HealthSouth

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Whit Marshall: All right. Good morning, everybody. My name's Whit Marshall, I'm with Morgan Stanley, and I'm very pleased to have Doug Coltharp here from HealthSouth, Executive Vice President and Chief Financial Officer.

We're going to go through, you know, a discussion format here this morning. I'm going to ask a number of different questions, and then I'll open it up towards the end for questions from the audience. So, good morning, Doug. Thanks for joining us today.

Doug Coltharp: Thank you, Whit.

Whit Marshall: So, I thought we'd start with just laying out a framework of HealthSouth and -- for the audience. Could you describe kind of your general business lines, how they sit within the post-acute spectrum, and really focus on the types of patients which are best served in your facilities, versus other types of post-acute locations?

Doug Coltharp: Certainly. And I want to acknowledge also, I'm joined today by my colleague, our Senior Vice President and Treasurer, Ed Fay, who is here as well.

So, as Whit mentioned, we do operate in the post-acute sector. And then, as is obvious by the name, that means that about 95% of the patients that we treat in our two business segments -- and I'll describe those in a moment -- come to us after an episode in an acute care hospital.

Our primary business segment is inpatient rehabilitation facilities. Those are specialty hospitals. And we operate 123 freestanding inpatient rehabilitation facilities. All of our facilities are licensed, because it's mandated by Medicare, as acute care hospitals, which means that they are required to provide certain levels of service, including 24-hour, seven-day-a-week nursing coverage. They're required to provide face-to-face visits from the physicians at least three times a week.

And I mention these standards because they differentiate us from skilled nursing facilities. And when you hear the name rehabilitation as part of our -- a moniker that describes our business, some people think, well, those services can be provided in a skilled nursing facility, and the level of services in the rehabilitation vein that are provided in a skilled nursing facility are markedly different than those that we provide.

Within our inpatient rehabilitation facilities, we address predominantly the Medicare beneficiary population. About 80% of our payments come to us from the Medicare program. We are focused, then, on the types of diseases and maladies that impact the elderly in a disproportionate amount.

So, a very good example is, about 20% of the patients that we treat in our facilities are recovering from a stroke. In a typical example, someone will have a stroke that will land them in an acute care hospital. They'll spend three to five days in that type of setting. They'll be medically stabilized, but they're still suffering from some type of impairment -- perhaps loss of mobility, or speech impediment, that means they're not quite ready to return to their home setting. The admitting physician can then decide that they require a type of intensive therapy regime that is administered in an IRF setting.

They'll come to one of our facilities for approximately two weeks. While they're there, they will get a very intensive, multidisciplined therapy regime that typically involves approximately three hours of therapy, five days a week -- occupational, speech and physical therapy. They stay with us on average about two weeks, and then the vast majority of our patients, more than 80%, are able to go back home to the setting to which they originally came into the system. So, that's our primary segment.

The -- about a year and a half ago, almost two years now, we entered a second segment, and that's home health care. And we did that because it is highly synergistic with our inpatient rehabilitation facilities. More than 55% of the patients who get discharged from one of our facilities, in spite of the very substantial recoveries they have made, require ongoing home health services.

And prior to our acquisition of Encompass, which was our entry into home health at the end of 2014, we weren't capturing any of that revenue, and also weren't able to be accountable for a continuum of care that saw the patient through from the time they got discharged from an acute care facility to the end of the episode. We acquired Encompass and have used that to grow the overlap between our IRF platform between our -- the markets in which we have a home hospital business, or a hospital business, and a home health business, and we now have 72% overlap.

Whit Marshall: Great. Thank you. Maybe just expand a little bit more around, you know, the patient referral sources. How do you kind of go out there and market your capabilities, bring those patients in; and talk a little bit about demographic trends underlying demand outlook for that.

Doug Coltharp: And I'll start with that last piece first, which is, one of the things that we're very excited about in our business is that the demographic trends really favor the continued growth of our business. And it's just a simple fact that the portion of our population that is aged 65 and over is growing more rapidly than the overall population. This is the result of really two things. One is, the vanguard of the baby boomer generation has pushed over 65 within the last couple of years, so that cohort will continue to grow. And the second is that you get increased life expectancy in the US, so we're really expanding the demographic that we serve on both ends.

You know, in terms of the -- how we market our services and the referral sources -- again, the vast majority of the patients who are coming into our facilities are coming to us after a stay has landed them in acute care hospital. We have a structure where actually almost a third of our hospitals are in joint venture relationships with acute care hospitals in the markets in which we operate. So, that gives us almost a natural referral source there. But even in those situations, we're drawing patients from multiple acute care facilities in each market.

The proposition is one -- the value proposition that we make to the acute care hospitals is one that would be appealing to any of you, which is, we are positioned as the highest-quality, low-cost producer of the services that we provide. And we are able to demonstrate with empirical data the effectiveness that we have in treating some very, very sick patients. We can demonstrate the success that we have in recovering stroke patients. We treat a lot of other complex neurological diseases that tend to impact the elderly. So, when you're speaking with the medical community, they want to be fact-based, and results matter, and we have a very good track record in that regard.

Whit Marshall: So, maybe just to continue on that, because this is, I think, a pretty important area, when you think about your cost comparison -- so, high quality, I think, is pretty straightforward from understanding what you're delivering. But on the cost basis, as you compare it other settings in the post-acute, how do you think about your per diem cost from a comparison standpoint, and is that the right way to think about it, or in -- you know, in the provider services landscape, there's a lot of discussion around 90-day spend. You know, how does it fit in that context? So, a little bit more around your cost comparison, please.

Doug Coltharp: Yes. And I think you hit on the key point here, which is, if you try to compare it on per diem -- and if you're speaking to somebody who's in the skilled nursing facility business, they'll want to do it on a per diem basis -- we're not going to win on that basis. and it's because you've really got to look at it over the full episode and factor in things like length of stay and what the result for the patient is after they leave their particular facility.

So, there are some -- there are many statistics that are out there but, again, on average, a patient will stay with us for about 14 days, and over that 14-day period we are required to provide them that 24-hour, seven-day-a-week nursing. We're required to provide them that very intensive therapy regime. Well, that's got costs associated with it. But our length of stay is very reliable around that two-week period.

And then, after that two-week period, again, as I mentioned previously, we have a very high success rate in terms of getting the patients back into their home setting -- sometimes, on about half the cases, with some follow-up home health services, which is the least cost-intensive -- and the readmission rates of our patients back into an acute hospital, which is where healthcare costs really start to escalate, is very low. When you compare our length of stay with the typical length of stay in a SNF, it's about half.

So, when you start to multiply the per diem rates by the length of stay, and then also look at their hospital readmission rates and the incidence of other relapses coming -- patients coming out of SNFs, and look at that over a 90-day episode -- and we're moving more and more, if you think about some of these, the programs like CJR and BPCI, moving more towards looking at things on an episodic basis -- our costs compare quite favorably.

Whit Marshall: Great. And we're going to get into some of those areas too. I'm going to take a step back real quick and just address, now we have a little bit of a foundation here, I think, around HealthSouth, you know, what's in probably a lot of people's minds in regards to, you know, President-elect Trump winning the election. A lot of his campaigning was around restructuring or repeal of the ACA. You know, everyone's going to be watching to see who he's going to be appointing as far as his cabinet, to get signals on what's going to happen. And we saw hospital stocks trade off very significantly yesterday.

How does -- you obviously mentioned hospital (inaudible) for what you provide. But how do you see HealthSouth from a risk standpoint with changes to the ACA? What are

the key areas that you're concerned about?

Doug Coltharp: So, our stock traded off yesterday with acute care hospitals as well. We like to say that we're -- don't like to say, but it's I think probably the case that we're somewhat guilty by association with the acute care hospitals, and that's because there really aren't other publicly-traded comps or businesses where their -- the primary focus is on inpatient rehabilitation facilities. And so, there isn't a peer group for us to otherwise trade with.

The fact is that we had very marginal impact from the implementation of the Affordable Care Act; and therefore, regardless of what happens with regard to its repeal in whole or in part, we expect very little impact as well. And we say that because, as I mentioned previously, about 80% of our patients are Medicare beneficiaries. And so, the expansion in coverage through the Affordable Care Act -- it was such a big part of the acute care hospitals' volume growth over the last several years -- did very little to impact us. Our patients already had insurance through the Medicare program.

It's also the case that the conditions that we treat are non-discretionary in nature. So, whereas, if you're looking upstream, again, in an acute care facility, you'd say that somebody who may be unemployed and doesn't have insurance can defer on a discretionary type of treatment, a type of surgery, or so forth. You can't defer treatment when you're having a stroke. And so, we really saw very little impact on a volume basis or any other basis from the implementation of the Affordable Care Act.

We think, on the margin, any repeal of the Affordable Care Act is going to be positive for us. There have been certain elements of the Affordable Care Act that are a little bit under the radar screen. Those of you who might be familiar with some of the programs that are coming out right now, the mandated pilot programs, are really the -- have been birthed by CMMI. And CMMI was formed under the Affordable Care Act. It's almost unprecedented that it has used its power to work without comment periods from the provider community; to work without comments from the -- from Congress, to implement some of these programs, and they've really forced these down the throats of the acute care hospitals in a way that is straining the system.

You know, we think that there's a lot of potential that CMMI goes away altogether. And if not, certainly there will be a more judicious process for how programs that come out of that body are ultimately implemented. That'll slow the pace of change, and ultimately we think that's a good thing for the system. When we look specifically at the CJR pilots, we've been able to respond much more quickly than our acute care partners, because the acute care hospitals are burdened with so many different elements of change right now, it's really more than they can digest.

Whit Marshall: Got it. Thank you. You know, I find in the provider services space, it's critical to understand, you know, how a provider is viewed by probably three key constituencies: you know, the local health system; payers; and the patients. And many times, this ends up coming back to quality of care; cost; technology. Can you discuss how HealthSouth, you know, fits in that context?

Doug Coltharp: Yes, certainly. So, again, with the payer community, start with Medicare, because it's about 80% of what we do. And we actually have -- we have a document, by the way -- many of the things that I'll be referring to today can be found in the document that we post to our -- the Investor Relations section of our website, and we update on a quarterly basis. It's a document called the Investor Reference Book. I think it's up to a whopping

123 slides.

We put that in place because of something that I mentioned earlier, which is, we're really kind of a one-off company that's out there. We are by far the largest operator of inpatient rehabilitation facilities in the country, and we are the only publicly-traded company that has that as our primary focus. So, we recognize that it's incumbent upon us to be able to educate investors and potential investors on the dynamics of our business and the regulatory environment and so forth. So, all of this -- the information I'm discussing, is bound in one form or another within the confines of the Investor Reference Book.

But from a payer perspective, we are able to draw from Medicare's own data and demonstrate that on average we treat a higher-acuity patient for Medicare versus other IRFs that are out there, and that we're able to do it in a more cost-effective manner. And we actually get paid in the IRF business on a per-discharge basis. So, when a patient is admitted into one of our facilities, they're coded for all of the conditions that they have, and that generates a fee that's based -- that's on a case rate basis. And when the patient ultimately leaves our facility, Medicare gives us a lump-sum payment. We're not paid on a per diem basis, and we're not paid a stipend for various services that we provide.

That being the case, the way that we're able to treat those more acute patients at a lower cost to the Medicare program is based on our cost-effectiveness. Because, within all of the Medicare programs, there's a provision for outlier payments. And an outlier payment means that when you are treating a patient who may be more medically complex than the coding for the patient initially indicated, Medicare doesn't want you to lose money on that patient. They believe that that would be a disincentive for you to continue to take the more complex patients. They've put a program in place that says, when you have one of those patients who have just an unforeseen amount of costs that's required to treat the patient, we'll put a stop loss in place, and over a certain level we will reimburse you at 80% of the cost to -- you know, to treat that patient.

Now, what actually happens is that that system gets gamed quite a bit, because how you load in (ph) the cost to treat the payment -- treat the patient, is highly variable. The outlier pool for IRFs is about 5% of total revenues. You've got IRFs that are out there in certain places that have as many as 20% of their patients who qualify for outlier payments. We have less than one-half of 1%. And it's not because we're not treating the more complex patients, but because we're better at treating them; and because of the scale of our operations and so forth, we can do so more cost-effectively, and we don't wind up in the outlier pool.

Whit Marshall: So, maybe just a little bit more on the competitive landscape for skilled nursing, just so, you know, I understand it a little bit better. Now, you talked about the costs, and we've talked about acuity of patient. But is your patient flow, coming into an IRF versus skilled nursing, because of the acuity level of that patient, or is there more competition for an individual patient, and it's really about, you're pitching, this is a better location because if you look at our quality of care, the length of stay is less, and the cost really ends up being less? What's the driver for kind of picking which location that patient goes into?

Doug Coltharp: In the system in which we operate today, the focus is almost exclusively on the quality of care, and what's the appropriate setting for the patient to make a full recovery. Now, as we move more and more towards episodic payments, cost is going to become more and more relevant. But the way that we are operating today, with very few exceptions, the focus is really on quality of care. Again, we think we win on both parameters.

Medicare regulations dictate that for a patient to be admitted into an inpatient rehabilitation facility, they have to meet two tests. One is that 60% of the patients over the course of the year admitted into one of our in particular rehabilitation facilities have to have one of 13 pre-specified conditions known as CMS 13. This is something called the 60% rule. So, if we don't have the 60% of our patients within those 13 diagnostic codes, we don't qualify to be reimbursed as an inpatient rehabilitation facility, and we default back to a lower per diem, that is an acute care hospital rate. 100% of the patients who are admitted into an inpatient rehabilitation facility have to meet what's known as medical necessity criteria. This is a somewhat subjective criterion that is determined by the physician who is providing the care to the patient.

And I should mention, we don't provide -- we don't employ physicians in our facilities. We employ nurses and therapists. Physicians that are admitting patients into our facilities and administering to their care are independent practitioners.

So, a physician -- 100% of the patients coming into our facility have to have met this medical necessity criteria, where the physician makes a determination based on their evaluation of the patient that the patient can both tolerate and will benefit from the intensive therapy regime that is administered in the IRF setting. And that, again, is three hours of multidisciplined therapy, five days a week. So, the physician is looking at the condition that the patient has when they're ready to be discharged from the acute care setting, and really trying to make a determination for what is the best course of action for that patient, in order to get them returned to the function -- level of functionality they had before the episode landed them in the acute care hospital.

And again, based on the quality measures that we have, and it's based on the level of care that we're providing, we think we're able to present a pretty compelling case. In many instances with these (ph), you don't have 24-hour, seven-day-a-week nursing coverage in skilled nursing facilities. Their per diem doesn't allow them to provide that level of service. So, one of the things physicians can look at is, is this a patient who requires that level of round-the-clock nursing? And you don't have the intensive therapy regimes administered in an IRF setting in a skilled nursing facility.

Another one of the requirements of therapy that we provide is that a preponderance, meaning more than 50%, has to be administered as an individual versus a group setting. Most of the therapy that's administered in a skilled nursing facility is done in a group setting. It's far more difficult for an acute patient to make progress in a group setting than it is in an individual setting, from the bond that's formed between the therapist, and the knowledge of the specific elements of the recovery, it's far different than that kind of group setting.

It's also the case that in most SNFs, the therapists are not full-time employees. They are in our facilities. They're contract employees, and they come in a couple of times a week. So, it's a very different level of care. And I think in most instances, and our volume numbers support this, we're able to demonstrate that for the segment of the population that has had the kind of acute impairment that the patients we treat have had, the physicians understand the value proposition.

Whit Marshall: Is -- you know, an example of that -- the American Heart Association, I saw recently, made some announcements regarding stroke patients being better served in IRFs. Is that -- I -- that sounds like an example of what you're talking about here. And is there going

to be any volume impact from that announcement, do you think?

Doug Coltharp: That was a very strong endorsement. What Whit is referring to is, in May of this year, the American Heart Association and American Stroke Association together issued a joint statement that said they had evaluated the recovery of stroke patients in an IRF setting versus a SNF setting, and that there was a very strong recommendation for patients recovering from a stroke to be admitted into the IRF setting. And that study was based on empirical data over an extended period of time.

What we are seeing right now is, we are -- our marketing liaisons are able to carry that study out to our acute care hospitals, and also where we're making a lot of headway now is with the Medicare Advantage and managed care programs that have been much more reluctant previously, just based on cost differential between our services and the SNF, to send us those types of patients. And it is beginning to resonate very strongly with those constituencies. And although we haven't seen a substantial movement in the numbers yet, we do anticipate that on a go-forward basis we will capture more stroke market share as a result of these guidelines.

Whit Marshall: So, let's hit upon Medicare Advantage, and -- but let's start with ACOs and bundled payment initiatives. It's a big theme in provider services. How are you positioned in regards to CJR, the comprehensive care for joint replacement model, and other similar bundled payment initiatives, and how are you participating in that, and how do you think about risk-taking along those lines?

Doug Coltharp: Sure. So, there are really three different initiatives that are out there, encapsulated in what Whit just mentioned. First is, you do have accountable care organizations -- ACOs -- that were one of the products of the Affordable Care Act. Our view on ACOs, and we're participating in a number of them out there, is that very few are generating any real volume of substance. Most of them were formed based on term sheets and Memorandums of Understanding and so forth, and there's very little throughput coming out of those organizations. So, we're participating in some, and we have the ability to learn. Encompass's participation is more robust than our IRFs right now. But still, we're seeing very little volume in aggregate, and we don't see a lot of momentum today behind the ACOs.

Then you've got two bundled payment initiatives that came out of the Medicare program. The first was BPCI. We are participating both from an IRF perspective and from a home health perspective in BPCI. But, again, the volumes are very, very small, and we're really only seeing our first learnings under there.

The third initiative is CJR, which is the mandatory pilot for bundled payments surrounding lower extremity joint replacements and hip fractures. And there, our participation is higher. This program only went in place on April 1st, during the first year -- and this is where you move to an episodic payment over a 90-day period for those patients. The responsibility is vested with the acute care provider where the patient originates their stay. And so, any penalties or any ability to participate in upshare is ultimately borne by the acute care hospitals. But they do have the ability to share that risk with downstream providers through a provision called the collaborator provision.

I won't take you through all the details on that. Again, we -- in the document that I referenced previously, the Investor Reference Book that's posted on our website, there's a very good description as to how the CJR program works.

In the first year of the program, there's no ability for anybody downstream to participate in the risk, and there's no risk to (ph) the acute care providers; there's only an upside participation. The risk corridors develop in the latter years of the CJR pilot program, beginning with the second year. So, now, the acute care hospitals will be at risk for a portion of the payment over that episode. And we think that provides us an opportunity to approach them with a proposal to serve as a collaborator and share some -- in some of the risks, based on the outcomes we're able to provide for relevant patients there. We're at the front end of that process. We're just now initiating the discussions with the acute care providers, and certainly the CJR markets, but we expect to have a lot more to say on that topic as we progress from 2017.

Whit Marshall: Great. Thanks. The -- you know, maybe let's switch to reimbursement. So, I think we've talked a lot about, kind of, your business; the demand around the services you provide; how you're participating in these bundled payment initiatives, which is important. But give us an update on reimbursement outlook.

Doug Coltharp: So, being 80% Medicare, we're a price taker, not a price setter. Our pricing is established on an annual basis by CMS, the administrator for Medicare. And there's a separate pricing schedule for the two service lines that we have, inpatient rehabilitation and for home health.

The inpatient rehabilitation pricing is set on a government fiscal year basis. So, it runs from October 1st to September 30th in a particular year. Therefore, our pricing for 2017 is known, and actually went into effect on October 1st of this year. It translates into about a 1.9% increase in our fee-for-service schedule from Medicare. We can live with that. It's not great. We're seeing wages rise more quickly than that, and wages consume about 50% of every revenue dollar, so that puts a little bit of pressure on us from a margin perspective. But still, that kind of price increase is something that we can live with.

The pricing environment on home health has been more difficult over the last several years. There was a real concern in -- amongst -- in the Medicare administrator, really dating back to about 2010, about the incidence of fraud in home health, and just the overall growth in that business segment. If you go back and you look at Medicare expenditure by post-acute segment and the growth curve in those services from a period of time beginning in about 2008 to the present, what you saw is that the IRF business, the overall growth in Medicare expenditures was relatively flat, growing only very modestly. But in home health and skilled nursing facilities, the curve just shot up immensely. Some of that was good, particularly for home health, because we were trying to push patients to a less intensive setting. But a lot of it was perceived to be due to the fraud and abuse in (ph) the Medicare system.

And so, beginning in 2012, there was a legislated rebasing of home health pricing, which was intended to drive some capacity out of the business and slow the rate of growth. And that rebasing is a euphemism for price cuts. And so, in 2017 we're moving into the last year of a multi-year rebasing. Our pricing for our specific home health care basis, because you've always got to take the general rule and then apply it to your specific agency, based on their location and the specific types of patients that you're treating within your agencies, is going to be down about 4%. So, that's a lot to swallow, a 4% pricing cut for more than 80% of your patients in the business line.

We're a little bit disproportionately impacted in our home health business in 2017

because of two things. One is, one of the things that Medicare has the power to do without any legislative action is that they can reallocate payments from one type of patient within a setting to another type of patient. And they do this from time to time if they think that there has been an overcompensation for a type of patient. But many times, it's done in an almost arbitrary manner.

And within the 2017 rule, which is on a calendar year basis for home health, the administrator made the decision to reallocate certain payments from more acute patients to less acute patients. The focus of our home health care business has been on the more acute care patients, and so our rate cut is going to be disproportional. They also made some technical changes in the outlier payment program which is more pronounced in our home health business than it is in our IRF business, and that also has a negative impact on us. 2017 in our home health business is going to be a tough year from the pricing perspective.

The good news is that rebasing ends in 2017. We resume a more normal pricing schedule beginning in 2018. And in 2018 there's also a value-based payment program that goes in place for home health care providers, where home health agencies that demonstrate higher-quality outcomes will receive higher payments. And it's a zero-sum game, because those that are not producing the high-quality outcomes receive less. On all of the national metrics, our home health business performs at the very high end from a quality perspective, so we expect that, beginning in 2018, we will be the beneficiary of that value-based payment program.

Whit Marshall: And if you look past 2017, do you see pricing declines, neutral, or growth -- positive growth in reimbursement rates for home health?

Doug Coltharp: We expect that the -- beyond 2018, that the rebasing program -- I (ph) struggle. The rebasing program, which has painful over the last years, has in fact accomplished what Medicare set out to do. It's bent the cost curve for home health services down, and it's caused many of the marginal players in the business to exit. There's been a tremendous amount of consolidation in the home health care space. We've been one of the players there. And that consolidation's going to continue over the next several years.

But because the rebasing over this multi-year period has accomplished what Medicare intended for it to do, we believe that the pricing environment beyond 2018 will be relatively benign. It's not going to be robust. But it'll be okay, very much like we've seen in the IRF segment. And again, because the cost curve in the IRF segment has been relatively flat -- we'll see some increases on a go-forward basis in terms of spend per beneficiary because of the demographic trend -- we don't think that's a real focus in terms of any kind of rebasing in the IRF segment. We would also characterize the pricing environment on a go-forward basis in the IRF segment as relatively benign.

Whit Marshall: So -- and I'm going to pick up the pace a little bit here from a timing standpoint. The -- obviously, in home health, just highlight the point, volume there is very positive, you know, from an institutional setting standpoint. I assume that is kind of the continued outlook from a volume growth perspective. That's going to continue as we've seen it.

Doug Coltharp: Yes. We've been demonstrating low-double-digit growth in admissions in our home health business, and it's really a function of three things. One is, we're able to take market share in those markets in which we operate, a lot of that having to do with the fact that with price cuts and more requirements for quality reporting and so forth, the smaller

mom-and-pop agencies that are out there just aren't able to keep up. They're exiting the business, and we're gaining market share as a result.

The second is a point that I mentioned early in our discussion, which is, we now have overlap of home health with about 58% or 72 of our IRF locations. We engage in a clinical collaboration, so the capture of discharges coming out of our IRFs and our home health business is helping to drive the admission growth there as well. And then we're also growing via agency acquisition. We expect those growth rates to continue into the foreseeable future.

Whit Marshall: And then a little bit on kind of financials and capital deployment. You know, your guidance for 2016 -- you know, $3.65 billion to $3.7 billion of revenue; $785 million to $795 million of EBITDA. You're going to generate, I think, a fair amount of free cash flow off of that base. How do you think about deploying that excess capital generation?

Doug Coltharp: Well, one of the things that we think is most attractive from our -- about our business, is that we generate very high levels of free cash flow. In a typical year, we'll take more than 50% of our EBITDA through to free cash flow number, and that allows us to be positioned as an "and" story versus an "or" story. And I'd say that means that we are able to deploy capital to multiple initiatives.

The first priority for us with regards to deployment of capital is always to high-quality growth opportunities within our two core business segments. And so, in the IRF segment, that means that we're able to either acquire other freestanding hospitals or build those on a de novo basis. We target adding four to six new units to our IRF portfolio on a per annum basis. We also have the ability to add additional beds to existing facilities. That's a very highly productive use of our capital. And on average, we're able to add about 100 beds to our existing hospitals on a per-annum basis.

As I mentioned, the home health business is really still highly fragmented in spite of some of the consolidation that has taken place over recent years. Today, there are still about 12,500 home health agencies operating in the US. About 95% of those have less than $5 million in annual revenue. And so, the growth in the home health business is predominantly by buying these smaller agencies that allow us to expand our geographic territory, with the prioritization of increasing the overlap between our home health business and the inpatient rehabilitation facilities. So, that's growth capital. That's the first priority.

This year, we've had a focus on delevering the balance sheet. We made three significant acquisitions in a 12-month period. We were fortunate, with the help of our partners at Morgan Stanley, to be able to access the debt capital markets on very attractive terms to fund those acquisitions, but it took our leverage up to in excess of 4.5 times at the end of 2015. Now, in the post-acute space, that's still relatively -- it's still absolutely and relatively attractive; but it was higher than we deemed appropriate for a run rate.

So, we wanted to focus this year on deploying cash and increasing our EBITDA to bring the leverage ratio down from the 4 times. That was an objective that we set to achieve by the end of this year. We ended the third quarter at 3.8 times. We were able to pay off our highest-cost tranche of debt in the process, some 7 ¾% notes that we had due in 2022, that we were able to complete the call of in September. And then we do believe that a balanced approach of growth of the appropriate leverage on the balance sheet and shareholder distributions is the right one. We have a common dividend that we've

continued to increase on an annual basis. And we also engage in opportunistic share repurchases.

Whit Marshall: Great. I think you hit a couple of things, including, you know, debt to EBITDA target ratios. It sounds like, you know, a little over 4½ -- is that -- do you think about any upper bounds in leverage for acquisition financing? Is there any guidance around that? Is that a good example for how you're thinking about the amount of leverage you'd want to put on the company?

Doug Coltharp: You know, I think that is a good example. It's not to say that if a unique opportunity arose, that we wouldn't potentially go above that. It would really depend on what terms we were able to access, the leverage that took us to the level, and the visibility we had in terms of the EBITDA growth of the company and the free cash flow growth of the company, to be able to reduce that down to a more sustainable level very quickly. But, you know, I think, ballparking, something in terms of 4½ times is appropriate.

There's a lot of change that's happening to our business. We think we're very well-positioned to capitalize on that change. But we think that it's more prudent and provides us more flexibility to operate at a lower level of financial leverage, so we're really more comfortable with something that's in kind of that 3½ times range.

Whit Marshall: And then, in regards to change, Jay Grinney announced his retirement this year as CEO, a long-time driver of the business and strategy at HealthSouth; Mark Tarr stepping in. Obviously, Doug, you being a key part of that core team, can you talk a little bit about, you know, the transition that's going to occur to a new CEO, and any expectation of change of strategy around the business as you look forward here?

Doug Coltharp: Let me first say that there will not be any change to the strategy. The strategy that I've been describing today is one that Jay and Mark and I have worked on over a multi-year period of time. We're all very vested in this strategy, and it's one that has been fully endorsed by the board of directors. I really give kudos to our board of directors and to Jay Grinner for a very well-planned succession here.

This is a bittersweet moment for our company, because Jay has done just phenomenal things to helm this business. He took over a very broken business in the aftermath of the substantial financial fraud at HealthSouth in 2004, and to bring it to the position of strength and leadership in the investment community and the medical community that we enjoy today, is just really unprecedented and really phenomenal.

But Jay has left -- has put our company in a great position for the next several -- for the next avenue of success, building on this foundation. And we're very fortunate that as part of our leadership team we have a guy like Mark Tarr. Mark's got 23 years of experience at HealthSouth. He's held almost every position of hospital administration that you can have out there, and he's a great leader, and he knows his business better than anybody that's out there. Mark and I have enjoyed a very close working partnership over the 6½ years that I've been at HealthSouth. We have very complementary skill sets, and we're very excited about the ability to partner together and really build the next level of success off of the foundation that Jay has put in place for us.

Whit Marshall: Great. Thanks. Maybe, with that, I'll see if anyone in the audience has any questions.

Unidentified Participant: When you think about the wage pressures, you mentioned (inaudible) how you see that

going forward?

Doug Coltharp: Yes. Absolutely. So, you know, this year, our merit increase, which is a good proxy for what we're seeing with regard to wage pressure, was right at about 2¾%. It's a little bit higher -- it's about a quarter-point higher than we've seen in the last several years. As is the case with most labor measures, it's a market-by-market basis, and there are certain markets where we're starting to see some pressures, particularly on the nursing side; not so much on the therapist side. We don't think it's something that's going to run away from us, but when you're in a skinny pricing environment like I described previously, and when 50% of your revenue dollars go towards labor costs, it's something that you have to watch very acutely.

Whit Marshall: I think we have time for one more. All right. I think we'll call it at that, then. Thank you very much, Doug, for joining us today.

Doug Coltharp: Thank you.