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

Okay, I think we're going to go ahead and get started. Good morning; I'm Whit Mayo, the senior healthcare facilities analyst at Baird. It's my pleasure to have the management team from HealthSouth. Representing the Company: Mark Tarr, Executive Vice President, Chief Operating Officer; Doug Coltharp, Executive Vice President and Chief Financial Officer. So with that, I think, guys, we might just get right into it. And we spent some time together recently and think we can all acknowledge that post-acute is undergoing some significant change right now. It's highly unorganized, overwhelmingly for profit. The lines often get a little blurry among providers with patient criteria.

Can you talk maybe generally about your two businesses and how you think the inpatient rehab sector is positioned going forward in the context of the evolving payment model changes? And just comment on how you're beginning to co-mingle your home health assets and rehab hospitals together.

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

Sure, I'll start out. First of all, we embrace this changing delivery model. We were – are one of two companies that are participating in voluntary bundles. We started first almost 1.5 years ago now with eight of our hospitals under bitsy voluntary bundles. So we have embraced this whole concept of thinking about care from episodic standpoint, a longer period of time versus a fee-for-service. If you look at our hospitals, we have superior outcomes in terms of getting our patients back home. Fewer patients are readmitted back to the acute care hospitals, and we are consistently working on decreasing the number of patients we send to skilled nursing facilities. So our cost profile when you look at it from an episodic standpoint in many cases is superior to those in a skilled nursing home.

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

And I think just to elaborate on that, all of the changes going on as in the category now are moving towards more value-based payments, more quality reporting initiatives, more episodic payments. And that's going to reward high-quality outcomes and efficiency in operations. And each of our two business segments, on the IRF and home health segment, are positioned as best of the class in the industry with regard to quality of outcomes and cost efficiency. This doesn't happen by accident. We've been preparing for these changes for a lengthy number of years here. And if you look at the investments that we've made in our business both in terms of physical plan, in terms of adding the home health platform, which we did two years ago, and now concentrating the development pipeline to create more overlap markets with our IRF.

The investment in the electronic medical record, the clinical information system that we made in the IRF business, all of these were proactive investments. I want to highlight just for a moment the investment that we made in the clinical information system. For those who don't necessarily aren't unaware of this, the Affordable Care Act mandated the adoption of the electronic medical record for the acute care hospitals. And provided they met certain milestones with regard to that implementation along the way under the high-tech provision, they were reimbursed for a substantial portion of that investment. They were subsidized. There was no such requirement for post-acute players and there was no such stipend available for making that investment.

Nonetheless, beginning five years ago, we determined that it was going to be a cost of admission and would create a significant competitive advantage to have an electronic medical record in place in our hospitals. And as we looked out there and canvassed the landscape, we discovered that there were no systems that were specifically tailored to the IRF. But those systems that were in place on a post-acute basis – and there weren't many of them – were essentially a dumbed-down version of an acute care system, and that really translated pretty poorly to our business. So through an RFP process, we ultimately teamed with Cerner and developed a customized system for implementation in our IRFs.

We began rolling that out. It's now in place in 97 of 122 of our hospitals. It will be completely in place by the end of 2017. It represents an aggregate investment of about $200 million, but it is already allowing us to engage in a higher degree of predictive analytics and a higher degree of integrated communication with our upstream referral sources. So we are very confident that, again, this is going to create sustainable competitive advantage for us.

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

Maybe just comment a little bit about just the flexibility that you see within the rehab hospitals versus some of the other settings of care, whether it is the engineering and the staffing. And just the ability to respond to some of the evolving changes.

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

Well, all of our hospitals are licensed as acute care hospitals. It's a specialty designation within the acute care hospital licensure process. So our buildings have medical gases in all the patient rooms. We are set up with nurses' stations to cover each of our corridors with a limited amount of patient coverage to make sure that we have that nursing ratio. All of our hospitals have in-house pharmacies. So when you think about the ability to move up or move down the acuity scale, it would be fairly easy for us to go in and take a corridor of our existing hospital, fit out those patient rooms to be ICU-level rooms in order to accommodate what is typically now seen as more of an LTAC patient.

We could do the same thing on a different corridor for a lower acuity patient that may be more of a lower extremity joint patient where we would not need the higher staffing ratios or the level of resources care for those patients, but adjust accordingly to the needs of the patients. So it's fairly easy for us in a IRF setting to move up slightly on the acuity scale. We've been in the LTAC business in the past. We know what that's all about. And certainly we could work our way down

to a lower acuity patient and take care of more of the orthopedic patients, which we, too, have seen historically.

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

As we look out there over a longer-term time horizon, it's our belief that the progression of episodic payments continues ultimately to the complete demise of fee-for-service. And as that happens, as you mentioned on the front end, with the need for these very specific Medicare patient criteria that define who can go into which post-acute inpatient setting go away completely. And what you have are post-acute inpatient boxes that can serve the first full acuity of patients that are now going from an LTAC to a SNF. And as Mark just alluded to, we think that the IRFs are best positioned to pivot from the center to accommodate the acuity above what's currently going into an IRF and below as well. And that's both terms of the physical composition of our buildings and also the existing staffing complement.

Mark hit on some of the key features in the physical complement. But again, our facilities are licensed as acute care hospitals. We've got the orientation around the gym and the dining facility and so forth so that you can easily adapt with minimal capital expenditures to that full array of acuity. But as importantly, we've got the staffing in place. We have 24-hour seven-day-a-week nursing requirement right now. That doesn't exist for the SNFs. It does in the LTACs, but there are going to be fewer and fewer LTACs as we go forward because they're not going to be able to adjust to the new patient criteria even before the boxes become agnostic.

And then as importantly from a therapy perspective, remember that in the IRF setting, we are required to provide on average three hours of multidisciplined therapy five days a week. So we've got a full complement of physical therapists, occupational therapists, and speech therapists already employed in our facilities. That doesn't take place in SNFs. In SNFs, even a lot of the therapists are there on a contract basis. And you don't have that degree of therapy orientation in the LTAC as well.

It's almost going to be as difficult if not more difficult for each of those two segments to adjust to the new staffing models that would be required for an agnostic post-acute inpatient facility as it would be for the substantial capital expenditures they'd have to retrofit gyms and nursing stations and add gases if you're trying to move up the acuity spectrum and so forth.

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

We also have a full complement of physician capacity on our hospitals. It's not unusual for a typical 40- or 50-bed hospital to have 100 physicians credentialed for our hospitals. Now, not all those would be attending physicians, but it would be a complement between those that are attending and those that are consulting specialists.

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

Bundling. You guys have sized up sort of what you see as the vulnerable elements of BPCI with maybe some simple joints. Maybe just frame up for us sort of how you see that program or your

experience with that program thus far. And maybe if you could sort of differentiate between the simple and the joints with fractures and maybe just comment on the cardio bundle as well?

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

Sure, sure. I'll start by the CJR. We did a deep dive in all of our marketplaces, each one of our hospitals, using information that was available through CMS as well as utilizing the help of Dotson diBonzo to look at each one of our markets that were overlapped with CJR to evaluate the types of cases that we were currently seeing at our hospitals, those that were included in CJR, and then do a cost analysis relative to our cost versus SNFs in the marketplace.

If you break out the CJR cases between those that are fairly simple joint replacements that are low acuity versus those that are higher acuity with more comorbidities that involve a fracture, those cases that involve a fracture, we had the cost advantage over SNF in nearly the majority of our hospitals.

If the lower extremity joint cases that are the healthy 67-, 68-year-old patient that was high functioning before they had the joint replacement that will come out postsurgically and be very active, those are the type of cases where we don't have a cost advantage. And those are the types of patients that we just aren't seeing much in our hospitals nowadays because they don't meet medical necessity.

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

Want to shift gears just for a second. Recently, the American Heart Association and the American Stroke Association issued some new guidance endorsing inpatient rehab as the preferred stroke setting of care. And how do you think about how that impacts HealthSouth? And do you have any idea what percent of the stroke patients could be available to the rehab community over time?

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

Well, we're getting that information. We don't know exactly what our total market share is of all the strokes across the marketplaces, but we do see this as being a very favorable survey or report. We are doing everything that we can in our marketplaces, as you may imagine, to saturate the marketplaces with this report to make sure that all the physicians, all of the discharge planners and case managers, anyone in the community that may have an interest or play a role in the referral patterns within the marketplaces to make sure that they know that this survey points out that if a stroke patient is going to receive in-patient relocation, they are better served to receive that in an inpatient relocation hospital versus a skilled nursing facility.

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

I think the issuance of those guidelines raises the bar very significantly for all of the referral sources and all of the payers in terms of where they ultimately try to send that patient post the acute care and discharge. With those guidelines having been issued, if a referral source or if a

payer, say commercial payer, were to direct a patient in order to try to save money to a SNF setting and there was a bad outcome and it wound up in litigation, how would it look on the stand if the attending physician is then asked by the attorney on the other side: were you aware of these guidelines? Yes, we were. Did your patient suffer from the malady that is described in these guidelines? Yes, they were. And yet, why did you elect to send them to a lower intensity setting? Well, we felt like we could save some money. That's probably not going to play out real well.

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

Got it. Maybe shifting gears a little bit just to the volume trends. You've enjoyed a very long favorable tailwind around your volumes, seeing discharge growth rate in the probably 2% to 3% range for the past number of years. What you think is the right sustainable growth rate for the rehab market? How much of that is driven by de novos and the bed additions. What you think the market growth rate is? And maybe just size up a little bit for us just the joint venture opportunity you see going forward.

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

Well, in terms of the rehab hospitals, we've put in our growth projections: 3% per year. We think about two-thirds of that will come from a same-store setting. So that's pretty much what we've been running historically. You'll see some variations from quarter-to-quarter, but overall, we believe that's the ongoing run rate that we would expect to see.

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

And that's supported by the demographic tailwind. You've got the aging in of the baby boomers now being north of 65. So the cohort that is north of 65 is growing slightly faster than the national average. I think the growth rate for that cohort is just north of 2.5%. It's helped by expanding life expectancy on the backend as well.

So at a 3% level, we are projecting a modest increase in market share. Not to say that that's aspirational, but we think it's a realistic assumption. We'll get there. Again, our target is to try to add on average four to six new units per year. We've got 11 active projects in the pipeline right now. So we've got a very active development pipeline. There will be years when we exceed that four to six. There may be years where just based on timing of projects we fall slightly short of that. We are also able to add capacity through bed expansions, which is a very highly productive utilization of capital.

Because we're building into a market where the demand is already established and where we are able to leverage components of our fixed infrastructure. We continue to believe that we'll be able to add 80 to 100 beds per year to existing facilities. That's at about a cost of $25 million. Your question on JVs. As we've alluded to a couple of times in the recent past, our development pipeline is more heavily oriented towards joint venture opportunities than at any previous point. We think that that's a direct outcome of the movement towards more episodic payments and towards more value-based initiatives. What we're seeing in a lot of markets is an acute care

facility that has had an IRF within its four walls. They recognize now that that IRF has been underproductive and doesn't produce the types of quality outcomes that we can.

That acute care hospital may have a need to repurpose that space for more general medical and surgical uses, and they'd like to recapture that space without a substantial capital expenditure. It's a great outcome for them if we can come into the market and say: we will build on or approximate to your campus a new freestanding IRF if you exit that space in your facility and repurpose it and sign a noncompete for the IRF business. We can translate that noncompete into an equity stake in the new facility, the new IRF facility.

So you continue to have a foot in the IRF business, but you're going to get a much higher outcome and a much more efficient operation as a result. And that's a model that is really resonating with a lot of the acute care systems across the country. We're getting a lot of inbound calls now.

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

34 of our 122 hospitals, 34 of our portfolio, are joint ventures with acute care systems. Many of those are academic-based systems. We have – this is not a new business model for us. Our first joint venture that we did was close to 20 years ago now. So we take great pride in our business model and knowing how to be a good partner.

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

And I think that point that Mark just made is an important one. This is not a new business model for us. We have a large number of these joint ventures that date back more than 20 years. And that means that they stayed in place through that very difficult period when the Company went through its fraud and so forth. And when you think about a courtship process with a new potential joint venture partner, when we can have as referral sources for them existing joint venture partners at the University of Virginia or Vanderbilt or Barnes Jewish in St. Louis, it creates a pretty compelling case.

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

Let's shift gears a minute to Encompass. A few years ago, you formed a partnership with the leadership team and have laid out a initiative and strategy to build a clinical collaborative effort among the two businesses. And maybe just update us to where you are with that initiative at this point?

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

Well, last year, we put in what we call our clinical collaboration model. And the real impetus for it was the fact that we had 55% of the discharges from our inpatient rehab hospitals go home with home health. And this was an area that we knew that we could do a better job on in terms of coordinating if we had a home health provider. So we now have 58% of our marketplaces where we have an IRF have an Encompass agency within a 30-mile radius. So we've used what we call

our care transition coordinator as part of this clinical collaboration model to have an individual that assigned. And their sole responsibility is to coordinate this process and be a conduit between the clinical team in the hospital and the resources, the family, the patient, take care of all the patient training, help with medication reconciliation at the time of discharge.

There's a lot going on at the time of discharge from our rehab hospitals. Remember, our patients have been in there for almost three weeks. Typical length of stay is 13 or 14 days. So there are a lot of questions at the time of discharge. Having this care transition coordinator, this clinical collaboration, gives us a better opportunity to make sure that there is a smooth transition to the home setting from the hospital setting. And ultimately, we believe will help us to eliminate the need for readmissions back into the acute care hospital because we've taken care of all these details. We're making sure that patient is taking their medication. We're making sure that the families have had the education at the time of discharge. And that we are well coordinated between the hospital team and the Encompass home healthcare providers.

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

And it's worth elaborating on that for just a moment. If you look at the acuity of the patients that we are treating in our facilities, these are very sick patients. They are sick patients and they're elderly patients as well. And they've had a very traumatic experience. They've had some type of episode that has landed them in an acute care facility typically for three to five days. They've become medically stabilized. They are not ready to go home yet. They are at a level of severity that requires a stay in an inpatient rehab facility for two weeks where they are getting 24-hour seven-day-a-week nursing coverage. Where they are getting the intensive therapy regime that is administered in an IRF setting.

And prior to our partnership with Encompass, as this patient was getting ready to be discharged and the attending physician determined that they required follow-on home healthcare, and as Mark mentioned in his comments, that was happening in about 55% of our discharges, what would typically happen is they would get introduced to a number – they, the patient, and the family – because many times, the patient is not in an emotional or a cognitive state to make the decision on their own – would be introduced to a number of home health agencies about 48 hours prior to discharge. And then they almost have to engage in speed dating. Well, tell me a little bit about your business and so forth.

And okay, do I like this person And boom, it happens very quickly. And that patient is going home. It's an intimidating time for the patient, an intimidating time for the family, because of their physical condition. As Mark mentioned, on average, a patient being discharged from our facility is on nine separate medications, so just the medication reconciliation that has to take place in the home is very intimidating. Fast-forward to where we are today right now, and even though the Medicare patient still gets choice about which provider they want to work with. We don't dictate which home health provider they go with. The Encompass care transition coordinator – and there's one assigned at every one of our hospitals in an overlap market – now meets the patient and meets the family very early in the discharge process.

So we are able to identify with great accuracy at the time of admission into our facility whether a patient is likely to require home health services at discharge. That being the case, the care transition coordinator gets an introduction to the patient and the family either on the day of admittance into our facility or the following day and is able to develop a relationship with them over that two-week period. And to get to know more about the patient setting at home and the ability of the family to help in terms of their care post discharge. And this has really resulted in a much better plan of care post discharge. And we're seeing our patient satisfaction scores and our quality outcomes both increase as a result.

We get asked the question frequently – we've made great progress and have shown incremental progress that we are making on a quarterly basis in terms of raising the capture we're getting of discharges from those IRFs in the overlap markets. We were at nearly 29% in the overlap markets during the second quarter. But why can't we get there faster? And there is a staffing change that has been going on. The position of care transition coordinator existed within Encompass prior to their partnership with HealthSouth. That position as it existed was focused on other referral sources.

So as we determined a strategy to place one of those care transition coordinators in each one of the overlap markets – and that's 72 of our IRFs today – we had to go out and recruit and train those individuals and get them placed into our hospitals. It's also the case that prior to the partnership with HealthSouth, Encompass's primary focus was on home health nursing services. Well, not surprisingly, the overwhelming majority of patients who were discharged from our IRFs and require home health therapy services.

So we've had to go out in those markets and recruit more therapists capable of providing services on a home basis. We're making great progress on all of those fronts, but that's one of the reasons why there's a period of time where we'll be ramping up that collaboration rate. It's also the case that the value proposition has to be presented to all of the decision-makers in the process. And the referring physicians, the physicians that are administering to the patients in our facilities, play a significant role there. They tend to respond very well to empirical evidence. So as we are able to demonstrate – and the good news is we have an increasing body of empirical evidence – that we are producing higher quality outcomes for these patients via this clinical collaboration model, we're going to win over more referral sources.

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

Back to the staffing issues of the fact that Encompass had to really beef up the therapists they had. When I reflect back on the Reliant acquisition, that was another transaction where you had to really change the service mix and required investing into some higher trained nurses, critical care nurses. Last year, you also noted I think some pressure I think on wages. Just what do you see happening in your markets right now with wages and nurse costs? Is there anything that is alarming, or you like you have your arms around this?

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

Let me address the Reliant comment first. Last year, we identified, when we took over the Reliant hospitals, 11 Reliant hospitals, that they were staffed pretty skinny. And lower staffing ratios than what we have in our hospitals. So we said that we are going to go back in and hire some additional therapists, nurses, in some cases quality directors. We have completed that now and we are virtually staffed up in those hospitals to better match what our legacy hospitals run in terms of staffing ratios. Whit, to answer your question overall, we've seen certain markets that we've had to go in and make some adjustments. But nothing across the board this year so far that we've seen was beyond what we had expected relative to our ability to recruit and retain nurses as well as therapists.

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

Got it.

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

One of the things that led to some of those premium pay numbers that we talked about in the third quarter of last year was that we had a spike in volume, which is typically a good thing, but it was unanticipated. And a lot of it related to the increased eligibility for enrollment in Medicaid programs in certain states where we have the significant presence as well as the increase in exchanges and commercial patients that we were seeing. And when we saw that kind of sudden increase in volume, we frankly weren't staffed adequately to be able to handle that. So we had to compensate for that with some of these premium pay packages and overtime packages and so forth. That has stabilize now, so we are able to get to more normalized staffing levels, which gets us at a more efficient labor ratio.

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

Okay. We've only got a few minutes. I wanted to address kind of two topics, maybe one topic. But home health: 2017, Encompass has – or at least the proposed rule is out. And again, it's not final proposed, but there are some outlier changes and case weight changes. Could you talk about that for a second? And also maybe touch on the pre-claim review and what your expectation is with that effort?

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

Sure. We'll have to do the condensed version. On the home health rule, there's a change to the outlier payment methodology that proposes to change the payments from a per-visit basis, albeit at 80% of the normal reimbursement rate, to instead dividing visits up into 15-minute units and paying an amount on a per-unit basis. When we apply that new formula to the patients that we are treating at home in our home health business that qualify for outlier payments, it's a significant reimbursement reduction. The reason for that is we have developed a model that allows us to handle chronic patients who are very difficult for many other providers to handle.

The example that we use is a blind insulin-dependent diabetic. That patient is going to require two nursing visits per day to check their insulin and administer the appropriate dose, because it's highly variable.

Two visits a day over a 60-day episode is 120 visits, which is going to put you into the outlier pool. Those visits, the way that we are able to handle that in a profitable manner is because we become very efficient. Once we do our initial assessment of the patient, we have a nurse that can go and conduct a visit very quickly. Check the insulin, administer a dose, and move on. So they can handle a lot of volume in a very short time. If you drop our rates on a per-visit basis to a per-unit basis, it's no longer a profitable business for us. We think the unintended consequence if that rule goes into place is that those patients are going to be denied care. If it becomes unprofitable for us to service those patients, we're not going to do it.

And we are one of the few providers in the market that currently is doing it. If that blind insulin-dependent diabetic can no longer get somebody like Encompass coming into their home, what's going to happen to them? They're going to wind up going into an emergency room and have an inpatient stay setting, which is going to be very expensive to the Medicare system. So we think that that is a proposal that has not been well thought through, but it is on the table right now. Very quickly then on the ADRs. Dialogue continues. The level on a quarterly basis has at least stabilized. We think we're making progress. It's going to be a long slug.

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

Great. Okay. Well, if anyone has any other questions, Crissy Carlisle is front row and has all the answers. So, guys, thank you so much.

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

All right, thank you.

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

Thank you.