Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

Okay, well I think we might be a little bit behind, the train's a little bit late pulling out of the station, but we'll go head and move on with our next presentation and fireside chat. We are very fortunate to have with us today, CEO, Jay Grinney with HealthSouth. Always a great – great got to spend some time with talking about healthcare and talking about golf too but I guess these folks probably want to talk more about healthcare.

So Jay, before we kind of go into our normal Q&A, I was just hoping you could just give a very brief snapshot overview of HealthSouth and kind of where your portfolio stands today and maybe a couple of points on your top strategies and then we'll get into some Q&A and we'd like to cover a lot of ground here quickly. So if you may have a question just raise your hand right in the middle of the conversation that'll be perfectly fine. So with that, Jay.

Jay Grinney, President and Chief Executive Officer

Great, thank you Frank. For those of you who don't have a copy, we just printed our most recent investor reference book, should be pretty handy guide for you answering a lot of questions about the company.

HealthSouth is the largest provider of inpatient rehabilitative care in the United States. For those of you, who may not be completely familiar with inpatient rehabilitation, it's a post acute service. We treat patients who have suffered from a stroke, some kind of chronic neurological condition that's debilitating hip fractures, spinal cord injuries, closed head injuries. Most of our patients are Medicare eligible. I would say 75%, 80% of our patients are Medicare patients and it's really just more a reflection of the fact that the older we get, the more the system starts to deteriorate, the more incidence for stroke, hip fractures and so on. And we treat these patients after they've been admitted and cared for in an acute-care hospital. They're discharge to our hospitals and then taken care for approximately two weeks, that's the average length of stay.

Our strategy, over the last several years has been to focus on deleveraging the balance sheet. So I guess at the end of 2007, our leverage ratio was over 5.5 times. We've taken that now down to 2.7 times at the end of 2011. So all the free cash flow or predominant amount of the free cash flow that we've been generating over the last several years has really gone to strengthen the balance sheet.

As we go into 2012, that strategy is now focusing on growth. And that growth is coming through de novos, new hospital constructions and then acquisitions of units, consolidating those into our portfolio. And when available, looking at other free-standing inpatient rehabilitation hospitals to acquire.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

Certainly, one of the more impressive things about your company and being a hospital guy I know you can appreciate this is that certainly the volume weakness we've seen in other sectors, you just don't seem to be seeing and have not seen. And certainly is there anything unique there that you see that really allows your volumes to hold up so much? How much of it is basically just taking market share and how sustainable you think this volume growth is?

Jay Grinney, President and Chief Executive Officer

Yeah, I think there are two things, one I think that and this is true for any healthcare provider, fundamentally you have to have a quality of products, the outcomes that you generate have to be superior. In our case, we are appealing to the medical necessity and the medical requirements of patients who have been in very

difficult circumstance. They had a stroke, they've had a hip fracture, they've got some kind of chronic condition that needs, where they need rehabilitative care. If we don't provide and demonstrate that we can provide superior outcomes as measured by our FIM gain and that's a measure we use in our industry to evaluate how independent the individual can function upon admission and upon discharge. And in the book, on page seven, there is a graph that shows how we compare to the rest of the industry. And our FIM gain, improvement in functioning capabilities upon admission and discharge, that gain consistently grows at a much faster rate and is higher than the rest of the industry.

So first and foremost, we have a product, a service that we think is superior. Second thing that we've done is we've put in place a standardized sales and marketing program that is standardized across all of our hospitals. We call that TeamWorks and that has really made a difference in really shortening the length of time that we can evaluate the patients, get the answer back to the case manger and admit the patient. And then the other thing that works in our favor, which is a little different than acute care, our patient base is primarily Medicare eligible people and as a result that whole population is growing about 2% a year. So you – we've got a demographic tailwind that actually helps to drive some of that volume.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

And more recently, it looks like pricing has gotten a little bit better too and I think maybe a part of that was due to an increase in acuity.

Jay Grinney, President and Chief Executive

Yeah that's right. What we have done over the last several years is to focus our clinical programs on those patients that are designated as compliant with let's call it the 60% rule. If anybody is not familiar with that rule, we can maybe address that in Q&A. But the 60% rule has a list of 13 qualifying conditions, and 60% of our patients have to come from one of those 13 qualifying conditions.

Those conditions tend to be stroke, neurological in nature. So we have and that's a mandate by Medicare. So we have created programs, clinical programs, clinical pathways and protocols that we've been disseminated across the platform to be able to provide a higher level of service for those patients. So part of it has been a deliberate shift.

Last year, we put in place a program to help standardize the pre-admission process, the post-admission care coordination, and then the standardized approach to discharge planning that again took best practices of our hospitals and refined them and then we disseminated that and implemented that across the entire company. That has helped us reduce the amount of patients who get transferred out of our hospitals into an acute care hospital. And the reason that's important from a pricing standpoint is every time the patient gets discharged to an acute care hospital, instead of getting the full Medicare payment, we get a partial payment. And so to the extent that we can reduce the number of acute care transfers, we see our pricing migrate to a full payment level.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

So that is a nice side effect of...

Jay Grinney, President and Chief Executive Officer

Yeah.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

And really you touched on this early, but certainly struck by just an amazing job you all have done since you've been on board there with the cash flow of this company, just from a few million dollars up to close to $250 million, so really amazing there in terms of the cash flow numbers. And great job using that cash to delever and really getting to the stronger, but going forward from here, I know you had a kind of a start and stop on de novo development, got a little head fake there from the some last fall with the Obama's budget proposal. But what gives you confidence now, that you didn't have maybe cause you to pause, what do you have confidence now that allows you to put the paddle back down and maybe even going a little bit faster on the de novos?

Jay Grinney, President and Chief Executive Officer

Well, a couple of things. First of all, the strategy itself is designed to be very flexible. So when we start a de novo, it's a $20 million investment on average to build a 40-bed hospital. That's our de novo model. It takes, if it's in a non-CON state, it takes maybe 15 months to put that in the ground. One of things that gives us confidence, so we can begin that process anew is that the doc fix is now in place. The prospect of some big Medicare reform that was looming last fall with the Budget Control Act and then the efforts to come up – the super committee to come up with a grand scheme or default into sequestration as we all know, defaulted into sequestration. So we now know what the landscape is going to look like in 2012 and 2013. So our push today is really designed to put new hospitals in the ground in 2012 and into 2013. We're going to continue to be aggressive on the de novo standpoint. But if we find say in middle of 2013, post election and all of a sudden there is – these big grand plans to completely change Medicare and we felt that that was going to adversely impact us. We'd be able to turn that and pick it off pretty quickly.

So our growth strategy is very flexible. We're looking at $20 million increments as opposed to looking at a company or a major acquisition where we're out there in kind of bedding the farm. We think that that makes no sense in today's environment.

So, we've got good visibility in 2012. We've got reasonable visibility in 2013. We've already factored in what sequestration is going to mean to us. We've talked about that previously. We think that the free cash flow deployment in growing the business makes the most sense and we're doing it because our leverage ratio now is down inside of our target or lead times.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

All right. On a related topic, using your comments about big acquisitions, but I mean are they one off assets or are they portfolios of smaller assets? I know we had a major transaction a few weeks ago with, I guess, Ernest Health and Medical Properties Trust?

Jay Grinney, President and Chief Executive Officer

Medical Properties Trust, yeah.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

Was acquired by Medical Properties Trust down in Birmingham. But does that kind of help you or hurt you when you see trends go up like that and where are the opportunities you're seeing?

Jay Grinney, President and Chief Executive Officer

Well, first of all, I don't know exactly what the multiple of that acquisition was but I can do a ballpark number. I just want to go on record of saying we think we ought to get that same multiple because I think it was like a 10 times.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

Right. When you said, you said $20 million to build, how many bed, 40 beds?

Jay Grinney, President and Chief Executive Officer

Yeah. So it was – it's a pretty hefty multiple. And I think the way to look at it is – they – it was a $400 million acquisition with basically $7 million of equity. So it's a pretty leveraging transaction, but it's a different owner.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

Right, so it has a different structure?

Jay Grinney, President and Chief Executive Officer

Yeah, it's a very, very different structure. So going back to your question, do we see more acquisitions? What we're seeing is a growing awareness among our competitors and most of our competitors are not for profit hospitals who have a rehabilitation unit inside their hospital, maybe 20 beds, may be 25 beds. What we're seeing is many of those hospitals and many of those systems are adjusting to the Obamacare pay fors pricing reduction for Medicare. They are anticipating what is going to be like next year with sequestration and they're realizing that the ability to be all things to all people is very limited. Very few systems have the financial wherewithal to say we can have a lot of loss leaders in our portfolio. ER is going to be a loss leader, maybe obstetrics is a loss leader, rehab is a loss leader, maybe SNF is a loss leader. I'm a big hospital acute care guy, I can't do that anymore. I have to start saying what can I monetize, what can I joint venture, what can I just – what businesses do I need to get out of. That's where we think over the next several years, there's going to be an increasing opportunity to either acquire those in markets where we have a presence and consolidate that into our hospital. We did that in Little Rock. So we can do that and have those transactions be extremely accretive. And that's where I think that there is going be some very interesting opportunities over the next several years.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

There has been this – you all commented about in earnings calls of late about this sort of increasing payor scrutiny, medical necessity claims review really and seeing a little bit of a – very modest impact income statement wise but probably a little more on the cash flow side. What do you, I mean given the fact that you've got the criteria for getting paid as an IRF has been tightened up. I mean what do you think is the issue, why does this seem to be a continual, it all seems to be related to medical necessity and doesn't the 60% rule capture in theory the medical necessity?

Jay Grinney, President and Chief Executive Officer

Yeah, it really does and it should. First of all the – to just put it in perspective, we have today under the current fiscal intermediary structure of Medicare we have about 70% of our hospitals being administered through a single FI. And it's the Cahaba FI. It's a Blue Cross subsidiary there in Birmingham. We had made the decision when CMS said, we're going from the FI infrastructure to the MAC structure, we made the decision that when that transition occurs, we will go to a diversified approach where each hospital will be administered by the MAC, that gets the contract for that geographic area. So over time, we will see the number of our hospitals being administrated by Cahaba going down.

Cahaba is the only FI that has really stepped up their review on medical necessity. We really don't know why, but I'm sure all of the rehabilitation providers that they administer are probably scratching their head and saying what is the big issue with Cahaba and why are they looking at it. We win the vast majority of these and so what happens is they say here is a diagnosis and we're going to be reviewing every single patient that comes in under that diagnosis and they tell us that proactively. So we say all right, we're only taking patients who need the care, meet the medical necessity criteria. We bring them in. The physician says they need the care, we assess that they need the care, we provide the care. We send them the bill, they say, as we told you, we're going to be reviewing these for medical necessity.

So immediately, we start accruing those for bad debt, they look at it, they may say, you know we need a little more information. We exchange information, they either decide okay, it meets medical necessity or they continue to say no, this doesn't really meet medical necessity.

We then have the opportunity to pursue this and to do so in a very formal process with an administrative law judge. The problem that we're finding is that the number of administrative law judges nationwide, not just looking at rehab, just nationwide is going down. There's huge vacancy. So the office in Ohio, I think, it's Cleveland, said okay, we're going to start bringing these together. We're going to start adding more ALJs to keep the process going. And we were very successful at litigating and getting these claims ultimately won in our favor. So, I think long-term, we just need to be, lessening our reliance on Cahaba for whatever reason they've got a Medical Director that just has a thing for rehab. They're not getting any more money and who knows why, but it is what it is. And so we know that's it just the cost of doing business, so we've got to deal with these guys and we've got very good documentation. It takes them a long time. I've actually sat down with the CEO of Blue Cross and said, do you guys know how much money you're spending, litigating these and you're losing 80% of them, why are you doing that? And he says, I can't talk to you, it's a subsidiary. There's Chinese wall, I can't really talk about it. So, it is what it is. It's not a big deal from a cash flow standpoint, but it could have an impact on our working capital this year.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

Sure. But you don't see anything, any kind of utilization review just on the commercial side, I know that...

Jay Grinney, President and Chief Executive Officer

Commercial side is different. I mean, commercial you just have to, it's much harder to get the patient in. There is more I think weariness on the managed care side to spend money on rehab. Although, we're starting to chip away at that, we're starting to help managed care companies understand, you can put a patient in a nursing home for 30 days at $400 million, $500 million a day. And you've got a 20% chance that those patients are going to come back into an acute care hospital or you know send him to a rehabilitation hospital maybe $800, $900, or $1000 a day therefore 10 to 14 days. And the likelihood of them being readmitted is very slow, very low. So that's kind of the approach we're taking with managed care and that's been successful.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

I've noted your reinvestment back in the business certainly have been very commendable and certainly now talking about a new clinical information technology system. Is this an investment decision that really relates to the positioning of the company for either ACO or post-acute or is it something you would have done anyway?

Jay Grinney, President and Chief Executive Officer

We would have done that anyway. I mean, the whole industry is moving in that direction. The fact that the acute care hospitals have some incentive with the high-tech payments, I think moved some of the not for profits may be along the integration line a little bit faster. We're not eligible for any of that support. So this investment is strictly out of our cash flow. The incremental operating expenses or expenses that we have to eat, but it's an investment. I mean, it's hard to imagine a hospital, any hospital five years from now, not having an electronic system of some type to manage the medical record. And certainly in the next seven years, I've just – I can't see it, I mean, our industry is really so far behind many, many other industries and so this is just an investment. It's like making sure you have a roof on the hospital that doesn't leak, it's a cost of doing business.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

I got you. On the cost side really you've done a remarkable job there. Margins are pretty good. What's left, are there any avenues on the cost management side that you can pursue or...?

Jay Grinney, President and Chief Executive Officer

Yeah, there are always opportunities. We're always looking for ways to provide a high quality care more efficiently. We're always looking at that labor metric. There's not going to be huge upside there. I think we manage things pretty tightly. Obviously there's always an opportunity on supplies to ratchet down, get more utilization of a standard list. But really our focus is not on finding ways to cut cost, the best way to deal with the metrics on the cost side is to bring more patients and do that on a very incrementally beneficial basis. And we've proven we can do that.

So our focus since 2007 has been, we've got a great product. Let's bring as many patients in as we possibly can. Let's manage those incremental patients in a very highly profitable way and grow in that way and so just cut, cut, cut.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

Sure. We're about out of time, I'll ask one last question, kind of a big picture. Is there a outcome, we've got an election coming up this year, kind of how you see the world? Do you think there's a particular scenario between President and Congress that might be better for the healthcare industry or might be better for the rehab industry?

Jay Grinney, President and Chief Executive Officer

Well I think, whatever happens in healthcare will be part of that. I don't think we're going to be targeted in anyway. I mean, I know that we've been targeted in the President's deficit reduction plan, in his budget but those are political documents as far as I'm concerned. I think the outcome for healthcare is going to be dependent on what happens in the Senate.

I don't think that White House really matters frankly. I think what happens – what we have to see is we have to see a Senate that is willing take some action. I mean think about, we don't have a budget; this country doesn't have a budget and hasn't had one for five years. It's because nothing is ever presented into the Senate. So if the Senate changes hands and there is more of a balance of Republicans in the Senate, I think we're going to then start to see Congress moving.

We're going to have to do something about our budget ceiling. We have to do something about our deficit and when is that going to happen, who knows. I think it's going to happen sooner rather than later because we're going to have to do that. And if we had the kinds of structural changes that were proposed say in Bowles-Simpson, everybody takes a little bit of the pain. But you moved the needle significantly in terms of means testing, raising the eligibility age, some of the other structural changes and to us that makes the most sense.

Frank G. Morgan, Analyst, RBC Capital Markets Equity Research

Okay, well thank you very much.

Jay Grinney, President and Chief Executive Officer

All right. You're welcome

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