GOLDMAN SACHS LEVERAGED FINANCE CONFERENCE

HealthSouth Presentation

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Cindy Guan: -- anyone who's new to this story. Okay, great. I guess we'll -- thanks Doug for joining us.

Doug Coltharp: Sure.

Cindy Guan: Very pleased to have with us here today Doug Coltharp, CFO of HealthSouth and Ed Fay, Treasurer. HealthSouth is a leading provider of in-patient rehab as well as home health. Doug, I know you guys just had an earnings call and you have a very extensive investor deck on your Web site.

Doug Coltharp: We do.

Cindy Guan: But maybe if you could just start giving a broad overview of what you do and maybe a quick recap of the quarter before we go into Q&A?

Doug Coltharp: Sure, and as Cindy mentioned, there's a document that we have in the investor relations section of our Web site called the Investor Reference Book. It is a slide deck that covers a lot of background information on the company; it of course addresses our financial position, talks about the composition in the industry and gives an overview of the major regulatory factors as well. It's a brief document, up to about 124 slides. We update it on a quarterly basis to reflect the most recent financial results as well as any other changes to the business or anything pending on the regulatory front and so I would encourage you, if you have an interest in the company, to access that document, I think you will find it very helpful.

As Cindy mentioned, we reported our first -- our quarter results just a couple of weeks ago and really had an outstanding quarter on all fronts. Both of our business segments; the in-patient rehab segment and home health segment posted very strong volume gains and revenue growth. Part of that was driven by acquisitions that were consummated during the course of 2015 in each one of those two segments but we also posted very strong organic growth and same-store growth in both segments and we also -- and so revenue growth was in excess of 23% and EBITDA growth with an excess of 23% as well as we were able to translate a lot of that top-line growth with the bottom line growth getting leverage off of some of the key components of our operating expense.

One of the things that we think is a strong attribute of our company is that we generate a high and consistent level of free cash flow and that proved to be the case in the first

quarter as well. Our free cash flow on a year-over-year basis was up almost 65% and benefited, to some extent, by timing issues that have reversed themselves somewhat throughout the balance of the year but it was a strong quarter for free cash flow almost anyway that you look at it and in addition to making some investments in the business, that gave us the ability to reduce our funded debt by about $55 million, knocking three tenths of a point off of our leverage ratio from year-end. That was important to us because I mentioned some of the acquisition activity that we had in 2015 and we were actually rather inquisitive in 2014 and 2015. Had started those acquisitions with a balance sheet that was positioned to take on more debt so we funded those acquisitions with debt but as we ended 2015 we were in a position where we had as a priority reducing the leverage.

In terms of background information, Cindy in her introductory remarks mentioned that we are one of the countries largest providers of post-acute services. We do so through, again, two business segments; in-patient rehabilitation specialty hospitals and home health. We believe that those two businesses today are highly complimentary and will be even more so as we move forward.

Both of our business segments are focused on serving the Medicare beneficiary population. If you include Medicare Advantage, about 80% of our total revenues are related to Medicare. We have the number one overall market share in the IRF which is an acronym for in-patient rehabilitation facility market; and by a significant share as well.

There are two types of in-patient rehabilitation facilities that are operated in the U.S. that make up the IRF segment. In rough numbers, there are about 1250 total IRF's in the U.S. A little bit less than a thousand of those are units that would be housed within an acute care facility and then the balance of 250 or 260 are free-standing units. HealthSouth operates only freestanding units, we have 122 of those freestanding units today, the next largest aggregation within any single company we believe would probably be within Kindred and that's 19 or 20 units.

So we have, in excess, of 20% of the license beds in this space. We serve in excess of 20% of the Medicare patients who require care in an in-patient setting. Our home health business is a segment that we entered at the end of 2014. We bought a very high quality provider of home health services, again also focused on the Medicare beneficiary named Encompass Home Health and Hospice based in Dallas, Texas, founded by a woman named April Anthony who if you know anything about home health is somewhat legendary.

The business had been owned by April and her management team and was sponsored by (inaudible). They took that through an auction in the back-half of 2014 and we emerged as the acquirer. That segment out of a total of -- that segment will do about $600 million in revenue this year. It's the fourth largest Medicare provider of home health services in the U.S. And one of the reasons why we were so attracted to that business is that in excess of 55% of the patients who were discharged from an in-patient rehabilitation facility whether it's one of HealthSouth's facilities or another, require follow-on home health and so this puts us in a position to capture some of that revenue and also to provide

a continuum of care that we think leads to higher quality outcomes for the Medicare beneficiary population.

Cindy Guan: Okay, great. I know IRF is the bigger part of your segment but I actually wanted to start with home health because it's been the new kind of exciting growth part.

So on volume growth you had mentioned on the first quarter call that a lot of it was actually market share gain.

Doug Coltharp: Correct.

Cindy Guan: I guess I wanted to see if you could elaborate more on that. Is it from competing home health agencies, are you actually taking share maybe from other post acute providers like skilled nursing or where is that coming from?

Doug Coltharp: I think it's both. We're in a market particularly as BPCI, the bundled payment initiative continues to gain momentum and not really impacting the first quarter but beginning April 1 the CJR pilot, comprehensive joint replacement pilot, both are, I think, putting a lot of pressure on the lower acuity patients who have been getting in-patient care in the SNF setting. And I think that the home health business, particularly those that are able to treat a higher acuity patient, that's really been the focus of the Encompass business are triggering some disintermediation out of that space.

What we also find in the modus operandi for Encompass, even before our acquisition, is that they move into new markets by acquiring an existing agency. That has to be the case almost anywhere because most states either have a highly restrictive CON process or a moratorium on opening new agencies, so HealthSouth will acquire an existing agency that maybe has a small market share but doesn't have any quality issues; they implement their business processes, their technology solutions and are able to pretty quickly grow market share there.

Cindy Guan: You talk about being able -- a home health agency to be able to take that higher acuity level patient. There's been also a lot of talk about labor costs, how have you seen -- you know, as you go out and recruit for nurses that can handle the higher acuity, have you seen your labor costs change or has it been tougher with nurse shortages? Can you talk to us about the dynamics there?

Doug Coltharp: You know, we haven't seen a lot in terms of just straight out wage inflation related to supply and demand characteristics. That's always going to be determined on a market-by-market basis. What you have seen in both of our segments, because both of our segments are really focusing on the higher acuity patients that are serviced within each one of those segments is that we've been pushing the skills level up and as we move the licenses of our technicians or clinicians up there is some inflation that goes along with that, they're higher salary people.

On the home health side the other thing that is impacting overall wages and percentage of revenue is the higher therapy component of the patients that they're serving as a result of

their collaboration with HealthSouth. On average those therapists, the home health givers who are capable of providing the intensive therapy that many of the patients coming out of our facilities require are going to be higher earners and so what you see is that the cost per visit for our therapy patients goes up but so too does the revenue per visit and the margin is about the same.

Cindy Guan: Okay. That was actually going to be my next question that you've already answered, how have the margins maybe shifted as Encompass -- you integrate that more into the overlapped markets but it sounds like the increase in both the cost and revenue side are roughly similar.

Doug Coltharp: Yeah, the change of the business mix at Encompass that results from them taking on a higher therapy component isn't really going to impact the margins overall but we do think that it has a favorable impact on volume. In the first quarter we saw some margin erosion at Encompass on a year-over-year basis and that was really results of two things; one is, again for anybody who follows home healthcare, the home health is in the midst of a rebasing in terms of their Medicare pricing. There's one more year in 2017 of that to go that will be a 2.4% reduction to the annual market basket update. Recall that home health operates on a calendar year for its fiscal year. As you think about 2017 and beyond as well, in addition to the final year of rebasing in 2017, you've got the second year of the coding intensification adjustment, this is the first year of that which takes off another 90 basis points that will extend into 2018. And then looking all of the way out to 2018 in terms of the home health pricing environment; there's another 70 basis points that is related to the elimination of the [ruled] adjustment factor.

So, you know, what we experienced in the first quarter was a Medicare pricing decrease and that was then exacerbated to some extent by a change in the patient mix that just related to the integration of CareSouth which was a [large] acquisition that Encompass made in the fourth period of last year and there CareSouth has historically been focused on a slightly lower acuity patient and a lower margin.

Overtime, we expect that margin to get elevated as a result of two things; one is the CareSouth agencies will begin a closer collaboration with the HealthSouth IRF's and then we think there are opportunities in certain of the markets in which CareSouth is historically operated to increase market density and take on the higher acuity patients.

Cindy Guan: Okay, great. How do you think about the reimbursement outlook after you go through kind of the last year of the [phase-in]. You talk about the 70 basis points, should we at some point start getting just the market -- closer to the market basket updates every year?

Doug Coltharp: That's our anticipation. I think if you look at what the rebasing, what the coding intensification, what those things were intended to accomplish with regard to bending the cost curve for Medicare expenditures within home health, that's being accomplished.

I think what you're also seeing, and this is certainly a driver in it, you're seeing a pretty significant consolidation in the number of agencies that are out there. It's still a highly fragmented business which is, again, something that we found attractive as we entered

into the business with Encompass as a footprint and saw opportunities to expand our presence via acquisitions. But even today there are about 12,500 home health agencies operating in the U.S. and 95% of those have less than $5 million in annual revenue. I think as you get all of the way through the rebasing and have some of these other price reductions that we've talked about, you're going to see capacity come out of the business.

Cindy Guan: And do you think, you know, right now you have about 58% overlap in home health in your IRF markets, is the goal to get to 100% and is the easiest way to, as you say, as those capacities start coming out to acquire those assets or to Greenfield entry into that yourself?

Doug Coltharp: So the goal is to get to 100% but, you know, it's unlikely that we ever will get there and that is -- and yes, the mode to get there is going to be predominantly via acquisition and that is why we get asked the question a lot. When we look at acquiring a national player, somebody who had the footprint like an Amedisys or something like that, not quite national but a very large player and the answer is most likely not in addition to the leverage reduction target that we have in place right now, acquiring a business like that would mean that our home health locations leap frog in terms of the national footprint of the areas where we have an IRF and then we'd be left with the task of trying to backfill an order to get both services in a given market with the more capital intensive, more CON limiting business segment and that's not the objective.

So we think it's more going after smaller regional players, many one-off players to fill in those markets where we operate an IRF but don’t currently have a home health business.

Cindy Guan: What kind of multiple --

Doug Coltharp: Some of the reasons that we won't get to 100% overlap, as I mentioned, we have 122 freestanding hospitals right now. A little bit less than one-third of those, about 30% are operated in joint venture relationships with acute care hospitals. Being in the post-acute sector we get most of our patients referred to us from an acute care hospital. In the IRF sector it's more than 90% of the patients who come to us, come to us after a stay in an acute care hospital and there are a number of our JV partners who own and operate their own home health businesses.

So if we tried to acquire a business in that market, it might create tension in the JV relationship and so there are certain instances where we may choose not to do that but overall our objective is to get almost complete coverage so that we can offer that collaboration as a service to the Medicare patients in those markets.

Cindy Guan: I guess that's kind of -- my next question is kind of related to that idea of maybe conflict of interest and you talked about, in some markets, where you do have an IRF and in home health you talked about the idea of maybe that bundle capability as you go to market to the acute care discharge planner.

Do you encounter any conflict or when -- you know, from a competing IRF that was historically discharging into Encompass Home Health and now you're trying to discharge more of your own IRF discharged into that home health agency?

Doug Coltharp: We do not. Encompass' legacy business had very little focus on patients coming from an IRF sector.

Cindy Guan: Okay.

Doug Coltharp: And so there wasn't any market share really to be lost there. The most important thing to think about in terms of engaging in clinical collaboration between the two business segments is that by law, Medicare beneficiaries have to be offered choice about where they're heading next. That doesn't mean that in the IRF setting we can't have a preferred provider and have it be Encompass and, you know, what we do in terms of the clinical collaboration between our staffs is on average a patient spends about two weeks in one of our in-patient centers before they're discharged.

The discharge home can be an anxiety ridden timeframe for the patient and for their family because although they have made very substantial progress and are deemed ready to return to the home setting by an independent attending physician, these patients are older, they've been through a traumatic experience, they're going to be on multiple medications. If they're living at home without the direct assistance of the family member, it's an intimidating environment to go into and in most instances when they're being issued the discharge instructions those are very complex as well.

What we're able to do in -- under the title of clinical collaboration is we have Encompass in those markets where we have overlap; we have Encompass home health workers who are in our hospitals on a regular basis. And early in that patient stay, they can identify a patient who's likely to require home health services after they're discharged from us. And they begin to get to know the patient and understand their home setting. They begin to know the patient's family and understand who the caregivers are and who's involved and can really kind of provide a more gradual path to the discharge and have established relationship so they really do become the caregivers of choice when the patient has to make that decision following their discharge.

Cindy Guan: This is a little bit going out of order but when you mentioned mostly through acquisition to get the one-off in home health in your market, what kind of multiples are you seeing? Has that changed over the years?

Doug Coltharp: It really hasn't changed much over the last several years although the public comparables for home health companies are up which we appreciate because we are now one recently. It really hasn't changed the multiples for a lot of the smaller independent businesses that are out there and the multiple can vary pretty widely because we have some instances where a smaller player in the market is operating pretty efficiently. In those cases just because of the scale and so forth you'd see an average multiple that might be in the six or seven times. It's not unusual that we'll wind up with a multiple that looks very high on the surface and it's because although it's in an attractive market and you're buying a

license to be able to operate in that market, they've been operating inefficiently and have very little EBITDA. So you're really just buying the license more than you're buying the EBITDA. In those cases, again, the multiple can look artificially high.

Cindy Guan: Okay. I know with the CareSouth acquisition on the home health side, one of the strategies is to kind of bring some of the acuity levels up in pockets where it makes sense. On the IRF side, with the Reliant transaction, can you talk a little bit about the strategy there? I know they've historically had higher margins that you're making some investments there, where are those investments and what's the strategy there going forward?

Doug Coltharp: So what Cindy is referencing is I mentioned some of the acquisitions that we've made in 2015, at the beginning of the fourth quarter of 2015, we closed on the acquisition of a company called Reliant Hospital Partners which was a company that owned 11 freestanding rehabilitation hospitals and if you think back to what I mentioned previously about the fragmentation that existed in the IRF segment as well, where after our 122 freestanding hospitals the next largest aggregation is 19 within Kindred. There aren't a lot of portfolios of hospitals to be able to acquire out there. So to be able to acquire a company that had 11 was kind of a rare thing.

Most of those hospitals are in Texas where we already have a significant presence. We acquired a hospital as well in Ohio and then two up in Massachusetts. The Reliant hospitals that we acquired had been operating under a different business model than we had on the IRF sector, than the HealthSouth IRF sector. Our HealthSouth IRF's had been focused on that very high acuity patient and those patients tended to have a longer length of stay because of the conditions that we were treating. It required a higher level of clinical care so you would see that translate into a higher revenue per bed for our HealthSouth hospital, higher salaries and wages as a component of that and a lower EBITDA margin but because the hospitals were operating off of a higher revenue base, the EBITDA dollars generated by that facility were generally more productive than at the Reliant hospitals. Reliant operated concentrating on the lower end of the acuity spectrum for patients who qualified for admission into an IRF and they had a much lower length of stay and were able to staff the hospitals at a much lower level.

Ultimately we believe that converting the Reliant hospitals to HealthSouth model made the most sense for the longer-term. And a big reason for that is, again, the movement towards these bundled payment initiatives that are taking place which we think is going to continue to take kind of a lower acuity patient in each setting and move it downstream and so we felt like that a portion of the patient mix that Reliant was targeting, could be subject to disintermediation in a more integrated environment.

What we have been doing is, we have been adding staff and increasing the skills level at the Reliant hospitals. We had also made a proactive commitment beginning in 2011 to install an electronic medical record into all of our hospitals. We're not quite there yet, we're at about 87 of our 122 hospitals, have the EMR installed. Again, for those of you who are not overly familiar with post-acute you may not know this but the implementation of an electronic medical record was mandated by the Affordable Care

Act for acute care hospitals and provided that those installations were made and that things that were called meaningful use standards, the hospitals were subsidized for the adoption of the electronic medical record.

There was no such requirement for anybody in the post-acute sector to adopt an EMR, nor was there any subsidization provided under the Affordable Care Act. Nonetheless, again, because of the fact that virtually all of our patients come to us as a referral from an acute care hospital, we felt like a key to success in future delivery reform would be to be able to communicate with the hospitals through an electronic medical record proactively made the investment without any subsidization.

Reliant had not been in a position in terms of their capital to be able to do that so throughout this year, each one of the 11 hospitals that we acquired will be placed onto the electronic medical records. So it's predominantly staffing and the electronic medical record.

Cindy Guan: Over the last couple of years we've seen a big shift from kind of in-patient to out-visit, lower acuity stuff that's in-patient moving to out-patient. Is the move to home health the kind of next big schematic move you think from post-acute?

Doug Coltharp: Certainly, we think that home health is going to be a significant beneficiary of the disintermediation out of certain in-patent settings but I think really if you look at the three in-patient settings in the post-acute sector, LTAC, IRF's and SNF's, the segment that is at the greatest risk for disintermediation is the SNF's and you saw that show up in the first quarter reports for a number of the public companies that have a significant SNF [presence] and that happened in spite of the fact that CJR Pilot didn't begin until April 1.

Cindy Guan: It's safe to say that's not an area where you might be interested in?

Doug Coltharp: No, it is not. We do operate a number of SNF beds in several of our hospitals; it was really a result of legacy acquisitions. You know, again, our -- if you look at the patients that are being admitted to our IRF's and to all IRF's, recall that 100% of the patients that are admitted into an IRF setting, and again whether it's one of ours or one of our competitors, are required to meet medical necessity criteria as determined by an independent physician and that physician is making their clinical assessment that the patient can both tolerate and will benefit from the intensive multi-discipline therapy regime that is required to be administered in an IRF setting. They're also making a determination that that patient requires hospital level care. It's important to note that all of our hospitals, even though we're specialty hospitals, are licensed as acute care facilities and being licensed as acute care facilities we have to provide hospital level services which means we have to provide 24 hour a day, seven day a week nursing care. That's not a requirement in the SNF, it doesn't happen in the SNF.

We have to require that each one of our patients has a face-to-face meeting with their physician three times a week. There are many SNF's where a patient may see the physician once a month and, you know, frequently if you've got a 28-day length of stay

from a Medicare perspective that means that they may see the attending physician once during their entire visit.

Also, again, I mentioned the therapy regime that is administered in an IRF, we're required to provide, on average, three hours of therapy five days a week; the preponderance of which must be administered in an individual setting. None of those stipulations apply to the SNF setting as well. So the patient's, even those that are subject to DRG's that are in BPCI and CJR, the patients with those conditions who are finding their way into an IRF are -- it's because they have co-morbidities that are making them more medically complex and they require that high level of intensity in terms of care and it would be very difficult for any of those patients to bypass the in-patient setting altogether and move home. That's not the case when you look at the patients within those DRG's that are finding their way into SNF's.

Cindy Guan: A couple of years ago there was a lot of fear on reimbursement. That's kind of died down a little bit over the last year. How do you assess the risk of this like neutral discussion coming back, what are you hearing in D.C. on that front and do you think the outcome of the election either way changes that?

Doug Coltharp: You know, we think particularly on the IRF side, I mentioned on the home health side before that it's really been all about pricing and I think it's -- what the pricing is doing in terms of not only bending the cost curve there, it's putting pressure on a lot of smaller less capitalized players in that highly fragmented business where frankly Medicare was having a lot of trouble policing compliance. So I think they were accomplishing what they need to over there. Now, there is some talk about preauthorization, there's a lot of resistance in the industry to the whole preauthorization discussion, I think implementing preauthorization within the home health segment would be enormously difficult from a logistics perspective and I just don't see it happening anytime soon.

On the IRF side, we think we're in a relatively benign regulatory environment. You know, as we look out there from a pricing perspective, the mandated reduction to the market basket mandate will -- excuse me, the and/or market basket update will increase 75 basis points in each of the next two years but the good news is, you know, we are required to get a market basket update through 2020 as part of the Affordable Care Act.

We see the bundle payment initiatives that are out there both BPCI and CJR. We are an active participant in those. Again, we think any risk of disintermediation out of our IRF's from those is low and that the opportunity, the upside on the home health side is very significant and that's really it, we don't hear any more discussion and haven't recently about site neutral. Obviously embedded in the rule and related to the implementation of the IMPACT Act we see more of the quality reporting requirements coming out there. If you tie that back to the fact that we had proactively taken on the implementation of the electronic medical record, we think that that bodes well for us in terms of what happens in the industry because a lot of the smaller players in our industry who haven't made that investment are going to have a lot of trouble keeping up with those increasing requirements and those things have to get implemented as a result of the IMPACT Act frankly because we operate at such a premium in terms of the quality of the outcomes that

we produce and because we've had the investment of the technology, we welcome those additions.

In terms of what happens in Washington as an outcome of the election, I guess the good news, if there is any in the choices that we will be facing, is that I haven't heard either one of the candidates really talking a lot about appealing Obama Care or engaging in significant entitlement and reform. So, my guess is that regardless of which way it goes, you're going to wind up in another period of stasis and stalemate. There's not an overwhelming endorsement for either one of the candidates and I think what the electorate will do is ultimately balance out congress from the executive branch, much like we have today and you'll see a little bit of stasis.

Cindy Guan: Any questions from the audience? Okay, and this is a leverage finance conference but I did want to touch on your balance sheet and cash flow. You've been really chipping away at the [7 and 3/4] bond of 22 for some time now. Should we expect that bond to be fully repaid by year-end?

Doug Coltharp: Do you want to take this Ed? I'll give you a chance to --

Ed Fay: There's $76 million remaining under that note at this point in time. The calls we've done, we've done three consecutive calls, one per quarter for $50 million each. So we've been steadily ratcheting that down and we've been very happy to fund that underneath our revolver because as we're generating free cash we're able to make use of a $600 million revolver on which we only had $130 million drawn at the end of the first quarter in order to finance that.

So that's what we're financing this second drawer. This third drawer now that we're doing this in the second quarter, and our anticipation is that that's the way we would fund the balance of this and might it be done by the end of the year, that is a possibility but we have no immediate plans to take out the last $76 million for that note.

Doug Coltharp: We still have more delevering to be done during the course of this year to get below four times which is a target that we have publically expressed and obviously because that's the most expensive tranche of pre-payable debt that's out there. I think it's logical to assume that there will be further reductions in that note issue. Whether it gets to zero remains to be seen.

Cindy Guan: And I think you've always in your slides have talked about a long-term leverage target of three times. Now that you think we're in a more benign reimbursement environment, would you be comfortable staying at that four times leverage level for longer or ultimately you still think getting down to three is the preferred target?

Doug Coltharp: I don’t like four times. You know, I don’t like four times as a run rate of leverage simply because of the uncertainty that always is going to exist in a regulatory environment when your revenue base is 80%. Medicare, when you're going through the type of reformation and delivery system that we are, you know, that said, even in periods when the reimbursement environment has been difficult, even when faced with unexpected items

like sequestration, our free cash flow has remained enormously strong and our balance sheet is extremely well positioned.

We are really unprecedented in the post-acute provider space is the fact that we own about two-thirds of our real estate. We think that that gives us tremendous flexibility in terms of how we position our assets should some reconfiguration be required on a market-by market basis as a result of further implementation of delivery system reform. It also means that we're not subject to the kind of escalators and leases that have really haunted companies like Manor Care and others that are out there. I mean, if you look at -- leases are non-prepayable debt where the interest rate goes up on a regular basis regardless of the environment and that's not a position that we want to be in.

So, you know, I think four times though even with those caveats is probably a little high. We do think that three times is an appropriate longer-term target to have but recognize that the reason that we had positioned the balance sheet that way previously was to position ourselves to be able to utilize the balance sheet with the right opportunities to pursue additional growth opportunities. And so if we pull the leverage down to that level and we identify other growth opportunities, we'll use the capacity that's in the balance sheet.

Cindy Guan: Okay. If there are no more questions from the audience; Thank you Doug, thank you Ed for coming here, we appreciate your time.

Doug Coltharp: Thank you.