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

All right, we're going to go ahead and get started. Thanks for sticking with us this afternoon. I'm Whit Mayo, head facilities analyst at Baird. It's my pleasure to have the management team from HealthSouth representing the Company, Doug Coltharp, Chief Financial Officer, and Mark Tarr, Chief Operating Officer. We're just going to move right into the conversation, and I think from my point of view, I'd love just to start with Encompass, and if you could spend a minute maybe going back to the history of the transaction, why this asset? Why this is the right fit? Maybe update us on the performance of Encompass and how it met up with your expectations?

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

Sure, Whit. I'll start on that and then ask Mark to join in afterwards. And, really, our desire to move into the Home Health Care space, we first began to articulate right in the aftermath of the Affordable Care Act back in 2010, and it was driven by some of the elements specific to the Act and also some of the things that we felt were evolving in the health care delivery system that were just related or ancillary to that.

However, at the time, we didn't feel it was actionable for us to move to the Home Health space for a number of reasons. One is, we had not previously operated in that space and felt that we needed to be further edified on operating a Home Health business. The second is that the regulatory headwinds that were facing Home Health at that time were pretty onerous, and it was difficult to figure out just how far any kind of rebasing or change in the reimbursement environment was going to go. And the third was our balance sheet needed some fixing.

So as part of the edification process, we started asking around about who were the Home Health providers that exhibited some of the same characteristics in their business that we do in our business; that focus on the Medicare beneficiary population; a real focus on producing high quality outcomes, and doing so in a cost-effective manner; and also focused on technology-driven business processes. And the most frequent name that we were given was Encompass Home Health and specifically April Anthony. So we got introduced to April, had our first meeting with her in 2011, and as they say, the courtship was underway. We were very impressed by the business that Encompass had put together and felt like it was highly complementary to our existing inpatient rehabilitation business.

We continued to get to know April and get further edified on the Home Health Care business over the next several years. As that was happening, we also were able to put our balance sheet in a good position to be able to seize on strategic opportunities and also we felt like the regulatory headwinds that were clouding the Home Health business were substantially cleared up. Rebasing was underway. The extent of it was largely known, and we felt that it had stabilized to the point where somebody could make a pretty accurate assessment of the risk involved in that element of the deal. And then last fall, not determined by our timing but by Encompass's private equity sponsor, Cressey, the business came to market in an auction. We were in a position to participate in that auction to open the lead through a creative structure, we prevailed as the winner.

I would say that the integration of the business has exceeded our expectations. It's really rolled out in a number of phases. I'd describe it as being early in Phase 3. The first phase being a public company, buying a new business segment, we needed to attach their business to our business in some rudimentary way so that we could engage in our financial reporting and basic communications and so forth, and we moved through that phase relatively quickly. The second phase, which is largely completed now is that we had operated 25 legacy hospital-based Home Health agencies within the health style platform, and we made the determination that we were not going to operate two separate Home Health platforms but instead we're going to merge those agencies onto the Encompass platform.

Although the revenue associated with those agencies was not very substantial, the fact that they were organized as 25 separate agencies meant that the administrative burden of converting those over to Encompass was requiring some undertaking, but we concentrated in the first half on getting that done in as smooth a manner as possible and, as I stated just a moment ago, that is largely complete.

And then a third and very important phase, which is just now underway is the area of clinical collaboration. One of the things that made the movement into Home Health so attractive to us is that about 54% of the discharge is coming out of one of our IRFs ultimately require Home Health. And even through those legacy health style agencies, we were capturing a very small piece of that. So we are now focused on working with Encompass on developing a set of protocols and rolling those protocols out across our IRFs to be able to convert in a way that benefits the patient, the more of those discharges onto our platform.

To give you an example as to how that has proceeding, about 54% in terms of the number of discharges available to us, to translate that, provide some context, that would be about 72,000 discharges based on 2014 number. And to provide you a couple of additional points of context, in January, the first month that we owned the Encompass business, we captured 79 of those referrals from 21 separate HealthSouth IRFs. In June, even before we had really rolled out that

initiative, that capture rate was up to 385 discharges from 35 different IRFs and, again, it's right at the beginning of that.

What we have seen is that we also reoriented the Encompass acquisition strategy where they're out buying incremental agencies to be now specifically focused on markets in which we operate a HealthSouth IRF, but there isn't a Home Health presence. And as a result of being able to do that and the result also of a recent acquisition that's larger in the Home Health Care space than some of these individual agency acquisitions that we announced recently, CareSouth, we expect to end the year with a portfolio of 120 freestanding IRFs, and we expect to have a Home Health presence in 69 of those, so about 58%.

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

Great, and maybe just transition right into Reliant and CareSouth, and we field a lot of questions from investors about how did HealthSouth value those two transactions. So if you could talk about the process you went through to value Reliant and maybe spend a little bit of time on CareSouth. It doesn't sound like that was really an auction transaction. It was sole source on your part. April's known the management team for a long period of time, and why that asset makes sense in their geographic locations?

<<Doug Coltharp, Executive Vice President and Chief Financial>>

Sure. Mark, do you want to start with just a strategic fit on Reliant?

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

Yes, so Reliant is a company of 11 hospitals, eight in Texas. There are two hospitals in the Boston marketplace in Massachusetts, then there's one hospital in Dayton. This is a company that we know very well. The vast majority of their Texas hospitals are in markets that we currently have locations in – Houston, Austin, DFW Marketplace, Dallas/Fort Worth. The two hospitals in Boston, ironically, we have owned before in the past, and then had to exit that marketplace due to a lease dispute.

And then the final market is Dayton, which has been on our development pipeline list in terms of reviewing as a potential site for de novo. So all these from a strategic fit are markets that we see high growth percentage in and markets like the Houston marketplace where we have existing hospitals, we'll be able to collaborate our sales and marketing team with the medical leadership in those hospitals. Many of these staff are former HealthSouth staff so we know them very well and see, from not only a strategic fit but from a cultural fit as well.

<<Doug Coltharp, Executive Vice President and Chief Financial>>

And the Reliant asset has been owned by a private equity sponsor, Nautic Partners, for a number of years. I think both we and Nautic realize that when it came time for them to monetize the business, we would certainly be a natural buyer of those assets because of the strategic overlap that Mark just described. So we had developed a relatively consistent contact over a period of years with Nautic Partners and also with the management team at Reliant. This spring they contacted us, they said they felt that the business was in a position where they were ready to monetize it based on the dialog we'd had to date they were willing to offer us an exclusive look at that. We had our balance sheet in a position that allowed us to move on that opportunity; performed our due diligence; we're satisfied with what we saw and put together what we thought was a fair valuation.

Please recognize that included within that valuation is an approximately $125 million to $150 million net present value tax benefit that comes along with that asset. So we're very excited about pulling these assets into the fold and are confident that, particularly at this purchase price, we're going to be able to generate a very significant return for our shareholders.

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

On Reliant, if my memory serves me correct, I think you plan on rebranding those as HealthSouth facilities, and can you just kind of comment on the margin performance or just the margin profile of that asset and maybe there were some staffing differences and maybe some investing differences that you're going to have – I just want to make sure that we're?

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

We will rebrand those hospitals as HealthSouth hospitals. They historically have run very high margin, higher than what we took a run in our hospitals as we were able to get in there during the course of due diligence, it became apparent to us that when you look at some of the staffing metrics that we saw, staffing ratios, some of the resources that we made sure our hospitals had they did not have in some of their hospitals.

So we'll go in and make some investments on additional staffing and, in some cases, therapy staffing, some cases nursing staffing, some cases quality reporting that's required for CMS compliance, we'll add some resources there. We'll also add our IT system in place in those hospitals. So there will be some additional costs that we'll put back into those hospitals that will perhaps lower the margin somewhat and bring them in line. We'll also be taking more of a neuro-based patient population in those hospitals. They have a distinctively higher orthopedic mix as it runs now.

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

In CareSouth, the purchase price 170-ish, and you disclosed may just over $100 million of revenue. So how should we think about what the margin profile is on that asset? Or is it better to think about the total opportunity that that Company gives you when we think about the entire clinical collaboration strategy?

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

Well, I really think it's the latter. I think it's important to think about the total profile of that business. So the $104 million revenue number that we've put out there, and CareSouth is a privately held company, so we didn't have the ability to disclose a lot in the way of financial information prior to closing. But that's – bear in mind that that's already a stale number as we're three-quarters of the way through 2015. It's a business that has a good profile. It's a business that, in many ways, has been attempting to mirror Encompass. It operates on the same IT platform, Home Care, Home Base, which, again, is the IT platform that April Anthony, the CEO of Encompass, developed herself.

As a result of the relationship on Home Care Home Base, April and the other members of her management team have gotten to know the CareSouth management team very well over the last several years, and they have spoken periodically about putting the businesses together. Again, there's a PV sponsor that stands behind CareSouth, determined that it was the right time to monetize that business and that Encompass now, with the backing of HealthSouth, would be a logical buyer. So we were able to remove that from the market on an exclusive basis. There are 45 locations predominantly in the Southeast and the mid-Atlantic that come along with the CareSouth acquisition. Fourteen of those give us a new overlap market between our Home Health and our IRF space, and that's very important. Those 14 that move us up to that 69 level that I discussed before.

So there's a great revenue synergy opportunity embedded in picking up these discharges coming out of the HealthSouth IRFs, and I can tell you that on a standalone basis, CareSouth was getting almost no discharges from the HealthSouth IRFs. The other thing that I would point to in terms of incremental opportunities, moving forward, that although CareSouth has been performing at a high level and exhibits high quality, in terms of the comparative operating metrics, they are not at the Encompass level. And what Encompass has been able to exhibit with all of its prior acquisitions is that over a relatively short period of time, through converting them over to the Encompass programs, they are able to raise the operating metrics of acquired businesses to their standard.

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

Maybe to shift gears a second to data warehouse. With the BPCI program now, I think a lot of stakeholders within the industry now have a lot of clinical information data around the total episodic costs of a lot of the Medicare patients and I know you're participating in a very small way within BPCI. But where are you in a kind of a strategy to aggregate a lot of this clinical data and try to extrapolate, okay, if we bundle together a HealthSouth inpatient rehab stay with an Encompass Home Health stay, how does that total cost compare to the alternatives in a marketplace? And then how do you monetize that back with either providers in a marketplace or health plans? And maybe I'm way too far ahead of things, but I think we're obviously sitting sometime is in that area.

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

We are participating in the Model 3 BPCI program. We have eight hospitals that have 60-day episodic. We have five episodic groups that we're participating in. It's our understanding that we're one of two rehab providers out there participating in the Model 3 bundling program. We are participating as a preferred provider within over 20 markets now. We are participating in Model 2 bundling initiatives – those that are being initiated by the acute care hospitals where we are part of their system.

So we are getting some exposure to what it would be like to operate in a bundled environment, and we don't have a large volume. We hadn't really put ourselves in position to be exposed to it, but we are getting some insight in terms of what resources we would need, as a company, to provide our hospitals and be able to better manage a bundled patient within that environment. As Whit said, we are starting initial phases of looking at data. We have our clinical information system – electronic clinical information systems now in 73 of our hospitals.

So we're able to capture some initial information using that system. Right now, we have a group of physicians in our hospitals that are starting that process. They are starting the initial review of some 80,000 discharges and looking at information, particularly around what are the risk factors that we have on outpatients that could indicate that they would be a readmission risk?

So the whole big data initiative within our company is only on the very initial phase. We will gain additional insight. If necessary, we will have to either bring in resources into our company or seek outside assistance in that in order to better position us to someday look at and better gauge risk that might be out there in a bundled or alternative payment world that's just introduced by CMS.

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

And, Whit, I think it's important to note that we sit in a very unique position with regard to the data that is specific to the relatively narrow definition of conditions that are treated within the IRF setting. We've got a market share that's roughly now 22% of all Medicare patients treated with an IRF and, again, it's a very deep database in a narrow market, and we are the only company that sits on that amount of data with regard to these of conditions. So I think as we are able to mine that data and use it effectively, it's going to position us in a very strategically advantageous position for these types of post-acute initiatives.

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

And relative to a bundled environment where we'd be working not only with the IRF hospital but also our Encompass Home Health we are working with a clinical leadership from both segments to help coordinate, clinically collaborate the exploration and review of this data so that we could better integrate ourselves as an integrated system and look at what types of patients – what would be the best protocols in terms of timing, risk factors, everything that you want to look at from a bundled setting.

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

Sticking with data and technology, I think one clear differentiating factor has been the investment into your Cerner system. I don't think really any other large non-acute care organization has spent the money without the hijack reimbursement. And so can you just talk us where you are in terms of that implementation and any benefit that you've seen at this point and how you think about the returns over the long term.

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

Sure. Well, several years ago we took the decision that was going to take a clinical information system, put it in our hospitals. We evaluated various vendors out there that an RFP ultimately selected Cerner. They had some exposure through the – we have Institute of Chicago that already worked up some templates for our rehab setting. We wanted a product that was specific to what we do in our hospitals not a product that was built for an acute care hospital that then gets manipulated into a rehab hospital. So we worked with Cerner. We developed the templates.

We piloted this system and initially two of our hospitals went back and made some tweaks, so we're now in our third full year of full implementation. We are capable of implementing it in somewhere between 20 and 25 hospitals a year. We have 73 hospitals that were up and running. By the end of this year, we'll have it fully implemented in 83 of our hospitals. We anticipate having it fully rolled out to all of our hospitals by the end of 2017. The Reliant acquisition will

be incorporated in, hopefully, within the next year, year and a half, and that's kind of – we had – hopefully, and earlier stated it would be the first half of 2017. Now we're in through, at some point, by the end of 2017 have it rolled out in our platform.

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

Got it. One of the headwinds, or issues that emerged recently – well, not recently, it's been going on for a while but only more recently has it become a more prominent issue is the MAC reviews. Any update around, just, the status of the administrative law judge and getting any of these claims overturned? And I know you've spent some money this year to really invest into coding and standardization to try to prevent this from being an issue, going forward. But just maybe along the lines of the entire MAC issue. Just what's the update?

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

Well, during our Q2 call we had said that we had a meeting upcoming with the MAC that covers a large percentage of our hospitals. It's also the MAC that has taking a bit of a different view on certain types of patients we take in our hospitals. There's so much of this they have created a rule of thumb on certain diagnostic categories that they don't like to see in rehab hospitals and don't accept their presence in rehab hospitals, even though they are approved by CMS as diagnostic categories to be in rehab hospitals. So – we have had ongoing dialog with that MAC provider.

We have also had discussions with CMS about that MAC provider. We're not the only patient provider out there that this MAC covers that's having issues. It just so happens we're one of the largest. So it continues to be an issue. We don't see a near-term relief on that, however, we are committed, and we have the resources put into it including the initiative this last year of going out and working with all of our physicians and educating our physician staff on documentation to put us in a better position during the appeals process. And the ALJ appeals process to have some of these denied cases turned over during the appeal process.

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

De novos – you've had a fairly active development pipeline for a number of years and probably, what, a third of your hospitals now are joint ventured with a health system at this point, and I don't think everyone oftentimes appreciates that. But looking out one, two, three years, how many more projects do you think you can get up and running? And over, I guess, let's just stick with three to five for the timeframe.

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

Well, we still get about four to six hospitals per year on either through de novos or acquisitions. In terms of our pipeline, we are seeing more and more interest from existing acute care systems that have rehab units that feel that there's an opportunity for growth and expand into a de novo hospital and looking for a partner in which to do that. As we have said, a third of our hospitals right now are joint venture partnerships with acute care systems. Many of those are academic based systems, some for profit, some not-for-profit, so we kind of cover all the bases on that. We do think it provides us a strategic advantage in many of these marketplaces. And as we evaluate future marketplaces to enter, there will be some of those that we would prefer to enter as part of a joint venture de novo versus going into a wholly owned.

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

When you look at the actual engineering of a new rehab hospital, the size of it, can lay out the configuration, the service – is there any difference today versus what a rehab hospital that was built 10 years ago looks like?

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

Well, we certainly – and we have a prototype hospital that we have refined over the past year. It's just based upon our own experience. It enables us to operate in the most efficient manner. We build them with the capability to expand, so we have actually looked at more hospitals now. Whether we should be at 50 beds instead of 40 beds since we have a track record of expanding many of our 40-bed hospitals that we've built over the past years within the first two or three years of existence. So we build them with a great deal of flexibility to add on. We've looked at materials, we've looked at layouts to be most efficient. So, yes, we have incorporated a lot of different design factors to make sure that it is optimum use for a rehab setting as well as certain technologies.

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

When I go back to, even, like the fourth quarter there was a number of startup costs that emerged that perhaps we weren't prepared for, maybe we should have been. The first quarter you had MAC issues that emerged. Not a big number, a couple of million dollars. The second quarter a $5 million SSI headwind. You're making another $7 million to $10 million, whatever the number is, around your coding and documentation initiatives. I'm not going to keep adding up. It's probably $20 million or more of what I guess I would call non-recurring one-time expenses isolated to the past couple of quarters. Is there any reason why all or some of these costs should be recurring, going forward?

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

Well, some of the investments that we're making in the operating system in that $8 million to $10 million number, those will become part of the cost structure, going forward, but you won't see them grow by similar increments next year. We have been – when we look at our performance over the last several quarters, we have been very pleased with the overall growth in the business. We've been very pleased with the organic volume that we're generating in both of our business segments. We've been pleased by the degree of integration. We have been disappointed that we have had some surprises pop up along the way. And in any given quarter almost any time we'll have something that pops up that we didn't expect but usually it is offset by something heading the other way.

And in the first two quarters of this year, in particular, it just didn't happen. We had, as Whit mentioned, we had an increase in our bad debt, and then we also had a settlement cost related to an employee issue in the first quarter. And then we filed that in the second quarter with an SSI adjustment that was larger than we had anticipated. There's nothing we can do about that, we don't control it as well as the increase in group medical expense. So, certainly, we'd like to get away from the noise, if you will, that is in those quarters. The specific ones that we would call out there are really – let's assume bad debt based on what

Mark's commentary just a minute ago on the MAC issue stays at about the level that we've got out there, the 1-5 to 1-7 range. Then I think in terms of the things that you would consider non-recurring for this year would be the settlement of $4 million, the SSI of $5 million, and most of the $4 million group medical expense. As you do a comparison to 2014 and move into the second half of this year, the upside is that we did have about $6 million in startup costs related to the four de novos that we were bringing onboard in the fourth quarter of last year that will be non-recurring.

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

In the second quarter I feel like you saw a slight, noticeable, evident uptick in Medicaid, and I think you were able to draw that back and say, "This is clearly probably coming as a result of Medicaid expansion happening in Medicaid expansion states." Does it seem like that's really displaced any of the volume that you're seeing? But just any update as you've had more time to explore that dynamic?

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

Yes, there has definitely been a noticeable increase in our Medicaid volume. And Medicaid, overall, for us is a very small piece. We exited 2014 and for the full year Medicaid made up about 1.8% of our discharge volume. And it would bounce around a little bit from quarter to

quarter, but 1.8% certainly didn't look like an outlier. Nonetheless, in the fourth quarter of last year we did speak openly about the fact that we felt like in certain states where there was – we had a larger presence in Medicaid we were seeing some increases, and we called that specifically in markets like Colorado, Missouri, and Ohio.

As we moved into the first quarter of this year, that kicked up to 2%, and in the second quarter to 2.6%, and those numbers are above what we have seen on a historical basis. As we look back at it, it's clear that we are seeing growth in many markets that are experiencing, experiencing an increase in their Medicaid enrollment, overall. And also in a number of states where Medicaid has now been expanded to cover IRF-specific services. This is now causing us, in terms of its impact on our overall pricing, to look at a very micro level down to not only a state level but a hospital level, because even within a state, depending on where a hospital was situated, the reimbursement that you get from Medicaid for treating certain types of patients can vary. And what we've discovered is that in a number of states where we have a relatively high Medicaid volume, the reimbursement that we're getting on a per diem basis is not sufficient to cover the average cost. And so whereas before this was just a relatively small number, we could view it as a cost of doing business and in order to maintain relationships with referral sources just take those patients as they would come.

We're probably going to have to get a little bit more surgical about that. The first thing we'll do is inform our staffs about how we compare with regard to those rates relative to our average cost to deliver those services because we can't treat those patients if we accept them any different than in the other patients. But it's going to lead to some discussions with our referral partners about the appropriateness of bringing those patients at those rates into our hospitals and ultimately it will lead to some negotiations with the state Medicaid agencies.

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

Well, great. We are just now out of time. Doug, Mark, thank you guys so much for being here. Thanks.

<<Doug Coltharp, Executive Vice President and Chief Financial Officer>>

Thank you.

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

Thanks.