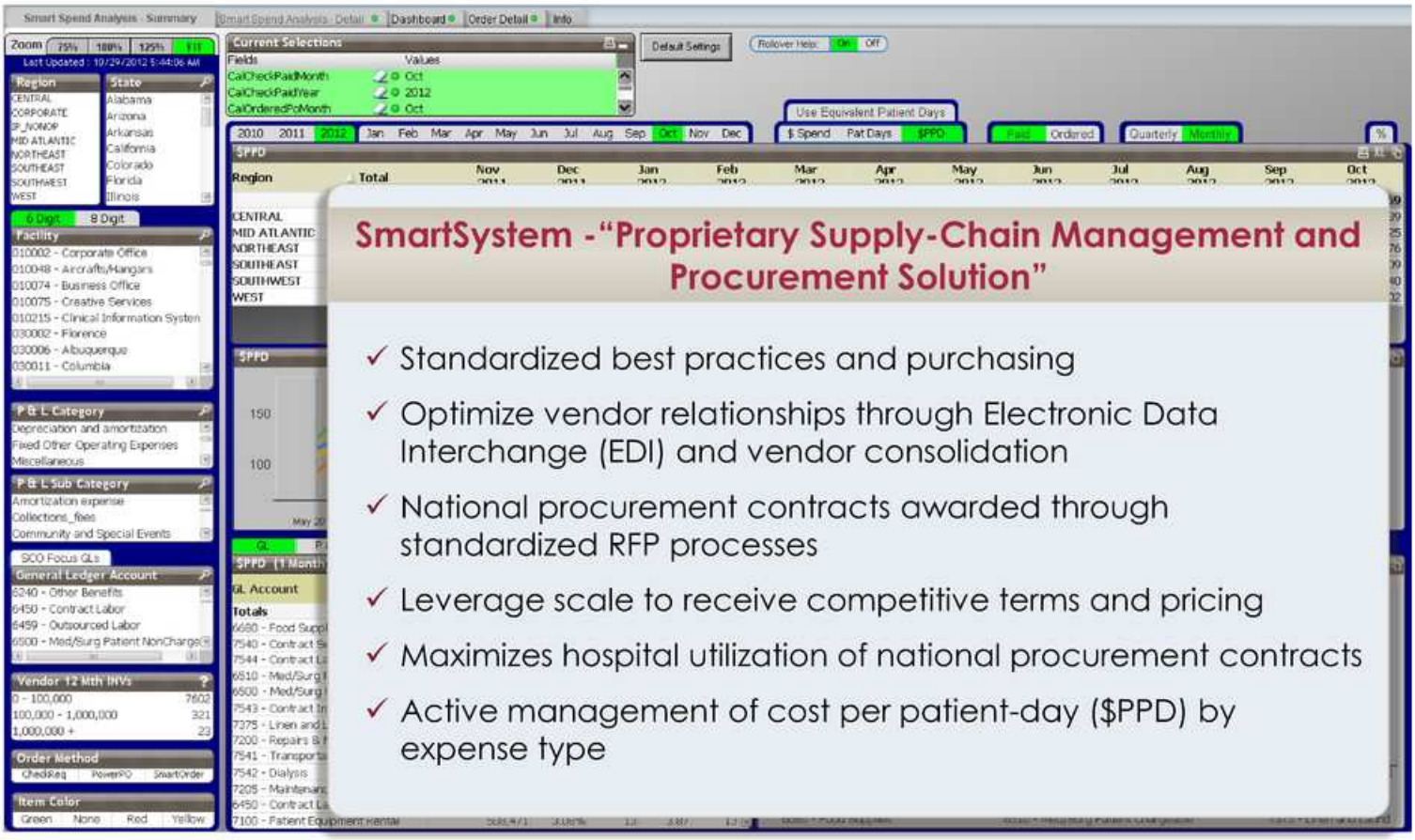


Beacon – "Proprietary Operation Management Tool"

- ✓ Provides regional and hospital leadership near real-time data to run the business
- ✓ Benchmarking – side-by-side hospital comparison to promote best practices
- ✓ Quality
  - Key care indicators
  - Patient satisfaction
- ✓ Volume metrics – admissions, discharges, and daily census
- ✓ Labor productivity
- ✓ Other variable expenses
- ✓ Accounts Receivable

(1) Numbers in screen shot have been modified for presentation and do not represent actual results.

BEACON: SmartSystem Analytics



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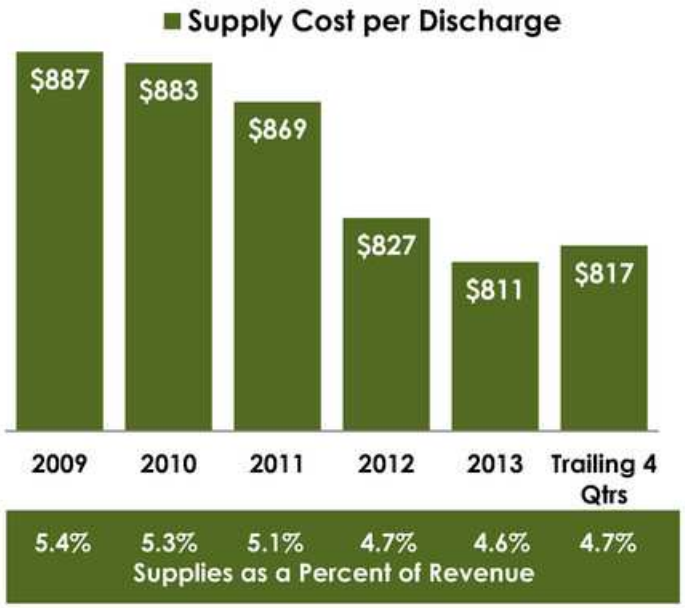
Operational Initiatives: SmartSystem

- Disciplined management of supply costs while acuity is increasing
- Savings have more than offset the effect of inflation.



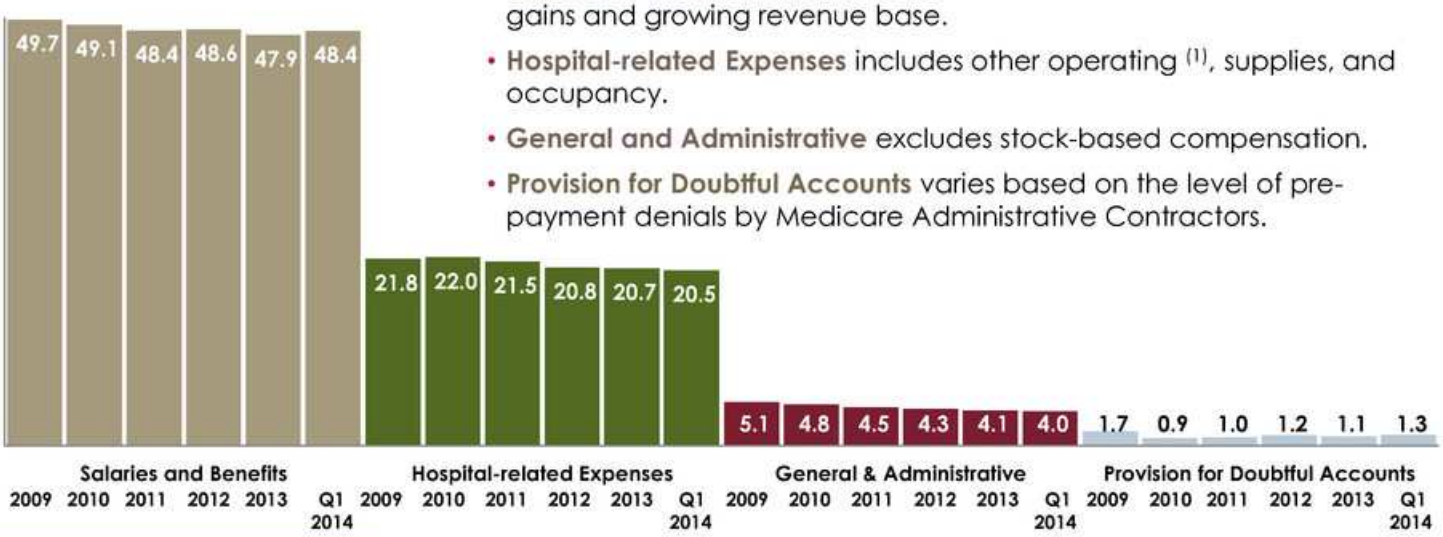
Completed initiatives:

- Dialysis
- Food
- Pharmacy
- Office Supplies
- Outside patient service
- Therapy equipment

Operational Metrics

Operational Metrics: Expense Efficiencies

(Percent of Net Operating Revenues)





- **Salaries and Benefits** reflects continued improvement from productivity gains and growing revenue base.
- **Hospital-related Expenses** includes other operating (1), supplies, and occupancy.
- **General and Administrative** excludes stock-based compensation.
- **Provision for Doubtful Accounts** varies based on the level of pre-payment denials by Medicare Administrative Contractors.
- **Employees per Occupied Bed ("EPOB")** is calculated by dividing the number of full-time equivalents, including an estimate of full-time equivalents from the utilization of contract labor, by the number of occupied beds during each period. The number of occupied beds is determined by multiplying the number of licensed beds by the Company's occupancy percentage.

(1) Excludes loss on disposal or impairment of assets

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Operational and Labor Metrics

	Q1 2014	Q4 2013	Q3 2013	Q2 2013	Q1 2013	Q4 2012	Q3 2012	Q2 2012	Q1 2012	Full Year 2013	Full Year 2012	Full Year 2011
					(In Millions)							
Net patient revenue-inpatient	$ 558.2	$ 537.5	$ 528.8	$ 527.4	$ 537.1	$ 518.1	$ 498.9	$ 495.0	$ 500.6	$ 2,130.8	$ 2,012.6	$ 1,866.4
Net patient revenue-outpatient and other revenues	33.0	34.6	35.2	37.1	35.5	34.8	38.1	38.4	38.0	142.4	149.3	160.5
Net operating revenues	$ 591.2	$ 572.1	$ 564.0	$ 564.5	$ 572.6	$ 552.9	$ 537.0	$ 533.4	$ 538.6	$ 2,273.2	$ 2,161.9	$ 2,026.9
					(Actual Amounts)							
Discharges [1]	32,889	32,906	32,307	32,645	32,130	31,695	30,569	30,719	30,871	129,988	123,854	118,354
Outpatient visits	182,170	192,474	202,479	211,207	200,471	198,139	221,648	229,152	231,243	806,631	880,182	943,439
Average length of stay	13.4	13.1	13.3	13.2	13.5	13.2	13.6	13.4	13.5	13.3	13.4	13.5
Occupancy %	71.9%	68.6%	69.0%	69.9%	72.4%	68.2%	68.3%	69.2%	70.7%	69.3%	68.2%	67.7%
# of licensed beds	6,825	6,825	6,789	6,777	6,646	6,656	6,598	6,538	6,500	6,825	6,656	6,461
Occupied beds	4,907	4,682	4,684	4,737	4,812	4,539	4,506	4,524	4,596	4,730	4,539	4,374
Full-time equivalents (FTEs) [2]	16,209	16,159	16,213	16,180	15,819	15,617	15,545	15,378	15,271	16,093	15,453	15,089
Contract labor	83	72	76	72	85	73	61	56	69	76	65	70
Total FTE and contract labor	16,292	16,231	16,289	16,252	15,904	15,690	15,606	15,434	15,340	16,169	15,518	15,159
EPOB [3]	3.32	3.47	3.48	3.43	3.31	3.46	3.46	3.41	3.34	3.42	3.42	3.47

(1) Represents discharges from HealthSouth's 101 consolidated hospitals in Q1 2014, Q4 2013, Q3 2013 and Q2 2013; 98 consolidated hospitals in Q1 2013 and Q4 2012; 97 consolidated hospitals in Q3 2012; 96 consolidated hospitals in Q2 2012, Q1 2012, and Q4 2011; 94 consolidated hospitals in Q3 2011, Q2 2011, and Q1 2011.

(2) Excludes approximately 400 full-time equivalents who are considered part of corporate overhead with their salaries and benefits included in general and administrative expenses in the Company's consolidated statements of operations. Full-time equivalents included in the above table represent HealthSouth employees who participate in or support the operations of the Company's hospitals.

(3) Employees per occupied bed, or "EPOB," is calculated by dividing the number of full-time equivalents, including an estimate of full-time equivalents from the utilization of contract labor, by the number of occupied beds during each period. The number of occupied beds is determined by multiplying the number of licensed beds by the Company's occupancy percentage.

Payment Sources (Percent of Revenues)

	Q1		Full Year		
	2014	2013	2013	2012	2011
Medicare	75.2%	74.7%	74.5%	73.4%	72.0%
Medicaid	1.3%	1.1%	1.2%	1.2%	1.6%
Workers' compensation	1.3%	1.3%	1.2%	1.5%	1.6%
Managed care and other discount plans, including Medicare Advantage[1]	18.1%	18.5%	18.5%	19.3%	19.8%
Other third-party payors	1.6%	1.7%	1.8%	1.8%	2.0%
Patients	1.0%	1.1%	1.1%	1.3%	1.2%
Other income	1.5%	1.6%	1.7%	1.5%	1.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

(1) Managed Medicare revenues represent ~ 8%, 8%, 8%, 8%, and 7% of total revenues for Q1 2014, Q1 2013, and full-years 2013, 2012, 2011, respectively.

Reconciliations to GAAP

Reconciliation of Net Income to Adjusted EBITDA [1]

(in millions, except per share data)	Q1 2014 Total	Q1 2014 Per Share
Net income	$ 61.5	
Loss from disc ops, net of tax, attributable to HealthSouth	0.1	
Net income attributable to noncontrolling interests	(14.8)	
Income from continuing operations attributable to HealthSouth [2]	46.8	$0.48
Pro fees - acct, tax, and legal	1.6	
Provision for income tax expense	32.8	
Interest expense and amortization of debt discounts and fees	27.9	
Depreciation and amortization	26.4	
Other, including net noncash loss on disposal or impairments of assets	1.3	
Stock-based compensation expense	7.3	
Adjusted EBITDA [1]	$ 144.1	
Weighted average common shares outstanding:		
Basic		87.3
Diluted		100.9

(1) (2) – See notes on slide 101.

Reconciliation of Net Income to Adjusted EBITDA [1]

	2013									
	Q1		Q2		Q3		Q4		Full Year	
(in millions, except per share data)	Total	Per Share	Total	Per Share	Total	Per Share	Total	Per Share	Total	Per Share
Net income	$ 65.9		$ 179.0		$ 72.3		$ 64.2		$ 381.4	
Loss (income) from disc ops, net of tax, attributable to HealthSouth	0.4		(0.1)		0.9		(0.1)		1.1	
Net income attributable to noncontrolling interests	(14.6)		(13.8)		(14.1)		(15.3)		(57.8)	
Income from continuing operations attributable to HealthSouth [2]	51.7	$ 0.48	165.1	$ 1.66	59.1	$ 0.59	48.8	$ (0.31)	324.7	$ 2.59
Gov't, class action, and related settlements	-		(2.0)		(21.3)		(0.2)		(23.5)	
Pro fees - acct, tax, and legal	1.4		2.2		4.2		1.7		9.5	
Provision for income tax expense (benefit)	33.5		(86.5)		35.2		30.5		12.7	
Interest expense and amortization of debt discounts and fees	24.2		24.4		25.3		26.5		100.4	
Depreciation and amortization	22.1		23.1		24.3		25.2		94.7	
Loss on early extinguishment of debt	-		-		-		2.4		2.4	
Other, including net noncash loss on disposal of assets	0.1		1.7		2.5		1.6		5.9	
Stock-based compensation expense	6.3		6.5		6.2		5.8		24.8	
Adjusted EBITDA [1]	$ 139.3		$ 134.5		$ 135.5		$ 142.3		$ 551.6	
Weighted average common shares outstanding:										
Basic		94.0		86.1		86.2		86.4		88.1
Diluted		107.1		99.8		100.4		100.8		102.1

(1) (2) – See notes on slide 101.

Reconciliation of Net Income to Adjusted EBITDA [1]

	2012									
	Q1		Q2		Q3		Q4		Full Year	
(in millions, except per share data)	Total	Per Share	Total	Per Share	Total	Per Share	Total	Per Share	Total	Per Share
Net income	$ 56.8		$ 59.9		$ 59.9		$ 59.3		$ 235.9	
Loss (income) from disc ops, net of tax, attributable to HealthSouth	0.4		(3.5)		0.5		(1.9)		(4.5)	
Net income attributable to noncontrolling interests	(12.6)		(13.2)		(12.8)		(12.3)		(50.9)	
Income from continuing operations attributable to HealthSouth [2]	44.6	$ 0.39	43.2	$ 0.38	47.6	$ 0.44	45.1	$ 0.41	180.5	$ 1.62
Gov't, class action, and related settlements	-		-		(3.5)		-		(3.5)	
Pro fees - acct, tax, and legal	3.6		5.5		4.1		2.9		16.1	
Provision for income tax expense	29.1		26.9		28.1		24.5		108.6	
Interest expense and amortization of debt discounts and fees	23.3		23.0		23.5		24.3		94.1	
Depreciation and amortization	19.5		20.0		21.3		21.7		82.5	
Loss on early extinguishment of debt	-		-		1.3		2.7		4.0	
Gain on consolidation of St. Vincent Rehabilitation Hospital	-		-		(4.9)		-		(4.9)	
Other, including net noncash loss on disposal of assets	0.8		0.6		1.6		1.4		4.4	
Stock-based compensation expense	6.1		5.9		6.1		6.0		24.1	
Adjusted EBITDA [1]	$ 127.0		$ 125.1		$ 125.2		$ 128.6		$ 505.9	
Weighted average common shares outstanding:										
Basic		94.5		94.6		94.7		94.7		94.6
Diluted		108.7		108.0		108.1		108.0		108.1

(1) (2) – See notes on slide 101.

Reconciliation of Net Income to Adjusted EBITDA [1]

	2011									
	Q1		Q2		Q3		Q4		Full Year	
(in millions, except per share data)	Total	Per Share	Total	Per Share	Total	Per Share	Total	Per Share	Total	Per Share
Net income	$ 91.5		$ 32.3		$ 68.3		$ 62.5		$ 254.6	
(Income) loss from disc ops, net of tax, attributable to HealthSouth	(17.6)		(2.5)		(34.8)		5.0		(49.9)	
Net income attributable to noncontrolling interests	(11.7)		(10.4)		(11.3)		(12.5)		(45.9)	
Income from continuing operations attributable to HealthSouth [2]	62.2	$ 0.57	19.4	$ 0.14	22.2	$ 0.17	55.0	$ 0.50	158.8	$ 1.39
Gov't, class action, and related settlements	-		(10.6)		-		(1.7)		(12.3)	
Pro fees - acct, tax, and legal	3.8		8.4		4.0		4.8		21.0	
Provision for income tax (benefit) expense	(7.4)		11.2		18.1		15.2		37.1	
Interest expense and amortization of debt discounts and fees	35.1		34.9		26.3		23.1		119.4	
Depreciation and amortization	19.5		19.6		19.5		20.2		78.8	
Loss on early extinguishment of debt	-		26.1		12.7		-		38.8	
Net noncash loss on disposal of assets	0.1		1.0		2.8		0.4		4.3	
Stock-based compensation expense	4.2		5.3		4.9		5.9		20.3	
Adjusted EBITDA [1]	$ 117.5		$ 115.3		$ 110.5		$ 122.9		$ 466.2	
Weighted average common shares outstanding:										
Basic		93.1		93.3		93.3		93.3		93.3
Diluted		109.0		109.5		109.2		109.1		109.2

(1) (2) – See notes on slide 101.

Reconciliation of Net Income to Adjusted EBITDA [1]

(in millions, except per share data)	2009 Total	2009 Per Share	2010 Total	2010 Per Share
Net income	$ 128.8		$ 939.8	
Income from disc ops, net of tax, attributable to HealthSouth	(17.7)		(9.2)	
Net income attributable to noncontrolling interests	(34.0)		(40.8)	
Income from continuing operations attributable to HealthSouth [2]	77.1	$ 0.57	889.8	$ 8.20
Gov't, class action, and related settlements	36.7		1.1	
Pro fees - acct, tax, and legal	8.8		17.2	
Loss on interest rate swaps	19.6		13.3	
Provision for income tax benefit	(2.9)		(740.8)	
Interest expense and amortization of debt discounts and fees	125.7		125.6	
Depreciation and amortization	67.6		73.1	
Impairment charges, including investments	1.4		-	
Net noncash loss on disposal of assets	3.4		1.4	
Loss on early extinguishment of debt	12.5		12.3	
Stock-based compensation expense	13.4		16.4	
Other	0.4		0.2	
Adjusted EBITDA [1]	$ 363.7		$ 409.6	
Weighted average common shares outstanding:				
Basic		88.8		92.8
Diluted		103.3		108.5

(1) (2) – See notes on slide 101.

Reconciliation Notes for Slides 96-100 and 102

1. Adjusted EBITDA is a non-GAAP financial measure. The Company's leverage ratio (total consolidated debt to Adjusted EBITDA for the trailing four quarters) is, likewise, a non-GAAP financial measure. Management and some members of the investment community utilize Adjusted EBITDA as a financial measure and the leverage ratio as a liquidity measure on an ongoing basis. These measures are not recognized in accordance with GAAP and should not be viewed as an alternative to GAAP measures of performance or liquidity. In evaluating Adjusted EBITDA, the reader should be aware that in the future HealthSouth may incur expenses similar to the adjustments set forth.
2. Per share amounts for each period presented are based on diluted weighted average shares outstanding unless the amounts are antidilutive, in which case the per share amount is calculated using the basic share count after subtracting the quarterly dividend on the convertible perpetual preferred stock, income allocated to participating securities, and the repurchase premium on shares of preferred stock. The difference in shares between the basic and diluted shares outstanding is primarily related to the convertible senior subordinated notes and our convertible perpetual preferred stock.

Reconciliation of Net Income to Adjusted EBITDA [1] - Impact of Consolidation of Fairlawn Rehabilitation Hospital at 50% Equity Interest

	Fairlawn Rehabilitation Hospital as Equity Method Entity		Pro Forma Fairlawn Rehabilitation Hospital as Consolidated Entity		
	Full Year 2013 As Reported		Full Year 2013 With Accounting Change		Difference
	Total	Per Share	Total	Per Share	Total	Per Share
Net income	$ 381.4		$ 385.6		$ 4.2	
Loss from discops, net of tax, attributable to HealthSouth	1.1		1.1		-	
Net income attributable to noncontrolling interests	(57.8)		(62.0)		(4.2)	
Income from continuing operations attributable to HealthSouth [2]	324.7	$ 2.59	324.7	$ 2.59	-	$ -
Gov't, class action, and related settlements	(23.5)		(23.5)		-	
Pro fees—acct, tax, and legal	9.5		9.5		-	
Provision for income tax expense	12.7		17.9		5.2	
Interest expense and amortization of debt discounts and fees	100.4		100.4		-	
Depreciation and amortization	94.7		95.5		0.8	
Loss on early extinguishment of debt	2.4		2.4		-	
Net noncash loss on disposal of assets	5.9		5.9		-	
Stock-based compensation expense	24.8		24.8		-	
Adjusted EBITDA [1]	$ 551.6		$ 557.6		$ 6.0	
Weighted average common shares outstanding:						
Basic		88.1		88.1		-
Diluted		102.1		102.1		-

(1) (2) – See notes on slide 101.