PARTICIPANTS

Corporate Participants

Jay Grinney – President, Chief Executive Officer & Director, HealthSouth Corp.

MANAGEMENT DISCUSSION SECTION

Unverified Participant

[Abrupt Start] presentation today. We have with us, CEO Jay Grinney from HealthSouth Corporation. Welcome.

Jay Grinney, President, Chief Executive Officer & Director

Thank you. Good to be here.

<Q>: Before we get into our list of questions that we do on our survey, being a surprise over here, but we're doing our weather survey. So, we're asking people about, it's been a pretty tough first quarter of the year on the weather side. Theoretically speaking, is there any part of your business that might theoretically be affected, not telling you to necessarily comment, but some investors should at least consider when they think about the weather we've had so far?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. I mean, we are in 28 different states. We have a lot of facilities in states that are not accustomed to the kind of weather we've had this year. So, there has been some disruption. We don't anticipate any huge impact on volumes but, certainly, there has been a lot of disruptions in some of the Mid-Central states and in areas that, like I said, just don't see the kind of snow and ice and cold weather that we've had. I mean, personally, at the corporate office, we spent one night, 300 of us, huddled up because we didn't get home. And that's pretty unusual for Birmingham, Alabama.

<Q>: Wow. Okay, duly noted. 70% of your revenues, well, give or take a little bit, tied to the Medicare funding obviously. Could you comment what you think in terms of the outlook out of Washington, D.C. as on the Medicare funding front, particularly for the rehab sector, particularly with another doc fix coming down the road?

<A – Jay Grinney – HealthSouth Corp.>: Yeah, I think that the big question mark for all providers is going to be, is there going to be a doc fix? And if the answer is yes – and I think the answer inevitably will be some kind of yes. We had a nine-month kick-it-down until the end of this year. Maybe push it into early 2015. I think there's a remote chance based on what we're hearing that everybody can agree on how to pay for a larger fix of five-year. I think the 10-year fix is really off the table.

So, within that context, I think all providers need to be prepared to potentially have some kind of savings taken out of their payments to pay for the doc fix. I don't think that inpatient rehabilitation is going to be disproportionately targeted. Inpatient rehabilitation facilities represent about 1.2% of total Medicare spending.

So, there are some out there who are overly concerned about the impact on Earth that a doc fix might create, but the money just isn't there. They're not going to pay for the doc fix by coming after inpatient rehabilitation facilities. If they do anything, it will have to be across the board and, conceivably, there would be non-healthcare funding that could be used to pay for a doc fix.

But like I've said, what we're hearing is that if there's a consensus that's something needs to be done, there's agreement that the CBO scoring creates a very unique opportunity because it's in the $130 billion to $150 billion range where, historically, it's been as high as $350 billion, and so I think there are a lot of members who would love to take advantage of that scoring opportunity, if you will, but there's just not a consensus on how to pay for it.

<Q>: To agree, there seems to be some growing clarity in a lot of reimbursement and policy areas in post-acute, you've had rebasing has now incurred in home health, patient criteria in the LTAC space. So do any of these developments any way change your view about these sectors? In the past, you've talked about adding some assets or looking to some of these new areas and you ended up waiting, and it's turned out to be the right move. But what's your view of those areas now with this perception of better clarity?

<A – Jay Grinney – HealthSouth Corp.>: No, that's a great question. And it has provided some additional clarity. Certainly with respect to LTAC, as you know, we used to own and operate long-term acute care hospitals. We sold the last of those several years ago, not because we wanted to exit the business per se, but we are very focused on our balance sheet and we used the proceeds from that sale to help pay down some of our debt and get our leverage ratio down below 3 times which was a very important milestone and objective for us.

So the patient criteria has provided some clarity. As we all know, it will take several years for that to begin to play out. But that certainly gives us a little more favorable view on long-term acute care. Home health, we have at least one year of the rebasing that's out there. It wasn't as bad as what CMS had originally indicated, it could have been, but it's still a negative pricing update. And whenever you're going backwards on pricing, you need to get a lot of volume to drive that top line.

So, while it has provided some clarity, I wouldn't say that it is as clear as we would like to see it. And there needs to be at least another cycle of updates to determine what Medicare ultimately is going to be – how they're going to be positioning this rebasing for the balance of the three years that they're going to be looking at this.

But there's no question, it's a little more clear today than it was a year ago. And so, we've said that, A, there's no compelling reason where we have to go out and we have to go into other complementary post-acute services, no compelling reason whatsoever, in large part because our core business, inpatient rehabilitation, serves primarily a Medicare population that is growing at 3% per year. So there's a very, very nice demographic tailwind that's creating a very appealing demand profile out into the future for the next 20 years.

And in fact, I mean, there are some people who are concerned there's going to be a scarcity for the inpatient rehabilitation beds when that baby boom population really starts to hit the utilization age of 70 to 80 years old. So, there's no compelling reason to do that.

Our belief is that if the change is in the overall delivery system, moving to accountable care organizations or greater coordinated care, integrated care, in that kind of environment, there may be benefits to offering a fuller continuum of post-acute care. And if that's the case, adding some of these complementary services would make sense.

But frankly, our view is that the jury is still way out in terms of whether or not ACOs are going to be the mode of payment in the future. I mean, it's a very complicated type of organization that creates the initial results of all of the ACOs that have been formed. It's very spotty.

<Q>: All right.

<A – Jay Grinney – HealthSouth Corp.>: I mean, not everybody is saving money. Those that are, on average, are saving less than what it took them to set the ACOs up in the first place. We've done a lot of that in healthcare over the years, but those models are not necessarily sustainable models.

<Q>: Right. You segued right into my question about organic growth and obviously...

<A – Jay Grinney – HealthSouth Corp.>: Because of the print on your monitor is so big, I can read it.

<Q>: Well, I better make it smaller.

<A – Jay Grinney – HealthSouth Corp.>: Yeah, right.

<Q>: So, to complement that organic growth, obviously, there are a couple of options, de novos, there's acquisitions that you could make. So, any thoughts on kind of the rate at which you would look at de novo activity to help drive growth in the – any comments on that part of the growth story?

<A – Jay Grinney – HealthSouth Corp.>: Yeah. So, what we've been doing over the last couple of years is to focus the growth opportunities on our core business, inpatient rehabilitation. And what we've done is we've targeted four to six new inpatient rehabilitation facilities per year for the next several years. And we think we're on track for that. We'll have at least three. This year we have several new developments that we're pursuing.

Many of those new developments are brand-new hospitals but built-in partnership with an acute care hospital in a new market for us where that acute care hospital has a sizable market presence, an inpatient rehabilitation unit embedded in the hospital that is underperforming, not meeting the needs of the population in that community and not operating at an efficient level.

We have several conversations and negotiations under way to try to help those hospitals with their rehabilitation product line by taking that out of the hospital, creating a freestanding 40, 50, in some instances, maybe a little bit larger freestanding hospital that would then be a partnership arrangement between us and that acute care hospital.

And as you know, we have about a third of our hospitals today that are already in that kind of joint venture arrangement. So we've got a 25-year history of doing that; we've been very successful. We have some great partners out there: Geisinger; BJC in St. Louis; University of Virginia in Charlottesville, Virginia; University of Missouri; Martin Health down in Stuart, Florida. So we think that that's really an attractive way to continue our growth.

<Q>: Sure. Do you have any footprint left for expansions? Are there any markets where you can expand? Would you...

<A – Jay Grinney – HealthSouth Corp.>: Sure, oh yeah. I mean, we're looking at California, for example. That's a little harder to get too excited about just because the length of time required to get the permitting for a new hospital construction is pretty extensive.

But we do have. We've got land and we're going through the process in Modesto, California, and there's several other markets in California that we're looking at. We're looking at markets in the Midwest. We're looking at markets in the Southeast where we don't have a presence. We're looking at markets in the far Upper Midwest.

So we're looking anywhere where we believe there's a demand for inpatient rehabilitative services, and that typically is related to the number of Medicare-eligible people in that market, whether or not there's an existing supply of inpatient rehabilitation facilities to meet that demand and then what that growth rate is at that over-65 population.

And so, as you know, like I said before, population is aging pretty dramatically, 3% per year for the next 20 years. We think that there's a lot of opportunities out there.

<Q>: And you said 73 is your average age of your Medicare...

<A – Jay Grinney – HealthSouth Corp.>: Average age – well, actually, average age of our patient is about 73. The average age of our Medicare patient is closer to 77, 78. And so, there's not going to be – the long-term profile, demand profile for inpatient rehabilitation is pretty strong because, as you know, the baby boomers are just now hitting 65 or two years ago, I guess, they hit 65. So, we won't expect to see utilization from that cohort for several years.

<Q>: Right. Anyways, I want to jump back on, just a second, one area we didn't cover, looking at the other areas of post-acute care, I forgot to ask about skilled nursing. There's a lot of rehab that goes on in some of those. Is there any interest there?

<A – Jay Grinney – HealthSouth Corp.>: Not at the present time. I think that skilled nursing offers a very different type of rehabilitative care. In fact, it's more custodial care. I mean, they – and I'm not taking anything away from the skilled nursing facilities but it's just – it's very different. It's apples and oranges. In our hospitals, it's required that we have 24-hour-a-day, seven-day-a-week nursing care. A good number of our nurses are certified rehabilitation-registered nurses. They have to go through special training and certification to get that designation. We have physical therapists, occupational therapists, speech therapists that collectively provide three hours of therapy per day per patient. None of those requirements exist in a nursing home.

So, they may get some limited therapy. But for the acutely ill complex patients that we're seeing, the only site that really makes sense is inpatient rehabilitation.

So, at the current time, nursing homes are not that attractive. But as we continue to look down the road, 5 years or 10 years, we're going to continually assess what do we think the demand is going to be from payers and then what is the need out there in terms of just demographics and underlying epidemiology of the markets we serve.

<Q>: Sure. The cash flow and the free cash flow for your company is really quite remarkable in the year, and it looks like you have another good year in terms of free cash flow generation. In a lot of all these areas of growth that we've talked about, considering those along with things like dividend, share repurchases, balance sheet opportunities to bring assets back on the books, how would you prioritize it from that perspective?

<A – Jay Grinney – HealthSouth Corp.>: Well, we have prioritized that. For those of you in the room, we have an Investor Reference Book for you. If you turn to page 57 – and for those of you who may be listening in, the Investor Reference Book is available through our website. Just to frame the adjusted free cash flow equation for you, you can see on 57 some of the assumptions that we have outlined as the uses of our EBITDA or cash from operations before we get to the free cash flow.

And then if you look at – so you can do the math, you can take our guidance range and subtract those numbers. You can then go to page 58, look at what we're assuming will be some of the free cash flow spend in 2014. And you can see that if you take that EBITDA, you take away some of the assumptions on page 57 and then deduct that bed addition, which we think is a very, very appealing way to invest cash into our business at existing hospitals, known markets. We have a very good sense of what the demand looks like. We're running out of beds. We're investing in new capacity in those markets, great return. As I've said before, four to six new ERPs per year. We're expecting to spend somewhere in the $55 million, $75 million range.

So if you do the math, you're sitting with a lot of excess cash flow depending on what kind of assumptions you want to take that can then be devoted to the bottom two areas, reducing debt, either paying down, which we don't really have many opportunities to do. Our leverage is below 3 times, that we don't have any near-term maturities. And if you wanted to just look at it, the maturity profile, go to page 62 in the IRB so you have a sense of what the capital structure looks like. So then the balance can be directed to dividends and share buybacks.

Last year was the first year that we're in a position to really execute on that strategy element. And I'm hoping that existing shareholders and potential shareholders were pleased with what we are able to do in 2014. And as we said then and we're saying again today and in 2014, this is going to be an active part of our strategy going forward. At the end of the day, we're going to have a lot of cash left over. We're going to be returning that cash to our shareholders.

<Q>: Sure. And I know at one point, you all had – wanted to keep the war chest for the repurchase program. To the extent you saw any pullback with all the headline noise out of Washington, D.C., has that changed or are you ready to – how do you think about it in terms of knowing that the Washington cloud is out there...

<A – Jay Grinney – HealthSouth Corp.>: Yeah. I think we'll talk about share buybacks once the quarter is completed. But I think it's fair to say that the uncertainty that we expressed earlier this year is still there because, as we had mentioned a minute ago, the doc fix has not been resolved...

<Q>: Sure.

<A – Jay Grinney – HealthSouth Corp.>: ...and won't be presumably until the end of March. So, we've seen things come out of Washington that's created a lot of volatility in our stock; we don't understand why, but we certainly now are in a position to do something about it.

<Q>: Sure.

<A – Jay Grinney – HealthSouth Corp.>: In 2011, when that happened, we didn't have a repurchase authorization in place, and it was a very different story. Today, we're a much stronger company, and we have a lot of offensive weapons at our disposal.

<Q>: Sure. Let's change gears a little bit and talk on the operational side. It's been interesting to watch how proactive you've been over the years with early investment in clinical information systems, and I know you're in the process of continuing that now. Kind of what is your long-term strategy? Why are you making the investment now and why are you being so proactive in this area?

<A – Jay Grinney – HealthSouth Corp.>: We just think it's the right thing to do to position our hospitals to be part of the new delivery system. And I'm not necessarily saying it's definitely going to be ACOs or bundled payments although a portion, I think, of Medicare payments will be in those kind of payment systems.

But increasingly, if we want to participate in a dynamic and high-quality healthcare delivery system, we need to be prepared to exchange information among providers, different providers. And our biggest referral source is going to be acute care hospitals. Well, they are compelled to put in electronic medical record systems. And with that, they have the capacity of sharing and potentially even facilitating admissions into post-acute settings. We want to be positioned to accept that information and be able to respond very quickly to discharge planners and discharging physicians' needs when it comes to an open debt, if you will, in a post-acute setting. But we think it's the right thing to do.

There's also just an HR-ish component. A lot of our therapists, a lot of our nurses are coming out of programs, especially the younger ones, where they're working on an electronic medical record system in their training site. And if they come into our hospital and they've never charted manually, it's all been electronic, that's a big jolt for them to kind of step back in time and to work the medical records like we've been working it for the last 100 years. So there's a strategic component in terms of positioning the hospitals. There's also an operational component in making sure that we're responsive to the expectations of our employees.

And then finally, we do think that the EMR is going to help us provide a better quality outcome, reduce medication errors, et cetera. So there are a lot of reasons why we're doing it, we just think it's the right

thing to do. Fortunately, we have a lot – we're generating a lot of cash and we have the ability to invest in something today.

<Q>: Sure. You referenced in the fourth quarter call some activity both around MAC and RAC audits and reconfiguring some geography on your P&L for that. But any updates you can provide there? I understand we – late last week, we got some news about suspension on RACs but is that in any way a positive for you?

<A – Jay Grinney – HealthSouth Corp.>: Yeah, of course. I think it's a positive for the entire industry. I really do. I think that the whole RAC audit process, while understandable in its objectives to try to discover overpayments and where there are problems, I think everyone would agree that it has not been structured as well as it could be. And right now our biggest concern is that we have RAC denials, RAC audit denials that we feel very confident are unjustified. And we are absolutely committed to working those through the administrative adjudication process. And it's wonderful that that process is available.

Unfortunately, there is a huge backlog. One of the reasons why they've suspended the RAC audits until the new contracts are let, and those contracts have not been let yet, because there's this huge inventory, just this building inventory of RAC audit denials that are being adjudicated. Well, sometimes, we're told that may take two to three years. Well, we think that's really almost unconstitutional that they're taking our money, and yet there's no recourse for us to get that money back. And so I think it's a big, big problem. I think CMS recognizes that. I think that the suspension is an acknowledgement of that.

For us, it's just new. I mean, the acute care guys have been dealing with this for a year. RAC auditors really didn't become a significant issue for us – and it's really not significant. I mean, we're looking at less than 1% of our claims in those hospitals where they've asked for medical records.

But it's new for us, and that's why we called it out. I mean, we took $4 million, we thought it was more appropriate to put these charges into contractual allowances than bad debts. We took $4 million, moved it out of bad debts into contractual allowance and then reserved another $4 million.

<Q>: Sure. Yes. Any questions from the audience?

<Q>: [Inaudible] (23:45-24:02)

<A – Jay Grinney – HealthSouth Corp.>: Unfortunately, there's not a single answer for that because our portfolio of 103 hospitals have very, very different physical plant configuration. All of our new hospitals are all private rooms. And in a private room hospital, you can get up to 90%. And at that point, you really need to start thinking about what kind of bed addition and when.

If you step back and look at our overall portfolio, where we have a mixture of private and semi-private and the preponderance of those beds are semi-private, that maximum level of occupancy is closer to 85%. And so when you get to 75%, 80% occupancy in that kind of situation, you start to look at bed addition requirements.

I think of the hospitals that we have that are, say, 50% less than that 85%, we have very, very few. So we're not sitting there with a lot of idle capacity. Some of our older, larger hospitals, we may have 20, 30 extra beds, but we don't have a lot of just idle capacity in our hospitals.

I mean, our average occupancy right now is probably 68%, 69%. If you look back – and it's in the IRB – you go back and look at what that has been trending over the last several years, you'll see that it remains fairly steady, but that's because we're adding beds. And so we build back up closer to that 70% boom and then we add some beds, occupancy goes down. I don't know if that is a response to your question.

<Q>: Yes, it is.

<A – Jay Grinney – HealthSouth Corp.>: Okay.

Unverified Participant

I think we're out of time, Jay. Thank you very much.

Jay Grinney, President, Chief Executive Officer & Director

We've got a breakout...

Unverified Participant

Right.

Jay Grinney, President, Chief Executive Officer & Director

...in the Stanford Room.

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