HealthSouth Corporation

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Gary Lieberman: Good morning. Welcome to day two of the Wells Fargo Health Care Conference. I'm Gary Lieberman, Wells Fargo's Health Care Facilities analyst. I'm very happy to have HealthSouth with us this morning. With us from the Company are Doug Coltharp, CFO, and Mark Tarr, Executive Vice President and COO.

I have a number of questions for the company, but if anyone in the audience has a question, please raise your hand, we'd like to get a mike out to you and hear your questions as well.

So I guess my first question is how has the integration been going with Encompass? Do you have any statistics on the market share that Encompass has been able to garner from HealthSouth?

Doug Coltharp: Great. Why don't I start off, and then I'll pass it over to Mark on that. So, generally speaking, the integration with Encompass is going extremely well and in accordance with our plans. It's a little different than some of the businesses that we've purchased before, not only because it's in a separate segment but because our strategy with regard to integration is different in that we have intended all along to provide this business with a bit more autonomy on an ongoing basis.

So, really, we've looked at the integration in three phases. The first thing that we needed to do just given our responsibility as a public company was to establish some basic connections from communications and make sure that we got things like financial reporting integrated, and we were able to proceed with that fairly quickly.

From there the next order of business was that we had 25 legacy health staff Home Health agencies. We didn't want to operate two separate Home Health businesses, so we set about transitioning our Home Health agencies over to the Encompass platform. And the revenue associated with our legacy agencies was not very significant because there were 25 separate locations.

Administratively, it required some logistics. We are pleased to say that virtually all of that has been completed. We have a few of those agencies that are owned in joint venture relationships with our acute care partner, so there's a bit of a tail on those, but we expect to have all of that accomplished by the end of the year, and it's really gone as smoothly as one could hope for.

And then really the exciting part of the integration is one that Gary just mentioned, and that's the opportunity to really further our clinical collaboration between the Home Health platform and the IRFs. If you look at our IRF business, almost 55% of the patients discharged from one of our IRFs requires some form of follow-up Home Health Care services. And in 2014 between the legacy HealthSouth Home Health agencies and the Encompass platform, which we didn't own at that time, we captured less than 9% of those discharges, which means that there is a very significant opportunity.

In the Investor Reference Book, an updated version of which was published at the beginning of this week, there's a waterfall slide, I believe it's slide 40 in that book, that shows you how we're prioritizing, accessing those discharges from a clinical collaboration perspective.

Basically, we believe that the addressable market in the near term is about 60% of those discharges. In 2014, the total discharges that went to Home Health were a little over 72,000, so that tells you that there's a pretty good pool of those out there.

In order to be able to engage in that kind of clinical collaboration, we first had to make sure that we developed the appropriate protocols for the interaction between our Encompass Home Health associates and the caseworkers and the other employees within our hospitals so that we remain compliant with all Medicare regulations. And Mark can highlight what some of those are in just a minute.

It was really June before we had those fully developed and began rolling those out to both of our business segments. I would say that that rollout is going very well. Gary mentioned some of the statistics we provided before. Even prior to the rollout of those protocols, we started to see a pickup in the number of referrals from our IRFs coming to our Home Health segment. And the numbers that we cited specifically were in January, the first month that we owned the Encompass business, we had 79 discharges from our IRFs, from 21 of our IRFs, go to Encompass. In June we had 385 discharges from 35 of our IRFs go to Encompass.

The last thing I'll comment on here before I turn it over to Mark is just the degree of overlap that we have on a market-by-market basis between our IRFs and our Home Health business. And now I'm going to look prospectively, assuming that we close on both the Reliant transaction and the CareSouth transaction, both of which are pending but both of which we expect to close in the fourth quarter.

Once we have completed those transactions, we will have 120 freestanding IRFs, and we will have a Home Health presence within 69 of those markets for a 58% coverage. And when we say "in the same market," we're using a 30-mile radius. We believe in most markets that's a good proxy.

Mark, do you want to just elaborate a little bit on some of the interactions -- ?

Mark Tarr: Doug elaborated a little bit on the collaboration of the Encompass Home Health staff and our hospital staff. All the patients that come into our IRFs are assigned a case manager. That case manager is responsible for any of the coordination of care while that patient is in our hospital and at the time of discharge along with coordination with the family and the patients themselves.

So the key to this collaboration is early involvement from the Encompass liaison to be part of that process working within our IRFs, connecting with the patients, connecting with the family members after that patient has been determined or assigned by the staff as a potential to go home with Home Health. Having an Encompass liaison in the process early on, say, after a week of the IRF stay or a week before they are determined to be discharged home is a key to this process. It's what has allowed us to capture more of these referrals from the time of discharge from our IRF into the Home Health setting.

Gary Lieberman: Thanks for your thoughts for that. How long do you think it takes in order to -- maybe not fully integrate -- but integrate to the point where you're able to get a substantial portion of -- or Encompass is able to get a substantial portion of HealthSouth discharges to [Home Health]?

Mark Tarr: So right now our focus is on capturing the Medicare discharges and, really, the reason for that -- and if you go through that waterfall chart, what we do first is kind of carve away a portion of the discharges in various buckets that we don't think are immediate priorities for us.

So, for example, we carve off the percentage that our commercial pay patients simply because most of those commercial payors do not provide an adequate reimbursement for our Home Health business.

Then we move over, and we look at situations where our IRF is operated as a JV with an acute care partner and then that acute care company operates a Home Health business in that market. We don't want to compete with that player. Then we move into a third bucket that says we get a very small percentage of all referrals into the IRF from a Home Health agency, but that same patient is then being discharged and requires Home Health, they're likely going to go back to the Home Health agency from which they came.

When you carve that away, that still leaves a pretty good bucket. Again, we were capturing 9% and then the residual we divide into two pieces. One is those markets in which we currently have or will, near-term, have overlap. And those markets there's really not any kind of significant barrier to being able to make significant progress on capturing those discharges. It's really just establishing the rapport with the physicians, with the caseworkers in the hospitals and so forth making sure everybody is following those policies.

In certain instances requires some staffing changes within the Encompass platform -- one to add personnel and, two, to reorient the staffing mix more towards therapy versus nursing. The core Encompass business is a little bit more focused on patients who require nursing. The patients coming out of our facilities require follow-up therapy.

That last bucket, then, is the markets in which we operate in IRF and don't currently have the Home Health presence. And one of the other things that we've done in the first part of our transition is we've refocused the Encompass pipeline so that it is directed towards markets in which we have an IRF but don't currently have a Home Health agency.

We're making good progress on filling that gap. If you look at the agency acquisitions and the one de novo that Encompass made during the first six months of this year, there were seven of those, and all of those were in markets in which we have an IRF presence. And then as part of the CareSouth transaction where we're picking up 45 new locations, we'll get 14 new locations where we now are adding a Home Health presence to a market where we have an IRF.

All of that said, on that first bucket we would expect that we should be making significant progress over the next 12 to 18 months. That second bucket where we need to fill in with new locations, that's a little bit harder to predict.

Mark Tarr: A key part of this is, as Doug mentioned earlier, is quality outcomes that Encompass is able to give. We have a number of slides in the Investor Reference Guide there that depict the outcomes that Encompass was able to give. So when we are able to share their quality outcomes with the staff and the clinicians in our hospitals that makes that a very easy sell.

Gary Lieberman: And what's the strategy -- or the primary strategy -- for growing Encompass's presence in the markets where they don't have Home Health, and you have the IRFs as a primary acquisition. Is it de novo or is it some combination of the two?

Mark Tarr: In most cases because of existing state moratoriums, an acquisition is required, and it's going to be very much like that activity you saw us engage in in the first half of this year, which is they tend to be smaller agency acquisitions. The five can vary. Sometimes we're literally just getting in there and buying a license and other times we're buying a very viable business.

And the strategy with all of those is to very quickly convert those over to the Encompass platform. We convert the name over to Encompass, we convert them over to the IT platform, we put all of our protocols in place very quickly. Encompass is very accomplished at that and has a very significant track record of being successful there.

Gary Lieberman: And what's the total capital, or ballpark capital, in order to sort of get you to where you want to be?

Mark Tarr: We continue to believe that just based on the pace of integration and what's available in terms of consummating these one-off transactions that allocating $30 million to $40 million per year for these, kind of, one-off agency acquisitions make sense. A question that we've been getting a lot is are there other platforms out there that look like CareSouth.

And when you look at the Home Health universe, it's really kind of a barbell distribution. There are a few large national platforms out there. The most significant is, obviously, Gentiva, which is part of Kindred. Then you've got platforms like a Medisys and even, to an extent, LHC and so forth. And as we've said before, those really are not of interest to us.

It's not because we don't think they're good and viable businesses, but our strategy really is to have this complement between the IRFs and the Home Health presence and buying any of those platforms that large, we would leapfrog our IRF network and wind up with a lot of Home Health locations that were in markets nowhere near any of our IRFS, not geographically approximate and in markets where we had no intention of building out an IRF platform. That's one end of the distribution.

Of the 12,600, roughly, Home Health agencies in the US, 95% have less than $5 million in revenue. And so those are the one-offs that we're hitting on a market-by-market basis. And the good news is, particularly in a lot of the secondary and tertiary markets where we have very profitable, very successful IRFs, there are agencies of that ilk that are available.

In between there's a very finite number of platforms that look like CareSouth, and one of the reasons that we're so excited about CareSouth is because they are a bit of a rare bird. If you look at the geographic fit of that franchise with our business, as I mentioned earlier, not only do we pick up 14 overlap markets with our IRF right away, but the geographic proximity of the residual locations both in terms of Encompass proximity and our IRF proximity is very attractive.

It's also the case that CareSouth business has been operating for a period of time on the same IT platform -- Home Health/home based as Encompass that eases the integration. I think many of you probably know that April Anthony, who is the CEO of our Encompass business, developed the Home Care Home Base platform. It's since been sold over to the Hearst Corporation. But that's a key part of how you manage the efficiency and the productivity of a Home Health business.

All of that said, Gary, if we can find one of the other few, kind of, Easter eggs that are out there that are, kind of, the regional players like CareSouth, those would be attractive to us. But in all

likelihood most of the fill-in is going to take place through these one-offs that are the smaller types that we did in the first half of this year.

Gary Lieberman: Maybe a final question on Home Health. Do you think that the proposals in the Home Health world will speed consolidation in the industry?

Mark Tarr: I think it probably does. I think it's almost inevitable. What we know about virtually all of the trends that are happening within health care right now is that they are creating increased advantages for players with scale. And we think ultimately the things that are going to contribute to being successful in the future are things that we've been very focused on for, really, the time that our senior management team has been in place. And that's, first and foremost, making sure that we deliver the highest quality outcomes for the patients that we serve, whether it's inside one of our inpatient rehab facilities or through our home-based offering.

To do that in a very cost-effective manner, both of our businesses are very focused on serving the Medicare beneficiary population. We feel a fiduciary responsibility for the Medicare Trust Fund, and so we focus on absolute cost-effectiveness. We also believe that having a commitment to technology-enabled business processes is important. We've talked already a little bit this morning about the strategic advantage that we believe Encompass has by being a super user of home care, home base. We've got the inside knowledge of the developer of that platform. That really contributes to their industry-leading margins.

And, as you know, on the IRF side of the business, we made the commitment when we didn't have to; when we weren't able to access high-tech subsidies to proceed with a clinical information system. You put all of that together, and I think that's the ticket for success, but I do also think it means that there's going to be continuing consolidation not only in the Home Health sector, probably within every sector of the post-acute.

Gary Lieberman: How do you think IRFs will do if post-acute moves to a site-neutral reimbursement? Do you think that lower acuity providers like SNFs and Home Health will take share from higher acuity providers like IRFs and [LPAC]s?

Mark Tarr: Well, we view it as an opportunity, for the most part. From a site-neutral standpoint, our main concern on any site-neutral program that would be rolled out is that IRFs would get some regulatory relief from some of the requirements that we have to have in a rehab hospital that a skilled nursing facility does not. So if we're going to be evaluated and paid on a common apples-to-apples basis, we would expect to have some regulatory relief -- three-hour rule, 60% rule -- some of these areas that would limit any type of a site-neutral compatibility.

But for most of our hospitals that have any excess capacity and given the regulatory relief that I mentioned, we would welcome the opportunity to compete for that orthopedic population that since the 60% rule has come in that we no longer take, in large regard, in our hospitals.

Doug Coltharp: If you take it to the extreme and think you go completely site-neutral with regard to post-acute facilities, we believe that the IRFs are best positioned, if you will, to pivot from the center. And that is all of our facilities are licensed as acute-care hospitals. That's a requirement.

And we have the ability, based on the construction of our facilities with very little capital investment to adjust the wing with, again, kind of nominal revisions so that it would be able to accept LPAC-type patients, and we have dealt with LPAC patients before because we used to own some LPACs. And in the same vein, it would be very easy for us to modify a portion of our

hospital to convert those to SNF beds and take some of the lower-acuity patients. We've operated SNF beds in the past. We had gotten out of those. We picked some SNF beds up again with the Cardinal Hill acquisition, so we've got those.

Conversely, it's going to be very difficult for an LPAC to modify its physical plant to be able to address that full range of acuity, particularly those that are hospitals within hospitals. And for a SNF, again, the capital requirement to be able to move up acuity is going to be difficult. They're not licensed as hospitals. They were never established with the same kind of physical construct that's required to address that higher acuity patient.

Gary Lieberman: Have you considered entering the LPAC or the SNF business in any significant way?

Mark Tarr: Well, we always look at where we need to position the Company both short term and long term. As Doug mentioned, we've had an LPAC presence in the past but right now we're focused on our IRFs and Home Health business and don't see a near-term or even that we would want to enter the LPAC or the SNF industry.

Gary Lieberman: In any given market, who do you view as your biggest competitor in the IRF business, and do you expect to continue to take share away from other IRFs?

Mark Tarr: Well, yes, we continue to expect to take share from other IRFs. We really compete with two areas within our IRF hospitals -- one, all of the IRF units that are located within acute-care hospitals and then in some markets we do compete with SNFs for a certain patient category.

Doug Coltharp: Yes, I think it's interesting to note there if you look nationwide at the percentage of CMS-eligible -- CMS13-eligible discharges from acute care facilities that ultimately wind up in an IRF setting, it's a relatively small number. It's less than 20%; it may be closer to 15%. So that suggests that there is a very vast portion of the population that would qualify for services in an IRF and would benefit from services in an IRF that are not currently getting there.

That's one of the things that we think has allowed us to and will allow us to continue to grow our market share without necessarily having to grab a patient from a [Select] or from a Kindred IRF.

Gary Lieberman: Will the change in patient criteria for the LTACs have any impact on your IRFs. Will the IRFs bring any potential patients that the LTACs will no longer be able to take?

Mark Tarr: Yes, we've taken a pretty in-depth look at that. We don't think there's going to be a big material impact from the LTAC rule and the -- essentially, their compliant case definition. There may be certain limited markets where LTACs, and there are certain LTACs, particularly on some of the HIH LTACs that are out there, that may have historically had a patient population that was similar in terms of rehab diagnostic categories. But, for the most part, we don't see it as being a large pickup for the Company.

Gary Lieberman: Encompass already has industry low cost of care. Do you see any opportunity for even greater costs of care efficiencies through home care/home based?

Mark Tarr: I think that's going to be tough. They have been very efficient operators. They were able to weather the rebasing and have their margin hang in there probably better than anybody else. Having said that, their margin from 2011 to where it is now just inevitably had to come down because they were already operating very efficiently.

If you look at the things that allow Encompass to operate so efficiently from a cost perspective, there are really, kind of, two or three things that we would point to. The first is I mentioned technology-enabled business processes, but to get more specific about that, they are extremely adept at managing a mobile workforce.

And so there's a whole logistics component to routing workers to specific patients, particularly when you think about some of the patients that require more frequent visits, like insulin-dependent diabetics and so forth, which can be tough addressable markets for a lot of players who aren't as sophisticated in the logistics routing. Managing in a mobile workforce is certainly one element of it.

A second is that Encompass has always -- also is very adept at getting the skills mix right for the patients. So it's this whole idea of leveraging the right license to the patient. And I think they do that better than anybody else that's out there, and that shows up in the cost per visit.

And then, finally, there is this element of market density, and when you have adequate market density, and when we enter a new market with a Home Health agency, we do that with an understanding that there's a strategy to get to market density. You need that density to be able to accomplish the first two, which is to maximize what you're able to do in terms of routing and logistics and to be able to get the most productivity out of your staff by leveraging the license to the right place.

I think the real opportunity for us there from a margin perspective is to buy other businesses that haven't been able to achieve the same level of efficiency and productivity and move them to that level. We have, again, been able to demonstrate that on an agency-by-agency basis. The CareSouth, I think, is going to be an interesting example for us because, as I mentioned previously, CareSouth has been on the home care/home based platform.

There's been a very close allegiance between the two management teams and, in many ways, CareSouth, over the last several years, has attempted to mimic some of the business processes in place at Encompass, but they are not to the same level as Encompass is right now either on revenue per visit or on cost per visit. And so that's going to give us an opportunity to see some margin enhancement post-acquisition.

Gary Lieberman: What's the opportunity for HealthSouth on the bundled care payment initiative program and how could it impact your business?

Mark Tarr: First of all, we think it's important for us to at least have some exposure. Any of the alternative payment models that are out there, we are participating in the bundled program. We have eight hospitals that are part of the Model 3 bundling program. We have five different episodes in the 60-day bundle. The Model 3 is -- are those that are initiated at the time of admission into our hospital. We have over 20 of our hospitals now are participating in a Model 2 bundling program where we are a preferred provider working collaboratively with an acute care system where they are the initiator of that bundle.

So we don't have a large exposure to the Model 3 bundling, but we have enough to give us some insight as to what it would be like to operate in this environment; gives us a chance to see how it would position us to work from a bundled environment with having both the IRF and Home Health to work between. And as the most efficient provider with the highest quality out there, it does position us to be an attractive partner working with any of the systems in the marketplaces.

So it's our understanding we're one of only two organizations to rehab that are involved with Model 3 bundling. So it's something we'll continue to look at and participate in. Like I said, we have not put ourselves in a large financial exposure on this, but we are getting an idea about what it would be like and take, from a Company standpoint, in terms of resources and skill sets to operate in that environment.

Gary Lieberman: How does HealthSouth intend to partner with acute care hospitals in order to participate in the joint replacement value-based model? Is there any clear incentive for IRFs to actually participate in that model?

Mark Tarr: Well, we do think there are opportunities with that. A third of our hospitals are partnered with acute care hospital systems. So that makes already us a viable option and a good partner as our starting point working with acute cares on this bundled initiative.

Once again, we would look to and have submitted our comments to CMS on the opportunity to get some regulatory relief that would put us in a better position with regards to -- or if, once again, out from underneath the 60% guidelines, out from underneath the three hours a day with therapy that perhaps these joint replacement patients won't necessarily need, but we could work collaboratively from an IRF and Home Health setting to better that bundle forward with acute care system.

Gary Lieberman: The Cardinal Hill acquisition was a sizable deal that you completed this year. Are there more opportunities like that in the future? And do you see the regulatory environment driving additional consolidation in that market?

Mark Tarr: Well, those of you that are familiar with Cardinal Hill, I mean, this is our largest hospital now in terms of bed count and, certainly, in terms of square footage for the building there. It's a 200-plus bed hospital in Lexington, Kentucky, so it serves as our largest hospital. That hospital was not doing well financially partly due to the changing environment for reimbursement and from a cost structure. They had just over-expanded.

So that presented an opportunity for us to go in and acquire a great hospital in a great marketplace, so the only IRF provider in that marketplace. That's an area -- there are other one-offs out there, though there are other Cardinal Hills that are out there with, as reimbursement and regulatory front tightens, I do think it will make the operating environment more difficult for those types of one-off operators.

Gary Lieberman: What kind of margin expansion do you think adding bed capacity that your IRFs can generate?

Mark Tarr: Our focus on growing our EBITDA not necessarily the EBITDA margin. But as we have added hospitals or added beds to our existing hospitals that typically at least gives us some leverage from a labor standpoint but, overall, we would say that we would expect the margins to be fairly flat. As you know, we've made some investments back into our operations that will position us for the long run, but in the short run has added to our cost of business.

Gary Lieberman: That's going to do it for me on questions. Thanks very much.

Mark Tarr: Thank you.

Doug Coltharp: Thank you.