HEALTHSOUTH

Presentation to the Alabama Treasury Management Association

September 25, 2014

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Forward-Looking Statements

The information contained in this presentation includes certain estimates, projections and other forward-looking information that reflect our current outlook, views and plans with respect to future events, including legislative and regulatory developments, strategy, capital expenditures, development activities, dividend strategies, repurchases of securities, effective tax rates, financial performance, and business model. These estimates, projections and other forward-looking information are based on assumptions that HealthSouth believes, as of the date hereof, are reasonable. Inevitably, there will be differences between such estimates and actual events or results, and those differences may be material.

There can be no assurance that any estimates, projections or forward-looking information will be realized.

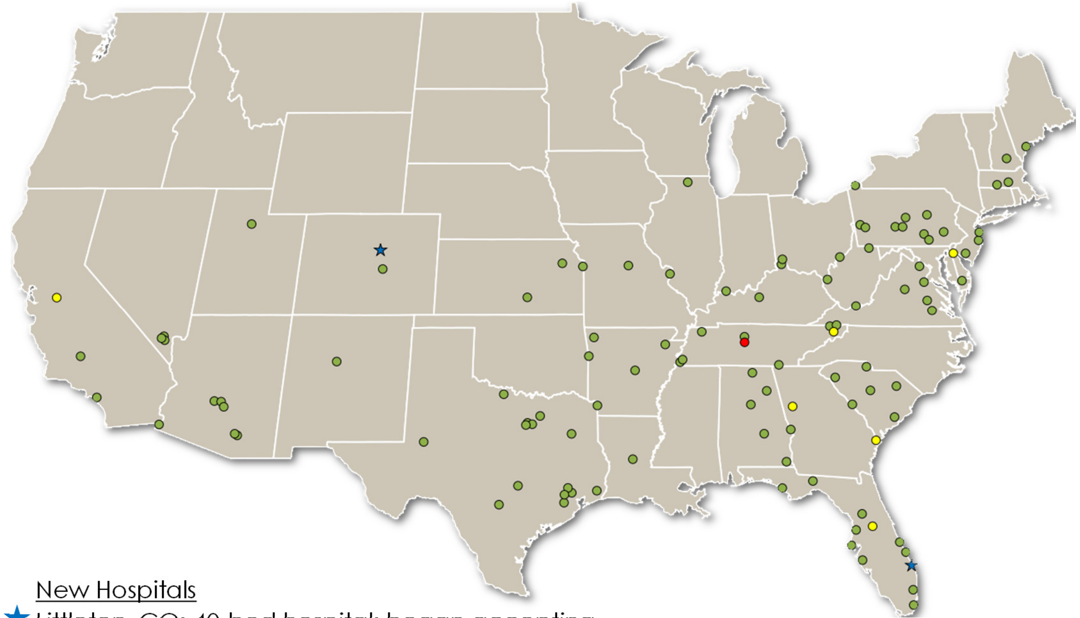
All such estimates, projections and forward-looking information speak only as of the date hereof. HealthSouth undertakes no duty to publicly update or revise the information contained herein.

You are cautioned not to place undue reliance on the estimates, projections and other forward-looking information in this presentation as they are based on current expectations and general assumptions and are subject to various risks, uncertainties and other factors, including those set forth in the Form 10-K for the year ended December 31, 2013, the Form 10-Q for the quarters ended March 31, 2014 and June 30, 2014, and in other documents we previously filed with the SEC, many of which are beyond our control, that may cause actual events or results to differ materially from the views, beliefs and estimates expressed herein.

Note Regarding Presentation of Non-GAAP Financial Measures

The following presentation includes certain "non-GAAP financial measures" as defined in Regulation G under the Securities Exchange Act of 1934. Schedules are attached that reconcile the non-GAAP financial measures included in the following presentation to the most directly comparable financial measures calculated and presented in accordance with Generally Accepted Accounting Principles in the United States. Our Form 8-K, dated August 20, 2014 to which the following supplemental slides are attached as Exhibit 99.1, provides further explanation and disclosure regarding our use of non-GAAP financial measures and should be read in conjunction with these supplemental slides.

Our Company



New Hospitals

- ★ Littleton, CO; 40-bed hospital; began accepting patients May 15, 2013
- ★ Stuart, FL; 34-bed hospital; began accepting patients June 5, 2013
- ○ Under construction; 50-bed hospital in Altamonte Springs, FL; expect to be operational Q4 2014
- ○ Under construction; 50-bed hospital in Newnan, GA; expect to be operational Q4 2014
- ○ Under construction; 34-bed hospital in Middletown, DE; expect to be operational Q4 2014
- ○ Johnson City, TN; 26-bed hospital; expect to finalize by year-end 2014
- ○ Savannah, GA; 50-bed hospital; expect to begin operations in early 2015
- ○ Purchased land for 50-bed hospital in Modesto, CA; expect to be operational in Q1 2016
- ● CON approved for 40-bed hospital in Franklin, TN; under appeal

Portfolio – As of June 30, 2014

103	Inpatient Rehabilitation Hospitals (“IRF”) • 31 operate as JV’s with Acute Care Hospitals
17	Outpatient Rehabilitation Satellite Clinics
25	Hospital-Based Home Health Agencies
28 + Puerto Rico	Number of States
~ 23,800	Employees

Key Statistics-Trailing 4 Quarters

~ $2.3 Billion	Revenue
131,722	Inpatient Discharges
766,663	Outpatient Visits

Marketshare

~ 9% of IRFs (Total in U.S. = 1,142)

~ 18% of Licensed Beds

~ 21% of Patients Served

Patients Served

Most Common Conditions (Q2 2014):

1.	Neurological	24.1%
2.	Stroke	16.6%
3.	Other orthopedic conditions	9.5%
4.	Fracture of the lower extremity	8.9%
5.	Brain injury	8.4%

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Our Hospitals

96 of our hospitals hold one or more disease-specific certifications from The Joint Commission's Disease-Specific Care Certification Program. (1)

Major Services

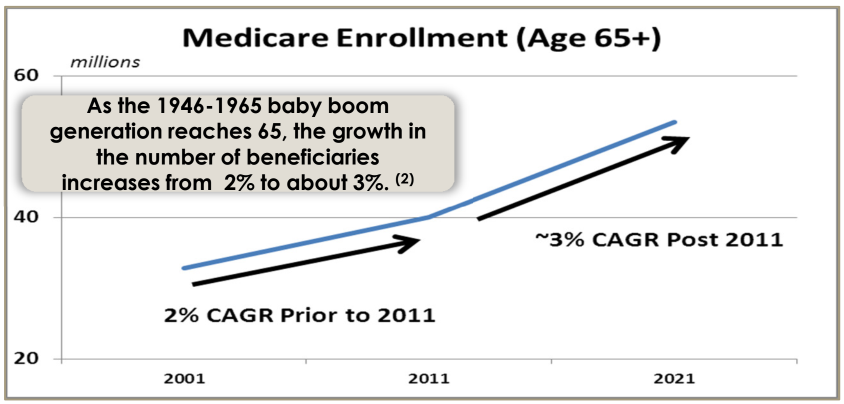
- **Rehabilitation Physicians:** manage and treat medical needs of patients
- **Rehabilitation Nurses:** oversee treatment programs of patients
- **Physical Therapists:** address physical function, mobility, safety
- **Occupational Therapists:** promote independence and re-integration
- **Speech-Language Therapists:** treat communication and swallowing disorders
- **Case Managers:** coordinate care plan with physician, caregivers and family
- **Post-discharge services:** outpatient therapy and home health

(1) Under this program, Joint Commission accredited organizations, like our hospitals, may seek certification for chronic diseases or conditions such as brain injury or stroke rehabilitation by complying with Joint Commission standards, effectively using evidence-based clinical practice guidelines to manage and optimize patient care, and using an organized approach to performance measurement and evaluation of clinical outcomes. Obtaining such certifications demonstrates our commitment to excellence in providing disease-specific care.

Our Patients

Average Age of a HealthSouth Patient:
- All patients = 72
- Medicare FFS = 76

Census Data [1] - Population Growth by Age			
5 Year CAGR			
Age	**2015 -2020**	**2020-2025**	**2025-2030**
65 to 69 years	2.4%	2.1%	0.1%
70 to 74 years	5.2%	2.5%	2.1%
75 to 79 years	4.3%	5.3%	2.6%
80 to 84 years	2.2%	4.5%	5.5%
85 to 89 years	0.3%	2.5%	4.8%
Total 65 to 89	**3.3%**	**3.1%**	**2.3%**



Referral Sources:

93% Acute Care Hospitals

6% Physician Offices/Home

1% Skilled Nursing Facilities

Most Common Conditions (Q2 2014):

1.	Neurological	24.1%
2.	Stroke	16.6%
3.	Other orthopedic conditions	9.5%
4.	Fracture of the lower extremity	8.9%
5.	Brain injury	8.4%
6.	Debility	8.1%
7.	Knee/Hip replacement	7.0%
8.	Major multiple trauma	4.2%
9.	Cardiac	3.6%
10.	All other	9.6%

Admission to an IRF:

- Physicians and acute care hospital case managers are key decision makers.
- All IRF patients must meet reasonable and necessary criteria and must be admitted by a physician.
- All IRF patients must be medically stable and have potential to tolerate three hours of therapy per day (minimum).
- IRF patients receive 24-hour, 7 days a week nursing care.
- Average length of stay ~13.2 days

(1) Source: www.census.gov/population/projections/files/summary/NP2012-T12.xls
(2) Center of Medicare & Medicaid Services, Medicare Trustee's Report July 2014 – pages 11, 20, and 22

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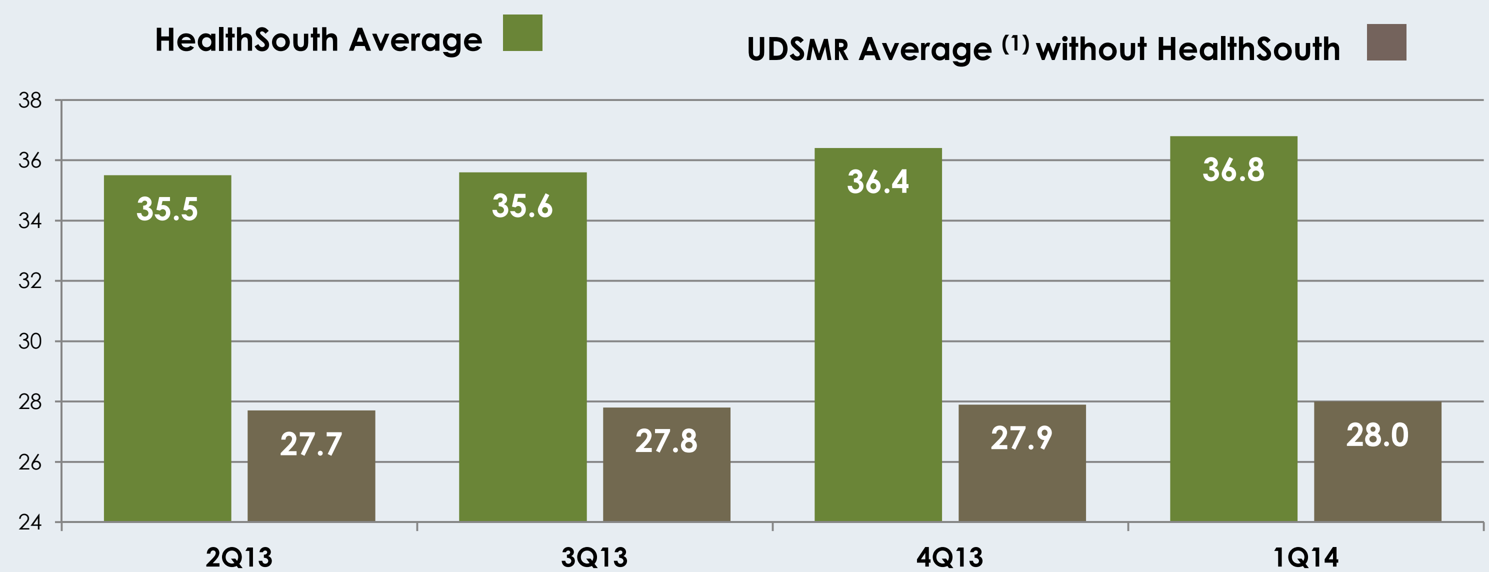
Our Quality



FIM® Gain (2) is based on the change from admission to discharge of an 18 point assessment.

- **Inpatient rehabilitation hospitals evaluate all patients at admission and upon discharge to determine their functional status.**
  - FIM® is the tool for measuring functional independence.
- **The difference between the FIM® scores at admission and upon discharge is called the "FIM® Gain."**
  - The greater the FIM® Gain, the greater the patient's level of independence, the better the patient outcome.

Source: UDSMR Database

(1) Beginning in Q1 2014, we will report quality outcomes without HealthSouth included in the UDSMR Average. As a result, we will be reporting one quarter in arrears. The UDS average is the risk adjusted average of a patient mix pulled from the UDS nation that is similar to the HealthSouth actual patient mix. Cases are placed into CMGs by admitting impairment code, functional status at admission, and sometimes age.

(2) FIM® instrument is a trademark of Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc.

Our Cost-Effectiveness

Total Inpatient Rehabilitation Facilities (IRFs): 1,142

		Avg. Beds per IRF	Avg. Medicare Discharges per IRF (2)	Case Mix Index (3)	Avg. Est. Total Cost per Discharge for FY 2015	Avg. Est. Total Payment per Discharge for FY 2015
HLS (1) =	103	66	932	1.24	$12,129	$18,529
Free-Standing (Non-HLS)=	143	61	617	1.21	$16,403	$19,413
Hospital Units =	896	24	229	1.16	$19,490	$19,533
Total	1,142	33	341	1.19	$16,975	$19,258

- The Avg. Est. Total Payment per Discharge has not been reduced by 2% for sequestration (4)

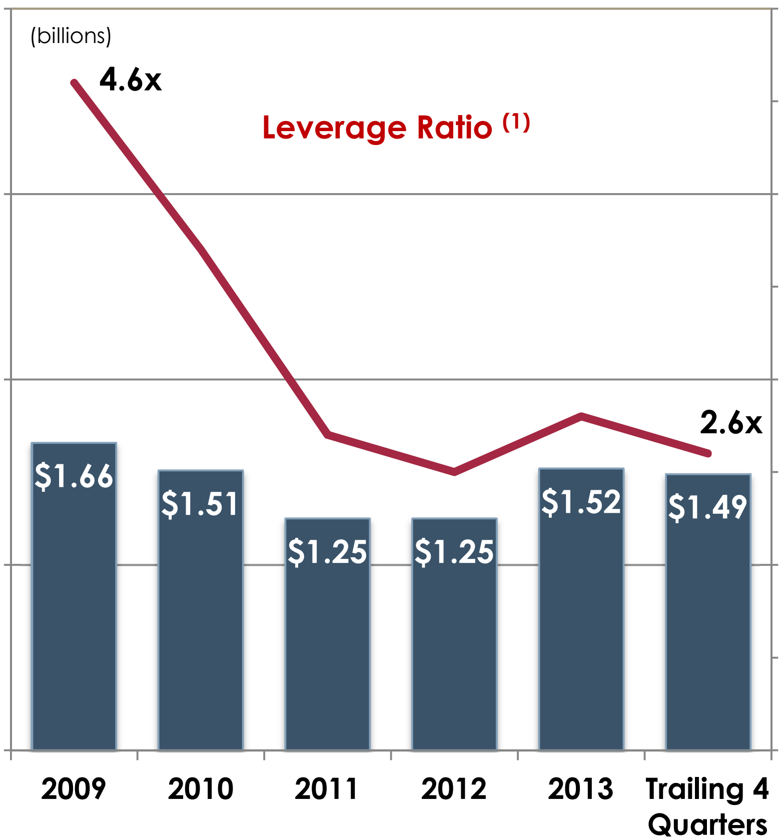
- Medicare pays HealthSouth less per discharge, on average, and HealthSouth treats a higher acuity patient.

- **HealthSouth differentiates itself by:**
  - ✓ "Best Practices" clinical protocols
  - ✓ Supply chain efficiencies
  - ✓ Sophisticated management information systems
  - ✓ Economies of scale

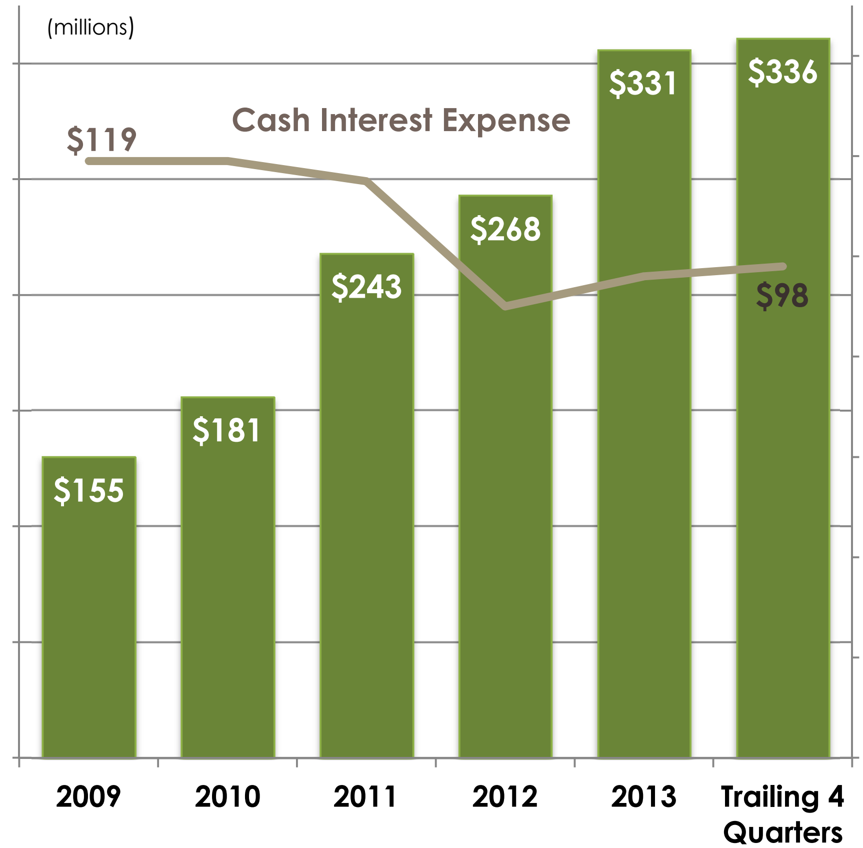
(1) The 103 for HLS includes all current HealthSouth Rehabilitation Hospitals,
(2) In 2013, HealthSouth averaged 1,287 total Medicare and non-Medicare discharges per hospital in its 101 consolidated hospitals.
(3) Case Mix Index (CMI) from the rate-setting file presented above are adjusted for short-stay transfer cases. HealthSouth's unadjusted CMI for 2013 was 1.34 versus 1.29 for the industry as measured by UDSMR, a data gathering and analysis organization for the rehabilitation industry; represents ~70% of the industry, including HealthSouth sites.
(4) The Budget Control Act of 2011 included a reduction of up to 2% to Medicare payments for all providers that began on April 1, 2013 (as modified by H.R. 8). The reduction was made from whatever level of payment would otherwise have been provided under Medicare law and regulation.
Source: FY 2015 CMS Final Rule Rate Setting File and the last publically available Medicare cost reports (FYE 2012/2013) or in the case of new IRFs, the December 2013 CMS Provider of Service File.

Our Track Record

Total Debt



Adjusted Free Cash Flow



(1) Based on 2009 and trailing 4 quarters Adjusted EBITDA of $363.7 and $574.6 million, respectively.

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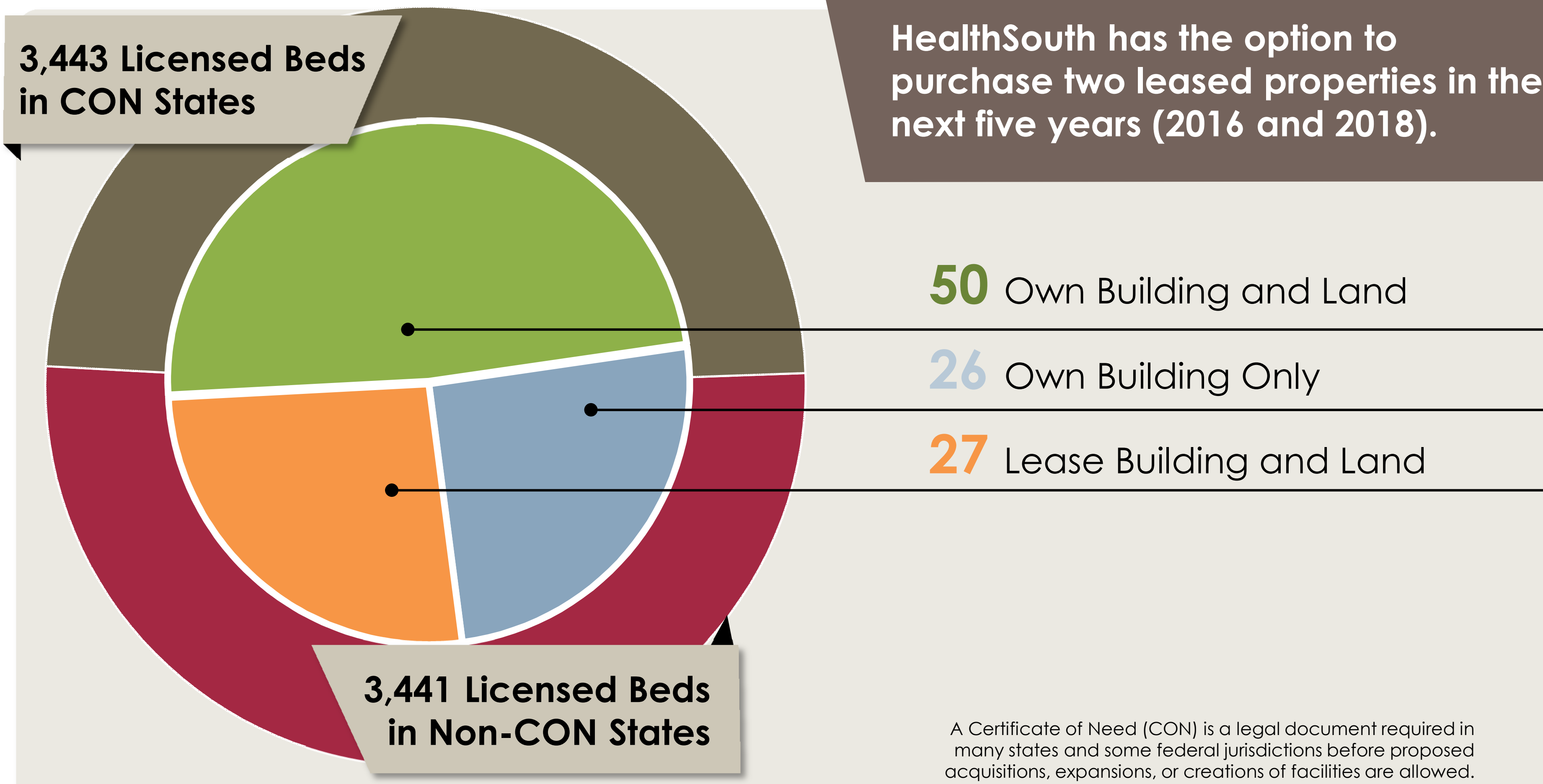
Our Assets

103 (1) Inpatient Rehabilitation Hospitals: 6,884 Licensed Beds(2)

HealthSouth has the option to purchase two leased properties in the next five years (2016 and 2018).



A Certificate of Need (CON) is a legal document required in many states and some federal jurisdictions before proposed acquisitions, expansions, or creations of facilities are allowed.

(1) 1 of the 103 HealthSouth hospitals is nonconsolidated. For that hospital, we own the building only.
(2) Excludes 41 licensed beds at the nonconsolidated hospital

Our Preparation for Shifts to Coordinated Care Delivery Models

- **Evolutionary rather than revolutionary**
- **Strong balance sheet and free cash flow enhance flexibility**

31 joint venture hospitals with acute care systems already in place (examples include):

- Barnes-Jewish
- University of Virginia Medical Center
- Vanderbilt University

Strong balance sheet and free cash flow:

- No significant debt maturities prior to 2018
- Relatively low financial leverage
- Ample liquidity under revolving credit facility
- Consistently strong free cash flow

Installing clinical information systems (CIS) in all HealthSouth hospitals:

- 51 installations completed as of August 1, 2014
- Cerner custom system capable of interfaces with all major acute care EMR systems
- Participating in Health Information Exchanges (HIE)

High-quality, cost-effective provider:

- FIM® gains consistently exceed industry results
- Scale and operating leverage contribute to low cost per discharge
- On average, Medicare pays HealthSouth less per discharge although HealthSouth treats a higher acuity patient.

Flexibility in managing physical plant:

- 102 HealthSouth IRF's are free-standing
- 76 HealthSouth IRF's are owned vs. leased

Participation in new delivery models:

- Exploring ACO participation in several markets
- Participating in bundled payment pilots

Our Strong and Sustainable Business Fundamentals

Attractive Healthcare Sector
- Favorable demographic trends
- Nondiscretionary nature of many conditions treated in IRFs
- Highly fragmented industry

Industry Leading Position
- #1 market share: above industry same-store growth and margins
- Consistent achievement of high-quality, cost-effective care
- Rollout of state-of-the-art clinical information system

Cost-Effectiveness
- Focused labor management
- Continued improvements in supply chain
- Significant operating leverage of G&A and occupancy expenses

Real Estate Portfolio
- Portfolio of strategically located, well-designed physical assets
- 103 IRFs (1); 76 owned and 27 long-term, real estate leases
- Option to purchase additional leased properties

Financial Strength
- Strong balance sheet; ample liquidity, no near-term maturities
- Minimal cash income tax expense ($12 - $17 million in 2014)
- Substantial free cash flow generation; $0.21 per share quarterly cash dividend on common stock
- Approx. $207 million common stock repurchase authorization remaining as of June 30, 2014

Growth Opportunities
- Bed expansion at existing hospitals
- Flexible de novo strategy
- Flexible IRF acquisition and unit consolidation strategy
- Ability to pursue other post-acute sectors opportunistically

(1) Inclusive of one nonconsolidated entity

Business Outlook: 2014 to 2016[1]

Business Model

- Adjusted EBITDA CAGR: 4-8% [2]
- Continued strong free cash flow generation

Potential depletion of the federal NOL during the 2014 to 2016 timeframe will affect Cash Flow CAGR.

Strategy	2013	2014	2015	2016
Shareholder Distributions	$234 million common stock tender; initiated dividends	• **Quarterly cash dividends (increased from $0.18 to $0.21 per common share)** • **Opportunistic share repurchases ($43.1 million; 1,303,201 common shares repurchased in first 6 months of 2014)**		
Leverage	**< 3.0x** Debt to Adjusted EBITDA	**< 3.0x Debt to Adjusted EBITDA** (subject to shareholder value-creating opportunities)		
Core Growth	**Bed expansion = 68**	**Same-store Growth** (Includes bed expansions and unit consolidations)		
Core Growth	**New IRF's = 3** Littleton, CO, Stuart, FL, Augusta, GA	**New IRF's** Altamonte Springs, FL; Newnan, GA; Middletown, DE	**New IRF's** (target of 4-6/year)	
Opportunistic Growth		**Consider opportunistic, disciplined acquisitions**		
Key Operational Initiatives	• **Enhancing outcomes and patient experience**			
Key Operational Initiatives	• **Implementing CIS:** Target 20 hospitals/year; Installation complete in 51 hospitals as of August 1, 2014; Expect installation at all hospitals by YE2017.			
Key Operational Initiatives	• **Positioning for evolving delivery and payment models:** ACO, bundling, etc.			

(1) If legislation affecting Medicare is passed, HealthSouth will evaluate its effect on the Company's business model.
(2) This is a multi-year CAGR; annual results may fall outside the range.

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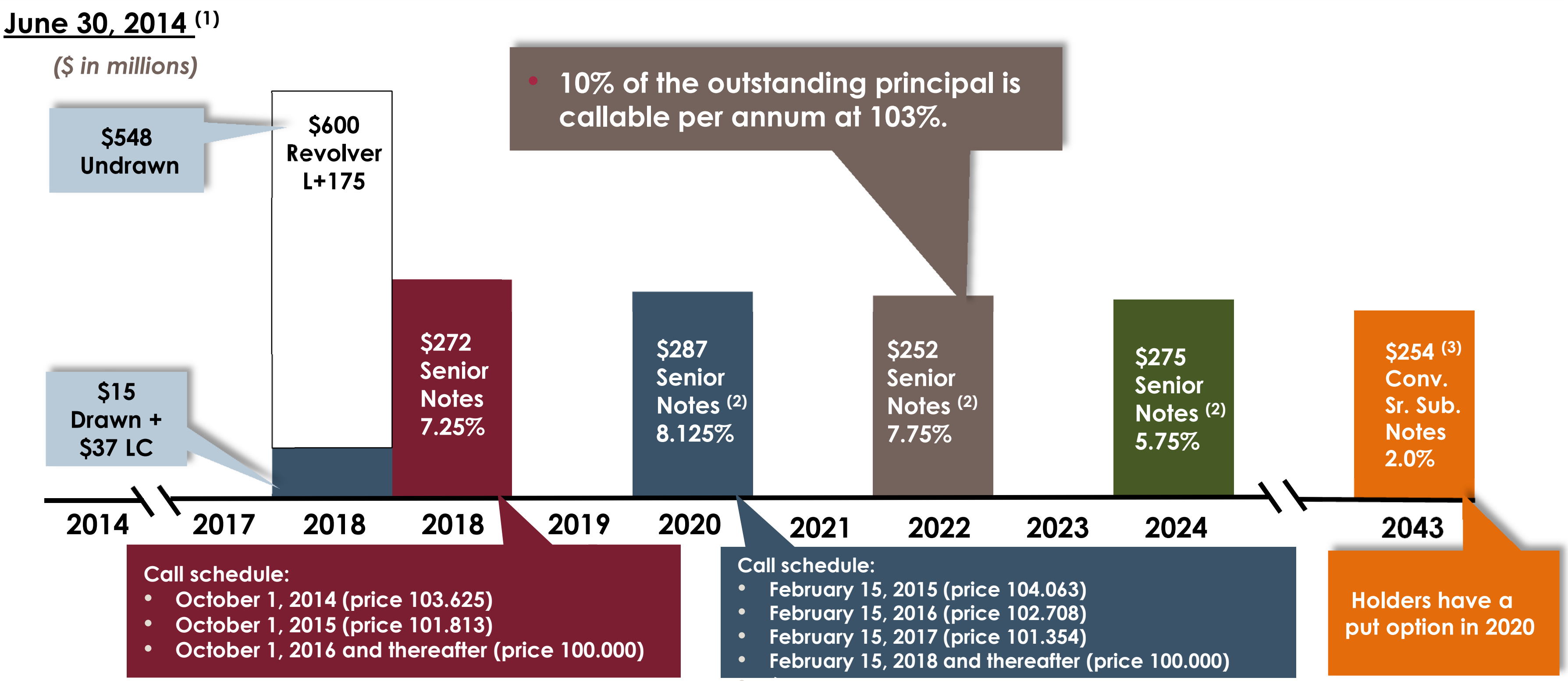
Debt Maturity Profile

HealthSouth is positioned with a cost-efficient, flexible capital structure…

- No near-term maturities and well-spaced debt maturities
- Limited exposure to higher interest rates



(1) Does not include approx. $93 million of convertible perpetual preferred stock, approx. $86 million of capital leases, and approx. $45 million of other note payables.
(2) The 2022, and 2024 Senior Notes become callable in 2015, and 2017, respectively.
(3) On November 18, 2013, the Company closed separate, privately negotiated exchange agreements under which it issued $320 million of 2.0% Convertible Senior Subordinated Notes due 2043 in exchange for 257,110 shares of the Company's 6.5% Series A Convertible Perpetual Preferred Stock. The Company recorded approx. $249 million as debt and approx. $71 million as equity. As of 6/30/14, approx. $66 million remains as an unamortized debt discount.

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Capital Structure Strategy 2014 - 2018

4 Major Tenets (Guidelines vs. Rules)

Ensure Sufficient Liquidity	Manage Debt Maturities	Maintain Access to New Funds	Reduce Cost of Capital
➢ Continued focus on free cash flow generation ➢ Target total liquidity (excess cash on hand + unfunded revolver) ➢ Build flexibility in financial covenants ➢ Maintain well-capitalized banks in Revolver ➢ Proactively seek opportunities to extend Revolver maturity date to improve terms	➢ Limit single year maturities to manageable level ➢ Attempt to space significant maturities at least 18 months apart ➢ Proactively utilize call options and open-market repurchases to chip away ➢ Begin refinancing efforts: • Opportunistically once fully callable or if rate environment creates economic justification • Proactively once within 24 months of maturity • Target current maturities (i.e. 1 year or less)	➢ Consistent operating performance ➢ Active Investor Relations programs ➢ Maintain "BB" credit profile ➢ Maintain good senior level relationships with Revolver banks ➢ Preserve owned real estate as a fall-back ➢ Evaluate purchase money financing case by case on de novo and acquisition hospitals	➢ Borderline investment grade profile offers best intersection of credit availability and impact on WACC ➢ Proactively identify strategies to refinance the Convertible Preferred Stock (most expensive component of capital structure) ➢ Opportunistically utilize excess FCF and balance sheet capacity to repurchase Common Stock (at or below intrinsic value)

Capital Structure Management is Forward Looking, Proactive and Opportunistic

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Capital Structure Strategy 2014 - 2018

Opportunity Set and Anticipated Priorities

2014	2015	2016	2017	2018
➢ 2018 Notes callable at 103.625 on 10-1-14 ➢ 10% call on 2022 Notes (fixed price of 103) ➢ Convertible Preferred repurchase or refinance ➢ Opportunistic repurchase of Common Stock ➢ Seek opportunities to extend Revolver and improve terms	➢ 2018 Notes callable at 101.813 on 10-1-15 ➢ 2022 Notes callable at 103.875 on 10-1-15 ➢ 2020 Notes become callable at 104.063 on 2-15-15 ➢ Convertible Preferred repurchase or refinance ➢ Opportunistic repurchase of Common Stock ➢ Seek opportunities to extend Revolver and improve terms	➢ Begin proactive refinancing of residual 2018 Notes – callable at par on 10-1-16 ➢ 2022 Notes callable at 102.583 on 9-15-16 ➢ 2020 Notes callable at 102.708 on 2-15-16 ➢ Convertible Preferred repurchase or refinance ➢ Opportunistic repurchase of Common Stock ➢ Seek opportunities to extend Revolver and improve terms	➢ Reduce balance of 2018 Notes to less than $100MM by 10-1-17 ➢ Refinance/extend Revolver not later than 6-1-17 ➢ 2022 Notes callable at 101.292 on 9-15-17 ➢ 2020 Notes callable at 101.354 on 2-15-17 ➢ Convertible Preferred repurchase or refinance ➢ Opportunistic repurchase of Common Stock	➢ 2.00% Subordinated Convertible Notes redeemable at par ➢ Begin proactive refinancing of residual 2020 Notes callable at par on 2-15-18 ➢ 2022 Notes callable at par on 9-15-18 ➢ Convertible Preferred repurchase or refinance ➢ Opportunistic repurchase of Common Stock ➢ Seek opportunities to extend Revolver and improve terms

Priorities will shift based on market conditions and the evolution of our business model.

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