HealthSouth Corporation
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<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

Good afternoon. I'm Whit Mayo, the senior facilities analyst at Baird. It's my pleasure this afternoon to have HealthSouth join us. Representing the Company we have Mark Tarr, the Executive Vice President and Chief Operating Officer; and Mary Ann Arico, who spearheads the Investor Relations effort, is dashing through the crowd with books. Jay unfortunately could not join us.

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Jay is suffering from a herniated disc. So if any of you have ever had the un-pleasant feeling of having a herniated disc and the thought of travel – so he sends his apologies for not being here today.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

I told everybody he injured himself through P90X.

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Well, he's been known to do that, just not injury.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

Yes, exactly. Well, Mark, thanks for joining us today. You didn't have any slides that you wanted to…

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Well, we have one slide that we are going to put up as part of the Company overview. Okay, so this is Slide number 4 from an investor reference booklet. And if you have not had a chance to look at our investor reference booklet, it's a source we are very proud of. Mary Ann Arico should – she gets credit for doing all the hard work. What we've tried to do in this booklet is essentially answer any of the questions you might have about HealthSouth, about the industry that we participate in.

We have developed this over several years and try to keep track of any of the questions that come from the investment community and essentially put the answers in this booklet. So for those of you that are not familiar with HealthSouth, we are the largest owner, operator provider of inpatient rehabilitative care in the United States. We treat what is typically termed as a post-acute patient.

Other words, it's a patient that has been treated in a short-term acute care hospital after suffering a stroke, after suffering some sort of a traumatic accident where they may have a brain injury or spinal cord. It could be a situation where they've fallen, had a fractured hip. They are stabilized or receive surgery in the short-term acute care hospital and then are ready – they are medically stable and ready for inpatient rehabilitative care.

90% of the patients that are admitted into a HealthSouth hospital come directly from a short-term acute care hospital. Our goal then is to work with these patients typically for a two-week length of stay. Our physical therapists, occupational therapists, speech therapists, and the specialty practice of medicine known as physical medicine and rehabilitation or physiatrist typically is the attending physician on the patients while they are in our hospitals for nearly two weeks.

You will see the term IRF term IRF, which I will refer to frequently. It stands for inpatient rehabilitation facility. We are an industry that has a lot of acronyms, and I promise I will try to refrain from using acronyms as much as possible. We are located, as you can see, in 28 states. We have two sites in Puerto Rico. As you can see from the bottom right-hand side of the screen, a large majority of the patients that we treat in terms of diagnostic categories fall into stroke and other neurological.

They have either suffered a stroke or suffer from some sort of chronic neurological condition that has rendered them incapable of caring for themselves on an independent basis. They therefore are ready to either come directly from an acute care hospital, in a small number of cases they will come directly into our hospital from a physician office, receive a minimum of three hours of therapy a day. They mix discipline of that physical therapy, occupational therapy, or speech.

Our goal is to send as many patients home at the time of discharge as possible. That is our ultimate success story is when we are able to discharge a patient back home to the community which they had come from. We send nearly 80% of our patients treated in our hospitals are able to go back home, back to the community of which they came to us from.

Over the last several years we started to invest our free cash flow into growing out our portfolio of inpatient rehabilitation hospitals. As you can see, we are concentrated primarily in the Southeast. We have concentrations in the state of Texas, as well up in Pennsylvania. Our goal is to search out marketplaces that have a dense enough population that have the required bed need as we measure it to grow our de novo and new hospitals.

From an industry standpoint, it's a highly fragmented industry. There are about 11,042 inpatient rehabilitation facilities in the United States. 246 are freestanding of which all of ours are freestanding hospitals, but the vast majority or 896 of those facilities are inpatient rehabilitation units located within a short-term acute care hospital. So we account for – we operate 9% of the hospitals, our hospitals tend to be larger, so we have 18% of the beds. If you want to look at it in terms of market share, we get about 21% of

the patients served in ERF, the United States is served in the HealthSouth Rehabilitation Hospital.

Some key things to remember, in order to differentiate HealthSouth from other post acute providers, we are much larger than the next ERF provider, as they may have, right now roughly about 12 ERFs and then it drops off from there. Only about 25% of our properties are leased. So we are not strapped with an escalating lease cost, lease expense. We currently have 31 – of our hospitals are joint ventured with acute medical systems. Some are academic-based, some not for profit, some for-profit. We were able to consolidate all but one of those into our financials.

Our cost structure, which we're very proud of, is significantly lower than the rest of the industry, while we still treat a higher acute patient. We are able to get higher outcomes in terms of our functional independent measurement or FIM score, which is the industry, standard when it comes to measuring outcomes and quality achievement on the patients receiving our care. And we are very proud of our balance sheet now and have ample cash to grow.

So that's a brief overview of HealthSouth as a company with some insight into the industry in which we do business.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

Great, thanks Mark. Just to start things off, I think stepping back – from my point of view one of the clear differentiators of HealthSouth in terms of the financial performance for years has been this, the consistency of operations and the consistency of volume growth, where you have reported positive same-store discharge growth, I don't know how many quarters now, as long as I followed the Company, I think and its I think exceeded consensus expectations for 26 consecutive quarters. And just stepping back, what do you think it is about the rehab industry maybe and HealthSouth specifically that accounts for the consistency of those results.

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Well, we are quick to say that our ability to achieve any of our volume growth metrics clearly lies in the quality of care we provide in our hospitals. And we've taken great pride in the resources that we have, whether that's our nurses, our therapists, the buildings and equipment in which we operate, but we are very, very pleased with the quality that we achieve in our hospitals and put a huge focus on that. And that leads directly into the volume and reputation that we are able to maintain and achieve in our marketplaces.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

In terms of thinking about the Affordable Care Act and the impact that we are seeing in the acute care space, is there any downstream impact that you think you are seeing from

that incremental volume? If you are much more focused on the Medicare elder population, so how do you think that...

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

I wouldn't say we have seen a direct impact. I think longer-term we'll prove whether or not we've seen an impact from that. We did not have the coverage or bad debt issued that the acute care hospitals have on a bed that runs about 1.5%. So we did not see – we were not suffering from that situation. So therefore, when the coverage guidelines or the coverage increased, we did not see a direct impact on that, that we can tell at least at this point.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

For the past year or so I think consistently you have reported higher acuity gains each quarter. What do you think is really driving the intensity of this? Programs that you have in your marketplace is it just the patients? Is it the case mix changing, meaning you are getting more neurology cases?

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

It's all of the above. We essentially design programs around the needs, to meet the needs in our marketplaces. Clearly, the rehabilitation industry has shifted over the past six or seven years from an industry that had a higher mix of orthopedic population, many of which are now being treated in a less intense setting – many of those cases quite simply are going home now with home health – to a program mix, as you can see, as defined by our mix.

We have almost 40% of our cases are either stroke or neurological. And typically, with those types of patients goes a higher acuity level. They are more medically complex. They have a lot more comorbidities. They are much more medically challenging. That is part of the industry trend. And quite frankly, the medical necessity guideline have also played a big part in that, such that the patients have to be pretty sick nowadays in order to meet the medical necessity thresholds that we are required to be in our industry.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

It might be helpful to step back. And when CMS implemented the 75% to 65% rule, whatever we want to call it at this point, where was your mix then? And where do you think the industry was and where the industry is now, and how do you compare now?

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Well, if you go back probably eight or nine years ago now, the industry – the highest single category of discharges in terms of diagnostic categories would be the joint replacements. And the industry as a whole was somewhere around 25%, if I remember

correctly. We were always a little bit less than that. I think the highest we were was 17% or 18% of our discharges came from joint replacements.

Now we are between 7% and 8% of our patients come from joint replacements. So you can see how that patient mix has changed over the years so the higher acuity of the case mix index has crept up really for two reasons. We are seeing a higher number of strokes and you are taking out the less acute patients at the same time. So that's what's having an impact on acuity.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

Yes. HealthSouth has been able to generate consistent same-store revenue growth because it's a same-store Medicare revenue growth. And then when you look at a lot of the MedPAC statistics, the spending within the industry has been mostly flat. Is that driven by market share gains? Is that driven by other capacity coming out of the marketplace? What do you attribute that dynamic to?

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

For the industry or for our consistent gain?

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

For both, I mean it's just interesting to observe that the Medicare spending has been mostly flat for a number of years, whereas you have continued to grow.

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Well, the program mix of which we are referred to took a lot of volume out of the industry back when they put in the 60% guidelines. And so that dropped the cases way down. The spending dropped off. So for the past several years it has been fairly flat for the industry. We've been able to take market share from other providers that has allowed us to consistently grow.

And then if you look at just the underlying demographics of the industry of which we participate in, there's about a 3% CAGR that's out there, just the growing Medicare population. So that's one of the reasons that we still – that we are in a good sector within healthcare. You've got the demographic, the aging populations are playing into a growing need for inpatient care.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

And then on – kind of the external development, you've for a number of years now have had several de novo projects and just new construction projects underway, I think maybe six to seven in a given year. What is driving those projects? Is it the need for capacity in

the market? Is it a hospital coming to you? I'm just kind of interested in what's driving that?

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Yes. Well, our goal is adding four to six new hospitals per year, whether that is through acquisition or de novo growth. So our development team has really refined a bed need model over the years, looking at literally every county within the United States in terms of bed need and the number of beds in the marketplace – is there a surplus, is there a shortage? That really has been the driving factor behind our de novo development.

At the same time, we are very aggressive about going out and cold calling on existing – they're typically one-off relocation hospitals across the United States and letting them know that if they would like to have some sort of a strategic partner or maybe even exit the field, that we would be interested in talking with them.

That has led to a number of acquisition opportunities or, in some cases, joint venture opportunities to take, let's say, an existing rehab unit within an acute care hospital, bring it out, and build a freestanding relocation hospital, grow the business, grow the marketplace, and joint venture on a new hospital.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

Really, that has been a theme that has been in existence for a period of time with non-profits looking to exit non-core service lines. And rehab certainly fits into that. Do you see anything that would alter the dynamic that is catalyzing the decision to leave those non-core markets?

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

I don't. We continue to see hospitals that recognize they don't have the expertise in inpatient rehabilitation. It has never been a strategic focus of theirs. And when they have limited funds and they are trying to figure out how to direct a limited capital investment opportunity, relocation is not always seen as a strategic product line from many of these not-for-profit systems. There are some that are avid about maintaining that service line. But there are plenty that see that this is not a business or a sector that they want to either remain in or want to remain in as an independent provider.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

You have had a number of operational issues underway for a couple of years. And TeamWorks is one that has been around and has gone through a couple different iterations. Can you maybe just refresh and remind that where you are with TeamWorks, what the origin of that project was, and where you are now?

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

So Whit is referring to TeamWorks, which is our moniker that we apply essentially to standardization. So we have 103 hospitals. We like to standardize our practices as much as possible. The first standardization project we did, or TeamWorks project, was our sales and marketing initiatives that we rolled out several years ago where we looked at all the marketplaces and essentially identified, using both our internal subject matter experts, and in this case we used an outside consulting firm to help us put it together and materialize it.

But we developed kind of a playbook, literally a playbook on our sales and marketing design. We had tools that help on accountability. We outlined a number of sales and marketing liaisons that need to be in every marketplace for every hospital. So, we've then standardized this plan and model across all of our hospitals. And we attribute that for much of the consistent growth that we have been able to see since we rolled that out. After that initiative we rolled out something we called care management.

And that, once again, looked at taking best practices for our case management, typically who worked to deliver and schedule the discharge process for our patients, and the whole communication aspect that goes with that, and standardize that across all of our hospitals. And then our recurrent TeamWorks project is looking at the patient experience as a whole. Press Ganey has been our vendor now on our patient satisfaction surveys.

There were certain questions on the survey that we wanted to make sure that we were best in class on. And so we've worked now with Press Ganey the same type of format, the same model, where we will develop a playbook, we will model it and pilot it in a couple hospitals, refine it and then roll it out to all three hospitals. So that final TeamWorks project that I've alluded to right now, the patient experience, will be rolled out before year-end of this year.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

Something that is unique about HealthSouth is several years ago the Board decided to make a major investment into electronic medical records. And you had a process of converting all of your facilities over to a Cerner system for a number of years. And I don't believe there was a great off-the-shelf product that Cerner really had to customize something for you, which is unique.

But can you talk about the decision, why you made the decision to invest in today's electronic medical records, what you are getting out of that now, how this could differentiate you in the marketplace as hospitals investment into electronic medical records, what you are getting out of that now, how this could differentiate you in the marketplace as hospitals invest and you can connect to some of the referral sources, and when you think HealthSouth will be at a point where you can actually talk about some tangible returns on that investment?

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

So just as a reminder, post-acute was not included in the high-tech payment. So any of the post-acute providers out there that have any type of electronic medical record which there are a few – they've had to make a major financial investment. HealthSouth is and was one of those. We looked at it for a number of years before we decided that we could financially afford it and support it.

We looked at the various vendors, did an RFP. As Whit said, there weren't really any off-the-shelf clinical information systems that applied to what we do in the relocation hospital. They are always what's done in an acute care, short-term acute care hospital, but it's kind of like fitting a square peg into a round whole. So we worked with Cerner. We developed the system. They had some experience with the Rehab Institute of Chicago, so they had a little bit of history and templates.

But we worked with them over a year and a half, piloted it in one of our hospitals in Loudoun County, Virginia once again, and then refined it, rolled it out to two or three other hospitals before we rolled it out across our entire – or are in the throes of rolling it out across all of our hospitals. We have it now in 51 of our hospitals. We will have it throughout all 103 hospitals by the first half of 2017.

We are rolling it out about 20 hospitals per year, we are able to implement it. We did not sell this to our Board in terms of expenditure as having a return on this investment. We knew that this was – ultimately, we think that post-acute providers are going to be required to have something of an electronic nature. We knew that we were going to be getting behind the markets in terms of recruitment and retention of nursing staff, of therapists, of the physicians who wanted work on our hospitals.

They just simply were going to be not as inclined to come on over if they were going to have to do all paper charting when every other acute care hospital post-acute care hospital was working in an electronic environment. Ultimately, we do think that we will be able to extract data that can be applied toward clinical protocol, clinical practices. That term big data is often thrown out there.

And we will have whatever, 140,000 discharges or whatever the number will be, this year. But we will have a lot of data that we will be accumulating and be able to apply toward the best course of treatment for patients. I think that there are other benefits, too, such as in an integrated environment we are already able to interface with our 31 joint venture partners that have the system.

So we will be able to exchange information upstream. We will be able to exchange information downstream. If you think about a bundling world or an exchange world out there, marketplaces, it's going to be a competitive advantage for us to be able to interface electronically with other providers that are out there. And that's really the reason that we went ahead and made this major commitment.

The Board saw that this was going to be something that's necessary. There was also the thought that this was not something you could just put in, in a one-year timeframe, this was going to take multiple years to put in. So, we didn't want to get behind the curve. We are ahead of the curve right now. We think it's going to truly be a competitive advantage for us in the future.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

Got it. And that's a good segue to the next topic. There's always a ton of focus on post-acute and organizing post-acute and organizing post-acute and reforming post-acute and bundling post-acute. It's got a ton of different terms and names and there has been a lot of focus from policymakers in the past year, a lot of staffers, it's had hearings and what is HealthSouth's perspective of what is going on? And how quickly do you think that we'll actually see any change in reorganizing the post-acute care sector?

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Well, we have been quick to say that we think it's evolutionary not revolutionary. I think that is playing out if you go back even a year, year and a half ago, in terms of what some people were saying the future would look like within a year's timeframe. It's not what many had thought it would. We are participating, particularly with several of our 31 joint venture partners who have put together ACOs. A system like Geisinger, Vanderbilt, BJC and St. Louis, all are working with ACOs or bundled situations or agreements. And we are participating on that.

We have submitted an application. We are in the throes of the application process now for a post-acute bundling project. And we will assess that once we fully get geared in with the CMS and they get the information distributed back. For post-acute providers, one of the things we have is fairly short insight, what happens to the patients post discharge from us. So what has happened as part of the bundling project is CMS is providing cost per provider on a 90-day timeframe.

So it's giving us great insight. Even if we don't move forward on bundling initiatives at all of our hospitals, we are still getting some really good insight in terms of what information CMS has and where we would need to move forward, but we think that there's an upside for HealthSouth, in a bundled environment we are the high-quality, most efficient provider in the marketplaces. And anytime you are positioned as such, we think you will be in a better position to respond to a changing provider of marketplace.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

Got it. Last question I have is just around capital deployment. And in the past two years HealthSouth has certainly I think had come out of its shell and the Board put in place a dividend, buyback, Dutch auction. I could probably go on and on and on. Your leverage is at or below two and a half times at this point. You still are sitting on a fairly sizable NOL which you will probably continue to extract value from over the next 18-months to

24-months or so. Where are the priorities at this point? How do you think about returning capital back to shareholders? So just kind of an open-ended.

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Well, right now we think the best use of our free cash flow is funding our growth and whether it's through de novos, whether it's through a potential acquisitions that might be out there and strategic opportunities for us. We are on a track to add about 80 additional beds to our existing hospitals each year to provide additional capacity to a number of our hospitals that literally have a waiting list of patients. And that is really one of the best ways we could bring value back, because the return on those bed additions is substantially high. So right now, we see the best way we can benefit the shareholders is to use that free cash to fund our growth.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

Got it. And I think on the balance sheet you have got a couple notes that are maturing in the next six to nine months or so. What should we expect in terms of calling those or refinancing those notes given today's rate environment?

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Well, I think you had mentioned earlier. There are two tranches that are out there and we have been and continue to evaluate the options of working with those that might be strategically advantageous to us. So, we are evaluating all options on that right now.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

Perfect. We are running out of time. Mark thank you so much

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Thank you.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

Appreciate it.

<<Mark J. Tarr, Executive Vice President and Chief Operating Officer>>

Appreciate it.

<<Whit Mayo, Analyst, Robert W. Baird & Co.>>

And thank you.