Andy Schenker, Analyst, Morgan Stanley & Co. LLC

So good morning, everyone. Thanks for joining us. I'm Andy Schenker, Morgan Stanley's Managed Care and Facilities Analyst. I'm pleased to have with me this morning Jay Grinney, CEO; and Doug Coltharp, CFO of HealthSouth today. Doug, thanks for being here with me today.

Jay Grinney, President and Chief Executive Officer

Thank you. Thank you for having us.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Real quick; please note that all important disclosures including personal holding disclosures and Morgan Stanley disclosures appear on the Morgan Stanley public website at morganstanley.com/researchdisclosures and as always we'd like to keep this as interactive as possible, so if anyone in the audience has a question, please raise your hand at any time and we will bring a microphone to you.

With that, maybe just kick it off, Jay or Doug if you could give us just a brief summary of HealthSouth and how you think the company is positioned well for the future.

Jay Grinney, President and Chief Executive Officer

Sure. And for those of you in the audience here, we do have an investor reference book available and then for those of you listening in, we can also – you can get that through the – our web page. The company, as you know, is the largest provider of inpatient rehabilitative care in the United States. We own and operate 103 hospitals in 28 different states. We have two in Puerto Rico. If you look at the company from a market share standpoint, we have about 7% of all inpatient rehabilitation facilities, but we provide care to about 20% of all patients in the United States receiving inpatient rehabilitative care and that's without having a presence in New York and only two hospitals, currently only two hospitals in the State of California.

So by far we're the largest provider as we look down the road and we think about the future of healthcare, we think those who can provide high quality, cost effective care are those who are going to succeed. We can demonstrate that both from a cost effectiveness standpoint and from a quality standpoint our portfolio of hospitals are at the top end of the range of performance. So we feel very good about where we're positioned. We've demonstrated over the last couple of years the ability to grow even when faced with situations like sequestration. So we feel that the company is well-positioned to continue to be successful.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Okay, great. Maybe jumping off on sequestration, maybe just jumping on the rate environment for inpatient rehab, the rates were actually kind of better than some other markets, but when you wrap in sequestration, few other things still not great. Maybe just highlight your expectations for the rate environment next year, I think, maybe looking out even further and then maybe commercial's a smaller portion, but any expectation there as well.

Jay Grinney, President and Chief Executive Officer

Sure. If you look to page 47 of the investor reference book, we've outlined what some of our expectations are on a volume standpoint looking at same-store, excluding acquisitions, would be somewhere in the 2.5% to 3.5%. We think that that's a very achievable number from a volume growth standpoint. We've obviously exceeded that every quarter, and we'll continue to try to do that, but from a pricing perspective, Medicare, which is about 80% of our revenues come from Medicare, this year we're going to get 2.6% market basket update, but that will then be reduced by two different Affordable Care Act related takeaways, 30 basis

points and then 50 basis points for productivity. If you look in the bottom right portion of that, you can see what we are expecting from a managed care perspective somewhere in that 2% to 4%, so you take the volume, you take these two pricing metrics and you can establish a pretty good top line projection.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Yeah. That makes sense. I mean, thinking – sticking with Medicare obviously, the regulatory environment is always kind of...

Jay Grinney, President and Chief Executive Officer

Yeah.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

...in flux on post-acute care but maybe there's obviously a few specific topics up for discussion right now, some movables, some non-specific codes, debate about maybe moving the 60% rule to 75%. Maybe if you could touch on some of those aspects and what the impact is to HealthSouth?

Jay Grinney, President and Chief Executive Officer

Yeah. The final rule for inpatient rehabilitation for 2014 did include the elimination of certain codes that CMS used to presumptively calculate compliance with the 60% rule. We're not happy. I don't think anybody in the industry is happy that those codes have been reduced. Frankly, some of them were a little bit vague. We think that we can easily accommodate the new codes that are more specific. The ones that are really more problematic from a patient standpoint, it's not going to have a big impact on us, we can accommodate this, but we do think that there are going to be certain patients with certain arthritic conditions that, because of this elimination, may not be able to get the care that they need and that the physician wants them to have.

Not a big impact for us. We're just looking at it from an industry standpoint and we think that that's going to be one of the negative unintended consequences. From HealthSouth's perspective, though, we feel very confident that we're going to be able to adjust to these changes. They don't go into effect until 2015, and so we've got plenty of time to adjust. It's not going to be something that is going to cause us any concern.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Okay. And then just following up on that, the 60% rule today, I think there's some discussion always floating around.

Jay Grinney, President and Chief Executive Officer

Yeah. There is. One of the proposals out there is to move that threshold from 60% to 75%. If you look at our portfolio of hospitals, we average changes quarter-to-quarter, but somewhere in that 72% to 74%.

So again if that were to occur, we could adjust to that. Our position has been, to members of Congress, that by moving the threshold from 60% to 75%, the consequence will be patients, beneficiaries, Medicare beneficiaries who need rehabilitative care, whose physicians say they need rehabilitative care are going to be forced into another setting and the other setting is going to be a nursing home.

CMS has come out and has said in the final rule last year that CMS does not believe that putting patients that need to be in a rehabilitation hospital into a nursing home setting is good for the beneficiary, nor do they believe that it saves the program money. In part because the length of stay is longer in a nursing home, there's higher readmission rates back to an acute care hospital, quality of care is not the same. So our alternative to resetting the 60% rule up to 75% is to look at outlier payments.

And if you look on page, I think it's nine of the investor reference book, you can see we've just done a very, very, very high level analysis of where the outlier payments are going; $212 million – $214 million last year went to pay for outlier patients in rehabilitation hospitals and 52.6% of that went to 10% of the hospital. Those 10% are not any different than the other rehabilitation providers in the industry. Their case mix isn't any higher, their patient acuity isn't any worse, their costs, on the other hand, are completely out of line. And therefore, they're eligible for these outlier payments.

Our contention is, rather than punishing beneficiaries by setting the threshold at 75%, which I just said means inevitably patients are going to go to nursing homes that CMS has already concluded is not the best alternative, why not put the burden on the inefficient providers out there, whose costs are out of alignment, who need to do a better job at operating in a cost effective way and put the burden on them by adjusting the outlier payments.

We've floated that idea with members of Congress and with various committees of jurisdiction. And frankly, the reception has been much warmer than what we had expected. Whether or not that gets any traction, we don't know, but we think it's a very solid alternative, if indeed the intention is to find some savings from providers, and they're going to be looking at rehabilitation providers.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Okay. Just want to get your cost effectiveness in a sec but last Medicare question, I promise. Post-acute care seems to always be on the table as a source of funding maybe for looking at SGR fix, maybe something, maybe something grander. And just since that site-neutrality pops up a lot, maybe just what your thoughts are on inpatient rehab within post-acute care as a funding source and maybe your thoughts on site-neutrality as well.

Jay Grinney, President and Chief Executive Officer

Yeah. I think all providers are going to be on the table when it comes to a doc fix or the SGR fix. As we look at where we are relative to other post acute providers, we account for about 1.2% of Medicare spending and that percentage has been pretty consistent for the last probably five or six years. Somewhere in this investor reference book and I'm not exactly sure where, we have that data, so you can look at it. Actually it's page 22. So if you look to page 22, you can see where the growth in post acute spending has occurred and it has not been in inpatient rehabilitation. So I guess first and foremost, we don't feel like we're a disproportionate target. And, in fact, if you look at just as a percent of total of Medicare spending, we're not an issue at all.

So – but our provider is going to be at risk. I think every provider out there, if there is a big doc fix is going to have to be prepared to potentially put something on the table. I think that is inevitable. But I don't think we're going to be disproportionately affected. And our track record has been that we've always adjusted to any change that comes out of Washington. And if you go back to when we first paid for the resetting of that compliance threshold from 75% to 60%, the rehabilitation sector paid for that with 18 months of no increase. And in fact in April of – I think it was 2008, we actually saw our pricing go down, and it stayed down for 18 months.

And yet if you go back and you look at the company, we grew volumes, we were disciplined in our expenses and EBITDA grew. So we've got that, now we've got sequestration, we're adjusting to that, we've got a very disciplined cost structure. We're very efficient at the hospital level. We continue to take market share. So, we were very successful and have been very successful in adjusting to sequestration.

Last issue, site-neutral payments, that is a very tough issue to try to quantify. RTI was engaged by CMS to see if they could come up with a site-neutral payment methodology. They started and I guess this was mandated in 2005. They had a report that was interim in nature last year, 353 pages. I encourage you to read it if you have insomnia, but go to the summary and basically says this is really complicated. We don't have a common patient assessment tool to use to evaluate how this might work and there's a lot more work that needs to be done.

So, is it something that is conceivable longer term? Yeah it's possible. We don't see that as necessarily being a negative for rehabilitation providers, because, we believe, that as we look at those patients that might be in a site-neutral payment, there'd be knees and hip replacements. We treat them very effectively, very quickly. We can get them in and out and frankly, we put our outcomes up against any nursing home in a site-neutral kind of payment methodology. So, we're not that concerned about it. We – and when I say we're not that concerned about it, we believe that we would be very well prepared to adjust to any payment change that might occur and in fact we could conceivably see ourselves taking market share in that kind of environment.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Okay. I mean switching directions here a little bit. So you guys have been driving cost out of the company for a while now. You are one of the – now the low cost provider in the space. I mean what is the opportunity to continue to gain expense leverage here?

Jay Grinney, President and Chief Executive Officer

Well we haven't necessarily taken cost out of the system. What we've done is we've managed the growth in a very disciplined way.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Sure.

Jay Grinney, President and Chief Executive Officer

And we – that occurs across all of the line items. We do look for cost saving opportunities. We've had some very nice success on our supply chain, our pharmacy spend. But the biggest cost for rehabilitation providers is labor. And so what we've chosen to do is to focus on growing the business, taking market share and making sure that that incremental patient comes in on a highly profitable basis. So rather than looking at how can we cut our labor cost, we've put our focus on how can we grow our market share, so that we can maintain those jobs but then over the long-term, grow and grow very incrementally – in a very incrementally positive way.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Sure.

Doug Coltharp, Chief Financial Officer & Executive Vice President

And I would just add to that, there are a couple of points of natural operating leverage in the business. The first is the expenses related to our corporate office, which are relatively fixed and where we have capacity to add a lot of additional growth without adding resources or adding to the incremental expense base there. And the second is our occupancy expense. We own approximately two-thirds of our real estate which I think stands in stark contrast to virtually all of the other providers in the post-acute sector. And that means that that becomes a fixed cost and is not subject to the kind of annual escalators that you see embedded in so many lease arrangements.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

I think that makes sense. And then I mean you talked about earlier the 2% to 3% kind of growth rate over the next two years on volumes there. I mean you guys have been out-growing the industry...

Jay Grinney, President and Chief Executive Officer

Right.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

...up to this point maybe doing better than that. I mean what are your thoughts on that number? I mean can you continue to outperform your own expectations in the industry going forward?

Jay Grinney, President and Chief Executive Officer

Well, I mean we're always going to be striving to outperform. I think that goes without saying, but we feel very comfortable that that 2.5% to 3.5% volume growth number is a number that shareholders can use as they establish their models and try to get some kind of a top-line projection for the company. Clearly, we've done a better job than 2.5% to 3.5%, but we don't take that lightly, we don't assume that just because we've done it, we can always do it. We will always strive to outperform.

We think that the biggest advantage is that the over 65 population, which represents about 80% of our patients, is growing at 3% per year. So we've got this huge baby boom cohort that is just now hitting Medicare eligibility. You've got another 20 years of this growth that is going to be flushing through. And frankly, I think that the bigger concern is, are there going to be enough rehabilitation providers to take care of those patients once they get into that 72, 75, 78 age group.

And so when – as we look down the road, and we look at the long-term view of this sector, we see tremendous growth opportunities, and are very, very happy to be in this particular industry, because that demand profile is so strong. And the kinds of patients that we treat more often than not have non-discretionary illnesses.

Now, people don't choose to have a stroke. They don't choose to fall and break their hip. It's an inevitable outcome of the aging process. None of us in this room want to think about it, but it happens. And when that does happen, somebody has to be there to take care of that patient, first at the acute care level, but then, more importantly, at the post acute level to get them back into some semblance of a normal life. And so as we look down the road, there is a very attractive growth runway for inpatient rehabilitation providers and the fact that we are the largest provider by a long shot with 103 hospitals I think the next largest portfolio of freestanding hospitals might be nine. And so there's – we've just got a huge advantage.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Maybe that's a great segue into kind of the next question here, talking about maybe capital deployment to support that growth. I mean your appetite for plans for de novo build versus additional beds versus acquisitions, I know you did lay it out...

Jay Grinney, President and Chief Executive Officer

Yeah and if you go to page 57, it does outline for you how we think about where we're going to deploy that cash. And first and foremost is just continue to fund that growth that we see occurring throughout all of our markets and frankly into new markets as well. What we've targeted and this is something to use as you build your models. We've said we think we can open four de novos each year. We think we can acquire two units or if there are another – if there are more Walton Rehabilitation Hospitals, free-standing we'll acquire those as well. So bring on about six new facilities per year.

And you can see how we've broken down the de novos four year and the acquisitions about two year. We don't have numbers here yet for all of 2013 because we're not done yet, but if you think about a free-standing hospital, we'd buy it at about the cost that it would take to build it. If you think about a unit it's going

to be significantly less than that, somewhere in the $10 million to $15 million range. De novos are going to be somewhere in that $20 million to $25 million range depending on the cost of land, cost of construct, and so on. So you can get an idea of where we're going to be deploying the free cash flow from a growth standpoint. We do have some of our hospitals that are leased this year. We have a unique opportunity to buy back, how many leases?

Doug Coltharp, Chief Financial Officer & Executive Vice President

Five.

Jay Grinney, President and Chief Executive Officer

Five releases of the 16 that have a buyout provision. So there's a – we've said somewhere in the $55 million to $110 million this year to buyout those leases. They've all gone pretty well. There's one that we're still negotiating may spill over into 2015 or 2014. Once you get into 2014, there's only really just from a lease expiration standpoint, there's really only an opportunity to buy out about one a year for the next 10 years. So this $55 million to $110 million is really 2013 specific. We're not going to see that kind of spend on buyouts of leases going forward. And then, of course, we've got the opportunity to buy back shares if we think the timing is right and then we've initiated or announced the initiation of a dividend that will start in October.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Maybe following up on that, I mean, you guys have paid down your debt pretty significantly.

Jay Grinney, President and Chief Executive Officer

Yes.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Are you happy with your current leverage ratio, because it actually maybe goes up a little bit and as you said, you did buyback quite a significant amount of shares. Is that really just opportunistic looking at where the market is and...?

Jay Grinney, President and Chief Executive Officer

The share buyback was definitely opportunistic.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Okay.

Jay Grinney, President and Chief Executive Officer

I mean, we've – this company has been – has not been valued properly in the market and finally we got our board to acknowledge that and got them to approve a share buyback. And as we said then, it is definitely that is not a one and done. I mean that is going to be part of our strategy, going forward, is looking at ways to return value to shareholders. And if it means a buyback, we'll do a buyback. Obviously, we've stated that we feel very comfortable with the initiation of the dividend. But the debt level, at 2.5 times we think that that's very conservative.

It gives us a lot of capacity. We don't think that we have to go out and lever up just for the sake of levering up. We think there's still going to be some nice opportunities over the next three to five years for exploring

opportunities outside of our core business. We don't have to do that. We won't do that unless we are absolutely confident that we have clarity on the rate, the regulatory environment in those adjacent services. But we want to keep our powder dry and we think that's a prudent way to manage a company and we feel very good about the capital structure. I don't know if you want to add anything to that?

Doug Coltharp, Chief Financial Officer & Executive Vice President

I think it's – we look at, as Jay was just alluding to, we look at not only the absolute level of leverage, and that is below the target of three times that we've established and we anticipate that there'll be a natural deleveraging that continues as EBITDA grows. But we also look at the structure of our debt arrangements and there we feel very positive. We don't face any maturities of any consequence until 2018. That's when we get into our revolving credit facility in the first tranche of our senior notes. We have very little in the way of required principal amortization. But we have some optionality around principal amortization and we think that that puts us in a position to very proactively manage the capital structure and to keep pushing those maturities out, and keep them out in front of us. And then within the specific governing documents for those debt instruments, we believe that we have all the flexibility that we need to operate the business and pursue some of these other strategic alternatives that are outlined on this cash flow allocation page.

Jay Grinney, President and Chief Executive Officer

And we can go after the 2018 and 2022s.

Doug Coltharp, Chief Financial Officer & Executive Vice President

Yeah, that's part of the optionality I was referring to. We've got that 10% call provision there which we exercised in 2012.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

So just to follow up on one of your earlier comments, so with the potential dislocations on synergy around reform and other payment methods in the post-acute space, you're open to making a adjacent acquisition if the opportunity is right, but it's not necessary if...

Jay Grinney, President and Chief Executive Officer

It definitely is not necessary. Our view is that there's no compelling reason today to do that. None. And so, we have made it very clear that our focus is on in-patient rehabilitation and exploiting the growth opportunities that we think are available to us in that very attractive space. Our job is to not think about the company on a quarter-by-quarter basis. Our job is to say, where we do we need to be in five years, and where do we need to be in 10 years. Now, that's always a hard topic to discuss in a group like this, because I'd love to think everybody in this room has the same kind of investment horizon, but I know you don't. And so when we talk about long term, we really are thinking about five years or 10 years down the road.

Five years from now could I see the company potentially be expanding into an adjacent service like home care? Absolutely. Would we do that through a potential acquisition of a national provider? I can tell you that makes zero sense. It makes zero sense. The – healthcare is such a local service and with local market dynamics, the only thing that would really make sense is for us to add home care services in those markets where we already have a presence.

So, how would we do that? We would look for home care providers, and remember, this is a highly fragmented sector, highly fragmented. It makes no sense to go after a national company, and now you've got two footprints that don't overlap with one another, except for maybe 20%. And now what do you do? You've got to build out all these other new markets, or do you go after local, regional providers and start to bring those two together under a platform that are synergistic and complementary to our inpatient

rehabilitation? The answer is yeah, we can do that. Why would we do that? We would do that if – and this is a big, big if. If the industry evolved to some kind of comprehensive coordinated care model, and our opinion is the jury is way out until – for that. Accountable Care or bundling, there's a lot of movement, that is not a proven concept, but let's just assume that it does evolve to that and we think it will be a three-year to five-year to 10-year kind of evolution.

We think being able to offer a facility-based post-acute range of services in a home base that are coordinated in nature makes the most sense. But I don't want anybody to – your time horizon and our time horizon, I think are very different. We're thinking about this on a five year to 10-year basis. We're not thinking about it on a quarter-by-quarter basis. So short-term, our focus is exclusively on inpatient rehabilitation.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Thanks a lot. I think we're actually out of...

Jay Grinney, President and Chief Executive Officer

There is one question.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Okay.

QUESTION AND ANSWER SECTION

<Q – Thank you. Can you talk about the considerations of fully owning your real estate versus…

<A – Jay Grinney – HealthSouth Corp.>: We love owning the real estate. If you think about what the larger – one of the largest providers – Kindred is doing right now, they're stuck. They've already sold their company. They sold their company to Ventas a long time ago just on an installment basis. So now they're stuck sitting there going, okay, what do we do with all these facilities that are not performing? We have no optionality. So the only optionality is to walk away from $800 million, $900 million of revenue and slowly make their company smaller before they can start growing it.

<Q>: Whereas Ventas shareholders have done very well, so I was just thinking…

<A – Jay Grinney – HealthSouth Corp.>: That maybe the Ventas – we don't care about Ventas shareholders. We're only interested in the HealthSouth shareholders. And so if we were to sell the shareholders on day one would be delighted. Okay, they get a special dividend, they're happy and then they're gone tomorrow and then the next shareholder is sitting there going, all right, how are you guys going to perform over this crushing this rent structure. And then we as management are sitting there, because we're shareholders too. And I'm not a shareholder that is going to be selling the day after I get a special dividend. I am a shareholder who does, unlike maybe others, have a view of where we're going to be three years, five years and 10 years down the road.

So we thought about it. We have no interest whatsoever. It is a onetime transaction that is short-term in nature and burdens the company from that point on and reduces tremendous amount of flexibility for the company.

<Q – Thank you.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Thank you very much, gentlemen.

Jay Grinney, President and Chief Executive Officer

Not that we have a strong opinion on it.

Andy Schenker, Analyst, Morgan Stanley & Co. LLC

Thank you, guys.