Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Good morning. I'm Whit Mayo, the Healthcare Facilities Analyst at Robert Baird. It's my pleasure to introduce a few members of the management team of HealthSouth. With us, we've got Chairman and Chief Executive Officer, Jay Grinney and Doug Coltharp, the Chief Financial Officer.

I think Jay is going to over a couple prepared remarks and go through a quick slide presentation. If you have any questions, there should be some slides on your – or some cards on the table. Feel free to write those and someone will come up and hand them to me. Otherwise, you can raise your hand.

But with that, Jay, thank you.

Jay Grinney, President and Chief Executive Officer

Great. Thank you, Whit. We also, with us, have Mary Ann Arico, who's our Chief Investor Relations Officer. She has for you both copies of this presentation and also what we published on a quarterly basis, which is an investor reference book. If you don't have that, you might find that to be a handy document and we update that on a quarterly basis.

So for those of you who are not familiar with HealthSouth, we're the largest provider of inpatient rehabilitative care in the country. We have 99 hospitals. We also offer some additional follow-on care for the patients that we treat, both on an outpatient basis and on a home health basis. The home care is limited primarily to therapy services for patients, who've been discharged from our hospitals.

You can see in the middle box down there at the bottom there, if you look at our company relative to the rest of the industry, we have about 8% of the total number of inpatient rehabilitation facilities; that's the designation given to us by Medicare, the acronym is IRF. You will also, from time to time, hear the term inpatient rehabilitation hospital, it's really interchangeable. There're about 1,150 IRFs nationwide. About 920 of those are actual departments or units of acute care hospitals to balance our free-standing hospitals; all of our facilities are freestanding hospitals.

As you can see from the next line down in terms of the number of beds, our hospitals tend to be larger, 8% of the number of facilities, we've got about 18% of the licensed beds and then more importantly, if you go drop all the way down and look at the number of patients served over the national market share, we've got about 23% share. So, another way of looking at that is one out of every five patients getting inpatient rehabilitative care in the United States gets that care at a HealthSouth Hospital. And that's despite the fact that by law, we're not allowed to be in the State of New York, we don't have a presence in Chicago and nor do we have a presence in Los Angeles, the three top markets.

So, we've got a pretty good reach and we're very proud of the services that we provide. The performance that we've had during the first six months, I think, reinforces the fact that the quality of care at our hospitals, we think, is unsurpassed. We really do believe that because our focus is exclusively on inpatient rehabilitative services, we're able to convince physicians, patients, family members that by coming to our hospitals, they have a much greater likelihood of recovering from the illnesses that they are suffering from. And as you saw from the previous slide, most of the patients we treat have some kind of neurological condition.

Maybe they've had a stroke. Maybe they – because of medical complications, they find themselves in a weakened state. They're not able to function independently. They get admitted to an acute care hospital, discharged to our care. They stay with us on average for about two weeks. We provide very intensive physical, occupational and speech therapy for those patients and then the goal is to discharge them directly to their homes and back into the community.

First six months of the year, volumes were up 4.5%. We got a little lift on pricing, so you can see revenues up 6%. The thing that we are very proud of is our hospitals are able to provide that care on a very

disciplined basis. We manage our costs very carefully, so we were able to leverage that cost structure and the new patients coming in to get EBITDA growth of 8.3% and then you go all the way down to EPS, you can see we came in at $0.79.

I'm not going to read the footnote for you, but I do think that it's appropriate for you to take a minute to see the year-over-year difference in EPS. On as reported basis, it's $0.74. Last year, $0.79, but that $0.74 does include $0.27 benefit and you can read that in the footnote. So the actual – if you were to sort of normalize, the increase is pretty significant.

So, everybody wants to know, how was the quarter looking and I would say the quarter is looking very good. We are only two months into it. We got another month to go, but we're feeling pretty good about the volumes that we're seeing. When we reported Q2 results, we talked about the second half of the year. The volumes is being up somewhere in the 2.5% to 3.5% range. As we look at the quarter, we're going to be trending to the higher end of that range. So we're very pleased with that and that's despite pretty tough comps, 5% last year.

We also went out and amended our credit agreement and as you see, we increased the size of the revolver, we eliminated the term loan and we extended the maturity. We're also out in the market today looking to raise $250 million. We use the proceeds to pay down about 10% of the outstanding balance on the 2018 notes and 2022 notes, 7.25%, 7.75%. We'll pay down what's outstanding under revolver and then we'll have some capacity going forward for other strategic and general purpose uses.

We also, in the quarter, went out and acquired a unit in San Antonio from CHRISTUS Health; brought that unit into our hospital. They're in San Antonio. And we continued the development on several de novos or new hospital projects. We're moving forward with the completion of the hospital in Ocala, began construction – continued construction actually in Littleton and Stuart, Florida, that's a partnership with Martin Health and then are moving forward with the permitting for a new hospital in Southwest Phoenix.

As you think about the company going forward, I think the de novo strategy is something that's important. We believe we can open at least four new hospitals each year in markets where there's a demand for inpatient rehabilitative care, but in inadequate supply. And as you think about how to model those new hospitals, we wanted to provide some information for you here.

As you can see, the capital cost is somewhere in the $17 million to $22 million range. There are some start-up costs associated with it. So as you think about the overall company going forward, we're out opening say four new hospitals a year, there will be some effect on our operating expenses as we ramp those up.

And then, from a revenue standpoint, as you see in the upper right hand box, the first 30 patients that we treat, we treat with no reimbursement and that's to get our Medicare certification. So, there is some drag on those new hospitals early on, but as you have seen in the past, we can bring those hospitals on pretty quickly. And within somewhere in the four to eight, nine months, hospitals that we open are at a position of being positive from an EBITDA standpoint going forward.

And as we look at our guidance at the end of the second quarter, we did increase guidance for the balance of the year. We moved our EBITDA range from $487 million to $495 million, EPS up from $1.45 to $1.50. You can see what some of the assumptions are that we use when we put this updated guidance together and we're just confirming that today.

So, in conclusion, I just want to say that I think we've got a company that has some pretty compelling fundamentals. We're in a great business. It's an industry that's growing about 2%, 2.25% per year, that's driven primarily by demographics as you saw from the earlier slide. Most of our patients are Medicare eligible. Most of them are dealing with some kind of medical condition that is limiting their ability to function independently. We're able to get in, help them and get them back into their normal activities, resuming their lives, joining their families.

We do have the leading position in that space and we are very proud of that and believe that that's a function of the quality of care and the fact that that's all we do. We focus on that exclusively. We're also able to offer that service on a very cost-effective basis. And so as you think about what the value proposition that all healthcare providers are looking for, payers are looking for, we as a country are looking for, are those who can provide high-quality, cost-effective care. And we believe that we hit both of those.

We own most of our hospitals. We do have some that are leased and over the next couple years, some of those leases are going to be up for renewal or buyout. We are going to be looking to take control of those assets and use some of the cash that we're generating to buy those hospitals, so we can control them on a go-forward basis. And as you know, we've got a very strong balance sheet. When I got here in 2004, we were almost seven times levered. Today, we're 2.6 times. So we've taken a lot of – put a lot of focus on our balance sheet, taken a lot of actions to position the company to be strong and flexible going into what I think is going to be a pretty challenging environment over the next several years.

And then, finally, we do think that there are some very compelling growth opportunities, both on the de novo side and on the acquisition side. The acquisitions will be one-offs. There'll be other inpatient rehabilitation facilities, either free-standing, there are obviously fewer of those, or looking, as we did in San Antonio, to purchase a unit in an existing market, bring that business into our existing hospital, the seller then signs a non-compete, reuses that space for acute care purposes and essentially, we're taking some capacity out of the market. So we think that there's a lot of good growth opportunities above and beyond just the organic growth opportunities that are out there by virtue of the aging population.

So I wanted to provide that quick overview of the company and then we'll open it up for questions

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Great. Jay, thanks a lot. I really appreciate. Maybe just to start with the financing announcement this morning, maybe for Doug, can you give a little bit more detail on how much of the 2018s and 2022s you're taking down and how much full capacity dry powder you'll have after that refinancing? And then maybe comment on kind of the capital structure going forward.

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

Yeah, absolutely and recognize, we are somewhat limited in terms of what we can say, because we're in the midst of the securities offering. But we are in the market today with $250 million in new senior notes. The intent is that we would utilize those proceeds initially to replenish the capacity under our revolving credit facility.

One of the slides that Jay covered showed that earlier this summer, we were able to successfully refinance our bank facility. We took what was a $500 million revolving credit facility and $100 million term loan facility that were both due in 2016, combined those into a new $600-million revolving credit facility now due in the third quarter of 2017 and lowered the interest rate substantially when we did that. That leaves us with about $195 million outstanding under that new revolver and the proceeds will pay that down again replenishing the capacity.

The residual proceeds will be used to call 10% of the outstanding amount under our existing 2018 and 2022 senior notes. Both of those are roughly in the $300-million range. The 2018 is a little bit higher than that, the 2022 is right there.

When we issued those notes, we were able to get a provision that allowed us in the first three years to call up to 10% of the amount then outstanding in any 12-month period at a fixed price of 103. And obviously, giving the rates that are available in the market right now, it's attractive for us to exercise that option.

So that will then leave us with what we think is a very well-balanced debt capital structure. We'll have that revolver with full capacity as our first maturity in 2017 and then relatively even disbursements of senior notes two years apart in 2018, 2020, 2022 and then beyond with the new issuance.

Jay Grinney, President and Chief Executive Officer

And if you go to page 58 of the investor reference book, you'll get an idea of what that maturity profile looks like today.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Great. Maybe just to talk about volumes, I mean I think you've produced some remarkably strong volumes relative to the peers and the broader healthcare universe in the past two to three years. And can you kind of talk about some of the initiatives underway, whether it's the bed expansions, de novos, team works, just what operation will you put into place that you think is driving that and what you expect the long-term admission growth rates to be?

Jay Grinney, President and Chief Executive Officer

Yeah. So the bedrock of our volume growth is the fact that we focus exclusively on inpatient rehabilitation. And as such, we're able to demonstrate to physicians, to case managers, to patients, to family members that all outcomes are superior to other alternatives in the marketplace. And we do that very specifically with physicians by demonstrating to them the success that we show with each of their patients. So every patient that's discharged, the physician gets a spidergram on the FIN score, shows where they were at the admission, where they were at discharge the progress that they were able to achieve.

So, first of all, we have a good product to sell. Second is we've standardized the process by which we market those services. And that is a marketing that is directed to physicians, to care managers in acute care hospitals and then to patients ultimately, because they have the choice of where they go and to their family members.

We standardized that in 2007, 2008; spent a lot of time, a lot of money. And so that approach, everything from identifying a potential patient to getting that patient in the bed has been standardized across all of our hospitals, with the focus on being able to turn around the decision of whether or not the patient qualifies, turning that around very quickly to the care manager, the physician and the patients, so they know where they're going to go.

On top of that, we have continued to enhance not only the clinical programs, but last year, we unveiled an additional approach of standardizing what we do with our care management. And so, there we said, let's look at everything that happens from the minute we identify that a patient qualifies to the point that they are discharged and at home and are there ways to look at best practices to then standardize those best practices and to then promulgate them across the entire portfolio, which we have done and we'll continue to do that into 2013.

So, there's no one single thing that we've done that you point to that and say, okay, that's what's driving the above market growth. It's really a combination. If I had to identify one, however, that we could not do without, it's really the quality and the outcome result that we've been able to achieve. That's really what drives our business..

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Got it. I wanted to talk about the clinical investments that you're making for a second with Cerner. I don't think you get enough credit for, there's a stroke of genius or you just don't enough to do with your cash right now. But can you talk about how this really positions you long-term and can you go over the – I mean, you're not getting reimbursed for it...

Jay Grinney, President and Chief Executive Officer

Right.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

You're not getting reimbursed, your not getting HITECH dollars. You'll be the only post-acute care provider in each of your market that will be linked in with the physicians and the hospitals with medical records. So you maybe help us understand from a board discussion how you got there and going forward the benefits you expect to achieve.

Jay Grinney, President and Chief Executive Officer

Yeah. And I think that if you look on page 73 and there are couple pages there that talks about the implementation of this electronic medical record. We did go with Cerner. They had a rehab-specific program that they had installed at the Rehabilitation Institute of Chicago. We spent a lot of time up there with them, spent a lot of time with the Cerner folks and tailored their product to meet our needs.

So the return on investment there, we think, is really sort of multifaceted. Number one, we do believe that with an electronic medical record, outcomes will be enhanced; error rates will go down specifically medication error rates. So we think that there is an enhancement to the quality that we're already providing.

Number two, there is going to be some ability to streamline the whole documentation process. So the nurses, the therapists, the physicians all have the ability to access the medical records simultaneously. So the efficiency that we'll generate there, I think, accrues to the benefit of the patient. So instead of the nurse looking for that medical record to chart, they can chart on a real-time basis and spend that time with the patient.

I think the other benefit, frankly, as we look down the road, is the opportunity to link with the acute-care referring hospitals and conceivably even with the physician offices to share the clinical information that will be needed to optimize the care of those patients.

And as we had mentioned, we don't get any HITECH payment for that. They're only certain – a limited number of dollars. They couldn't put in rehab providers, behavioral health providers, et cetera. They're limited to acute-care hospitals. And we made the decision frankly and told the board, we feel we have to make this investment; we're going to spread it out over the next five years; we'll bringing on about 20 hospitals each year, but we just – we need to put this investment into the hospitals for the reasons that I just mentioned.

And I think that as we look down the road three to five years, it's hard to imagine providers not having that capability. And what we don't want to do is find ourselves three, five years down the road just now starting to catch up with the rest of the acute-care world.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Got it. Okay. Got a couple questions from the audience. I might paraphrase, capitated arrangements with payers, the world appears to be kind of moving in a more at risk environment maybe.

Jay Grinney, President and Chief Executive Officer

Yep.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Just any comments on – any arrangements you have with managed care today and if you just want to touch on any of the immediate near-term reimbursement...?

Jay Grinney, President and Chief Executive Officer

Yeah, I agree that the industry appears to be moving in that direction. What we're seeing is that it's a slow adoption. We've got about – a third of our hospitals are in some kind of joint venture arrangement today. And many of those joint venture partners are very large sophisticated systems.

Geisinger is a good example. Vanderbilt is another example, Barnes-Jewish in St. Louis, University of Missouri, and then we have partnerships with large systems that are not necessarily academic medical centers.

None of them have gone in full-throe adoption of ACOs or bundled payments or capitated arrangements in large part, because, I think, people are still smarting a little bit from what happened in the 1990s and wondering is it really going to be different this go around.

Having said that, what we have said is we want to participate, we want to put our toe in the water. We think we can bring to the table not only a superior quality, but we also believe that we can provide very effective cost to that provision of care. So we don't have any formal arrangements today. I think it's fair to say we've got maybe half-a-dozen discussions underway as the acute care hospitals are slowly starting to think about, do we go all in, maybe we take risk for a specific product line, maybe it's strokes, maybe it's some other condition.

But we're definitely at the table, but I think the – I don't believe this is going to be a revolutionary change. I think this is going to be an evolutionary change. And, frankly, I think whatever we see happening next year, when all providers are going to have to deal with sequestration and the fact that that's on top of the Affordable Care Act pay-fors, I think that's really going to create a very different dynamic for all providers.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Yes, absolutely. The other question I have here, again, we'll paraphrase, GOP administration, what does that mean for HealthSouth?

Jay Grinney, President and Chief Executive Officer

For what? What did you say it was?

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

GOP administration, White House.

Jay Grinney, President and Chief Executive Officer

Oh, GOP administration. I was – such a foreign concept. No, I don't – I think frankly that it's not so much, who is in the White House. I think really, for us, we're looking at who's going to control the Senate. Today, the Democrats have the gable in the Senate and nothing is happening. The House going in one direction and Senate doing nothing and that dynamic is really the dynamic that determines what kind of legislation gets passed.

So, if Romney gets in or Obama stays, I think that there'll be potentially some difference in the direction that's taken. I think that if the President stays, it's going to be business as usual, implement the Affordable

Care Act and we're really no different than we are right now. I think the bigger issue is going to be what will Washington do with the next debt-ceiling debate.

We saw that happened last year and it was really nothing. I mean, they just kind of kicked the can down the road. Now, we got sequestration, okay. Now, we've got a $16.4 trillion debt. We've got the debt ceiling. It's going to be breached again and there's going to have to be, I think, a national discussion on, okay, how long can we continue to kick the can down the road?

Again, I don't think it's so much who's in the White House, it's what is Congress going to be willing to do. And it's anybody's guess. I don't see a veto-proof Senate either controlled by the Democrats or the Republicans. So, there's going to have to be some kind of compromise and my hope and our hope is that Congress does something substantive, Bowles-Simpson, Ryan-Wyden, I mean, we need to move to the ball forward and not just kind of kick the can down the road and try to pretend that these problems are going to be solved by themselves.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Yes. And I have two questions. I guess one, last year we dealt with a lot of stock volatility with the idea that maybe the 75% rule will be re-implemented. I would surmise that in any deficit conversation, somebody is going to throw that idea out as a plausible way to pay for this although bad policy. Maybe if you could comment on that and then, Doug, as want to throw out priorities with capital, free cash flow and if you could talk about buying back some of your preferred, and dividends, kind of what the thoughts are there.

Jay Grinney, President and Chief Executive

So, first of all, anybody thinks that we're going to solve our deficit and debt ceiling on the back of the 75% rule is very misguided. It was out there. It was a proposal. There's no traction for that in CMS. There's no traction for that in Congress. I think it was put out there as a placeholder.

Frankly, our hospitals today on average are north of 70% on the compliance threshold and that's really just because we're putting all the clinical focus on our neurological program, stroke programs, et cetera. So whether or not that pops up, who knows? I do think that the market, as it is prone to do in today's environment, way overreacted. I mean we were at $28 and then I think what...

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

$14?

Jay Grinney, President and Chief Executive Officer

Maybe six weeks later, we are at $13.85 and we were updating guidance, increasing guidance, had great quarter really result, so that makes no sense.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Yes, I agree.

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

Well, we are generating very high and consistent levels of free cash flow and then following today's securities offering, we'll also have very substantial liquidity in our revolving credit facility.

With regards to our priorities for investing the capital that the business has, the top priority is investing and expanding our franchise and inpatient rehabilitation. And the good news is that we have many avenues and many compelling opportunities to do so.

Working down that list of priorities, it really starts with expanding our existing hospitals. That's a very high return on capital and a low risk, because we're adding capacity in places where our presence is already established and where the demand for additional capacity is also established.

So we have stated previously that we have a target of adding 80 to 100 beds per year to our existing capacity.

Next on that list would be unit consolidations. And that's where we're able to purchase a unit from an acute-care facility, specifically one that is located in a market that is already housing one of our free-standing hospitals and then we consolidate that business into our plan. Again, that's a very high return on capital, because we're increasing the productivity of an additional – of an existing asset. And an example of where we did that was one that Jay mentioned in his comments, this summer; we closed on such an opportunity in San Antonio with the CHRISTUS Healthcare System.

Moving that list then, we would go to adding new hospitals. And there are two ways that we can do that, one is to acquire an existing free-standing hospital. If you think about the industry composition that Jay took us through, that's a little bit more challenging, because dispersion of hospitals beneath HealthSouth is very wide, and obviously, it takes a willing buyer and a willing seller and agreed-upon terms, but we're targeting two of those acquisitions a year and that would be consistent with the activity that we've had over the past several years and then de novos which gives us a little bit more control. We have been ramping up our de novo activity. So a little bit slow here in 2012 in terms of new openings with just one, but we're targeting approximately four per year in the years after.

When we move beyond investments in our core business, we look to things like the repurchase of outstanding securities. And as Whit mentioned just a moment ago on a year-to-date basis, we were able to repurchase approximately $45 million of our 6.5% convertible preferred. We'll continue to look at opportunities like that. We'll continue to look across the capital structure at ways of improving our overall capitalization.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

And then the purchase of the lease properties.

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

Yeah. That's another good point. One of the things that we have done in the past as well and that we will have increased opportunities to do on a go-forward basis is to exercise purchase options that exist in the operating leases for certain of our facilities.

We always start from a very advantageous position with regard to our real estate holdings and that we own approximately two-thirds of our real estate and that's really unprecedented anywhere in the post-acute space.

Out of the residual 34, 35 leases that we have, a number of those have purchase options embedded in them. Approximately six of those will be exercised a little over the course of the next 18 months. There are really a couple of advantages that go along with purchasing that real estate. First is, it gives us complete control over the real estate.

In a limited number of circumstances that may involve also giving a hold of a license or a CON that maybe subject to yield-up provision, but it allows us to really manage the real estate portfolio in the way that we best see fit as opposed to having to ask for permission from a REIT partner or anybody else.

The second is that we're able to access funds at a rate that's much more attractive than the cap rates that are being offered today from REITs or that are existing in our current leases. And we also get away from

the annual escalators that are embedded in virtually all real estate leases, which can create additional margin pressure, particularly in the period of time when reimbursement conditions may be difficult.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Right.

Jay Grinney, President and Chief Executive Officer

And that prioritization is – that Doug just outlined for is on page 54 of the investor reference book.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Great. Guys, we're out of time.

Jay Grinney, President and Chief Executive Officer

Okay.

Whit Mayo, Analyst, Robert W. Baird & Co. Equity Capital Markets

Thank you so much for your presentation.

Jay Grinney, President and Chief Executive Officer

Great. Thanks, everyone.