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Josh Raskin: Very happy to introduce Doug Coltharp, the particularly well-educated CFO of HealthSouth. I'm going to ask a whole bunch of questions. We do have a breakout after this. I know it's getting late in the day. I appreciate you guys being troopers and getting through this, but I'll ask the questions here and then, like I said, we'll do the breakout.

So first is just maybe start broadly, an overview of the two main segments now at HealthSouth.

Doug Coltharp: Sure.

Josh Raskin: And where do IRFs and home health sort of fit in the broad post-acute spectrum.

Doug Coltharp: Sure. Well, thank you, everyone. It's a pleasure to be here today. First, Josh's allusion to particularly well education is simply because he and I attended the same undergraduate institution.

In terms of the positioning of the business, our core business and the only business that we were operating in up until about 14 months ago is the inpatient rehabilitation facility business, so it's our specialty hospitals that exist in the post-acute segment. And about 14 months ago we made our first foray into a second business segment. We entered the home health business, acquiring from a private equity sponsor Encompass Home Health in a strategic partnership. We own about 84% of that business. The strategy behind that is that we believe that, in order to succeed in the post-acute space on a go-forward basis, you need to operate a high-quality, cost-effective inpatient post-acute setting and to be able to complement that with a high-quality, cost-effective home-based setting.

We are by far the largest player in the IRF. And again, IRF, I-R-F, is an acronym for inpatient rehabilitation facility. We are by far the largest player in that space. As of today we own and operate 121 freestanding hospitals. We've got about a 20% market share both in terms of the number of licensed beds that are in that space and also in terms of the number of Medicare patients that are treated in that setting.

Our presence on the home health side is a little bit smaller. We complemented the acquisition of Encompass at the beginning of 2015 with an add-on acquisition of a company called CareSouth. It closed at the beginning of November of this year and that positions us with the fourth largest home health care provider from a Medicare perspective. We believe that the opportunities for clinical collaboration between those two businesses are very substantial and that those opportunities will increase as we move down the spectrum towards more collaborative payment models like the bundling payment initiatives which are really just in their infancy now.

Josh Raskin: So I think you alluded to a couple of my next questions, but just as we think about as people leave the hospital in the post-acute setting, what are the most important trends that you're seeing? I feel like historically it hadn't been as well managed and I feel like there's a lot of sort of forces moving post-acute these days.

Doug Coltharp: Yes. I guess I would take a little bit of issue with that and I think that particularly for admission into an IRF it has been pretty well managed. And I say that because I think the patient criteria for

admission into an IRF had been, and continue to be, very well defined. And there are really two primary criteria for admission into an IRF. First, it remains the case that 60% of the patients being admitted into one of our facilities have to fall within one of 13 CMS-prescribed diagnostic categories.

And then the second thing is 100% of the patients who are admitted to an IRF have to meet medical necessity criteria as determined by an independent physician. And that medical necessity criteria is a bit subjective, but basically it states that the physician has made an assessment that that patient can both benefit from and tolerate the intensive therapy regime that is administered in an IRF setting. And that intensive therapy regime includes multi-discipline therapy, physical, occupational and speech, and on average three hours of therapy five days a week which is, again, very significant with the preponderance of it administered in an individual setting. It also means that the physician has determined that that patient requires inpatient care in a hospital setting. And by being licensed as an acute-care hospital, which all of our IRFs are, we're required to provide, for instance, 24-hour-a-day, 7-day-a-week nursing staff and that's not administered in a SNF.

Where we think that the dynamic is changing right now, and it's particularly coming out of the bundling payment initiatives, and to a lesser extent the ACOs because I think those are a little bit more loosely organized, is around the necessity for stay, I think particularly in a SNF setting, and whether or not the length of stay can be shortened by complementing that with a quality home health offering or whether or not the inpatient setting can be bypassed altogether by taking a less acute patient and moving them directly into the home setting with a more intensive home health offering.

Josh Raskin: Alright, that's fair. What about the outlook for reimbursement? Any-- we're getting in towards reimbursement season soon. Anything you're expecting from CMS or any initiatives you see them trying to do?

Doug Coltharp: So, yes. I think the base case that's out there, and we've actually got this outlined on a page in the business outlook section of our investor reference book. And want to comment, just to make sure everyone knows, so our IRF business from a Medicare perspective is on a fiscal year that runs from October 1st through September 30th and home health is on a calendar year perspective.

If you look at our expectations for Medicare reimbursement in the IRF sector, we continue to assume that we'll get a market basket increase on an annual basis of about 2.5% to 3%. That's -- the fact that we'll get that market basket update is mandated by the Affordable Care Act and then there are a number of deducts that come from that. And most significantly, as we move from 2016 into 2017, we're going to see the mandated healthcare reform reduction to the market basket update increase from 20 basis points to 70 basis points and then you'll have to further subtract from that to get your Medicare pricing on an IRF perspective the productivity adjustment, which is formulaic, but is a bit unknown. If you factor that in altogether over the next three years, we're assuming that our average annual price increase from a Medicare perspective is going to be in the 1.5% to 1.75% range. And on a commercial pay perspective, which is a smaller part of our business, only about 20%, we would expect annual increases in the 2% to 4% range.

The environment is a little bit more difficult on the home health side. You've got another year to go on the rebasing into 2017 and that's driving negative pricing changes on a year-over-year basis from Medicare. You've got a three-year period of 90 basis point reductions for the market basket update in home health based on the coding intensification. And then looking out a couple of years you're going to have the elimination of the rural stipend go away as well.

So over the next three years we're expecting the Medicare pricing for home health to be slightly negative to just about flat by the time we get into 2018. And although the commercial business is a smaller piece of the home health business from a payor mix perspective, we would also expect that those increases will be more nominal, probably in the 0% to 2% range.

Josh Raskin: Okay. What about other changes to reimbursement? We're seeing bundles and CCJR programs and all that sort of stuff. Do you think MedPAC is having some influence or why -- it feels like CMS is getting a little more aggressive of, hey, we really got to get more value-based reimbursement. What's going on there?

Doug Coltharp: Yes. It's always difficult to judge just how much sway MedPAC has over CMS. Historically, many of the recommendations, really all of the recommendations that have been made by MedPAC, have not factored into CMS policy formation. I think directionally they all have a desire, both bodies have a desire to try to control cost and to minimize the increase in overall spending.

When I think about some of those other things that are out there, we definitely feel like we are progressing down the path towards increased bundled payments and towards more value-based payment initiatives and we welcome those in both of our business segments, but it's a very slow-moving train. If you look for instance at the CJR that you mentioned, well, first of all it hasn't started yet. It doesn't start until next month. And if you look at the impact on our business from an IRF segment, only about 1.5% of our total discharges fall within the impacted DRGs and the impacted geographic markets. So we'll get a taste of it but, again, it's going to unfold very slowly. And out of that 1.5% of discharges that fall within those markets, recognize that about 40% of those patients have really, really significant comorbidities, which means any thought of kind of transitioning them out of a hospital-based post-acute setting is going to be very difficult. When you think about bundling or the model to bundling, which is really where we operate, Model 2 and Model 3, that's going to add about another 3% or so of our discharges; again, very slowly. We welcome those initiatives. And a similar incidence of comorbidities there around the DRGs that are in play there.

And I want to make one additional comment on CJR because I know that there's been some suggestion that the IRFs would be subject to disintermediation based on the rollout of CJR. But when you look at the DRGs that are contained within CJR and look at the most recent data available, for the discharge destination out of the acute-care setting, less than 10% of those patients were flowing into an IRF setting and then you had about 35% each going into the SNF setting and about 35% going directly to home health.

That 10% of the patients -- again, not to beat a drum too loudly, are ones -- are those that have very significant comorbidities. And I think it's going to be very difficult to say, well, we can save money and produce the same result by skipping the IRF and maybe putting them into the SNF or moving them directly to the home setting. I think the greatest threat for disintermediation is out of that SNF piece and I think there that the disintermediation can come in one of two forms, both requiring pairing with a high-quality home health operation, which fortunately we have. One is a tremendous reduction in length of stay for some of those patients. And I think there's, at the lower end of the acuity, those patients that are finding their way into the SNF, they can bypass that setting altogether and go directly home.

Josh Raskin: I want to get back to the SNFs in a minute, but on the commercial side, a similar question on the commercial side. We've had a lot of the health plans down here talking about value-based reimbursement and that same idea of bundling and things like that. Are you seeing anything on

the commercial side that's ahead of the government changes or is it just more sort of talk, discussion at this point and just not a lot of implementation?

Doug Coltharp: I think right now it's really all just in the discussion phase. We welcome those discussions and are actively participating in them. If anything, what we've seen more on the commercial side is some movement in the other direction where, as we've been able to I think demonstrate with increasing effectiveness the value proposition that we provide out of the IRF setting, lower acute-care readmissions and so forth, we've had more of those commercial payors move to a case rate versus a per diem. Now the case rate's still at a discount to our Medicare rate, but not at a significant discount.

Josh Raskin: Okay. That makes sense. You mentioned some of the SNFs and this idea that there's a disintermediation fear. We're seeing sort of a new breed, I guess we'll call it, a transitional SNF, right, where they're trying to take faster turnover, lower length of stay, more intensive rehab and the genesis of power-back type of facility.

Doug Coltharp: Sure.

Josh Raskin: Is that a real threat or again is it just -- you've got to define criteria and your patients are IRF patients and it just seems to be--.

Doug Coltharp: Yes.

Josh Raskin: Is it just that simple?

Doug Coltharp: Yes. So I think that in many instances that is a viable strategy. It is not -- we do not perceive it as a threat to our business and I don't think it's showing up in the numbers. I mean evidence the fact that 2015, from a comp store sales growth, was our strongest performance in quite a few years at just over 3%. And it's really because it is a very different type of patient. When you look at power-back, for instance, I picture the ideal patient for that setting to be a healthy 55-year-old who's had a single knee replacement and wants to get back and be active very quickly. They don't require treatment in a hospital setting. They don't require the same intensity of services. Compare and contrast that to the average patient finding their way into an IRF setting, particularly our IRFs which treat on average a higher-acuity patient, and you've got somebody who's instead in their mid-70s, it's a more significant malady that's landing them in our facility and they come in with more comorbidities.

Josh Raskin: That does help. And then the next topic would just be sort of management efficiency. HealthSouth has a reputation of tremendous leadership and really impressive efficiency. And I look at things like outliers where you guys are probably a quarter of all discharges and receive, I don't know, maybe 1% of outliers and--.

Doug Coltharp: 0.5%.

Josh Raskin: It's just 0.5% now.

Doug Coltharp: Yes.

Josh Raskin: Right, it's gotten somehow more efficient than when I last looked. And your acuity's actually higher than--.

Doug Coltharp: (Inaudible).

Josh Raskin: So what drives that? What is HealthSouth doing that others just simply can't get to?

Doug Coltharp: So I think there are two or three things that I would point to. First of all, remember, when you're talking about the IRF segment there are two types of IRFs that operate out there. In aggregate there are about, rough numbers, 1,150 licensed IRFs in the United States. The vast majority of those, about 900, are units that are housed within an acute-care hospital and they are smaller. And also, the costs that roll up into their cost reports to determine the qualification for outlier payments can include allocations and those allocations aren't always made on a highly exact basis, to be diplomatic. So they don't have the benefits of scale and you've got cost allocations factored in.

The other 250 units are freestanding units. They vary considerably in size. The average size of one of our units is a little over 60 beds. Again, we operate 121 of those units. The next largest aggregation that we're aware of in any single facility is less than 20, in any single company is less than 20. And so we -- and then if you go back to the CMS 13 criteria for our patients, we see a very large number of patients in a fairly narrow spectrum and it allows us to get very precise about the clinical protocols that are used to treat those patients and with that precision comes an efficiency. And if you layer that on top of the scale that is resident in our hospital, and then leveraging the corporate infrastructure as well, all of that translates into a highly-efficient cost structure. And we deploy automation to our business processes as well.

Josh Raskin: Alright. (Inaudible). One of the things that strikes me is just the returns on some of your de novo development projects. They just seem -- particularly high returns. And so why not accelerate that spend, I guess, right? Is it just really a geographic need or is there -- it doesn't seem like you're restrained from a capital perspective. Your balance sheets are also very efficient.

Doug Coltharp: No, it's not a capital perspective. I would point to two major things that kind of govern the pace there. One is recognize that about 50% of the states, almost exactly 50% of the states in the country, and they tend to be those with the highest populations, are certificate of need states. So there's a gestation period that goes through negotiating the certificate of need process and in a number of states that process remains highly politicized. And so that I can demonstrate that I'm not casting stones afar, probably the most politicized CON process is in the state of Alabama where we'd love to extend our presence but it's been difficult to do that.

The second factor is we currently operate about a third of our IRFs in joint ventures with acute-care hospitals. Most of you are probably aware that being in the post-acute sector and in a hospital setting about 95% of the patients who get admitted to our facilities come to us from an acute-care hospital. Again, about a third of our hospitals currently are in joint ventures with acute-care hospitals and our pipeline is dominated now by opportunities for incremental joint ventures. We think much of that is related to both the implementation of the Affordable Care Act and the advent of some of the bundled payment, value-based payment initiatives and so that's going to continue to be the trend. Many of those partners are one-off, not-for-profit hospitals. They are sophisticated in many ways, but they have not had a lot of experience in terms of forming financial joint ventures and so the gestation period on those is also a little bit longer. When you can get one done it is substantially de-risked because you have that kind of partnership as you enter a new market.

Josh Raskin: Maybe taking a step back more broadly on your capital deployment strategy, could you just remind us of your cash flow expectations for the year and how you're thinking about the deployment?

Doug Coltharp: Sure. And we've got this all outlined in our investor reference book as well. We provided this year actually a range of expectations from about I think $365 million to $445 million in free cash

flow. That ties back to our EBITDA guidance and then also some projected areas of spend on things that are non-discretionary such as maintenance capital expenditures and cash interest expense. So the midpoint of that is roughly $400 million.

Josh Raskin: Okay. That's helpful. And in terms of uses it's the same that we've seen historically, the development, the acquisitions (inaudible)--.

Doug Coltharp: Yes. We think that -- fortunately, generating that kind of high level of free cash flow, and it's high and consistent levels of free cash flow, we find ourselves in the envious position of being able to say and with regard to these alternatives as opposed to or. Having said that, what we've outlined is on the discretionary growth side we're going to target opening four to six new IRFs per year. On average, that comes with a spend of about $20 million to $25 million per IRF so you can kind of pencil in a range there. Again, we've done this in our investor reference book. We also get a very high return and a very low risk profile associated when we add beds to existing hospitals. And we like to target adding about 80 to 100 beds per annum by doing that and that's another spend of roughly $20 million to $25 million. So the sum of those two is the discretionary spending on the IRF side.

On home health we continue to grow that business via one-off agency acquisitions. We're not talking about something of a magnitude of CareSouth that we did in 2015. If you think about the composition of the home health industry, there are roughly 12,500 agencies out there and about 95% of those have revenues of less than $5 million. And it's really on that smaller end that we have the opportunity to pick up at an attractive price additional agencies, turn them over onto the Encompass platform and try to create more overlap in the markets in which we operate in IRF, which again is part of that clinical collaboration strategy. We've earmarked $30 million to $40 million for spend there.

When you deduct that, that still leaves a substantial portion that is available for two other categories, debt reduction and shareholder distributions. We have a dividend, a common dividend in place right now. It's our expectation that that will be at least maintained. So you shave that off and there's still in excess of $150 million, depending on where you pick your point in that range, available for deployment.

There's going to be an emphasis-- back to the audience participation on the front end, there's going to be an emphasis on debt reduction this year. We levered up over the course of the last 14 months, funding all three of the acquisitions that we made. I previously mentioned Encompass and CareSouth. We also bought an IRF portfolio called Reliant Hospital Partners that closed at the beginning of the third quarter of last year. We had built the capacity into our balance sheet to be able to fund those with incremental leverage. We got that leverage in place on very favorable terms. But at the end of the year we were up with a pro forma leverage of about 4.25 times and we believe it's more appropriate for us to pull that down.

The growth in the EBITDA will help with that during the course of the year, but we're also planning to allocate some capital towards the debt reduction. And in terms of immediate initiatives, we did make a call for $50 million on our 7.75% notes that are due 2022. That's the most expensive piece of debt capital on our capital structure and we'll be funding that call later this month.

Josh Raskin: So we've got -- I'm going to cheat and go a little bit late because I know there's no one next. I just-- I really want to talk a little about the Encompass acquisition. That was the first sort of major acquisition of non-IRF properties that you guys had done in a long time. Why from a timing perspective did it make sense to diversify to home health and specifically why home health?

Doug Coltharp: Sure. So a couple of things from a timing perspective. First, we had been following the Encompass business closely and had been engaged in a rapport with the founder there, April Anthony, since mid-2011. And we were wanting to get edified on the business. We were wanting to get greater visibility as to how we felt the shape of delivery reform was transpiring on the post-acute sector, and we wanted to get greater visibility into what kind of rebasing or other regulatory hurdles the home health space would be facing. We felt we were able to gain a lot of those things over the course of time between 2011 and mid-2014 when the discussions regarding the acquisition of Encompass became live.

What drove it there specifically is that Encompass was private equity owned by Cressey and Cressey determined that it was time to take that asset to market. We had identified that Encompass was the best-in-class operator and had the best fit with our IRF network. When I say best-in-class we mean both in terms of the quality of outcomes that they produce for their patients and also the cost effectiveness. They had the same -- they had a very compatible culture about the business. And so that was the unique asset that we wanted and that was the final factor that drove the timing.

And the integration has gone incredibly smooth. We used a bit of a unique structure there. It's actually a joint venture. HealthSouth owns 86% of our home health subsidiary. The Encompass management team rolled substantial equity into that subsidiary and they've got -- and I said 86%. It's 84%. The Encompass management team owns 16%. And it really is more of a joint venture partnership, but the integration has gone really well. And we cited the degree of progress we're making on the clinical collaboration and I'll give you just one statistic there. But in December of 2014, which was prior to us closing on the acquisition of Encompass, Encompass captured 35 discharges out of HealthSouth IRFs. And in the month of December 2015, so a year after the acquisition, that number had increased to 900. To give you a sense as to the potential there, we will have about 150,000 Medicare discharges out of our 121 IRFs during the course of 2015 and about 55% of those patients require home health follow-up care.

Josh Raskin: Alright. We're a couple minutes late. I apologize. We're going to take it over to [20-CNF-3] for the last breakout. Whoever wants to join us we'll have Doug and Crissy.

Doug Coltharp: Great.

Josh Raskin: Thank you.

Doug Coltharp: Thank you.