HealthSouth Investor Day
New York

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Jay Grinney: I think we'll go ahead and begin. I'll welcome everyone to today's HealthSouth Investor Day. We're very pleased to be here with you and to share with you some of the exciting things that are going on at the company.

If you perceive that the team is a little bit shell-shocked this morning, it's because that around 6.15, I sent them an e-mail. I had a copy of -- an old copy of the decks. I saw a mistake.

I sent out a blast e-mail that was not particularly positive in nature, and got everybody's attention. Then realized that I had an old copy of the deck. So I apologize. You guys can relax; it was my problem -- my fault.

So what we would like to do today is to review with you how we believe HealthSouth is uniquely positioned to be successful in today's evolving healthcare-delivery and payments system.

As you know, we have two businesses. Two segments. Our inpatient rehabilitation and our home-health segment. They are both going great-guns in 2015; we're very pleased with the operations of both of those businesses.

Today really is focusing on where we're going. And how we're going to be successful two years from now, five years from now -- 10 years from now.

I think one of the things is going to be that we don't have a crystal ball. We don't know exactly what the timing and the pace of change is going to be. But as you'll see in the presentation, we do believe that change is inevitable. That the current fee-for-service system is not going to remain perfectly intact for Medicare payments, indefinitely. There will be changes.

Now is it going to be 100% of Medicare payments will be under some kind of value-based system? Will it be 50% as CMS would like? Is it 30%? Nobody knows. But a portion of our business is going to be value-based.

I believe that we have taken the steps to position the company to be very, very successful in that kind of environment. So the timing may be still a question, but we do believe that there are enough changes going on. There's enough momentum that we need to be positioned for those changes.

So it's really focusing on where we're going to be down the road and how can we be successful longer-term.

But I do know that everybody here -- management included -- is always focused on the here-and-now. As you saw in the 8K, we did give you a little glimpse into the second-quarter.

We're very pleased with where we are, both in in-patient and the home-health side. Buy-ins look very good.

We're certainly not through the end of the quarter, but where we are at this point, we're very pleased with what we're seeing -- in terms of discharge growth and admissions growth on the home-health side.

You'll also note that there was an SSI adjustment that we got from the government. We now are incorporating that. That's going to be about a $4 million to $5 million hit to EBITDA, estimated, for the second quarter.

Just what I was saying -- sometimes they work in our favor. Sometimes they don't. This time they didn't. We're absorbing that.

I think one of the takeaways of when I was talking to -- I think -- Kevin, earlier, outside --

One of the takeaways from today is, the base business is really strong. I mean in the first quarter, we had that bad-debt adjustment surprise that we didn't anticipate. We climbed over that.

We had the settlement in West Virginia and now we've got this SSI. It's a little bit pressing for us, because we've got these headwinds.

But the good news is, we're still staying with our 6.70/6.80 guidance for the year. So the base business -- the takeaway -- is the base business is doing very, very well. And it's able to overcome these unique and one-time headwinds.

So that's one of the takeaways that I'd like for you to take away from the meeting, today.

That's probably all we're going to really talk about in terms of quarter. And we're not going to really go back and reconstruct Q1. We really want to focus on the future.

And as we do that, one of the things that is critically important to understand -- I know most of you do understand it -- most of our business is Medicare. Both on the inpatient rehabilitation side, on the home-health side. Our business is to take care of Medicare beneficiaries.

As we all know, the baby-boom cohort is aging. Back in 2011, that cohort started to hit 65. So we're seeing that grade of growth in the over-65 population trend from a 2% CAGR to a 3% CAGR.

We think that that presents a very, very nice tailwind for our business. Both on the inpatient and on the home-health side.

As you see from the charts, that growth is going to continue. There's going to be a demand that is inexorable.

The other thing -- a component of that -- is that a lot of the care that is required by seniors is non-discretionary care. People don't choose to have a stroke. They don't choose to fall and break their hip. They don't choose to have multiple chronic conditions. They don't choose to have debilitating neurological conditions that afflict many people in old age. Those are inexorable. They're inevitable.

In many cases, they're not going to be prevented in this generation or the next generation. If there are going to be cures for diabetes and congestive heart failure and some of these other issues, it's down the road.

The demand -- as we see it for the long foreseeable future -- is very strong for the services that we provide.

Demand is there. What's going to happen to the payment and the delivery system?

I want to just touch on a couple of trends that we see. I mentioned it earlier in my comments just a minute ago. That is the movement away from being paid episodically on a per-procedure basis. Everybody gets paid separately.

Frankly, I believe, in a very uneconomical way. A very inefficient way. Fee-for-service.

A lot of trends are pushing -- and I don't need to convince you, I don't believe, that those trends are definitely in place.

If you look at what the commercial side is doing, they're recognizing that their costs have to be brought under control. Particularly now that they are serving a much-greater population. The previously under-served, uninsured that are now part of their underwriting needs as a result of Obamacare.

Then on the Medicare side, as well.

So there's a lot of momentum, moving to getting us away from a fee-for-service into some kind of coordinated care, coordinated payments system. Maybe it's bundled. Maybe it's shared savings. Maybe it's ACOs. Maybe it's capitation. Maybe and probably it's a combination of all of those.

But in that kind of environment, providers -- I believe -- who can demonstrate that they provide high quality. And that's always going to be, in my mind, the determiner of whether or not a provider is successful.

High-quality, cost-effective care are going to be the ones that will succeed.

I think one thing, as we look at the environment that is unique today, is the push from CMS to get us away from the fee-for-service. Very aggressively.

They put out goals. I think that they are optimistic goals. Whether or not they'll be achieved, I think, is still up in the air.

They've put out some pretty dramatic goals for the industry, where they have said and put a marker out there, in terms of how many payments they expect to be value-based, and in a very specific time-frame. Again, timing on that -- I think that's still up in the air. But I think that the takeaway for us is the train has left the station.

What are those models? ACOs.

I think ACOs get probably more airtime than some of the other payment-and-delivery system models. In our opinion, that model is still subject to validation.

As you can see on the left-hand side, in terms of the pioneer ACOs, the average savings over the first couple of years is about $6 million per ACO. And if you look at the reports on, "Well, what does it cost to get an AC up and running and operating?" It's about $6 million.

So I'm not sure that based on the very early preliminary results that this model has demonstrated its sustainability over the long-term. I think it's still in an experimental phase. Both on the shared-savings side as well as the pioneer side.

I just don't think that the provider community is going to embrace something that requires an enormous amount of effort and very little return. And in fact, as you see on the slides, there are a lot of participants in both the pioneer and the shared-savings who got in, and they're not seeing any benefit. And many of them are dropping out.

That's not to say that we don't think ACOs will have a role. We're just not convinced at this point that it is going to be a dominant form of payment for Medicare beneficiaries in the immediate future, as defined within the next 3 to 5 years.

Ten years out, I think that's still a question. And we'll have to monitor that.

The other pilot that's being driven from CMS as a result of the Affordable Care Act is bundled payments. I think everybody here knows that there are many more participants in bundled-payment arrangements. We're participating. Both on the hospital side as well as the home-health side.

In part, because it's a little easier to get your arms around the risks associated with a bundled type of environment. You can choose which hospitals. You can choose which agencies are going to participate. You can choose which conditions you want to take that risk on. You have the ability to start choosing on a more narrowly-defined basis who your partners are going to be.

So we do think as we look at value-based systems, that the bundled environment has a little more potential than the ACOs. At least at this point, in the very early stages of the evolution of the healthcare-delivery system.

As you probably saw in the deck, Mark will talk a little bit about what we're doing on the

hospital side, with respect to bundled. April Anthony will get up and she will talk a little bit about what's going on on the ACO and bundled side in our home-health business.

Another trend is the movement toward site-neutral payments. It's a concept as everybody knows that's been around a long time. It's been proposed for a number of different provider groups.

In our world -- in the post-acute world -- the focus is on looking to pay inpatient-rehabilitation facilities and skilled-nursing facilities. The same for certain conditions that are treated in both settings.

I think everybody is aware of the Impact Act passed last year. Sets the stage. Not for an inevitable site-neutral payment system, but sets the stage for the government to evaluate and to determine, "Does it make sense?" And, "Are there cost savings to the program by implementing a site-neutral payment system?"

So it's another trend that I think is moving us to sort of a point where the silos that exist today -- particularly on the facilities side of the post-acute spectrum. Long-term acute, inpatient-rehabilitation and skilled-nursing. Those silos are -- as we look out over the next three to five years --

Those silos are starting to get blurred. Today, those silos exist for really one purpose. That's strictly to define how Medicare is going to pay each silo.

So, we have the 60% rule. We have coverage requirements. The three hours of therapy. All of those are designed not to enhance patient care. They're not designed to identify the best protocols for treating patients. They exist for only one purpose, and that is to define how that provider -- and in this case, inpatient rehabilitation facilities -- are going to be paid.

Well if we're moving toward a system where the payment is going to be coordinated, or that payment is going to be bundled, or that payment is going to be somehow a single payment -- the need for those silo regulations that define how we get paid start to become irrelevant. Because the payment now is not specific to a facility. It's going to be specific for a patient need.

We believe that that's one of the key pieces of going forward. This notion that five years from now or ten years from now, the post-acute environment is going to look exactly the way it does today. We'll have long-term acute-care facilities. We'll have inpatient rehabilitation facilities. We'll have skilled-nursing facilities on the facilities side.

I don't think there's going to be any change on the home-health. But those are all going to exist exactly the way they do today -- with the criteria and the rules and regulations --

We don't think that that's necessarily how that future is going to look. We believe that there is a future that will have a facility need for post-acute patients, and a home-health need. And for those who can coordinate the services between those two. A facility and the home. Those are the providers whom we believe ultimately will be positioned for success.

So that's precisely why HealthSouth and Encompass partnered in December of 2014.

April and I have been talking for several years. I had started thinking about, "Okay. How do we get this home-component that will complement the facility component of what we do?"

Did a lot of research. Talked to a lot of people. And there was one name that kept coming up over and over and over again as the Premiere high-quality, high-integrity home-health provider. There was only one.

It wasn't like, "Here are two or three." There was only one that consistently came up. That was April Anthony and Encompass. Actually, I guess that's two names.

But it was the one company that we felt if we were to make that move into home-health and to provide that follow-on care, that was the one company we wanted to partner with.

It was very fortuitous that Cressy decided that the time was right to position Encompass for sale. We worked very hard and we're very pleased that at the end, we were chosen to be their partner.

That was a strategic decision on our part that had been 4 to 5 years in the making. We were just waiting for that right time, to be able to make that acquisition. To be very aggressive in getting that. Looking for the opportunity both near-term and longer-term. To bring both facility-based and homebased services together. So that we can provide the full range of services needed for patients that are being discharged from acute-care hospitals.

We do think that the bringing together of the inpatient rehabilitation -- today it's inpatient rehabilitation. We're thinking of it more in terms of facility-based post-acute care. And home-based post-acute care. Will position us to be successful in this new world order that is going to be characterized by coordinated care in some fashion. And coordinated payments in some fashion.

Maybe it's bundling. Maybe it's capitation. Maybe it's something in-between. But we do believe that the future will include a significant portion of those, in terms of our business -- and in terms of how we get paid.

As we summarize just the key elements of our strategy, first and foremost, as I mentioned --

We are focusing on the Medicare-beneficiary population. That 3% CAGR growth that we believe is really the core market.

The really foundation for the strategy is to maintain a focus on operational and clinical excellence. We have to continue to focus and ensure that on the hospital side and on the home-health side, we are providing the highest-possible care we can for the patients that have been entrusted to us.

We're very pleased with the ability to do that, today. We know as we look at how we compare to other industry-participants that we are at the leading edge from a quality standpoint. Mark will go over that in his remarks. April will go over that in her remarks and sort of reinforce that.

But we are committed to maintaining that focus. And always looking for ways to enhance that.

We need to make sure that we maintain our industry-leading margins. Being able to offer high-quality cost-effective care, as I said before, is really the bedrock of success, going forward.

We are very pleased with the fact that we operate our facilities and our home-health agencies on a very high-quality cost-effective basis. We need to continue to do that.

We are right now beginning to test the waters and lay the foundation -- and it's very early -- of establishing that clinical collaboration between the services in our rehabilitation hospitals and the services in our home-health agencies.

As you know, the initial focus for us is to take our 25 home-health legacy health-style agencies and to integrate them and to convert them over to the Encompass platform. That is underway.

We are pleased with the results, thus far. There are a few bumps, inevitably, early on. I think we're on the other side of those. And we're learning.

Tracey Kruse, who is the chief operating officer for Encompass, has done an outstanding job of managing that process and really leading that. Frank Brown, who's our regional president in the Southwest region, has most of the overlap agencies. So he's been very involved.

And we're seeing some nice success. A long way to go, but we're pleased with where we are right now.

April will address later in her comments where we think the opportunities are in terms of capturing some of those referrals and providing that care on a higher-quality basis, going forward.

So that's something that we're starting to do right now. We're laying the foundation. There's a lot of work that has to be done. So it's not anything that's going to move the needle in 2015 or 2016.

But as we start to really understand how we can collaborate clinically, I believe it then positions us at some point down the road to consider whether or not we want to take risks. If we want to go to the advantaged plan and take some of that post-acute risk off of it.

I think everybody is aware today the plans really like to shunt a lot of the post-acute patients into SNF (ph). It's just easy. It's simple. They do it on a per-day basis. It's

cheap.

They don't always step back and realize, "Yes, it may be cheaper on a per-day basis, but they're there for three weeks as opposed to two weeks," and in a rehabilitation hospital there are readmission-rate issues -- and so on.

As we think about the future, we think that a collaborative model between facility-based post-acute in our hospitals and the home-based services provided through our partnership with Encompass really starts to obviate the need for a lot of the patients that are currently going into skilled, for more convalescent care. Before they get comfortable or their families get comfortable that they can go home and can go home safely.

We're seeing that even today. The patients that we think could be discharged home, but we don't have an Encompass home-health provider in that market to make it a smooth and easy and safe transition -- the patients are saying, "You know what? I'm not sure that I'm ready."

Oftentimes it's the family saying, "I don't think we're ready," to have this patient come home. "Can we put them into a skilled facility for a period of time?" They work with the physician, and that's exactly what happens.

Our belief is that if you think about where we could be down the road, those patients don't need to go into a SNF setting for any kind of continued convalescence. They really should be -- and virtually all of them want to be -- in their homes. Where they are with their loved ones and in familiar surroundings.

We believe with our partnership with Encompass, we can provide that. And allow those patients then to move seamlessly to the home. And not ever have to set foot in a skilled facility.

So that's kind of the foundation of the strategy. High-quality, cost-effective. Collaborative. Clinical. Cooperation and establishing those protocols. Then eventually evaluating whether or not that gives us the ability to move to the payors to take some risk.

During that time-frame, we think that there is a lot of growth opportunity yet to be realized in both the home-health and the inpatient rehabilitation businesses. Mark will talk about the IRF growth opportunities. April will talk about the home-health growth opportunities.

But we're very excited about the continued growth that we think is achievable, going forward.

Obviously when we do that, we're going to be very mindful of protecting the balance sheet. In the past, I think the focus -- back in the 2007/2008/2009 time-frame -- was to maintain a strong balance sheet. We were über-focused on getting our leverage down below-3-times and keeping it down there.

We did that in part because of the uncertainty back in those times.

As we think about the balance sheet going forward, we really recognize it's something to be used for the value of our shareholders, in a lot of different ways. But we can use that capacity not only for shareholder-distributions. We're going to continue to maintain our dividend policy. We'll opportunistically evaluate share buy-backs. But we ought to be using that to help grow the business. To expand the business.

Now we have two platforms to do that. We have very exciting opportunities.

So we'll be utilizing the balance sheet. You saw us do that with the acquisition of Encompass. We have been getting for a lot of years, "Why are you guys keeping the leverage-ratio so low?" We were at 3.2. Then we were at 2.8. Then we got to 2.5.

Well, it wasn't just because we like to be able to tell shareholders, "Hey. We've got 2.5-times leverage." We were doing that so that we could have the capacity and the dry powder and the ability to make strategic moves when we saw that those strategic moves would be to the benefit of our shareholders and the company.

So what did we do? We levered up to get to the position where we could acquire Encompass. And we'll be able to now move that back down, because we've got a larger operating platform that will generate incrementally stronger EBITDA. That will then, over time, lower that leverage ratio.

We'll utilize the balance sheet as we believe is appropriate, but we'll do it in a disciplined way.

I think part of the reason we were focused on demonstrating to shareholders our commitment to a strong balance sheet and very strong leverage, meaning low-leverage, is to demonstrate to shareholders, "That's really where we want to be." But if we need to lever up, we'll do it.

If we need to utilize the balance sheet to build and to grow the company, we will do that.

So as we think about the future, the balance sheet that we have and that we've established -- and Doug Coltharp, our chief financial officer, will talk to you a little bit more later in the presentation -- about how we think about our capital structure. How we think about utilizing the free cash flow that we're generating.

I think you'll walk away from today with a high degree of confidence. Hopefully an even-higher degree of confidence that we will indeed be very, very good stewards of this very strong balance sheet that we have established.

Those are my comments. Opening comments intended to try to set the stage.

What we're going to do now is, I'm going to ask Mark Tarr, who's our chief operating officer, to come up. Talk a little bit about what's going on in our inpatient rehabilitation segment.

Then I'll come up and introduce April Anthony. She'll talk a little bit about what's going on in our home-health segment. Then we'll take a break.

Doug will come in. Talk a little bit about our capital structure. Free cash flow utilization.

We'll then wrap it up and then open it up for q-and-a.

Mark?

Unidentified Participant: Green, forward; red, back.

Mark Tarr: All right! That was the first question I had.

Good morning, everyone.

So our provider portfolio of 109 rehabilitation hospitals provide us with a number of strategic advantages. These are strategic advantages of which we use currently in the marketplaces we're in. And in today's existing healthcare world.

But maybe more importantly, these are strategic advantages that position us well for the future.

Many of those changes that Jay alluded to, relative to where Medicare is going, and the future healthcare world, we feel that we'll be well-prepared for any of those changes that have come down and into the future into our path.

So we'll do a deeper dive on these strategic advantages as I go forward.

There are a number of things I want to point out on this existing slide. Starting first with the bullet-point that you see up there that relates to our hospitals, themselves.

All of our hospitals are freestanding rehabilitation hospitals. They were either built from ground-up or retrofitted in a manner that maximizes patient-flow. Maximizes staffing efficiency.

They all incorporate the latest technologies relative to clinical tools; clinical equipment that can be utilized and facilitated to advance our patient care.

Rehabilitation itself is not really a segment of healthcare that uses a lot of high technology. A lot of it's just manual with therapists working hands-on with patients. But we believe that we want to make sure that of those technologies that are out there and available, that we make sure that we have them in our hospitals if it helps to advance our patient care.

You'll hear me talk here in a few minutes about our clinical information system that we now have in 68 or our hospitals. And we'll roll out to our entire platform.

We believe that, too, is a strategic advantage; particularly as you think about the future world. Where collaboration with other providers in the marketplace -- well -- for us, that's acute-care or home-health. The ability to integrate and interface in a collaborative

manner.

All of our hospitals are located in convenient sites, relative to our referral sources. Relative to physicians in the community. That may be practicing in our hospitals or also covering in the acute-care hospitals.

Then another point that we like to make is that we own 75% of our buildings and real estate. So we think this, too, is a strategic advantage as we move forward.

We like the idea of having the ability to avoid escalating lease costs that may come if our buildings were owned by REITs in that setting.

Jay talked about our importance of quality. We are quick to always call our quality and our quality outcomes. That is our secret sauce in our hospitals. I'm sure April feels the same way about her home-health sites.

It is an area that we look at, monitor, put a big focus on with our staff. With our medical staff.

A couple of different ways we look at patient outcomes and quality in our hospitals. One is through what we call our FIM scores. Our functional gain that our patients make in our hospitals.

Then we also look at it to a large degree on the discharge status. So are our patients going back home? Back to the community? Are we able to avoid acute-care transfers or readmissions back to acute-care hospitals?

Can we avoid unnecessary discharges to SNF? Can we get more and more of our patients back home and back to the community? Many of which will need home-health care.

That is critically important to us.

Then also, our buildings are laid out that they all have medical gasses. They're typically single-story. Some of them are multiple-stories. They're easy to add.

But they're also easily adaptable to a future world that maybe has those silos torn down that Jay talked about. Where it may be at some point just a post-acute facility. Without the various segments of silos or buildup.

So this is a list of a number of what we would see as our strategic advantages in the inpatient sector.

We're very proud of the fact that one out of every five patients treated this year in inpatient rehabilitation hospital will be treated in a HealthSouth hospital. You can see here on this map where we are located with our 109 hospitals.

We have two hospitals in Puerto Rico. Heavy concentrations of hospitals in high-growth states such as Florida. Such as Texas.

We also have a high concentration in states that maybe aren't growing as fast from a population standpoint -- like in Pennsylvania. But it's an aging population. The population that exists in that state is a population that needs the type of care we are providing in our hospitals.

You'll see that we are heavily focused in states like Alabama, Tennessee. We have a strong representation in high-growth states such as Virginia. The majority of our hospitals or the majority of our beds -- a little bit over half -- are in certificate-of-need states.

These are states that have a state-regulatory body that regulates the ability to be granted a rehabilitation license for those beds. We have almost half our hospitals in non-CON states. Such as Texas.

So there are two ways of looking at that.

If you're in a CON state and you have a presence there, it's a little bit harder to grow. But your franchise is protected through the certificate-of-need rules.

In non-CON states, like Texas, it's great for us to be able to grow. We don't have to go through that regulatory process to add beds or enter certain markets. So we look at advantages or disadvantages that come with these silos. Nonetheless, those are the rules that govern the states that we're in.

Our average-size hospital is 68. That's a bit of a misnomer in terms of bed-count. The majority of the hospitals that we have built in the past 6 or 7 years are what we call our 40-bed prototypes. That's the size that provides efficiencies. It's the size that's needed for the marketplaces that we have been growing in.

That being said, we're starting to see more and more of our new development relative to our de novo growth being 50-bed hospitals. We've found ourselves adding beds to our 40-bed hospitals within the first few years of operations.

So we started thinking that maybe we should branch out and look at opportunities to have 50 beds from the very start, rather than that 40-bed platform. And then be already prepared for that growth that we had seen in those hospitals, as occupancy rate went up.

The range in bed-size of our hospitals ranges from a low of 34. We have one hospital that's 232 beds. That's our Cardinal Hill hospital that we've recently acquired in Lexington Kentucky. But somewhere in our sweet spot, it's right in that 50- to 70-bed space, right now.

Our outcomes. Our patient-assessment tool as it stands now, in terms of how we look at our outcomes, is used by what we call a FIM measurement tool. Functional independent measurement. That is what's used in this entire rehabilitation industry as the way of looking at and monitoring the progress made with patients.

It is a tool that has an 18-point assessment component to it. Where every patient is evaluated within the first 72 hours of admission. Then given a score on a wide range of

assessment areas. Typically, what you would call activities of daily living in the patient.

Are they independent to grooming? Eating? Bathing? Dressing? How are they on transferring in-and-out of beds? In-and-out of chairs?

We'll work with the patients on transferring in-and-out of cars.

What is their cognitive ability? What is their bowel-and-bladder ability?

So all of these are areas that fit into the FIM scores that our therapists, nurses and physicians use in assessing our patients. That within their first 72 hours of admission, they're assessed. That becomes their admit-FIM score.

Within 72 hours of discharge, they are once again scored. At that point, that's their discharge FIM score. Then the difference is called FIM-gain. That's what this graph here shows you. It shows you how we compare in our hospitals on that FIM-gain metric, to the database which is called UDS. Uniform Data System.

It's a database affiliated with the University of Buffalo that accounts for -- I think -- some 70% of the discharges in rehabilitations.

So this gives us a nice opportunity to go in and compare our progress, our functional outcomes, with where we stand against the industry. You can see we do very well against the industry. We're very proud of this. This is an area and a metric that we look at constantly among all 109 of our hospitals. And we're very proud to share these scores with you.

One of the areas that we're also putting a greater focus on, now -- as I alluded to earlier -- is the discharge status. And how many of those patients are we getting back home?

If we can collaborate closer with home-health, then that would give us an opportunity to maybe have some patients that previously would not have gone home -- because their physicians or therapists didn't feel that the patients would be comfortable going home --

But if we can collaborate closer and tighter with the home-health agency, then our therapists and physicians would feel that certain patients that they're currently sending to a nursing home, because they're just not comfortable with their level of safety and their independence, could now be sent home.

This all ties back into our FIM scoring. The higher our gain on FIM scores, the more likely that these patients are functionally capable of being returned back to the community.

We also take great pride -- not only in our clinical outcomes -- but our ability to achieve these clinical outcomes in a very efficient setting.

This table takes a little bit of explanation. This is from -- this information is pulled out of -- CMS cost reports and rate settings filed.

I want to draw your attention to the top row. You'll see the HLS. If you go from left-to-right, on that row, that gives our metrics on the various categories.

At top, this is comparing HealthSouth hospitals to non-HealthSouth. Other freestanding rehabilitation hospitals. It also compares us to the hospital units. You see that down on the left-hand side.

If you go up to the upper right-hand side in the blue box, you'll see two numbers. One is what we're paid by Medicare per-discharge. That $19,120. If you go down that column, you'll see what the non-HealthSouth freestanding hospitals are paid -- and the hospital units.

You'll notice that we are the lowest number up there. So we get paid less for caring for those CMS patients. Less-per-discharge.

If you go over to the $12,524, you'll see that's our cost-per-discharge. So we may get paid less, but we treat these patients in a more-efficient setting. Therefore, our costs are less.

And oh by the way, we're doing that with a case-mix index that represents the patient-acuity. You can see our case-mix index of 1.26 versus the non-HealthSouth freestanding case-mix index of 1.21 or 1.18.

So those numbers individually may not mean much to you, but if you think about them as being representative of the acuity level of the patients -- how difficult and how medically complex are the patients.

So we're very proud that we can provide this outstanding quality with sicker patients. But we do it in a more cost-effective manner. That's where many of our strategic advantages are laid out relative to our ability to staff more efficiently. To take advantage of our supply-chain and the initiatives that we've put in place.

Our best-practices with our clinical collaboration. We have 109 hospitals. That gives us a lot of information to compare in terms of who's doing what types of clinical protocol with strokes, with brain injuries and spinal-cord.

Then we make best use of the best-practices, and rolling those clinical collaborations and clinical protocols out to all of our hospitals.

Jay Grinney: You may want to mention why that payment differential exists vis-à-vis the outlier payments that we don't get.

Mark Tarr: Yes. The one key driver on here that I failed to mention are outlier payments. Outlier payments are patients that typically have high costs that fit a threshold that Medicare has established to try to make sure that hospitals get reimbursed for extremely high-cost patients.

Those patients that may be particularly complex. That may be in hospital for a really long length of stay. There's kind of a safety net that CMS has established, to make sure

that patients are appropriately cared for, that reach that high level.

Only less-than one-half of one percent of our patients reach that high-cost outlier. That means we work those patients through our system. Through our more-efficient provider manner. And get them discharged home or discharged to whatever that next step is.

But we do it in a cost-efficient manner that does not hit that threshold that Medicare has in place for these sick, sick high-acuity patients.

One of the really strong aspects of our company that has helped over the years is our internal IT group. It's been I think 5 or 6 years ago now, our own IT group came to us in operations and said, "We'd like to take on a project involving," in this case, it's called a Clickview software.

To help provide dashboards for the operators that are out in the hospitals, as well as our regional teams, as well as having the ability to roll up information and provide it for those of us in the corporate office, as well.

We had a number of different silos and repositories for information. Whether that was clinical information for our patients -- whether that was cost information -- whether it was labor-usage information. It was all out there, but it was not in an organized manner of which our operators and our hospitals or those of us that have rollup information in the corporate office could easily retrieve.

So our IT group put together a series of dashboards so that we have one location. We can provide one location for our CEOs at the hospitals. Their management teams at local hospitals. To access on their laptops or their iPads.

That will provide them with key operating information for them to make daily operating decisions every day at work.

The easiest way to explain this is through our labor. The initial application of this dashboard was using our staffing matrix. We think about our staff getting paid every two weeks. We have two-week payrolls. All of our information used to be that there was a 2-week lag on the information that we were able to provide our hospitals. It was based upon payroll.

We have variable census levels in our hospitals. A key aspect of our labor-management and being as efficient as we can be, depends on us being responsive in our hospitals on managing our labor.

This tool -- this operations-tool -- this Beacon (ph), as we call it, provides real-time information. There's about a day and a half lag now, instead of that two-week period relative to our staffing --

So our chief nursing officers, our CEOs, our HR directors in our hospitals can help make staffing changes up or down as our volume fluctuates from day-to-day. We can also control skills mix. Gives us a better opportunity to manage our overtime per-diem use or contract-labor use.

It just helps us be more efficient in our hospitals. Because we have real-time data, real-time information from which to make these management decisions on.

We've also through the years added a number of different types of information on here. You can see our volume metrics are on here. We have our quality metrics. So we know on any given day where we are on our FIM scoring. On our ability to discharge our patients back home.

We have AR information on here. We have the ability to look at our other variable expenses.

On the right-hand side, you can see that this same Clickview software has been used for our supply-chain. It helps us to make sure that our hospitals are compliant with our national contracts.

So this has helped us to drive our hospitals to an 85% or 90% compliance rate with our national contracts. So they're not out buying all of our national contracts with local suppliers and such that may not be as cost-effective as if they would incorporate through our national contracts.

We like to show this Beacon application. These dashboards. Because we do think it gives our management teams -- it gives our regional teams -- it gives myself the opportunity to have one site where we can go and pull up from this dashboard this critical information. That helps us manage daily our line of business.

Talked earlier about our clinical information system. We call it ACE IT; Advancing Clinical Excellence through IT. Yes, we are guilty of taking acronyms and applying to a lot of different things that we do in our hospitals.

We first started talking about rolling out a clinical information system probably about 7 or 8 years ago. At that time we wanted to make sure of a number of things.

One -- could we afford it? Could we sustain it?

We wanted to make sure that we found a vendor that had the scale and the abilities to support a system once we started down that path. We also looked for a vendor that had some experience in working with rehabilitation.

Our hospitals operate very differently than acute-care hospitals. The McKessons and Epic applications that you would find in acute-care hospitals have templates, patient-flows that are very different from what we have in rehabilitation hospitals.

We thought it was important to work with a vendor that had at least some presence in in-patient rehabilitation. We chose Cerner. We started working with Cerner. They had some experience working with the Rehab Institute of Chicago.

They had some basic templates already established that had been digitized. And worked up into a system that they were implementing up in Chicago.

We worked with Cerner. We adopted and modified some of their basic templates. We worked with our own operations team, working with Cerner. We piloted this software in one of our hospitals in Northern Virginia.

We brought it back in. We kind of made some changes; tweaked it. Rolled it out for four hospitals. Just to make sure that it would be achieving what we wanted to achieve with the clinical information system.

As you know, there are a number of hospitals that have had EMRs or clinical-information systems, and one of the greatest challenges -- one of the failure points on this -- is on implementation.

So we wanted to make sure that we not only had a good product, but yet one that we could roll out and implement in our hospitals. After we did the four test-sites, we set up a full-fledged rollout schedule.

This year, we're in our third year of the full rollout schedule. We're doing somewhere between 20 and 22 hospitals a year, in terms of rolling it out.

I mentioned earlier, we now have it in 68 of our hospitals. The current plan is to have this fully rolled out and into all of our hospitals by the first half of 2017. And we're on-track of doing that.

Up to this point, we're very pleased with the way this system's working. We've been able to roll it out, educate our staff on it. Convert out of a paper environment into this electronic environment.

We think it has given us an opportunity to strategically -- A -- keep up with acute-care hospitals in our marketplaces. It gives us the ability to recruit nurses and therapists that otherwise would not want to work in an environment where they're still having to do a lot of hand chart-work.

Same thing with physicians. There are fewer and fewer physicians that want to practice in rehabilitation hospitals that are all paper-charting. They're used to practicing in acute-care hospitals where there are clinical-information systems.

Then maybe most importantly, if you think out in the future, our clinical-information system -- our ACE IT, as we call it -- has the ability to interface and send and receive information. We currently do it with our lab reports, as well as our diagnostic reads.

So we have the ability to interface with acute-care hospitals. We've interfaced with all the major vendors throughout our phase.

So we can interface with Epic. We can interface with Meditech. We can interface with McKessons of the world that are out there. So that we can retrieve and send information.

It also puts us in a position to exchange information with any of the health exchanges that are out there. We already have now, for the past year and a half, been working with the

State of Missouri on their health exchange. And soon will be working with the State of Florida on theirs.

So we're very pleased with the rollout and how our clinical information system is working. This will also at some point provide us a lot of information that we'll be able to tap into as we look at our own clinical outcomes and start to extract data electronically as to these best-practices or these clinical protocols. That we can identify indicators that may help predict certain outcomes or certain issues that our patients may be heading down the path clinically. So that we can intervene with clinical interventions earlier-on.

About a third of our hospitals -- 33 of our hospitals -- are joint-ventured with major acute-care systems. They range in ownership, as you can see. Ranges from a low of 2.5 up to 50%.

We do have one hospital that is joint-ventured. Our Yuma hospital is joint-ventured. But we are unable to consolidate that, just based upon some of the language that's in the agreement.

You can see a subset of our 33 partnered systems. These are all systems that the typical scenario was, these systems had a rehab unit within their hospital. Say a 20- to 30-bed rehab unit.

It was an area that they knew that they either wanted to expand or knew that they didn't do it very well. And did not want to put a huge focus on that within their existing platform.

So they began searching out partners. A HealthSouth would come in. We would put a value on their unit, apply that value to their equity stake in the foregoing partnership. Then we would build a freestanding hospital at a location that was convenient for that hospital and the existing referral sources.

This gives us an opportunity for clinical collaboration. Many of these partnerships are with academic institutions. Academic medical centers.

We have residents in some cases rounding through our hospitals. We certainly take advantage of therapy programs, whether that's physical therapy, occupational therapy, speech.

We're affiliated with a number of nursing schools.

So having these partnerships not only gives us the ability to clinically collaborate with them; it also gives us a strategic position in these marketplaces to pair up.

Many of the marketplaces that we enter now, we determine as we look at marketplaces strategically, are they marketplaces that we feel comfortable with going in without a partner? Or are some of these marketplaces where we would be positioning ourselves to be more successful if we did partner with an acute-care system.

Jay mentioned earlier that we're involved in bundling projects. If you think about the

bundled world as it's set up now -- if you think about the various models -- we're involved in Model 2 and Model 3.

As you can see here, Model 2 is where the acute-care hospital is entered into the bundled program for that with specific episodes that they have determined that they want to be involved with.

The Model 2 involves the acute side, as well as the post-acute. Our role in that, with the Model-2 setting of which we're involved with 16 of these, now -- where we have a preferred-provider type of arrangement with the initiator of the Model-2 bundling.

We also have a number of our hospitals that are participating in the Model-3. That's where the bundle starts on-admission into our hospital. And we're responsible for that 60-day period, as we've chosen for our hospitals, as part of that 60-day episode.

Last year when CMS called for interested parties that would want to sign up or at least apply for the bundling process, we did that with all of our hospitals. What that allowed us to do through the initial application process is to have access to information that CMS had on the 30-, 60- or 90-day episodic period for patients that we were treating.

We knew what happened with the patients in our 13- or 14-day length-of-stay. We knew what was going on with a number of our patients; particularly if they were discharged from our hospital into home-health.

What we didn't know is, if we discharged home, we didn't know what happened to that patient. We had no way of knowing what happened to those patients that further-time-frame out. That 60- ; that 90-day time period after discharge from our hospital.

By applying for that information, receiving that information from CMS, it gave us a lot of insight into what was happening with our patients. What were other providers doing in our marketplace. What home-health. What nursing-home providers in our marketplaces that we may or may not be sending our patients to at discharge. What their profile was from a cost standpoint with CMS.

Just going through the application process last year helped prepare us for this year in terms of going through the formal application process with eight of our hospitals.

We have five of our hospitals that have been participating on the bundled episodes since April 1st. We have another three that will go live July 1st. You can see that we chose episodes here ranging from stroke, simple pneumonia, the double-lower-extremity joint-replacement.

Sepsis, which is infection. A body infection.

We chose hospitals based upon a number of factors. One -- we wanted to have representation in each one of our six geographic operating regions. So that each one of those regions and those regional teams would have an idea and have some experience on bundling.

We chose the episodes on the patients that we had a fair amount of confidence that we could have a positive outcome with those patients. They didn't present a huge amount of risk, but yet would give us some insight as to what it would take to manage in a bundled world.

Then you can see that we chose a 60-day time period. That was just one that we felt once again would be representative of what we might face if the bundling initiative became more prevalent throughout.

Overall, we went into this project wanting to make sure that we kind of had an idea about how the process worked, what information we would be getting from CMS. Much of this information was information that we had never seen before.

Then what would it take within our organization to best-manage these patients in a bundled setting? What type of resources? What types of manpower? What types of tools?

How would our own electronic information systems deal with these patients?

Those are all things -- we're early-on. As you can see, we have five hospitals started on April 1st. We have three more coming on in July. But we do think this will give us some valuable information relative to what it would take to be a provider in a bundled setting.

As you can see here, we do have a multi-faceted growth strategy. When we think about growth in the inpatient statement, we look at really three different areas.

One -- if you start at the bottom of that chart -- bed-expansion. We have a pretty good track record of having somewhere about 100 beds added each year. So all of our hospitals, we track and meet every other week, relative to bed-capacity. What's the occupancy percentage on each one of our hospitals?

So if our hospitals start inching up toward that 80% or 85% occupancy level, we know that we have to have a game plan in terms of expanding that hospital, where we can. Some of those I alluded to earlier in the certificate-of-need states. It takes a little bit wider window to take a look at in terms of time-frame in the non-CON states. Then we can then progress fairly quickly on bed-need.

But this is a great way for us to use our capital. It is in areas where there's a proven need -- proven demand -- for our services.

We love to do bed-expansion and see this as a great opportunity for us to pursue growth and the growth strategy.

Next are acquisitions. Much of like what we did with Cardinal Hill, the hospital that we recently acquired in Lexington Kentucky. We've brought that on.

Our track record of bringing on acquired hospitals and putting our systems in place has been pretty strong. That particular hospital -- Cardinal Hill -- is a large hospital, by scale. It separates itself out a little bit different within our system. But we're quite confident

that we can work with that hospital and get our standards and best-practices in place.

And our de novos. We've been very successful with our de novos. We've brought on four hospitals in the fourth quarter of last year. Very successfully.

We've brought on, as you can see listed up there, Savannah, which is a partnership. Franklin, we're in the midst of construction now, in a suburb of Nashville. That will be a 40-bed de novo.

I believe that our track record stands pretty strong.

We do feel that we have a varied and multi-faceted growth strategy that will allow us to continue to grow our hospital segment.

Jay Grinney: Good. Thank you, Mark.

We're running just a little bit behind. So don't obsess on the 9.55 break. It you need to take a break, please do.

But I've told April that I'd like to have her take as much time as she needs to walk through her presentation.

As I mentioned earlier, when we started looking for a partner in home-health, there was one name -- two names -- that came up. April Anthony and Encompass.

Once we got in and we started to meet with the rest of the senior management team at Encompass, we recognized that there were a lot of other people that April had assembled as part of her senior team that were incredibly impressive.

We have two of those individuals here, today. Tracey Kruse, who is the chief operating officer. And Luke James, who heads up development and strategy for the company.

They in turn have exceptional talent that works with them. So not only did we partner with April, but we partnered with an enormously talented, highly-capable team of professionals that has really given us even more confidence in the future of our partnership together.

With that, I'm going to introduce April Anthony to review our home-health business.

April Anthony: Very good. Well, without a tie, I didn't have a good place to put that microphone. So I'm going to stand behind the podium here and share with you a little bit about our Encompass story.

We are very excited to be part of the HealthSouth family. Honestly, when we began looking at a transaction opportunity back in the fall of last year, we really thought that we would continue to proceed down a private-equity world -- which had been our former partnerships a couple of go-rounds.

But when we met this team from HealthSouth and we really began to look at the way that

our companies could work together -- it really synergized the opportunities to drive revenue. It was simply too compelling of an opportunity to pass up.

So we're thrilled to now be associated with HealthSouth in this way. We look forward to the next couple of years, as we move through this integration process, so that we can really capture the opportunities that we're going to share with you here in the next few moments.

Let's jump in.

Notice how I skipped right over that slide with my picture very quickly. That was kind of strategic.

The first thing that I want to do is give you just a high-level orientation to some of the things that are unique about the Encompass story. Then we'll dig into each of these points a little bit more as we move through the presentation.

Some of the key elements of the Encompass story that we'll talk about a little more start with our size and scale. Encompass is actually the fifth-largest Medicare-certified Homecare company in the nation. That puts us right up on the edge of all the dedicated public companies within the home-health space.

So it gives us the size and the scale and the density within our respective markets to really take advantage of the opportunities that are before us.

Just as Mark and Jay both mentioned outcomes, it's certainly right at the heart of any healthcare business. And we pride ourselves at Encompass, as well, on having very strong outcomes, and creating a unique clinical experience for our patients, to both drive quality clinical outcomes, as well as very high levels of patient satisfaction -- both of which we'll share with you a little bit later.

One of the biggest challenges that we face in home healthcare is managing a mobile workforce. Our workforce is out in patients' homes. Out in their residences. All day, every day.

We see them on average two -- maybe three hours in any given week. So we've got to have the right tools. The right technology and the right ways to motivate that mobile workforce. That's one of the things that the Encompass organization has proven over the years to be very successful at doing -- thanks to the technology platform that we have.

As this world of healthcare changes, the other thing that'll be a key success driven for the future is how we collaborate with others. So we're going to talk about some of the projects that Luke James leads for us.

The ways we're seeking to collaborate with new partners in this space. Come up with new payment models and new approaches to delivering Homecare services.

Then finally, how do we build growth as we go through the coming years? And the three-pronged strategy of organic growth, acquisition-based growth and then really

looking at those collaborative partnerships that we can have. Not only with HealthSouth, but with other payors, as well.

With that, let's dig into a little bit more of the details. As we mentioned, the story starts at outcomes.

Encompass, again, prides itself as being an organization that stands out from the crowd in the outcome story. These are just a couple of metrics that we want to share with you. It's our relative positioning as it relates to 30-day all-cause readmissions to hospitals.

As a home-health provider, our objective is to make sure that patient doesn't make their way back up to that high-cost setting once they get to us. As you can see on average, we have performed at about 15.7% as our average readmission rate, compared to the most-recently-published national rate, which is 18.6%

So we've got a significant opportunity to continue to improve those outcomes, but are starting ahead of the crowd with a reasonable margin.

It's also very important that we manage patient-satisfaction. Getting that word of mouth and that patient experience to be a positive one is a good factor that can help us grow in our respective communities.

The chart on the right reflects what we've done, relative to the five core patient-satisfaction metrics that are tracked by Medicare and posted for public viewing on the Medicare website.

A new metric that we're excited about coming out that'll be released in July is the quality-star rating. Historically, in Homecare, Medicare has tracked 22 what they call CMS-compare statistics.

As a consumer, it was very difficult to sort of work your way through those 22 metrics and understand what they meant.

So earlier this year, the decision was made by CMS to revert to a star-rating system. Not unlike what you see with the Medicare-Advantage payors. Also, utilized in the nursing-home sector.

Home-health in July will have publicly-reported star-ratings. Encompass, among our provider numbers, has 91% of our providers rated as a 3-star or higher. That compares to an industry-average of 75% of 3-star or higher.

So, a large portion of our provider numbers provide above-average care. And we believe we can continue to improve that statistic now that we know the metrics that are part of that.

Another part of our organization that is key -- as I mentioned -- is, "How do we manage this mobile workforce?" We have over 5,000 employees that are out of sight. It is difficult in a world like that to make sure that you're always controlling the things that you're doing with that staff.

At Encompass, we have worked on a variety of different approaches to managing that mobile workforce. One of them, as I mentioned, is our technology platform. Utilizing technology to create virtual supervision of that employee. To give them the right guidance from a clinical perspective. To have good clinical judgment and make good clinical decisions.

But to also create accountability structures, which allow us to achieve our productivity standards for our full-time employees. To optimize when we utilize a lower-level discipline. For example, an LPN that can perform the clinical services versus an RN.

That's helped us drive very efficient cost models.

But when you effectively put all of that together and surround it with the right kind of cultural elements, that's really where the magic happens. We've got the tools; we've got the guidance. We've got the focus on quantity and quality. But surround that with the right kind of environment and support for those clinical staff members. They will really carry our mission of quality to the patient, day in and day out.

Last year our company was honored to win 15 best-place-to-work awards. When you think about the challenge of delivering home-based services, and the fact that we send our nurses into tough neighborhoods and into tough homes and into situations where some have difficult family dynamics --

Being able to have those same employees who work in that kind of environment all day, every day, say, "This is the best place I've ever worked," is really something that we pride ourselves on. Creating that kind of environment.

We do it not by making their jobs easier. But by really working on making their jobs better. That's allowed us to really make sure that as an organization, we produce a lower-cost visit than many of our competitors in the public sector.

Not only are we creating a great environment, but we're doing it in such a way that provides a lot of value to our organization. We'll look forward to telling you a little bit more about that as we go along.

But specifically as it relates to our technology platform, Encompass originally -- back in the 1999 period -- began the development of an in-house software product. It didn't take us very long to figure out that we were better-served to spin that out.

So in 2001, we spun out and created Homecare Homebase . But Homecare Homebase has proven to be the technology platform for the Encompass organization, really since the early days of our existence.

It's a core platform that is now used by a lot of different providers in the industry; particularly the larger-scale providers. 75 of the 100 largest providers in the nation use the Homecare Homebase platform.

I think the key to success for Encompass is not so much the tools of Homecare Homebase

, but really how we as an organization and Encompass utilize that tool to really drive performance.

In the clinical area, it really drives that clinical performance for our clinicians. Guides them to particular care protocols. Ensures that retail and (ph) orthopedic surgeons -- this is exactly how we'll treat your hip patients. That he can be confident that every clinician that enters that home has that protocol at his fingertips and that it, in fact, is going to guide their performance while they're there.

As a result, it's going to make the outcome of that performance much more predictable to that physician. That creates a huge value proposition for that physician.

From a sales perspective, what it also allows us to do is create those same kinds of accountability with our sales force. Gives them information to have better market share understanding -- to know what's happening with that particular account. To make sure that their time is managed well and that they're accountable to particular goals.

And then to make sure that at their fingertips, they always have core communication tools. So that, "When I've committed to that doctor or particular protocol," not only could he be confident that the clinicians are going to deliver it, but he's going to know that his sales-rep who's following up is going to have that same quality of information at her fingertips.

So every time she makes a return visit, she's now no longer just a nuisance that's coming in to take up his time; she's somebody coming to share clinical information with him. And she has that data at her fingertips through the Homecare Homebase system.

It also provides the ability for physicians to sign all of their orders online, electronically, and to take some of that paperwork burden away. That's a great sales benefit, as well.

From a management perspective, the benefit of the Homecare Homebase tool is, it really lets you define a workflow process. So that you have a way of doing business.

We truly at Encompass have an Encompass way of operating. That way is being delivered across our network of Homecare providers, across our entire region -- from Boston all the way up to Oregon, down to South Texas. To make sure that every office is following the same protocols -- the same approaches. That they're following the same operational procedures. And that they're getting the same kinds of metrics and data.

So at the home office, we can really manage and support those providers and understand where their opportunities for improvement are.

Then finally, that last benefit that I'll talk about in the Homecare Homebase tool, is that compliance component. In an industry that is prone to have compliance issues, having a tool like Homecare Homebase that makes sure that you can't send a bill if you don't have the proper orders signed. That you don't have an opportunity to skip processes in a regulatory process. That you have to go in a particular order. And that one thing can't get ahead of the other.

All of those really drive a culture of compliance in our organization.

In addition to working with our employees to train them and teach them about compliance, our system really guides compliance-behavior. So those are some of the key ways that we utilize the Homecare Homebase system -- to be more effective from a technology perspective.

Let's shift gears a little bit and talk about what's happening from a clinical- collaboration perspective. Because as Mark mentioned, and Jay, as well -- the market is evolving. Maybe it's not at a very rapid pace. But we're definitely seeing an evolution beginning to occur.

What we're seeing in the Homecare space is that as the payors and providers begin to align themselves with ACOs or bundled-payment systems of some form or another, they're really looking for a preferred-provider network of Homecare providers. We'll share with you in a minute the number of providers in the Homecare industry. But it's a very fragmented industry.

When those opportunities present themselves, they're looking for some core attributes that their Homecare provider can bring to the relationship. Encompass really aligns well with those core attributes. Scale and density is right at the top of the list.

If you're an ACO provider in Dallas Texas, you can't not consider Encompass as a potential partner. Because we are by far the largest provider of Homecare services in that geographic region.

If you're thinking about an ACO in the State of Oklahoma, Encompass is going to be your preferred choice. Because we can cover the entire market.

So having the volume and the scale to address the market is key. Having technology that can give you confidence of outcomes and communication of data. Having a sustainable and replicable model so that as we grow, you know you can continue to follow that.

All of those are key attributes that allow those partners to see the value proposition of Encompass, and the in turn select us. Because we can be a preferred partner that can really address their whole issue.

So we are finding ourselves really at the heart of a lot of different conversations. Just one example of those that I want to share with you is our relationship with the Premiere ACO that's based in the North Texas area. A little over 20,000 covered lives that are part of that ACO.

In the second quarter of 2014, Encompass became their exclusive provider of Homecare services within that ACO program.

In their first year as an active ACO, they actually participated in the Medicare Shared Savings. They were able to save dollars. And we were a key partner in helping them do that.

It's also important to note that not only are we providing Homecare services to this particular ACO, but we're really providing a care-coordination service, as well. So in addition to just the traditional Homecare services for those that have that need, we are also acting as a care-coordinator for their sickest, most-chronic patients.

We've taken their 2,000 top-10% of their providers that have the highest spend, and we've created within our organization a division that does care-management for those patients. Really, making sure that we're calling them -- checking in on them.

If in fact we have signals that they need a Homecare visit, well, then we can send a Homecare nurse out.

In other instances, it may all be telephonically based. But it's really proven to bend the cost curve significantly on those top 2,000 patients. So much so that Premiere is now asking us to expand the population to their top 5,000 patient-spend patients.

So we're looking for ways to really be innovative. To find new models. To not only drive our traditional Homecare volume, but to recognize that the marketplace is changing in Homecare, and to make sure that we can be a value-added partner in that.

We talked a little bit about scale and density. We won't linger here very long. Just to let you see a little bit about the importance of that.

I'll call out the box on the lower right-hand corner that really reflects our respective size in each of the states in which we operate.

We really do take seriously the intention to become a dominant player in the market when we arrive. So in the states of Texas, Oklahoma, New Mexico and Idaho, we are actually the largest provider of Medicare services in those particular states. In Colorado and Utah, we're the Number-3 largest provider. In Virginia, we're the 4th-largest provider. We've only been in that market for a little over 2.5 years, now.

As we enter a market, we very quickly look to take a large market share by growing through acquisition -- as well as organic growth. So that we can create that density that not only drives near-term economies of scale and margins, but long-term positions us for the evolving marketplace. And to be that key collaboration partner, going forward.

The next component that I want to talk about is our traditional organic growth. At the heart of long-term success of any company is the ability to grow organically. This chart gives you a little bit of an overview of the growth that we have experienced in our various cohorts of acquisitions.

Obviously, growing from our traditional base is important. We've done a good job at that. But we thought it would be valuable for you to see that as we acquire companies, the growth that we're able to create on the other side of that acquisition.

Not only margin-enhancement, but more importantly, long-term topline growth opportunities. So each set of bars represents what we were able to do in those respective years, relative to admissions and the overall organic growth.

The green bars represent where we were in 2014 compared to the year-of-acquisition. So you can see low-double-digit numbers in all of those recent acquisitions has really helped fuel a strong, long-term stable growth story for Encompass.

Another part of our organic growth that we're very excited about as a result of our HealthSouth partnership is the opportunity to really grow together with HealthSouth.

You all may recall from some of our early announcements, the discussion that we had of nearly 72,000 referrals that were coming out of the HealthSouth facilities into home health agencies. We thought we'd break that down for you a little bit here and give you a bit of a waterfall. To show you how those 72,000 patients really distribute among the different types.

Not every one of those patients is going to be actionable for us. 24% of them are non-Medicare patients, whom we may or may not have a contract with that particular payor. We'll be working together with HealthSouth to try to align our contracts so that we have more opportunities to capture those, when it makes financial sense to do so. When we can provide greater service to those patients.

But at this moment, many of those patients are not immediately actionable.

The next tier of patients are those that come to us from a particular referral source, who already have that home-health relationship. Obviously we're not going to cut off our nose to spite our face. We're going to maintain those relationships.

If the referral's coming to HealthSouth from a hospital with a home-health agency, then as good partners, the right thing to do is to work back with that hospital and their home-health agency.

A lot of hospital-based home-health agencies only cover very small service areas. They don't have great weekend coverage, sometimes. So even in those situations, Encompass will be able to be the backup partner to that hospital facility. If that hospital home-health agency can't take that patient, then Encompass will be there ready with open arms to take those patients that can't be seen.

That really begins to move us down to the more actionable part of that 72,000 market. If you go all the way to the end of the chart, the first place that we'll be focusing our priority is on the 15,000 Medicare referrals that currently exist in the overlapping Encompass markets.

In December of 2015, Encompass got right at 50 admissions from HealthSouth facilities. So the opportunity to increase up to that 15,000 is exponential. Already in May, that 50 moved up to 300. Now that's not nearly where we need to be or where we're headed, but in just the first few months of integrating our platforms, we've already been able to see significant growth in those numbers.

So we look forward over the coming 6, 12 and 18 months to really capturing a large portion of that 15,000.

Our next piece of our initiative would be to move over to the 19,000. The next bar that you see. One step up. That's the market that we could address through acquisition. So as we begin to look at our acquisition strategy, Priority Number 1 is to go to places where HealthSouth has facilities, but Encompass is currently not able to serve.

If we can do the right kind of collaborative acquisition strategy with HealthSouth, we'll be able to pick up that incremental 19,000 patients opportunity. Then slowly but surely, we'll work our way up that waterfall chart, to try to capture a larger and larger part of the 72,000 opportunity.

The other piece that this chart doesn't address is the opportunity to really work as we move through BPCI programs and other things. To address whether or not there are patients that are currently going to nursing homes, that might be better-served in the home-health environment.

There's another 13% of discharges from the HealthSouth facilities that currently go to nursing homes. And there may be some portion of that 13% that can also find their way to home-health, once we really create the right kind of partnership model.

So we're very excited about the opportunities for organic growth that will come through this.

The other piece of our strategy is the acquisition strategy. We already talked about the geographic focus of that. But just to give you a little bit of the sense of what the marketplace looks like --

Homecare now has over 12,600 total providers. So it's a deeply-fragmented industry. About $18 billion in total revenues. And if you look at the market, 95% of those 12,600 providers have less than $5 million of revenue.

What we've been able to prove at Encompass is that we have the ability to really integrate and acquire those smaller-sized agencies. So it's great to be able to do big deals, but in the Homecare space, there are just not that many large-scale deals out there. 95% of the market is small deals.

So our organization has been able to prove that we can identify those small transactions, complete transactions at very effective pricing multiples. And them oversight importantly, integrate those transactions into our operating model. Get them onto our core Homecare Homebase platform, and then guide them through those Encompass processes that help drive efficiency.

Growth will be a key part of our strategy in a fragmented industry through acquisition.

Then finally, we'll just speak momentarily about the hospice segment. Encompass is a relatively new entrant into the hospice market. We made our first small acquisition in late 2011 in the hospice space, and currently have about 500 patients on service.

We do see this as an opportunity for growth, and as you look at the totality of the

continuum moving from home-health to hospice for certain polychromic patients, which is certainly what we see happen very often. So we'll be looking for ways to expand our hospice operations -- particularly in markets where we have overlap with our home health providers.

That will allow us to move one step further down the continuum.

Hospice has grown to being nearly the same size of an industry. $15 billion in Medicare payments, compared to the $18 billion in Homecare. But you'll see just under 4,000 total providers in the hospice space.

So on average, the hospice providers could be 2- to 3-times the size, on average, from a revenue perspective, of the Homecare market.

We look forward to continuing to acquire in the hospice space, as well. And recognize that it may be our second-tier priority after we increase our coverage with the HealthSouth facilities. But that definitely remains a key part of our strategy.

So we're very excited about where we're headed. We think the distinctives (ph) that we bring at Encompass and in an efficient operating model -- a strong culture -- and our ability to grow organically, through acquisition and with our HealthSouth partners is going to create a very bright future for our organization in the coming years.

Thank you.

Jay Grinney: All right. Thank you, April. Thank you, Mark.

With that, we'll take a 10-minute break. And then when we come back, Doug will get up, talk about our capital structure, balance sheet, free cash flow utilization.

At the conclusion of that, I'll just have some final comments. Then we'll open it up for q-and-a. So let's come back in about 10 minutes.

Jay Grinney: Okay. Thank you.

As I mentioned before the break, I'm now going to introduce our chief financial officer, Doug Coltharp. Talk a little bit about our capital strategy, balance sheet and utilization of free cash flow.

Doug?

Doug Coltharp: Thank you, Jay. And good morning, everyone.

These are the tenets of our financial strategy. The objectives of our financial strategy are to support the execution of our operating initiatives and our operating strategy. Also, to facilitate the creation of shareholder value.

I'm going to touch upon each one of these very briefly. Then we'll in turn go through each one in more depth.

First, our business model is one that generates strong and consistent free cash flow. We are committed to a cost-efficient and flexible capital structure. Jay touched upon this earlier.

This gives us the capacity and flexibility to seize upon opportunistic acquisitions, and to support the overall initiatives in our business.

We're committed to maintaining an appropriate degree of financial leverage. Historically, we've couched that in terms of a leverage ratio -- a target leverage ratio -- of about 3-times. As we move through some of the balance sheet restructuring initiatives over the last five years -- and I'm going to go through those more specifically in just a few minutes -- we changed the orientation on that. And began saying that we would feel comfortable utilizing the capacity on our balance sheet, and moving that leverage up from time to time if there were a compelling acquisition opportunity.

And if with that acquisition opportunity we could see a clear path toward bringing the leverage back down. That was clearly the case when we elected to utilize increased leverage to fund the Encompass acquisition at the end of last year.

Then finally, and this is one that is really unique to us -- particularly unique as a facility-based provider in the post-acute space. That is, we place an emphasis on the control of our real estate portfolio.

Move first into a discussion of our free cash flow. This is a view that looks at both the generation of free cash flow and its utilization over the last five years.

What you see as you move from left to right is that the free cash flow generation is increasing. Stabilizing a bit in the last couple of years. And that the prioritization is shifting.

This is really because in the early portion of the timeline shown here, we were very much focused on reducing debt and repositioning the balance sheet, in order to ultimately establish the capacity to begin growing the business again.

When you move into 2013 and 2014, we see that free cash flow is higher as a result of consistently-improving operating performance. Because the business was delevering and because the debt that did remain on the balance sheet had been restructured in a most cost-efficient way.

The freed up more cash flow to go away from debt-service into other initiatives. The primary initiative at that time was regenerating the growth via acquisitions, bed-expansions and de novos in our IRF business. Because all of this was pre- the acquisition of Encompass.

Then you also see a designation on here in the yellow bar, related to some options that we had to increase our real estate ownership position by buying out some operating leases.

Then finally the blue bar that is on here relates to the fact that two years ago, we initiated

a dividend on our common stock. We've subsequently been able to increase this.

On a go-forward basis, you should see a similar orientation toward these priorities.

Our first priority for the utilization of free cash flow is going to continue to be investing into the growth of our business. Now, via two segments.

We have the opportunities in the IRF segment that Mark addressed in his comments. And the opportunities in home-health and Hospice that April just covered prior to our break.

We do have some near-term opportunities to pay down debt, and we're not uncomfortable with the degree of financial leverage that resulted from the Encompass transaction. But there are actionable ways that we can pay down the debt. Most notably in the form of the amounts-outstanding under our senior bank facility. Both the revolver and the term loan.

And the 7.75% notes that are due in 2022 become callable in September of this year. As Jay mentioned during his comments, we remain committed to a policy of augmenting the returns that we're getting from investments in our operating business, with shareholder distributions.

Skip ahead.

Our capital structure has been completely rebuilt over the last five years. If you were to go back and look at the way that this chart looked five years ago, there were a lot of near-term maturities. At that time, being in 2010, we faced significant maturity hurdles in the 2012 and 2013 time-frame.

There were some instruments that were very punitive from a cost-perspective. You may recall that at that time we had a very significant debt-maturity. In 2016, in 10.75% notes -- and as a non-tax-payor, due to the NOL, that was really expensive to us.

And we had instruments like the convertible preferred stock, with a 6.5% coupon that were also expensive to us, in terms of their impact on our overall cost of capital.

In a very systemic way over the last five years, we have undertaken steps to be able to refinance all of those high-cost instruments under more favorable terms. And the key parts of our capital-structure strategy center around flexibility.

We define flexibility as having longer-dated maturities. Having fewer covenants. And the covenants that do remain, containing more headroom. And sufficient headroom to execute to our operating initiatives.

Then also, having prepayment ability or prepayment optionality without any kind of onerous penalties.

We also focused on the cost-efficiency of our capital-structure strategy. Obviously one component of that is the coupon rate on the debt we have out there.

The component of the cost is always also, "What is the required principle amortization?" Then we also look at the extent to which there are any equity-linked options embedded in our debt instruments.

We place an emphasis also on maintaining an appropriate level of unfunded liquidity. We define liquidity, and you see it here in chart form on the upper right-hand portion of this slide, as the amount of excess cash that we have on hand. Plus the unfunded liquidity and committed liquidity under our revolving credit facility.

You can see that in both of the timeframes shown here, we maintain a very significant amount.

The liquidity ensures that we are able to -- on the front -- as a first priority -- cover any unforeseen shocks or disruptions to our business. Which we hope we never have to utilize it for. It's our insurance policy.

But more importantly, it does give us the flexibility to move very quickly to seize upon growth opportunities. And we think that those are going to be even more prevalent now that we're operating in two business segments.

I mentioned the control of our real estate. This is one that at times generates a good deal of discussion in a community like this.

If we go back to the adjusted free cash flow chart, between 2013 and 2014, we spent about $110 million to buy in lease properties. That, combined with our recent de novo activity and the acquisition activity, has led to a position where we now own 82 of our 109 hospitals.

We think that that provides us a great strategic advantage. Because as Mark addressed in his portion of the comments, it means that we are not subject to increases in occupancy expense related to significant rent escalators in the lease agreements.

We think it gives us the ability to manage our real estate portfolio on a market-by-market basis. And we also believe that our marginal cost of debt is significantly lower than the cap rates that are made available on specialized post-acute-type properties from vehicles such as REITs.

If you don't think that these types of initiatives are important in terms of maintaining that flexibility and that cost-effectiveness and so forth, look at two recent examples.

First, go back and look at the difficulties that Kindred encountered and continues to encounter in repositioning its real estate portfolio. And trying to rationalize its asset base on a market-by-market basis.

Then second, look at the difficulties that Manor Care is now experiencing, having stripped out the real estate and separated it into an OpCo-PropCo structure, and burdened the operating company with onerous leasing.

We think that any such transaction might provide some very short-term gains. But on a

long-term basis, it's an impairment to the operating company. And greatly limits your flexibility to adjust your delivery system to an evolving healthcare landscape.

Jay talked a little bit during his opening comments about the 8K that we put out, and some of the comments on the second quarter. He also mentioned that we have reaffirmed our EBITDA guidance for 2015, at $670 million to $680 million.

I want to remind you that that is overcoming the $4 million legal settlement related to West Virginia that we incurred in the first quarter.

It's overcoming the impact from the SSI adjustment -- that retro-adjustment -- of $4 million to $5 million that was contained in the 8K that we released yesterday. And it's overcoming the increase in bad debt, related to heightened ADR activity that we identified in the first quarter. And that now we have assumed will continue at a similar level throughout the balance of the year.

The guidance has also been updated to include our acquisition of Cardinal Hill. And of Savannah. Our partnership with Memorial Health.

If you look at the impact of those two acquisitions on our guidance, they have a very favorable impact on the volume metrics. But they're essentially breakeven from an EBITDA perspective.

There are three reasons for that.

First, look specifically at Savannah. There, we transitioned to a new Medicare provider number. That has the phenomena that you've heard us talk about on any number of previous occasions related to an acquisition. That is that we have to treat 30 patients for no revenue. That has the effect of depressing the EBITDA contribution we get from that business.

Recall that that is also --

We're in a bit of an interim state in Savannah. That is, we are operating a unit in place as we build a new JV-de novo facility. The ability for us to really extract the type of operating efficiencies from that unit in place is very limited.

Cardinal Hill's a bit of a different story. There are two things that are going to depress or hold back the EBITDA-contribution from Cardinal Hill this year. And I want to mention that both of these are opportunities that we are very excited about in terms of their long-term viability.

Keeps moving on me.

At Cardinal Hill, the first item that we have called out is that we are going to proceed immediately with the installation of our CIS. That's a big hospital. 232 beds.

CIS installation, as you recall, has both a capital implication. It also has an expense implication. And the operating expenses related to the immediate installation of CIS will

impact Cardinal Hill's contribution over the balance of 2015.

More importantly, it is a 232-bed facility. You compare that even to the chart that Mark had before that showed our average beds-per-IRF at 68. As Mark suggested in his comments then as well, our prototype's really being 40- to 50-bed units.

There are any number of business lines that are currently a part of the Cardinal Hill offering platform that are not part of our core IRF platform. We need to digest that business.

It's going to take us a little while to get in there and to work with the team that is in place. To ultimately raise that facility up to the level of labor-productivity and general operating standards that we see in place across the HealthSouth platform that really are our standards of operation.

Within that guidance, as well, as Jay mentioned -- we remain very pleased with the production that we're getting out of April and her team, and the home-health business. We continue to hold fast to our assumption that that business will contribute $72 million to our adjusted EBITDA for 2015. That's the expectation that we have had since the beginning of the year.

There has always been an acquisition component of that EBITDA contribution. That differs a little bit from how we've historically talked about the IRF space in the past. But we can tell you that, as we are almost halfway through the year, the anticipated pace of those acquisitions -- the agency acquisitions and the contributions that they are making -- remains in line with our expectation.

You convert this over to our EPS guidance. Again, reaffirmed at a range of $2.13 to $2.19. And it's really just because those same changes that we've discussed. The same headwinds. The same factors related to acquisitions are flowing through here.

With that, Jay, before I further flip through random slides --

Jay Grinney: I don't know what it is about your aura. But you keep moving us forward. So I guess that's good.

Okay. So I want to wrap up and then open it up for q-and-a.

You've seen this slide, before. It's just a simple way of outlining what our overall business model looks like over the next several years.

At the core, and it always will be at the core of our strategy and our business model, is operational excellence. Clinical excellence.

We're going to maintain that focus, no matter what. That's really what I believe differentiates us today. It's also what will differentiate us in the future.

That's not only looking at the clinical outcomes. It's looking at the patient-satisfaction. It's using the technology platforms that we have in our company, in both of the

businesses.

It's then using that clinical competency that we have separately, and integrate those into clinical protocols and clinical pathways that will eventually allow us to provide a broader range of care for patients requiring post-acute care.

We're going to continue to look for growth. We've got exciting growth opportunities on the inpatient side. We have exciting growth opportunities on the home-health side.

We're looking to complement that growth. Particularly as we look for those tuck-in acquisitions that April talked about. The smaller home-health agencies that are out there that today are struggling with the regulatory environment. Struggling with the payor environment. Struggling with the reduced payments coming from Medicare. And looking for an opportunity to potentially exit.

We'll be there for those providers to step in, in those markets where we have a presence -- a hospital presence -- and we need a home-health presence.

We think that there are some very exciting opportunities in that level.

Then of course we're going to continue to grow the inpatient portfolio through acquisitions. Through de novos. And in both camps, looking for partnership opportunities, where they make sense.

Strong balance sheet is very important to us. That doesn't mean that we're going to maintain always a low-leverage, no matter what, even if there's a compelling growth opportunity out there. We're going to utilize that.

But we're going to do that only when we have a clear path to get that leverage back down to a level in that 3-times target range.

We did that with home-health. We'll do it again if there's a compelling opportunity. But we're not going to stress the balance sheet.

We understand that a company's financial strength is one of the most important assets that it has. We've I think demonstrated our ability to protect and maintain and to preserve that. To utilize it appropriately. To use it strategically when we do that.

Ultimately, if there is excess cash flow at the end of the day, we want to return that to shareholders. We will continue with our dividend policy. We're very pleased that we have the ability to provide shareholders with a return. We'll look opportunistically where it makes sense to potentially buy back shares.

But the intent is really to grow the company. To return excess cash to shareholders. And then -- I hope, as you've learned today -- to position ourselves to be successful in this evolving delivery-system, payment-system new world order.

With that, I will open up the floor for questions. Ann?

Unidentified Participant: (inaudible)

Jay Grinney: April? That wasn't very fair of me, was it?

April Anthony: The penetration of the 15,000 opportunity is something that's going to come along probably over the next 9 to 12 months. We've got a dedicated team at Encompass that's working with each of the independent facilities at HealthSouth to really create a referral process.

We're working with the corporate group from the HealthSouth side to really create a consistent model and work with the hospital CEOs. To make sure we're all kind of following a best-practice model, and how to do that.

Really, just again that process in March. We're working firstly on the home-health integration of the HealthSouth home-health agencies into Encompass. Then simultaneously pushing through the facilities.

I would say it's reasonable to say it's going to take 12 to 18 months to get through all of the inpatient rehab facilities, and get that relationship really running.

But we are seeing it grow. We saw it grow 100 admits a month between April and May. It was growing about 50 a month prior to that.

So we're making progress each month. And as we begin to accumulate more facilities in partnership with Encompass, that number will begin to grow faster, as we begin to pile them on.

Jay Grinney: You might as well stay up there, because I know you'll get other questions.

Unidentified Audience Member: (inaudible)

Unidentified Participant: Some of what's happening in the peer group were transitioning in advance of that transition actually taking place. The hospitals are already beginning to.

It may not necessarily be a one-for-one, where those may otherwise have previously been captured already within the HealthSouth.

April Anthony: Right. That 9% category on that step-chart reflects that. Those have to convert, first.

Jay Grinney: Doug, why don't you come on up here, too. Because I'm sure you'll get a few questions.

Unidentified Audience Member: Maybe just a technical one and then maybe a very quick answer (ph). A lot of comments about strength in discharge growth. You mentioned the Cardinal Hill and so it will help a lot.

Any comment on what you're seeing (inaudible)?

Jay Grinney: Oh, we're very pleased with what we're seeing on both our same-facility as well as our new-store ex-Cardinal Hill and Savannah.

Unidentified Audience Member: Okay. And then maybe to go back to the home-health comment. You're doing tuck-in acquisitions. You've got some planned for the rest of the year.

Is the model such that you really want to do tuck-ins? Or would you be more open to a bigger transaction?

Can you insert your model on a bigger transaction?

Then second, can you just comment on the pipeline and pricing a little bit of the deal?

April Anthony: Sure. We really think both strategies are possible.

We have historically at Encompass not done very many very-very large transactions. But as I mentioned, there just frankly aren't very many to do.

We definitely think that our engine -- our integration engine -- can support a larger-scale transaction. We think by-definition, there are going to be a lot more tuck-ins, just in volume, as you look at the way the industry distributes.

So we think it's a "both" on that case.

Relative to the pipeline, we have a very strong pipeline at the moment. Luke James, who leads our business-development component has a team under him. We really go in a targeted fashion, looking for those tuck-in acquisitions.

Particularly going to where we have HealthSouth hospitals. Blanketing that market with a calling dialing-for-dollars approach, to see if we can't find somebody who's interested.

In a non-CON market, it's obviously a little bit easier to find opportunities. In a certificate-of-need state, then it may take a little bit more patience to get into those markets. Because there are just not as many agencies for sale.

From a pricing perspective, obviously we're an active participant in the market. So don't really talk a whole lot about pricing.

We do feel like we have a history of being very efficient in our acquisition pricing, and yet finding quality transactions. But as a buyer in the market, we don't really want to disclose specific pricing conversations.

Doug Coltharp: I want to make one clarification in-between, as well. This is based on a question that I got during the break. It relates to one of the slides that Mark had used, where he was highlighting our JV opportunities.

On that slide where we noted that the JV ownership was 2.5% to 50%, that is the amount that our JV partner owns. There are no facilities in which we have a 2.5% interest.

We have a 50% or greater interest in all of our JVs.

Jay Grinney: Very important.

Unidentified Audience Member: On the future of acute-care and bundling and ACOs and BPCI, et cetera, I guess the obvious question -- and I think you had a brief comment on your last side --

What does that mean around HealthSouth and complementary or other post-acute services?

Talk about the likelihood of you entering into. Maybe if you could rank LTAC (ph)? Maybe more home-health. Where do you guys think that goes?

Jay Grinney: Good question.

In the near-term, the focus will be on building out our inpatient rehabilitation and the home-health. We think that's really where we need to be.

As we think about where the system is evolving, if you agree that that future-state will be a facility-based post-acute capability in a home base, and that the silos become less clear, we think that the inpatient facility -- that box -- is better-positioned to be that post-acute provider than either skilled boxes or LTCHs (ph).

Number-1, many of the LTCHs are units. They're HIHs. So there aren't a lot of freestanding LTCHs that could expand and convert to a post-acute facility provider.

On the skilled-nursing side, there would need to be a significant amount of CapEx to go into those nursing homes to create the gases and the environment -- the hospital environment -- that we see or that we have, I should say, in our hospitals.

If that post-acute facility is going to be able to provide higher acuity, and then let's say we decided to add eight beds of LTCH, we are already set up in our hospitals to do that, today.

We would need to bring in some additional ICU beds and telemonitoring and so on. But we have all of the other infrastructure. Skilled nursing facilities don't.

If we needed to provide a lower level of acuity of care -- again, in this new world order -- we can easily convert a wing or a unit into that lower acuity. Or provide care in that lower-acuity setting.

That gives us the opportunity to kind of pivot in both directions. So, skilled nursing is not on our list. It really isn't.

I think that we can provide that if the market demands that. We can provide that lower-level acuity without having to become a skilled-nursing provider. Especially if those siloed regulations start to dissipate.

In terms of LTCH, my belief is that the LTCH criteria -- and this is just my opinion --

I know there are others who believe this is going to be a godsend for the LTCHs. I think

it's going to be tough.

We've looked at it a lot. We've looked at it hard. We've done some pretty deep analysis.

It's hard for us to envision that -- A -- there's this pent-up demand for patients who are, today, going somewhere. They're going either into a rehab facility -- they're going into a skilled facility -- maybe they're going home. Because now some of the opportunities are there in the LTCH, they're going to flock to an LTCH.

They're not going to an LTCH today. Why would they want to go to an LTCH or need to go to an LTCH tomorrow if these new patient-criteria are in?

You then sit there and think, "Okay. If half of your business --

You've got to have at least half of your business that's meeting patient criteria, and the other half is the greater-of costs or the hospital -- and that's the best you're going to do --

It's going to be, in my view or in our view, really, really hard to get through that transition. Because you're going to be coming up against some really significant headwinds. Now that's just our view.

So that puts us on the sidelines in terms of LTCHs for a considerable period of time. Until that criteria works itself out.

Those who were very optimistic and say, "No, this is going to be fabulous for LTCHs. Can't wait for the patient criteria to come." If that happens, great. We'll certainly be monitoring that sector. But we're not going to jump in.

Part of it is a reflection of we've gone through something similar.

In 2004, if you remember, a 75% rule that had not been enforced. CMS had suspended enforcement from 2002 to 2004. Now everybody was going along; everybody was feeling really good.

Boom! They start. In July of 2004, new criteria.

Between 2004 and the end of 2007, 20% of the IRF market went away. And into skilled and into home. 20%.

Now in our business, we saw about a 12% reduction. But we had to live through that very difficult period of adjustment, going into the new criteria.

Frankly, I don't want to do that again. It was bad enough doing it on the IRF side. It makes no sense for us to jump in and buy a portfolio and then just have the pleasure of having to work through that transition.

But we're going to definitely be on the sideline for a while.

Home-health, again, you heard April talk about the opportunities there. We really do

think that there are some very exciting opportunities. To continue to grow that portfolio in collaboration with the growth that we're seeing on the rehab side.

Unidentified Audience Member: Very helpful answer.

Just one follow-up. And I certainly understand the value and how you perceive this box in sort of the post-acute.

Jay Grinney: I think today, payors are waking up to this whole value-purchasing paradigm that is emerging.

I do think we're at a point -- certainly on the commercial side -- and I think it's being driven by the influx of the previously-uninsured. Many of whom have chronic conditions. Many of whom are driving up medical loss ratios because of their underlying health condition, which is not overall particularly good.

I think on the Medicare side, there is a realization that the per-day rate differential -- say for example between SNF and IRF -- needs to be viewed within the context of the episode. I think that's why you're seeing the bundling and pilots and so on. That's why I think a lot of us are jumping in there. Because we think there is an opportunity to provide a higher quality of care.

Especially in our case, with a home-health provider that can then provide that care seamlessly, all the way home, into a safe and secure environment.

Unidentified Audience Member: Just a follow-up on that last question.

In Medicare Advantage, there's about 8 to 9. One -- I guess could you just confirm that those numbers are roughly correct? Then more importantly, what you're saying about convincing the value proposition --

How do you get the MA plans to buy into this? Because they're there today. And it looks like the market penetration of MA in your inpatient markets is pretty high. But it seems like there's --

How do we reconcile what you're saying with the way the providers are actually viewing the business today?

Jay Grinney: First of all, there's a difference between MA enrollment and utilization of post-acute care. A lot of that growth in the MA plans are the 65-year-olds and 66-year-olds. They're coming in. They're relatively healthy.

It's really similar to what we saw when HMOs started back in the '90s. Who were the ones that flocked to the HMOs? The young and healthy.

As soon as they needed healthcare and their doctor wasn't in the network, their hospital wasn't in the network, they couldn't get the specialist in their network -- what did they do? They backed out.

That's exactly what happened. That's what I believe could happen again. The young and healthy 65 and 66 -- hey -- why do I need the full range? I'm going to go with the MA plan.

The average age of our patients -- the average age of our patients on the hospital side and the home-health side -- is 78. A lot of those patients have multiple chronic conditions.

I think there's a little bit of a disconnect. I don't see that there's a direct correlation of higher penetration; they're going somewhere else. It's higher penetration they're not going anywhere.

It's not that, "Yes, there's growth of Medicare Advantage." But they're not the patients that are going into our facilities.

In terms of the question of the value proposition. As we approach --

We were actually starting to have these discussions. I know we were definitely doing it on the home health side.

Approaching the payors with the value proposition that we can coordinate that care and we can reduce the (inaudible)

That, to me, is the first real key. That's the hook that will get the plans to really pay attention to what we can provide to them.

This is down the road. This is not any time in the next 2 or 3 years or so. I don't know when it would --

But we could conceivably go and say, "We'll take that risk. We'll take the post-acute risk for these kinds of patients." For stroke patients. For hip-fracture. Assuming that we don't have the regulatory constraints that we operate in today.

We believe, just based on our discussions today with payors, that there's going to be receptivity to that.

Unidentified Audience Member: The SSI adjustment of 4 to 5. I think that was just all catch-up. Is there a go-forward impact in the numbers?

Then what is the Medicare Advantage?

Jay Grinney: Doug?

Doug Coltharp: The SSI is all retro. No.

Unidentified Participant: (inaudible)

Doug Coltharp: But we're not suggesting that there's any further implication with regard to the EBITDA guidance for this year.

It's a degree of magnitude.

The retro -- the last adjustment was in 2012. The adjustment that you have covers more than 2.5. You've got a half-year left with the new assumption.

And it impacts a very small portion of our overall patient base. It only gets to that $4 million to $5 million level because of the cumulative on a retro basis. Its impact on a go-forward basis is relatively diminimus.

Jay Grinney: And the way that the SSI factors into the LIP adjustments. Low-income program adjustments. That's a fairly small amount.

But as Doug said, on a cumulative basis, they issue these updates. Then we take that and we have to then make adjustments to how we have accrued for those. And if we've been under-accrued, we have to make adjustments.

But it's really more a function of it's been a while since we had the last update.

April Anthony: On the home-health side, 8% of our revenue is coming from the Medicare-Advantage side.

Unidentified Audience Member: A couple questions. A picayune question for Doug.

How many of the 27 lease facilities (ph) out there have purchase options?

Second question is -- and (inaudible) Model 2, that includes the acute hub (ph) -- one of the concerns we hear is not that you couldn't. If you have a static pool of patients, you guys are positioned well to (inaudible).

But what about the incentives in a hospital-based bundle, where they (inaudible) and they've got a direct incentive (inaudible) signs of that in Model 2, where the (inaudible) patient strengths.

Because then is that a top-of-mind concern for HealthSouth? Or is it something that people are --

Doug Coltharp: So, start on the lease side, John. And I don't -- I apologize -- I don't have exact figures for you. But the answer is, it's relatively low.

Particularly over the next three years, the number of leases that are either expiring and/or have interim lease-purchase options is just a couple.

Doug Coltharp: John, on Model 2, I'd say it's too early to tell. I don't have a great concern that we would be cut out. But the acute-cares are just now signing up for more and more of them, what we're seeing.

We have a listing because it's through information provided with CMS, of who all is signing up for these Model 2s in our marketplaces. And then if they haven't reached out to us, we're reaching out to them and letting them know of our willingness to be part of

that, and want to be a preferred provider.

It's really early-on in process. We've not seen any trends going one way or the other.

Jay Grinney: But I do think that -- it doesn't matter if it's bundled or ACOs. Ultimately, let's say it's an acute-care hospital that's bundled or they're the ones at the heart of the ACO. They're running the ACO.

They're going to be -- they're going to have to be worried about and focused on -- clinical outcomes. And that will drive cost.

So you could --

And we're seeing this in some of the plans that are starting to understand. That sending a patient to a SNF lower-per-diem setting that has a 2- or 3-times higher -- actually higher than that in some instances -- readmission rate, and poorer patient satisfaction and quality --

It's not as efficient as sending it to an inpatient rehabilitation. Especially if we had that home-health component that we can bring that patient to in a safe and secure manner.

I think it is a little bit too early to know. But it's not a top-of-mind risk. I think the risk is always going to be there. "How do we position ourselves to be attractive in this new world order?"

I think as long as we continue to focus on the high-quality, provide that quality on a cost-effective basis, and be able to provide a full continuum of post-acute services --

I believe that we will be successful in whatever of the hierarchy. Whatever that payment structure might look like.

Unidentified Audience Member: Hey, April. Can you update us just on where your recertification rate is and how that's trended?

Then as we think about the clinical collaboration opportunity, is there any meaningful difference in what the recertification rate of home-health looks like versus your corporate average?

April Anthony: Yes. So our average has been slightly-over 1. About 109% of admits are recerted (ph). It's dropped down to 96%.

At the moment, some of that drop is because of the HealthSouth referrals that we've been bringing in, which tend to be more one-episode oriented patients.

Another portion -- a bigger element of it -- is really that in the core business of Encompass, not just the HealthSouth referrals, our percentage of patients that are driven from orthopedic surgeons who used to go up. So our joint-replacement patients. And those, by definition, are generally one-episode patients.

So we're seeing it drop below that one-to-one ratio for the first time in the history of Encompass. And we think it'll continue to kind of moderate down probably into that sort of 80% range.

Unidentified Audience Member: From HealthSouth to Encompass, we should think about a --

April Anthony: Generally, it'll be one-episode patients. As their mix shifts a little bit more with their neuro patients, that could be different. Certainly their ortho patients are going to more likely be that one-episode patient. But a neuro patient who's a stroke patient could very well make it into two episodes if there's a lot of speech therapy and other things.

So it's going to depend on the type of patient. But the primary expectation will be one episode.

Unidentified Audience Member: Got it.

My second question, Jay, just kind of back to the whole, "How do you demonstrate the value proposition?" Of environment.

Can you kind of remind us where you are in your data warehouse? I know Rusty's not here. But you're (inaudible) aggregating a lot of clinical (inaudible) that you've aggregated from Beacon and your Homebase with April. And sort of what's the strategy right now to try to aggregate that data? Be able to assemble it to say, "Here's the episodic costs of the patients coming through the entire HealthSouth enterprise?"

Jay Grinney: Yes. And that's a great question.

We are in the early stages of assembling a strategy around that.

What we're doing is both on the hospital side, as well as the home-health side. We're establishing a fact based on what are the capabilities today. What kind of data is being generated? How can we communicate between homecare home base and ACE IT? To start to look at that.

Then, literally, we have just begun that.

We have put a team together and we're starting down that road.

The next step then will be to look at how we can use that data to establish those clinical protocols and better understand the outcomes and the costs of those clinical programs that then can be used ultimately to determine on a diagnosis-by-diagnosis basis, where are the opportunities for us. Based on the information we have on the BIPC (ph).

Because remember, over there, we have all of our hospitals, and we're getting from all -- in every single market -- on the total cost of care for that 60- to 90-day episode.

To be able to then start thinking about, "Okay. We're seeing that in this market for stroke patients," we've got a huge opportunity. Based on the model that we've established over here with ACE IT and Homecare Homebase, for how we are taking care of stroke

patients in those markets. How can we now bring that to the payors and say, "We think we can save you some money?"

That's frankly a couple-year process. But we've already begun to go down that road.

Doug Coltharp: To follow on that one, too.

One of the things we're looking at are, "What are some of the predictor models that we can pull out of that information?"

If we had an idea about what some of these types of circumstances that may lead to a patient being readmitted --

Discharged from us and readmitted back to an acute-care hospital --

What were the things that led up? What were the status-change of our patients that then we can intervene on earlier and present that acute-care transfer?

Something like that is where you start thinking about how valuable this data is, that we'll be able to retrieve and pull out of in quick fashion, just because we have electronic clinical information.

Unidentified Audience Member: A couple questions.

Jay, you started off by talking about the demographics in front of you. People over the age of 65 growing 3.4% in IRF volume perspective.

The number over the last five years was 2.8%. HealthSouth has spent a lot of CapEx -- it was probably 50 bps less than that.

And even if you had 200 bps less than you, and we haven't even gotten to the point where ACO hit (ph) target, what kind of -- five year -- if you start to see these (ph)

Jay Grinney: You know, at this point, first of all, I think it's a tailwind for volume.

Part of that is a function of the age of our -- average age of our -- patient. I mentioned before, it's 78 for the Medicare population.

So the fact that we are seeing the over-65 growing at a faster clip -- that's again a function of those newly-minted Medicare patients coming in under Medicare coverage.

So it's going to maybe be a little while for us to see that downstream.

It's hard to really quantify, I think. Kevin, I think what we see -- what we've said is -- 2.5% to 3.5%. That's what we've got in our model today.

When we get on the other side of Cardinal Hill and Savannah, we'll look to update that.

But I think there's an opportunity for us to see that number over time increase. I really

do. I think frankly if we look down the road far enough -- 10 years -- I think there's going to be a scarcity of provider beds to meet the demand that this Medicare cohort is creating.

We don't see it today. Because at 65 and 66, the hardcore reality is, people don't have the same kind of medical conditions that they do when they're 78, 80, 82.

But that time is coming. And what we're trying to do is position ourselves to be ready for that time.

Unidentified Audience Member: Okay. Then a question, which you think about in post-acute care online (ph).

Now I can't give an answer, if it's best of options would be good in everything (ph). But if you could only be really good in one or be located to have an inpatient and an outpatient setting, is it better to have an inpatient and an outpatient setting? Or to be --

Which is going to matter more to partners on the hospital side? Partners on the payor side? Conceptually?

Jay Grinney: The answer's probably not going to be the one you want. I think you have to be both. I mean I really do.

And that's what's really driving our strategy.

If we felt that -- if we -- well -- let me put it --

If we didn't think that having both was essential for that new world order, we probably never would have acquired Encompass. We wouldn't have looked for that partnership.

Frankly, they wouldn't have looked to us as a potential partner. They would've just kept on going down that private-equity road.

But I think we both recognized that that new world order is going to require a collaborative clinical approach. And that that clinical collaboration is going to define if you're successful or if you're not.

And as we've said before, for the hospital side, it doesn't have to be IRF-specific. It's really facility-based, post-acute care service.

So I can't answer the question on saying, "Which one." Because I truly believe that you have to be really, really good at both.

Again, as we've said throughout the presentation, the absolute -- the absolute core requirement -- is to be able to provide high-quality care.

One thing that we really didn't touch on today, but I believe is going to differentiate us going forward, is today quality is assumed. There's sort of this notion that all providers are created equally.

In the future, quality is going to be measured and is going to be communicated. And it's going to be that everybody is going to have those standards.

So today, the quality differentiation, we may know it. Some physicians may know it. Maybe even some of the plans know it.

But nobody's acting on it. Nobody's really driving volume or pushing volume or making decisions really on true, hard, clinical quality measures.

They've got patient-satisfaction and the stars. But it's kind of mushy. Right now, it's really mushy. It's not really as sophisticated as I believe it's going to be in a 10-year period of time.

When I'm 75, I think when I need healthcare services, I think I'm going to have an enormous platform -- an enormous data-source to go out -- and to really understand who gives the best care. Not just who gives the best food. But where am I going to get the best outcome? Where am I going to get the best outcome?

That's really where I think we're going. That's why I believe we have to be focused on clinical excellence and outcome excellence in both facility-based as well as the home-based.

Unidentified Audience Member: That will be important.

Unidentified Audience Member: Last question.

As we think about the returns to this business, as you move to the new payments, it's become a better business. If you're able to actually --

I mean there's obviously execution risk between here and where half of it's pay-for-value and you're making money on keeping people out of other post-acute care settings. Is this a better --

Is there capital that you need to spend to get there? I mean how do you think about how the business evolved? The returns evolve over time?

Jay Grinney: I don't see a lot of capital required. There may be some additional CapEx required to supplement and to develop the data mining and analytical capabilities. But that's not --

That'll be, I think, fairly modest. It's not going out and building the data sources. We have them. It'll be more, "Do we need to add some incremental costs to our model to be able to really refine how we utilize that?"

I think it's too early to really know what the return metrics are going to look like. It's far-enough out. It's really hard to say what that will be.

The thing that we keep falling back on, though, is that the demand-curve is inexorable. That 3% or 3.5% growth is inevitable. We know it's going to be there. Someone is going to have to provide that care.

It can't be outsourced. It's going to have to be provided.

Who is the winner? We think we're going to be part of that group. What the returns are going to look like is very hard to know, because there are so many factors that are still up in the air to be able to make an intelligent prediction.

Doug Coltharp: Kevin, I think the most-likely outcome, though, for Jay's comments is that it expands the addressable market. And it expands the volume flowing into our facilities against a fixed-asset base.

Even if those presumably lower-acuity patients then come in at a lower margin because it's against the fixed-asset base, it's going to be accretive to the returns.

Unidentified Audience Member: And there are questions for April.

I guess the first question is, "What do you need to do as you enter new markets, to achieve scale and kind of how long does that take?" And then the second question is, in your chart, the 24% of non-Medicare discharges. How come you've excluded that? And I've got a few (ph)

April Anthony: First, on the scale side. It depends really on the market.

As I mentioned earlier, in a CON state, getting to scale could be much slower. Because there are just fewer providers that you can purchase out there. Fewer that are making sell-side decisions.

So, a CON market can be quite a bit slower.

In a non-CON market, we have historically been able within a 3- to 5-year period to move up into that top-1, 2 or 3 position in the state, giving a strong regional performance.

Virginia's a great example of that in recent years. Idaho -- the same story. We've cobbled together 2 or 3 different acquisitions and very quickly moved into the Number-1 position. Same in Colorado. So we've been able to really prove it in a relatively short period of time, through a hub-and-spoke approach.

We can enter a market and then penetrate it pretty significantly.

On the 24% that we excluded --

Those are one that today we do not have contracts for. So we again are working with HealthSouth to try to understand where the largest concentrations are within that 24%. And then to go see if we can come up with lucrative contracts.

We're not really interested in trying to come up with a contract that's a loss-leader contract. A lot of these preferred managed-care providers pay home-health in a way that doesn't make any sense economically.

To the extent that we could come up with either a bundled approach that we could go together with that provider and say, "Let us think about this differently," or we could get a fee-for-service approach that would be an acceptable rate, we would go after that market. But it will have to be one sort of on a case-by-case basis.

When you look at that 24%, it is very fragmented, as well. Because you're talking about facilities all across the nation. Different providers.

So there's not just one or two big-hit relationships in there. There obviously is a hierarchy, and we'll go after them that way. But it's a pretty fragmented subset.

Unidentified Audience Member: You guys talked a lot about clinical collaboration and working with your IT platform. From a (inaudible) data component of that. Leveraging the payment models.

But maybe can you talk to some of the other initiatives you're working on?

Jay Grinney: Sure.

Interestingly, and this goes back to the comment I made earlier about ACO evolution is still -- in our minds -- a bit of a question mark.

As Mark mentioned, about a third of our portfolio is aligned with joint ventures. Or in a joint venture.

And many of those are with large academic medical centers. None of them are deep into this ACO model. Not a single one.

Many of them are sort of dabbling and putting together organization documents and structures, and having discussions. But we're really not seeing a lot of activity where they're just going full-bore to get into this model.

The work that we're doing with the joint ventures is really keeping pace with them as they --

Because there's a lot more that they have to do to position themselves to jump into an ACO environment than what we do. What we're really trying to do is just kind of keep pace with them.

That is really all we're doing with our partners right now.

If they want to move fast, we're ready to go. If they're sitting back saying, "You know, I don't know about this ACO model. I'm a little leery of it. I've got a friend who was in one and they lost $8 million. I'm not going." That's all right. Then we'll just hang back with them.

But it's really a function of, "How fast do they want to go is how fast we will go." We're just not seeing a lot of activity.

Unidentified Audience Member: A question about home-health and that relation of cost-per-visit.

I wonder if you could just comment a little bit on what is your cost-per-visit? How does that compare to the HealthSouth home-health agencies and what that opportunity might be?

Then just stepping back from the numbers piece --

Just the operating model. Could you talk about what you think is different?

April Anthony: Cost-per-visit -- we run about 22% below the other public comps. If you look at the other public-company statistics that are out there.

The two main drivers for that are really productivity. 75% of our workforce is full-time employees of Encompass. So it's critical that when we bring on a full-time employee and we have a committed salary for that person, that we get them to the agreed-upon levels of productivity.

So our Homecare Homebase technology helps us do that. But equally-importantly, our culture helps us do that. Of really creating those everyday accountabilities -- to hitting those.

Another key element, and that's actually a larger percentage of the story, is how we utilize the Homecare Homebase technology to make it possible for us to utilize LPNs to provide those skilled-nursing (ph). PTAs to work in collaboration with PTs. Finding what we call the optimized level of staffing, that utilizes the right balance.

Where RNs are only doing work that they can do. Truly working at the top of their license. And the work that's not at the top of their license is being done by LPNs whenever there's authority to do that. That is an equally-critical component.

So that has given us a nice headroom between us and the public companies.

As it relates to the HealthSouth comparables in the past, their biggest challenge has been one of scale. In the absence of scale, they've had a lot of small home-health providers across the country. That just makes it difficult, if you have a small number of employees and you're covering a big geographic region. You spend a lot of time behind the windshield that's not very productive. If you don't have enough patient-census ebbs-and-flows and that patient census can really have a significant impact.

So I think we're going to see significant improvement as we bring the HealthSouth operations into our Encompass locations. Getting that capacity utilized more successfully in bringing them to our cost-per-visit very quickly.

In the markets where they're not overlapping with Encompass, the strategy there will be to diversify away from just the HealthSouth referral source. That's how the growth will happen in markets Maryland, Pennsylvania, Arizona. Where we're going into new markets that HealthSouth had that we didn't.

We very quickly will put salespeople on-the-ground in those markets to go approach the

traditional home-health market. Still absolutely capturing as much as we can out of HealthSouth, but not relying on that as our primary or sole referral source.

Unidentified Audience Member: We've talked through the years about being less. And when you factor in the length of stay and the readmit rates, I'm wondering if you guys in your work have looked at IRF-plus-home-health? And compared that to SNF plus staff (ph).

Anything in terms of numbers or directionally? How that looks.

Then a follow-up to that is, I'm just wondering -- Jay or Mark -- or anyone, really. What are your biggest opportunities on the model for rebundled (ph) payment system for now? To be more cost (inaudible) episodic basis?

You talk about the early intervention on the readmission. Is it right-setting? Is it current-costs you have within your companies, relative to the group out there? If you could just --

Jay Grinney: Maybe let Mark answer that in a second.

The first part of the question is, we have not yet modeled out what an IRF-plus-home-health would look like. That's part of the process that I'd described we're starting to lay the groundwork for.

But some of the analysis of what we're seeing on the Model 3 as we look at IRF-plus-SNF plus non-Encompass home-health gives us a lot of confidence that there are opportunities in both of those buckets. To reduce SNF, in many respects, I think we can obviate the need for skilled nursing.

At least for that portion of the skilled-nursing population that is there for really -- It's more -- it's a much lower level of acuity that could easily be handled in the home.

But Mark, you can take that.

Mark Tarr: Yes. Jay's absolutely right.

If we look at our portfolio and we did this as part --

I mentioned earlier this information that we got from CMS just through the application process for bundling. We found it very enlightening. It was information that we'd not been able to see before. But CMS had.

And it helped to profile the various post-acute providers in any marketplace of which many we were using.

We looked across our portfolio of our hospitals, and their discharge-to-SNF rate. We had a low of somewhere around 5% and a high somewhere in the mid-20s in terms of percentage of patients being discharged to SNF facilities.

So we're tackling this like we do any other portfolio type of information.

Where you have highs and lows on the outlier side, and what can we do to go in and work with those hospitals that had north of 20% or -- for better instances -- north of 15% of patients being discharged to SNF? What is it that we can go in and do?

Do we need to extend length of stay by maybe one day to better achieve functional outcome? Can we coordinate better with home-health in terms of working with family members?

Earlier on in the stay of the inpatient stay. So that they just know the end goal is to get home, and in this case, with home-health.

But all, as part of reducing our discharge to SNF. Because in a bundled episodic rate, we're responsible for those costs to cover that SNF within that 60-day time period.

That's the area that we think offers the greatest opportunity near-term on both dollar-amount and quality. It could be better quality for us to provide for our patients and patient families.

Jay Grinney :That's where that data-analytics again comes in -- to identify what are those best practices. So that when the patient is literally being one day or two days away from being discharged from the acute-care setting and we know what that diagnosis is coming into our hospital, we already have a clear understanding of exactly what that best-of-class protocol is to get that patient home.

That's not to say that we're going to just march along that lock-step and not adjust to individual patient needs that may arise. But it starts to give us the opportunity to really standardize that care. To take that variability.

It's what Mark said. It what we try to do in any operational and now clinical undertaking. That's to recognize that we -- as we look across our portfolio -- now to include home-health --

On any given metric, there's going to be some kind of distribution of performance. There's going to be best-of-class and there's going to be not-so best-of-class.

What we want to do is, we want to reduce the variability and then move everything to that best-of-class.

It's one thing to say we're going to do it. It's another thing to be able to use the data that we are now getting, to be able to do it. We never had that chance to do that, clinically.

We did operationally, because of Beacon. That was one of the reasons why we jumped on and said, "Yes. We need the ability to manage our operations. To manage labor. To manage supplies. To manage all of the operating components."

Productivity. And to be able to do that at the hospital-level, at the regional-level, at the corporate-level.

That's why April with Homecare Homebase did exactly the same thing. That's why our margins are so strong. Because we use that technology to drive efficiency on the operations side.

Now we're on the cusp of being able to do the same thing on the clinical side. That, to me, is really where it's exciting. Because it gives us an opportunity to then be able to go with data to the plans, and to say, "Here's our model." We'll be able to take --

Obviously we know the operating costs. We'll be able to take these patients on a bundled basis, and to provide care for them. And to know that we're going to do that on a high-quality basis.

April Anthony: When you add in the home-health component, the ability to have a really reliable partner. Most of the bundled-payment value comes in not letting --

It's not so much about what you do in your spending and your silo; it's just don't let them go back up to the higher-cost silo.

So as you start working your way through that process -- moving that patient down to home-health -- having a partner that you can trust to say, "Boy. They're in this boat with me, in recognizing that we've got to everything we have to do."

Even if that means spending more at the home-health level, that is a much cheaper answer than letting that patient -- cutting their care down -- and letting them go back to that high-cost setting.

So what we've found in our bundled-payment programs -- both pre- and post- -- our relationship with HealthSouth is, it's not really about giving less care. It's about giving more care, and the appropriate level of care, including some of that phone-based interaction. Not just home visits.

That can drive -- significantly drive -- down the amount of rehospitalization.

So I think there's a collaboration partnership that we can put together with our two organizations, and the ability to rely on one another, that can really create a unique dynamic in the BTCI world.

Jay Grinney: Let's say there is a patient that needs to go back into a higher-acuity setting. Why do they have to go back into the acute care? Which is the highest setting?

We're there in partnership with Encompass to be able to provide hospital-level care. Or now there may be some that are crashed and they need to get into an ICU. But if they just need a hospital-level care, why do they have to go all the way back up to the acute-care setting?

So there's a lot of -- I think -- really exciting value that we believe is there in our model. We're putting the pieces together today to be able to realize that, going forward.

The question is, "How much does the 75% or 50% rule hamstring?" At this point, we

don't see that it hamstrings us dramatically, if at all.

Clearly, if we were in an environment where 50% of our payments were value-based ACO-bundled site-neutral, we would need to have some relief. We'd need to take those patients and get them out of the denominator in terms of the 60% rule.

The good news is, to hear everything and read everything that Med Pac says about site-neutral payments -- which is really kind of where their focus is. They acknowledge in a site-neutral world, there ought to be regulatory neutrality, as well.

You talk to the folks at CMS and they say exactly the same thing.

Today we don't see it as a limiting factor. We really do believe that there's a lot of consensus building that if we're moving to this environment where the payor -- Medicare -- is really looking for the best clinical outcome, then they should be very unconcerned about all of these historic silos that they've established.

Unidentified Audience Member: So as a follow-up to the BTI discussion --

April, are you seeing any signs of care shifting down to a lower level? So from SNF to home-health with any --

Do you see any signs of changes in discharge patterns so far? I know it's early.

April Anthony: Not probably measurably. There are some anecdotes that you can definitely see some skilled doctor --

Particularly where we see it is the bundler. They've become much more aggressive than when the hospital is the bundler, in trying to really align with partners and find ways to drive that cost down.

We do have a couple of BPCI programs that we're working with as kind of a downstream provider with orthopedic surgeons, where we're seeing them be much more aggressive about going directly to home for the rehab, instead of stopping at the SNF, first.

So we're seeing some of it almost always doctor-based. When we see those little behavior changes.

Unidentified Audience Member: And then one question for Doug.

The FPAI exercise -- that option -- is that more opportunistic or is there something to be thinking about there?

Doug Coltharp: It was pure opportunistic. That was a -- to use a term that I'll borrow from my days in retail -- that was a "gift with purchase," that came on the sale of SCA. It had sat out there for a long period of time. It became actionable.

We exercised the option in April, based on the proximity of us exercising the April to the secondary offering. We were subject and are subject to the lock-up agreement. That

expires at the end of this month.

But there's no intent for us to be a long-term holder for any strategic purpose.

Jay Grinney: We have no aspirations to be an activist shareholder in SCA.

Unidentified Audience Member: When do you think you'll have --

Jay Grinney: It'll be at least a year before we have any information on this. And we'll see.

I mean if it moves the needle, obviously we'll either positively or negatively. But if it's relatively inconsequential, we'll probably just say it's still relatively inconsequential.

I think it needs to sort of mirror what's happening in the rest of the market.

My guess is, it's going to continue to gain momentum. So it will be, over time, increasingly something that we talk about -- again, either as positive or as negative. "Here are the opportunities. Here's what we need to do to course-correct."

Unidentified Audience Member: And one for April.

Your recert (ph) rates are higher. I know you've addressed that. But do you mind just resetting the (inaudible) you have to run with Medicare?

April Anthony: Sure.

Unidentified Audience Member: Those are flags.

April Anthony: Encompass has a higher percentage of outlier patients. Mark mentioned outlier patients in the IRF setting. We have the same concept in the home-health setting. Those patients who have high-utilization of services.

We tend to see them cluster around the diabetic population. So patients that are insulin-dependent diabetics. Live alone. Have an inability to self-inject. So they have to have a nurse come in and do that.

We have about 4.5% of our total episodic population that falls into that outlier category. That compares to something in the 1% to 2% range in most of our other public peers.

That population, by definition, recertifies 6-times a year. If we do our job well, they don't have to go back into the hospital. They just need that constant care.

So they tend to be very-long length-of-stay patients, and they skew our recert rates up a little bit.

If you carve that population out, we're already lower than some of the public companies -- even with them in. But carve that population out, and we get very much in that common spot.

We've had some ADRs on those particular patients, and we haven't really had any concerns, relative to them. They do review them, but we haven't any denial concerns on those, because our system does a really good job, in the way we built the documentation in Homecare Homebase to justify the basis of that care on an episode-after-episode basis.

If you look at the average visits-per-patient, for example, on those -- 120 visits per-episode. And the episodes are 6-a-year versus a lot of patients that are 1-a-year with 20 visits.

So it doesn't take a large percentage of those episodes to skew (ph).

Unidentified Audience Member: You guys, there's been a lot of emphasis on clinical outcomes and differential (ph).

A question for April.

How does Encompass differentiate itself clinically? Above and by the lower-than-average readmission? Is there another metric you could point as to -- comparable to the FIM gains?

April Anthony: Historically, we've had this 22-metric based approach. You can sort of pick and choose the ones you're good at, and claim that that makes you better.

So it's been difficult in the homecare space.

I think the star-rating concept that will become publicly-released in July is going to be the best consolidated measure of really patient outcomes that we'll have in the home-care industry. We're encouraged that that's coming out.

Recognizing that it came out with no one knowing what the metrics they would use to calculate it were. So now that we know the nine metrics that are part of it, we can really begin to focus on how we drive quality in those particular nine metrics.

But it was one that came out arbitrarily with no kind of foreknowledge.

We got our first view of it in April, internally. Then it becomes publicly available in July.

I think that's going to be the best way to really measure that quality, and to do it with a consolidated metric versus these kinds of random 22-data points that have been the historical.

Jay Grinney: One of the things that appealed to us about Encompass was the fact that they can demonstrate that quality difference.

On the inpatient side, we could look to FIM-gain or we can look to PEM scores. But we don't yet have in our industry any of those same consistent measures that CMS uses for every provider in our space, that is then distributed and reported on, on a periodic basis.

As I said before, I believe that time is coming. I think that the pace of that change is actually going to be faster than the pace of change on the payment and delivery system evolution. That information -- everybody wants that now, and it's increasingly becoming more available.

Everybody's focusing on the fact that we need to pay for quality. And we need to pay for value.

All right. How do we define that?

I think that that's going to be actually in our space coming sooner rather than later.

Unidentified Audience Member: I just had a question around the expectations for that. We've seen three hospitalization demo projects. And I think there's been some concern on how much CMS was going to withhold from that. Do you have any update in expectation?

April Anthony: You know, from the SGR legislation, we feel like we have some hope of a moderate financial reimbursement. They made some pretty significant changes in case-mix weight-allocation last year. Which really made last-year's rate-analysis a very noisy one.

There were a lot of variables.

So we don't expect that again this year. We expect them to stick with this case-mix weighting, which will make the analysis much easier. But from an overall net-percentage impact, we feel like we're going to have a moderate impact.

Last year, I think we were at point. We think it'll be somewhere in that same kind of 1-percent-ish range this year.

The only thing that may come out that we're not certain of yet is, if you'll remember in last year's proposed rule, there was the value-based purchasing discussion that was in the proposed rule, but didn't make it into the final.

So any time you see that, you always kind of watch for, "Okay. Is that going to circle back around this year?"

There are some rumors in Washington that we may see that come back in the proposed rule again this year. Which is to withhold dollars for value-based purchasing programs.

So everything we're hearing is that it would mimic what they proposed last year. And there's some debate whether or not that would come through the legislative arm or whether it will come through the rules. It's a scoring battle on who gets credit for it.

So we'll have to kind of watch how that comes out. But it seems like in the next month, we'll know something on that. Whether that's coming in the proposed rule or piece of legislation.

So that's one we're watching for. The biggest unknown.

Jay Grinney: All right! Any other questions?

Well, before we conclude, I wanted to give a shout-out to Amy Gibson, who helped put this all together. And Mary Ann Arico, who is -- as you know -- our chief investment relations officer.

I also want to take this opportunity to share with you some bittersweet news. That is that Mary Ann has told us that as much as she likes working with us, she really wants to play a lot more golf.

So she's given us a one-year notice that she is going to be retiring in 2016.

We're going to be spending the next couple of years -- actually, couple months -- developing our strategy on cloning. We're almost there. And as long as she hangs in there until we get that refined, we're good.

It'll be a little -- it's going to hurt, initially. But I think it'll be good.

She's been a phenomenal addition to our team. She gave us the courtesy of saying, "Listen. I've done this a long time. I really want to move on to self-actualize. I think a lot of golf is going to be part of that. I want to get off the train, but I want to give you guys plenty of time -- plenty of room -- to make the decisions that you need, in terms of replacing me."

It will be very difficult.

But I did want to share that with you. It'll be sometime in 2016. And I'm sure all of you would agree with me, she's done a phenomenal job in establishing a very strong relationship with our shareholder base. Being responsive to you.

We've been ecstatic to have her as part of the team.

With that, I want to conclude. I want to thank all of you for joining us today.

I hope this has been helpful. I hope it has provided you with some comfort that we really are looking at where we want to be three years from now, five years from now. Paying a lot of attention to where we're going to be in 2015 and '16.

But we're really positioning this company to be successful into this new evolving world order. Thank you very much.