HealthSouth Corp.

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Gary Lieberman: All right. Good morning, everybody. Welcome to day two of the Wells Fargo Healthcare Conference. I'm Gary Lieberman, Wells Fargo's healthcare facilities analyst. We're very happy today to be joined by HealthSouth. HealthSouth is the nation's largest provider of inpatient rehab healthcare services with over 100 inpatient rehabilitation hospitals, 20 outpatient rehabilitation satellites, and 25 hospital based home health agencies.

I have a number of questions. We have Jay Grinney, CEO, Doug Coltharp, CFO, and Mary Ann Arico, Chief Investor Relations. I have a number of questions for the company. If you'd like to ask a question, please put your hand up and we will get a microphone over to you. Alternatively, you can text me a question here and I can read it that way.

So my first question would be on the K that you put out yesterday. You said that volumes were solid in April and May. What other details could you give us on that?

Jay Grinney: Well, not really a lot of other commentary other than we're pleased with the way the second quarter is evolving. We obviously, along with other providers, had a little more challenging first quarter due to the very severe winter storms that hit many of our markets. But as we said on our Q1 earnings call, we saw a rebound as we began the quarter and yesterday's update further reinforced that second quarter looks good from the volumes standpoint.

Gary Lieberman: It looks like overall for the inpatient rehab, industry volumes have been mixed, but HealthSouth has consistently grown admissions in the 2.5% to 3.5% range. I've asked you this before, but is there -- do you see this slowing down any time soon or do you think that's going to continue?

Jay Grinney: No, we really don't. We think that that can continue. We're adding new facilities. We're adding new beds at existing facilities. The underlying demand profile for inpatient rehabilitative services is driven in large part by the aging of the population. 80% of our patients are Medicare eligible. As we all know, one of the inevitable consequences of getting older is that you're more susceptible to the kinds of conditions that ultimately result in inpatient rehabilitative care.

So the demand for inpatient rehabilitative services looks good for the long foreseeable future. We think we're in a position where we can continue to take market share. So we think that that growth rate is very sustainable.

Gary Lieberman: How do you see the regulatory environment playing out over the next few years? There seems to be noise every once in a while.

Jay Grinney: Yes.

Gary Lieberman: How do you see it, I guess, with the continuation of having to do DocDix? We've got elections coming up and so forth.

Jay Grinney: Yes, I think that the next big milestone is going to be in 2015 when the debt ceiling has to be revisited and at the same time, the DocDix will be revisited. How that gets resolved will be a reflection of what happens in the midterm elections this fall. But even if the republicans maintain their control of the house, took control of the Senate, they would still need to be able to pass legislation that would be veto proof, because the President will still be in the White House.

So how that debt ceiling DocDix gets resolved I think is anybody's guess. In the scenario where the republicans have control of the Senate and the House, it's not inconceivable that some strongly republican biased programs would be put in place. I don't know that the President would necessarily be in a position to sign those, in which case the can gets kicked down the road and whatever that showdown is in 2015 then is really setting the stage for both parties for the presidential election in 2016.

I wish, frankly, we could be more optimistic that there would be solutions to these issues, but if history is any guide, that optimism is probably not well founded. So our sense is that it gets kicked down the road and everybody then puts the eye on the prize for 2016, getting control of the White House. And if the republicans maintain their control of the House and the Senate then they're set up in 2017 to really try to solve some of these very important fiscal issues.

So what does that mean for us? It means that there's a fairly high likelihood that for the next several years, the regulatory environment is going to be pretty benign. And that's kind of our view of how the next couple years will unfold. Worst case scenario there's a DocDix, worst case. I mean best case scenario, there's a DocDix and the debt ceiling gets resolved in a responsible long-term way. The impact that that might have on providers is unknown, but we think we're in a very strong position to do well under almost any kind of scenario.

Gary Lieberman: The idea of site neutral payments comes up once in a while, whether it's in a budget or not. Do you have any clarity on what that means or what, where CMS is thinking about that?

Jay Grinney: Not a lot. We're getting some different reference points with respect to site neutral payments. Number one, it's been around a long time so it's not a new concept. Number two, you've seen Congress enact with CMS input site neutral type payments for different sectors, and most recently, you saw that with the LTACs. There are two markers out there that I think investors can look at. One is the bipartisan, bicameral Impact Act that was presented coming out of Ways and Means and Finance in the Senate that looked at site neutral payments within the context of post-acute payment reform. And in that Act, both parties and both committees were essentially saying this is really a complicated issue. There needs to be a common patient assessment tool to help measure and evaluate the kinds of patients that are going into the different post-acute payment delivery systems. And by 2020 or 2022, we Congress expect that CMS would come up with some sort of reform to address post-acute payments.

That's one marker. Everybody acknowledges that is it nothing other than a starting point and it's a very, very complicated and I think Congress is

acknowledging that. The other marker is the most recent MedPAC report that just came out last Friday talking about post-acute payment systems, site neutral payments. In that report, MedPAC was saying again, this is very, very complicated. If you look specifically at IRF and SNF patients, there's an acknowledgement that IRFs treat a much higher acuity stroke patient. So we're going to focus only on orthopedic and focusing on hip replacements and knee replacements, and then hip fractures.

So you get down to that level. Then they're saying, okay, if you look at knees and hips, there are certain patients who are treated for the same kind of conditions in IRFs and SNFs. We ought to come up with some kind of site neutral payment. And then if you look at hip fractures, do the same thing. Knees had hips represent about 6%, 6.5% of our business. Maybe we would see some degradation in pricing on the existing patients, but presumably in a site neutral environment, and MedPAC is recommending this, the regulatory constraints that we operate under, the three hour rule, physician visits, et cetera would be eliminated, which would actually give us a growth opportunity to get in and to take care of patients that are currently being forced into or choosing to go to a skilled nursing facility.

Then you look at the hip fractures. MedPAC is estimating that IRFs would actually do better from a pricing standpoint for hip fractures. So the idea that site neutral payments are automatically a negative for us, we do not expect that at all. And so we're kind of excited that it's moving down that path. We don't see it happening anytime soon, but clearly, the momentum is building to at least experiment with and test site neutral models. We would be delighted to be part of that. We think it could be very positive for us from the volume standpoint and more importantly, much more importantly, we think it'd be better for patients from a quality standpoint.

Gary Lieberman: So assuming that we get some kind of reimbursement clarity, whatever that means, what other lines of business does it make sense for HealthSouth or might it make sense for HealthSouth to look to, whether that's SNF, or LTAC, or home health?

Jay Grinney: Well, we've said in the past that the services, adjacent services would be the ones that make the most sense, either long-term acute care or home health. SNF is a different animal. It's a very complicated service on the one hand. It's somewhat of a Medicaid repository for the elderly and the poor, sort of more of a convalescent type of service. They do offer some limited clinical services. So we're not interested in skilled nursing, but homecare and LTACs have been of interest in the past. They remain something that we continue to monitor; we continue to evaluate where there are opportunities.

The one thing we're finding, though, is we go out and we look to expand our rehab footprint and many of those development opportunities are joint venture arrangements with acute care hospitals or systems. We're not finding that our inability to bring all service, post-acute services to the table is a limiting factor.

So I think as we think down the road and as we talk to many of the acute care hospital providers, what they're really focusing on is quality. Who can provide the best quality in the rehab sector, or in the home health sector, or in the LTAC sector? The ability to offer all services is not as important. The ability to offer high quality services is extremely important. And then you complicate that with

a lot of -- the fact that a lot of those acute care hospitals and systems themselves have homecare capabilities. Maybe they already have an LTAC provider that they use or maybe even occupies a wing. They're really looking for who can add value from a quality standpoint. And so we don't see any compelling reason where we have to go into those adjacent services.

If and when the right circumstances presented themselves, if we thought that there was a good opportunity to improve our lie (ph) in the markets where we have a premise, homecare makes sense. LTACs makes sense. So we're always looking, but we're -- at this point, we're very comfortable continuing to build out our rehab platform and opportunistically looking for the right opportunities to expand into adjacent services.

Gary Lieberman: Questions?

Unidentified Audience Member: What do you view as the best opportunities to allow HealthSouth to grow their cash?

Jay Grinney: Well, I think what we've been able to accomplish is the path that we're on and the path that we're going to stay on. And that is to focus on providing, as I mentioned just a minute ago, the highest quality services in inpatient rehabilitative care and doing that on a cost effective basis. Expanding our existing hospitals where we have the opportunity to add beds incrementally and we are adding anywhere from 80 to 100. Some years it may actually be more than that, to our existing portfolio, which is the equivalent of two new 40 bed rehab facilities. We're going to continue to expand in new markets through acquisitions, through de novos, and we think that -- well, what' we've said is we can add four to six per year new facilities to the portfolio.

We've already announced that we're going to be adding four this year. I fully expect that there will be other opportunities to expand and to exceed that number. So that's really the trajectory we're on. We think that that's sustainable for a very good long time and we're actually very pleased with the growth opportunities and prospects for the company.

Unidentified Audience Member: Is there anything you could do to accelerate the acquisition growth?

Jay Grinney: We are actually ramping up some of the development capabilities, adding some more resources, and I believe that over the next 12 to 24 months, there's a good chance that you will see that that target range is bumped a little bit. We feel good about the development pipeline. Because it's so fragmented, most of the growth has to be one offs. So there's not a big portfolio of rehab facilities that we can go and purchase en masse. We have to go one off, one off, one off, but we feel pretty good about the pace that we're on. But we feel pretty good about the pace that we're on.

Unidentified Audience Member: What percentage of your facilities are operating close to full capacity and how long does it take to add additional beds when you decide to do that? And how do you think about the marginal profitability of additional beds at the facility?

Jay Grinney: At any given time, we may have 15 to 20 hospitals that are being evaluated for additional beds. And we have an every other week meeting where we're looking at bed additions, the status of those hospitals. Once the decision is made to bring those beds on, it's -- it could take anywhere from three months to 12

months depending on whether or not CONs are required, whether or not we have the physical space to add those beds in place or if we have to actually add bricks and mortar. And in terms of the profitability, all of our projects have an IRR pretax of 15%. It's not unusual to see the bed additions in the 30% plus. They're a very profitable way of adding capacity.

Gary Lieberman: What effect would capping outlier payments have on the broader industry?

Jay Grinney: Well, I think the outlier payments were designed to compensate providers for carrying for those medically complex patients. And that sounds great, and that's the right thing I think to look for. The reality is that the way the payments are structured or calculated, it's a cost to charge ratio. So you've got a lot of inefficient providers who are benefiting from outlier payments even though they are their case mix index, so the patients that they treat are at or below industry averages.

So I think what would happen is if you took that premium payment source out, it would expose the inefficiency in many of those providers who are benefiting from the outlier payments because their costs are high. Which, if those payments go away, would then put pressure on them to either become more efficient or they may go out of business, which would create I think growth opportunities for us.

But we do think it's -- outlier payments were designed with the right intent but the means by which those payments are determined is a formula that can be, frankly, can mask inefficiencies and really kind of rewards the high cost providers, not necessarily the providers who are offering more medically comprehensive care. It's just there -- the payments are going to, oftentimes, to the smaller inefficient providers and are really kind of propping them up.

Gary Lieberman: Question?

Unidentified Audience Member: What are your thoughts on the patient criteria rules for the LTACs and how might that impact HealthSouth?

Jay Grinney: I don't know how it's going to impact us. I think that the criteria were welcomed by the industry. It was a long time in coming. I'm not as persuaded as some that this creates a huge growth opportunity. That presupposes that patients who currently are in an alternative setting other than LTACs, that are being treated in an ICU for an extended period of time, that they're being shunted to another post-acute setting other than an LTAC. That's not the way it works in the real world. I mean the patients are in an ICU. When a determination is made where that patient has to go, more often than not it's being -- that decision is based on the clinical needs of that patient.

So it's not like there's a pent up demand for LTAC services that now the criteria is set is going to deem that. Furthermore, the 28 day length of stay still has to be achieved for the compliant cases. So I think there's going to be a very interesting transition over the next several years. I think it's going to put, my personal opinion is, I think it's going to put a lot of pressure on the LTAC industry. Some are going to do okay. There are going to be some that just, they don't have enough compliant cases and there aren't enough compliant cases in the market to meet that 50% threshold.

So I think if you really dig into the criteria and really look at it analytically, it's not all upside. I think there are a lot of challenges. So what does that mean for rehab providers? I don't know that it means a lot. Again, I go back to what I said a minute ago. From an admissions standpoint, or if you look at it from an acute care hospital or discharge status standpoint, those decisions are being made today based on clinical needs.

Now, the doctor isn't there sitting, thinking, I've got to think about the 60% rule or I've got to now think about patient criteria. They're just saying, I've got a patient. They need a post-acute setting and I want to have that patient go to the right setting to get the right care to get them home and back into their communities. And so I don't see a lot of impact on us.

Gary Lieberman: Okay. You mentioned home health is one of the areas that might make sense to move to. What's your plan in terms of whenever that becomes a priority? Sort of how you think about it either regionally or geographically?

Jay Grinney: So we've got 20 some home health agencies today. Many of them serve multiple markets. As I know you know and perhaps some of the shareholders know, there are moratoria in place in many states where you can't buy anymore or you can't get any new licenses that just put a hold on that. I think from a growth strategy standpoint, we still look at the next several years of rate compression for homecare and see that that's going to create a significant headwind for that space.

I think that that will then inevitably result in some dislocation for homecare providers. I don't think that we bottomed out in that sector. I think that there's more disruption to come, which creates opportunities down the road. If and when we do that, however, we're going to be interested in augmenting our existing portfolio with rehab services. It really doesn't make sense to go after a national provider and we've got rehab hospitals in Florida, and Texas, and Pennsylvania and they've got homecare providers in maybe Florida, North Dakota, and California. And there has to be that overlap, that market overlap to really create the benefit. If you don't have that, then you're buying into a challenging sector with significant regulatory headwinds with no synergies at the local level.

Gary Lieberman: Questions?

Unidentified Audience Member: Last year, the company did a Dutch tender and repurchased about $230 million worth of stock. You had about the same amount of cash on your balance sheet at the end of the first quarter. How do you think about whether a tender makes sense or just repurchasing shares back on the open market makes sense?

Jay Grinney: So that Doug doesn't ask why did he come up on the stage and not answer any questions, I'm going to ask him to take that one.

Doug Coltharp: And as Gary mentioned, in the first quarter of 2013, we lost the tender offer. We actually tendered for up to $350 million of our common stock. We were successful in getting about $234 million back. That represented about 9.5% of the amount that was then outstanding and that was at a price of $25.50, which represented almost a 50% premium over where the stock had been trading. And obviously, we've seen a nice movement of the stock upward since then.

Just a clarification, at the end of the first quarter we weren't sitting on $230 million of cash. I think what you meant is we had roughly the same amount of cash on our balance sheet as we did at the end of the first quarter last year. And clearly, we have the capacity to engage in similar types of transactions down the road. In addition to the cash on hand, our free cash flow generations remain very snug and we had almost the full amount of our $600 million revolving credit facility, which doesn't mature until mid-2018 available to us.

We did note in the first quarter that we had engaged some open market repurchase activity and we have noted along the way that we have now committed to a course of utilizing shareholder distributions, both in the form of continuing and repetitive share repurchases, as well as the quarterly cash dividend that we initiated in the second quarter of last year to augment the returns that we're generating off of the investment in our operating assets.

So I think you will see more of that type of activity in the future.

Gary Lieberman: Question?

Unidentified Audience Member: Can you talk a little bit about some of the operational benefits that you've achieved from your clinical information systems?

Jay Grinney: Yes, so we're one of the few post-acute providers making the investment in the clinical information system, electronic clinical information system. I think as most people know, we do not -- we're not eligible for any reimbursement or that investment. And so we think there are a couple benefits and I guess we now have that installed in 46 of our 103 hospitals. We'll have it fully implemented some time in 2017.

I think the biggest immediate benefit is improved coordination of care. We don't find nurses, therapists, physicians chasing around a medical record looking for it to be able to chart or to assess where the patient -- what the patient status is. It's on an electronic platform every can see that simultaneously. That also gives us the ability to enhance the team conferences that are required involving nurses, therapists, physicians in the coordinated care. So I think we're getting better outcomes. We also think that it will help us reduce medication errors. It's not a huge issue for acute care rehabilitation hospitals, but many of our patients are on complicated drug regimens. So this gives us the ability to ensure that they're getting the right medication and the right dose at the right time.

And then it also serves as an enhancement from our recruitment and retention efforts. Many of the therapists and nurses that we're recruiting are coming from settings where there's an electronic clinical information system and being able to walk into our hospitals with a similar kind of system is retention -- excuse me, recruitment tool.

Gary Lieberman: Would HealthSouth consider going private at some point and how do you think about that?

Jay Grinney: I think any company has to evaluate what's in the best interest of its shareholders at every given minute and every given minute they ought to be looking at the full range of those different scenarios. It's fair to say, we have no plans to do that but I think every company owes its shareholders that obligation to evaluate all aspects that are open to it.

In our case, we think the growth that we've been able to achieve, the shareholder friendly capital deployment strategy that we have is rewarding our shareholders accordingly. But as I said before, you always have to be thinking about are there benefits to a strategy that may involve going private. But we certainly don't have any plans to do that.

Gary Lieberman: We have about a minute and a half left so maybe I'll try to sneak in one final question. Healthcare reform, I don't know that HealthSouth is thought of as being a huge benefactor from it, but what are your thoughts in terms of healthcare reform and how it might impact the company?

Jay Grinney: It impacts us primarily on the pricing side and we've already baked that into -- well, we've dealt with it now for two years, three years, and we'll continue to do that going forward. We're part of the pay for (ph) so Affordable Care Act was put in place. Providers have to come up and come to the table and our contribution is reduced payments relative to what we otherwise would receive.

So we're not the beneficiary of seeing our bad debts go from 15% or 18% down to 5% like the acute care hospitals potentially might be if in fact those patients who were previously treated for free are now coming in with some kind of coverage, either through the exchange or through a commercial payer. So we really don’t' see much impact for us. In many ways, HealthSouth is really sort of in a single payer system today and our single payer happens to be Medicare. So we're pretty different than what you see on the acute care side. I would say that we have demonstrated that we can operate very efficiently, very effectively and compete both on quality and price in that system.

So we're comfortable where we are. We don't see much of an impact.

Gary Lieberman: Okay, great. I think that's going to do it for our time. Thanks very much for being here.

Jay Grinney: Great. Thanks, Gary.