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Gary Lieberman: I'm very happy today to be joined here by HealthSouth Corporation. With us from the Company are Doug Coltharp, Executive Vice President and CFO, and Mark Tarr, Executive Vice President and Chief Operating Officer. I have a number of questions for the Company. If you have a question please put your hand up and we'll get a microphone over to you so that you can ask your question. Thanks very much for being here today.

Doug Coltharp: Sure, it's our pleasure.

Gary Lieberman: So there's been a significant amount of investor focus on the potential risk from the potential risk from post-acute bundling of services. What do you think the risk is to HealthSouth?

Mark Tarr: Well, we really don't see it as a risk. We see is as opportunity. Our general approach to this changing delivery model and alternative payment systems that are out there, we're embracing it. And we believe it's going to happen. We believe that we have positioned our Company to be successful in such an environment. When you look at the acquisition with Encompass at the end of 2014, the integration that we have been able to do this past year working collaboratively from a clinical standpoint with our rehab hospitals, with Encompass. We now have 72 marketplaces that are overlapped where we have an Encompass presence within 30 miles of our rehab hospital.

We like the opportunity to work within a bundled setting. Ultimately, we are positioning ourselves to even take a risk working in this collaborator role that Medicare presents us the opportunity within the two mandatory bundles.

Doug Coltharp: The conditions that are going to determine success in any kind of value based payment or episodic payment model are going to be the ability to deliver the highest quality care in the most cost-effective manner. And both of our businesses are positioned as the industry leaders on both of those key metrics today.

In addition to that, we've made a significant investment in technology even though we weren't required to do that. As a reminder, the acute care hospitals proceeded with the implementation of an electronic medical record because they were required to do so under the Affordable Care Act. And provided they met milestones of implementation along the way, the need for use standards, they were provided with a subsidy under the high tech provision.

There were no such requirements. There was no such subsidization for post-acute providers. Nonetheless, five years ago we made the decision to proceed with the design and the implementation of an electronic medical record in our [IRF]. We had a custom-made system designed by [Cerner]. We began the rollout of that system again almost five years ago.

Today that facility is fully implemented in 97 of 122 IRF. We'll be up to 103 by the end of the year and I hope to have the balance of our facilities completed in 2017. One of the things that attracted us to Encompass when we partnered with that business at the end of 2014 was that they too had made a commitment to technology. April Anthony, who is the CEO and the founder of Encompass was also the founder of Homecare Homebase, the technology product that is utilized by more than 50% of the home health agencies the US today. And we are the single highest super user of that product.

Within last 45 days, we've established the interface between Homecare Homebase and our Cerner Earth System. So we now have the seamless flow of information not only between our own business segments but the ability to also have that seamless flow with our primary referral source being the acute care hospitals, regardless of the system they're on, and where it's implemented in other post-acute providers, we can do that with third parties as well.

Gary Lieberman: Can you give us a real world or maybe tangible example of some of the information that might get passed and how that would help you increase the conversion rate from an IRF into an Encompass Homehealth?

Mark Tarr: The care transition coordinator role is a role that we have fit as part of our clinical collaboration where Encompass has a liaison that's sole purpose is to make the transition easier for a patient from our rehab hospital into the home health setting with Encompass

At the time of discharge for our patients from the hospitals, keep in mind they've been in our hospitals anywhere from 12 to 14 days. They're on numerous medications. They have a series of patient family and education training that happens. It's a very anxious time for our patients and patient's families. So having a smooth transition, someone to help coordinate that process with the inpatient hospital clinical team and medical staff to the Encompass or home health resources and team, making sure that everything is taken care of before that transition happens makes it better for a smooth transition, more likelihood that the patient and patient's family are satisfied with that process, and ultimately will help to eliminate some of the risk that goes with the readmission after the patient has been discharged home.

So there's a lot of benefit to our patients by having a very well-coordinated, smooth transition that this care transition coordinator helps to facilitate.

Doug Coltharp: And Gary, maybe two specific examples and straightforward examples of where the technology commitment benefits us in the process. The first is in terms of getting the referrals into our IRF from the acute care hospital. And one of things that's very important to our acute care referral sources is the speed with which we can respond to a patient who's being discharged from their facility to determine if we can accept them into the IRF. And because we have the electronic linkage to our upstream acute care referral sources, we're able to get the information on a patient about to be discharged from the acute care setting very quickly and respond to it very quickly as well.

That's being responsive to the acute care patient's need. It also means that the faster they can get the patient out, the lower their cost of having treated that patient and it makes their bed available for another patient to come in, which allows them to continue to run at a higher ADC .

If you look then downstream, and now the interface that we've established between Homecare Homebase and our clinical information system is going to allow the attending physician to track what is happening with the patient in a real-time fashion post discharge from the IRF and hopefully to identify any problems that seem to be arising, whether it's a result of medication reconciliation or whatever, and to head those problems off before they get to the levels that result in an acute care readmission.

Mark Tarr: This technology is also enabling us to start to do some data analytics on our patients and one of the things, as a matter of fact, our Chief Medical Officer, Lisa Charbonneau, is here with us today. Her and her team have been doing some analysis and creating what we call a predictive model on patients and their vulnerability or likelihood to be readmitted to an acute care hospital, looking at those types of clinical indicators that maybe they can intervene earlier on in the patient's stay so that a patient doesn't reach a point where they have be readmitted back to acute care and have all that encapsulated in the templates of our electronic medical records. So that it cues the patients or

the physicians on what types of aspects of the patient care that they need to pay particular attention to that if they don't, could lend towards a patient going downhill and having to be readmitted.

So those data analytics will come -- we'll do more of that as we have this rolled out to our entire platform. It just presents another opportunity for us to take advantage of this technology.

Gary Lieberman: In some of your markets where the comprehensive joint replacement initiative was implemented, can you talk about what the impact has been, if any, to the company?

Mark Tarr: So we've seen it really, from an impact standpoint, we've seen as an opportunity to go out and educate the CEOs, CFOs of acute care hospitals on the analysis that we've been able to do from a cost perspective on these joint replacement cases. What we've done is enlisted the help of Dobbs and [Debonzo], and Dixon and Hughes to analyze the data that's made available through CMS on the longer term cost of this 90 day period for these types of cases and the various marketplaces where we have overlap, where we have a hospital that's in a CJR marketplace.

What this data analysis showed is that we actually had the cost advantage with certain types of cases of CJR. If you look at the types of cases that make up the CJR patients and look at them in two different buckets. One, the joint replacement cases that don't involve fracture versus the joint replacement cases that did involve a fracture. Those cases where patients did have a fracture we actually had the cost advantage in caring for them because they're more complex, more acute. The lower level, lower acuity patients, kind of what we'd call the clean-cut joint replacement patients that are otherwise very healthy, we did not have the cost advantage on those.

But it gave us a chance to go and show data that supported that the inpatient rehab hospitals are not always the high cost provider for these types of cases when you look at it from an episodic standpoint versus a per diem cost.

Doug Coltharp: The other thing we're doing there in those discussions is we're pointing out that even in those instances where based on the 2014 data, we may not have shown a cost advantage, there's no reason to believe that we can't create a cost advantage on a go-forward basis. There are at least three things that are meaningfully different today from 2014, the period on which the most recent data that drives that cost analysis is available.

First, going back to something that was referenced earlier is we did not have our clinical information system widely deployed at that time. We do today and that's a very important element of effectively and successfully competing in an episodic payment environment. The second is we didn't have our partnership with Encompass established at that point and our ability to work collaboratively and early in the admission process into the IRF, on the plan of care both during the IRF stay and post discharge with a home health partner is going to lead to more favorable outcomes.

And finally, the 2014 data is based on a period of time on which not only did HealthSouth but none of the providers had any incentive to really focus on what was happening to their patients post discharge from their facility. And to give you a very specific example, the patients who'd come into one of our ERs are very sick. I mean they've started their episode with a condition that has landed them in an acute care facility for three to five days. As they've become medically stabilized in the acute care facility, the attending physician has now determined that they can be discharged, but they're not well enough to go home. As a matter-of-fact, they are in need of such intensive care that the physician is recommending, in the cases where they come to us, that that patient spend up to approximately two weeks in another inpatient setting, an inpatient setting that 24-hour, seven day a week nursing, that require three face-to-face visits per week from the physician and that administers a very intensive therapy regime that on average includes about three hours of therapy five days a week and it's multi-discipline therapy.

So that patient has got a long way to go on recovery. If they get into the setting with us in what historically would have happened is as they progressed through their stay in the IRF, if they were progressing well, approximately 48 hours prior to the point of discharge, the physician would sit with the patient who may still be suffering some cognitive impairment, and then typically with a family member as well and say, well, the good news is your mom who had suffered from a stroke and has been here is making very good progress. And she's going to be ready to go home in about 48 hours. And she'll need some home health care when she goes home and there are three providers that we work with on kind of a regular basis, and a marketing liaison from those firms will be in here to talk to you about what they can do for you some time over the next couple of days. Thank you.

And the physician leaves the room and the patient and the family member are now overcome with anxiety because their safety net is about to go away. That round-the-clock nursing coverage is not going to be there when they go home. The therapists aren't going to be working with their family member and the physician isn't going to be there readily. And you've got a family caregiver who's looking at this and saying I've got a full-time job. I live five miles away from mom. I may not be able to get over there until 7:00 in the evening. She's on nine different medications. Perhaps she's still suffering from some degree of incontinence. How am I going to deal with this even with a home health worker?

And in those cases back in 2014, it would not have been unusual for us to respond to that set of conditions by saying, you know what, your mom can get transferred to a [SNF] for a period of time and that will ease the transition back into the home and allay some of your concerns. And it was no cost to us based on that decision, even though the patient with the right home healthcare plan could have gone directly to the home.

Well, operationally we're different today because of the partnership with Encompass and the focus will be different under the new bundled payment program. So now what will happen with that patient and is happening in the markets in which we have an overlap with Encompass is when a patient is admitted into one of our IRFs with a very high degree of accuracy, we can predict the day they come in whether or not they're likely to require a home health services when they get discharged.

And so the care transition coordinator, who is an Encompass employee assigned to one of our IRFs begins working with that patient within 48 hours of admittance into one of our facilities on not only coordinating their plan of care during their stay with the IRF, but also anticipating what the situation is going to be like when they get discharged into the home. Understanding better what their current home conditions are like, understanding the capabilities of a family member to participate in their care post-discharge, and all of that is built into a plan of care post discharge that is discussed in great detail over a period of time with the family member of the patient so that the anxiety comes down dramatically and the potential pitfalls in the home discharge are resolved in the plan of care on the front end.

Gary Lieberman: So implied in your answer is it safe to assume that in those bundled instances, you're no longer discharging to a SNF at all or only in extreme circumstances?

Doug Coltharp: I would say that we anticipate, particularly in markets where we have an overlap with Encompass that it is already coming down. It's already coming down very substantially and it will be a key focus for us in all markets.

Gary Lieberman: For just bundled patients or for really any?

Doug Coltharp: No, it's an initiative across the board. As of today, roughly 10% of the patients who get discharged from one of our facilities go into a SNF and I don't know that Mark can speak better to this than I can. We don't know if we'll ever get that number to zero but we think that we should be able to reduce that very substantially and that virtually all of those patients who are now getting

discharged into a SNF setting would be candidates to go into a home setting. If that were to occur, you'll see that the aggregate number of discharges from our IRF who require home health, which is about 55% right now, would go up by a comparable amount.

Mark Tarr: We'll always do what's best for the patient but there are certain cases that I described that there is going to be some level of comfort for our physicians in our rehab hospitals to feel more comfortable sending a patient home because they have a better trust and better feel for this coordination with the home health agency because of the partnership that we have with Encompass that we haven't had before.

Gary Lieberman: Got it. Makes sense. HealthSouth has consistently grown discharges in excess of the overall industry. Can you just remind us of some of the key factors that have allowed you to continue to do that?

Mark Tarr: A number of years we standardized our sales and marketing approach to all of our hospitals and rolled out everything from sales training to clinical education. We looked at the makeup of our sales liaisons in terms of having the right amount that were clinical background nurses and therapists versus not. We have put into place a number of electronic devices, whether those are iPads or handhelds of some sort that help to expedite the process of the actual nurse liaison going out and doing the patient appraisal, gathering that information then getting it back to our medical directors to evaluate to see whether or not the patient is appropriate to admit to rehab.

So there have been a series of things like that, that has certainly given us kind of that first to market response and being able to be service oriented to the acute-care hospitals. Our clinical programs and our outcomes have been a leading reason why we've been able to grow our volume as we can go out and show that we get a higher percentage of our patients back home, back to the community. Our patient satisfaction has continued to increase over the years.

So there are a lot of things that go into it, Gary, that would play as to how we've been able to grow our cases over the years. We've also been able to handle a higher acuity patient and as our patient mix over the years has migrated more towards a neuro component away from an orthopedic component and we've seen our overall acuity rise during that time period, those are all areas that some of our competition and certainly skilled facilities could not accommodate that level of acuity.

Gary Lieberman: What kind of competition are you seeing on the IRF front? Are you seeing hospitals become more aggressive, less aggressive?

Mark Tarr: We're not really seeing a lot of new players come into our area. We've always competed against the rehab units of acute cares where sometimes we get referrals from those acute care systems even though they have their own rehab unit. And then there's always been some level of competition against the skilled nursing facilities in certain marketplaces. I would not say we're seeing new entrants into the market. I think that overall, systems are trying to look at the leakage that might be getting out of their systems and wanting to make sure that patients stay in their systems if they have the services to offer. But that's all nothing new.

Doug Coltharp: I think in general, we're probably seeing more acute care systems make a decision to exit the IRF business then to enter the business. And they're really doing that as we have conversations with them and our development pipeline right now is dominated by JV opportunities. We talk at the end of the second quarter that we had 11 active development projects on the IRF side and nine of those were JVs. And the JVs most likely or most frequently arise when we approach a hospital in a mkt that we're not currently in. That hospital is currently operating and IRF unit within its four walls and many, many cases in that IRF unit is unproductive or underproductive and the hospital is seeing an increasing demand for its general medical and surgical services, and wants to repurpose the space.

At the same time, because we're moving into more of these episodic payment environments, they don't want to completely exit the IRF business. But they're looking for a partner who can run that business more effectively. And so we bring a very elegant solution to the table there and that's where we can say, look, we can build the de novo IRF facility on or approximate to your campus. When we have constructed that facility, you can shut down the unit that is in your hospital and repurpose that space. As you do so, you will enter into a non-compete for the IRF services in this marketplace. We're able to place a value on that non-compete agreement and then we translate that value into an in-kind equity position in the de novo IRF.

So for no cash at all, they can get the space back in their hospital and get an ownership position in the new de novo facility, which runs much more efficiently and also then helps them handle a complex patient over a longer episode of care.

Gary Lieberman: You reported a 24% collaboration rate for the IRFs with home health in the second quarter. You've talked somewhat about the (inaudible) integration and it sounds like it will help you to drive that higher. Can you maybe give us a sense for what's a reasonable target for 2017 for collaboration and what are some of the challenges with increasing that collaboration percentage?

Mark Tarr: Our next near term goal is to increase it from 24% to 35% to 40%. We have markets that we get to be best practice markets that are at 60%. So that's our long-term goal. Part of the challenges we've had, I don't know if they're challenges, but we've had to address just some basic staffing, just hiring the care transition coordinators. We've had to hire some therapists and nurses in certain markets to handle the increased volume that's been discharged from our hospitals to Encompass.

We've also had to, as part of those additional admissions, they are more rehab oriented. The needs of the patients are rehab oriented versus nursing. So that all ties to the additional hiring of therapists by Encompass to accommodate a patient with greater rehab needs versus nursing needs.

We also have some physicians and other referral sources in our markets that may refer to our rehab hospitals that have a preference towards a home health agency other than Encompass. A lot of that is just they may not be as aware of the outcomes and quality that Encompass is able to provide, but those are opportunities for us to out and introduce our Encompass representatives to those physicians and referral sources, and give them a chance to develop a relationship and hopefully win them over at some point in the future. But those are all reasons why we would -- may be at a certain level, say 24% now, that we think that we can work towards a 35% to 40% in the future.

Doug Coltharp: And just to be clear, that 35% to 40% is not a 2017 objective. We'd be happy if we got there in 2017, but really more of an intermediate term objective.

Gary Lieberman: What do you think could be the impact or might be the impact from the home health pre-claims review?

Doug Coltharp: As we said on the second quarter conference call, we're not anticipating much of an impact although there will be some extra administrative costs that we incur, which I would imagine would be over a short period of time. And I say over a short period of time because if the pre-claims review stays in place, then for a period of time we'll have to deploy administrative resources to deal with that process on the front end, at the same time that we have resources still diverted to dealing with the post-claim reviews and audits that take place today.

Ultimately, if the pre-claims reviews stays in place, the need to conduct the audit activity on the back end will go away. You're not going to review the claim twice in the process and as that activity drops off, the resources that had been applied there will either be redeployed to the front end or they'll go away.

And so the extra cost will go away as well. If the pre-claims review does not take hold and the demonstration ultimately proves to be ineffective, it will go away on its own. But either way that incremental administrative costs that we're going to bear is likely to be for just a shorter intermediate term. We don't anticipate that it's going to have any impact on our volumes and we don't anticipate that it's going to have any significant impact on our working capital.

Gary Lieberman: Question here.

Unidentified Audience Member: (Inaudible -- microphone inaccessible) presumptive method of eligibility.

Doug Coltharp: No, it's been very stable. We range anywhere from 75% to 76% collectively as a company. Keep in mind, each hospital has to meet that threshold but that's where we've been for quite some time.

Mark Tarr: And our focus on such high acuity conditions such as stroke and neurological really helps in that regard. We also think that there's a pretty significant incidence of those conditions existing in the population that we serve. And one of the things that we're very excited about with regard to both of our business segments is that we benefit from a very significant demographic tailwind that's likely to prevail over the next 10 to 15 years. And that is if you look at the average age of the patients that we're treating in both of our business segments, it's well into the upper 70s. And the age cohort north of 65 is growing at a rate faster than the overall national population because the vanguard of the baby boomer population is now pushed north of 65 and you're also seeing an increase in life expectancy.

Gary Lieberman: Since the American Health Association provided guidelines for stroke patients to use an IRF instead of a SNF, have you seen any impact there or do you think you might see some impact going forward?

Mark Tarr: We think we will going forward. It's just yet one more opportunity for us to make a very valid argument and statement about the quality of outcomes seen from stroke patients in a rehab setting facilitated through a rehab hospital versus a skilled nursing facility. So we've really tried to take out the message from the American Stroke Association in this study and make sure we saturate our markets, and make sure that all the referral sources, physicians, the general public knows as far as that goes relative to if you are going to receive inpatient rehabilitation after suffering a stroke, it needs to be done in a rehab hospital and the outcomes and quality show that there's a major difference seen from a rehab hospital versus a skilled nursing facility.

Doug Coltharp: We certainly think it brings a lot of pressure to bear on those referral sources and on payers about where they send their stroke patients for their rehab care.

Gary Lieberman: I've got a couple seconds left. Maybe I'll sneak one last one in for you, Doug. Maybe talk about your target leverage ratio and most likely uses for cash flow.

Doug Coltharp: Sure. So we had said at the beginning of the year that we wanted to get to the end of 2016 with our leverage ratio at our below four times. We are tracking to be at that level by the end of the third quarter. So we're making very good progress based on the strength of our free cash flow. We've taken out the residual portion of our 7.75% notes, which are the highest coupon notes that we had in our capital structure so that every piece of debt that's left in our capital structure has a coupon that begins with a five or less, which is not a bad place to be in.

In terms of cash flow deployment, we generate very significant amounts of free cash flow. We are in the fortunate position of being able to say that we are an and story versus and or story, and that is we have sufficient free cash flow to be able to fund the high quality growth opportunities that we have in both of our segments. In the IRF segment that's four to six new IRFs per year but bed additions of about 80 to 100 beds. In home health that's $30 million to $40 million in anticipated agency acquisitions per year.

That leaves free cash flow available to both reduce debt and to continue our policy of shareholder distributions, which includes the dividend on the common stock, which was increased again this year. It's been increased every year since it was implemented three years ago. And also, we have been buying back some shares under our existing authorization, which stands at about $137 million.

Gary Lieberman: Great. That's going to do it for time. Thanks very much for being here.