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PARTICIPANTS

Corporate Participants

Mark J. Tarr –President and Chief Executive Officer, HealthSouth Corp.

MANAGEMENT DISCUSSION SECTION

Unverified Participant

Okay. Welcome to day two of our conference. It's my pleasure to welcome HealthSouth Corporation this morning. HealthSouth is one of the U.S. largest providers of rehabilitation services. The company operates inpatient rehab hospitals, outpatient centers, home health agencies, over 360 centers in about 30 states.

And it's my pleasure to have the President and CEO, Mark Tarr, this morning.

Mark J. Tarr, President and Chief Executive Officer

Thank you, and good morning. It's a pleasure to be back here at J.P. Morgan Conference again this year. I want to start by introducing some of our management team that are here with me today. First of all, we have Doug Coltharp, our Chief Financial Officer; we have April Anthony, the CEO of our Home Health Encompass; we have Crissy Carlisle, who some of you may know as our Chief IR Officer; and we have Barb Jacobsmeyer, who is our newly crowned EVP of Operations. So, it's great to have the team with me here today.

I will note that we are an Alabama-based company. And so, therefore, the results of the game last night are still weighing heavily with some of us. So, you'll have to ignore the fact that we may not have that same swagger about us that we had this time last year at this very same meeting as a matter of fact.

So, for those of you that aren't familiar with HealthSouth, we're made up of two business segments. We have one that is a facility-based segment with 123 rehabilitation hospitals, 37 of

those hospitals operate as joint venture partnerships with acute care systems. The other segment that we have, Encompass, is obviously home-based, made up of 188 home health locations, 35 hospice locations. Both of the segments enjoy a large percentage in market share. The hospitals are the largest market share. As a matter of fact, 28% of the Medicare patients this year receiving inpatient care will receive that in a HealthSouth facility. Our home health locations account for the fourth largest Medicare home health company. So, we have a strong foothold in both of these segments.

It's important part of our strategy to create overlap, you can see via the red square in the middle that we reference the 59% of what we call overlap. When we first started our venture with Encompass, we started out with 30% of our inpatient rehab hospitals had overlapped with Encompass Home Health. As we've grown out that segment, we've made a real priority to acquire agencies that would create this overlap or otherwise this 30-mile radius around our rehabilitation hospitals. So, that's a key part of our strategy to create this integrated network that we can work within. Also, to point out on the map you can see large concentrations of our locations in State of Florida, Alabama, Texas, on up in the Massachusetts. We've also posted the 10 development projects that we currently have in the works that will come online in 2017 or 2018.

We attribute a large part of our ability to capture the market share that we enjoy to the quality outcomes that we're able to provide to our patients, and you can see both of our segments are at leading positions within their categories. On the left-hand side, starting with our IRF quality, we've chosen to show what we consider to be the priority quality metrics and that is, what is the destination of our patients at the time of discharge from the rehab hospital. Our key focus for the last several years have been to make sure that we get our patients back home to the community and not have a reason for readmission to an acute care hospital or have the need to discharge to a skilled nursing facility at the time of discharge from a hospital.

So, we're proud to show these results, where we're able to achieve a much higher percentage of our patients discharged back to the community than expected according to the database. The database here is compared against what we call the UDS database, which accounts for about 70% of the providers and inpatient rehab submit their data to this database. So, it serves as a good comparison. In similar fashion, Encompass in our home health sector looks extremely strong on the quality metrics. I might note there at the bottom, relative to the 30-day readmission rate, they exceed the industry by 170 basis points, and of course, they are compared according to the Star Ratings from CMS.

We're able to achieve that high quality, but we're also very proud of our cost advantage in both of our segments, and we achieve it in very similar ways. I'll draw your attention to the top row, highlighted in blue. And if you go across from left to right, you'll see in the box where it indicates our Case Mix Index of 1.25, indicating a higher acuity than the industry comparison when looking at the other freestanding IRFs that are non-HealthSouth at 1.23 or the hospital units at 1.18. Continuing across that row, you will see that we experience a significant cost advantage when you look at the cost of our treatment per discharge coming in at $12,600 versus a comp of the non-HealthSouth freestanding of $16,600 or the hospital units of $19,800.

We're able to achieve those costs, but yet we are still reimbursed lower than the industry norm per discharge at $19,300 versus the freestanding non-HealthSouth of $20,000, and then going on down to the $20,500 of the hospital units. The reason that we are reimbursed lower is that we have a very small percentage of our discharge, a very low number of our patients actually hit the high-cost outlier threshold. So, we are able to achieve this efficiency in a number of different ways. One, our productivity of our staffing is exceptional. We do have larger scale; our hospitals run larger than the units or the other freestanding. And then, we have invested heavily in technology for the past several years with our management systems and management reports that we can provide back to our hospital base, regional base or our corporate base management team that help us manage our hospitals in a very efficient manner.

It's a similar story in our home health sector. If you go to the second column here, you can see where they do receive an average revenue per episode higher than the peer average. They have a higher acuity patient, they take a sicker patient. But if you go across to the final column there, you can also see the cost per visit. They, too, experience a cost advantage coming in at 14.3% less than the peer in spite of treating a very high acute patient. The home health group does an excellent job in managing their productivity, and they are also the top of the class for using their IT system, Homecare Homebase, of which April and her team design, so they're able to apply this system in a manner that gives us cost efficiency advantages.

One of the focuses that we have in these overlap markets that I referred to earlier is making sure that we coordinate the discharge process as patients discharge from our rehab hospitals into the Encompass Home Health agencies. It's an opportunity for us to excel on not only on the communication side and coordination side, but when you think about patient satisfaction, our ability to work with the patients, work with the families, make sure that their drug regimen, and their drug education, everything that goes along that is important at that time of discharge is well coordinated. If we do that, then we'll have a successful transition into home setting and also lower the likelihood for readmission back into acute care hospital.

You can see that we have increased this collaboration rate over this past year. When you compare it to Q4 2015, we've increased it up to 28.2%. We believe that this is an area that we'll continue to see an improvement upon. We think, likely near-term goal for us is somewhere between 35% and 40% this next year. I can tell you we do have best practice markets that are at that 60% level. We'll never be at 100%, because there is always the patient choice and there are other factors such as physician preference. But we believe that this is an area and a key part of our strategy that we'll be able to excel on in the going future.

One of the notes that [indiscernible] (9:55) made is this strong push from this demographic tailwind that we benefit from in both of our segments. As the population ages out, patients get older, they are more likely to have stroke, they're more likely to have conditions and maladies that the types of programs that we have in both our hospitals and our home health agencies have developed to treat this aging population. The average age patient for our hospitals on the Medicare side is 76. The average age patient for the Medicare in our home health side is 77. So, you can look at any of these graphs and tables here. The first table shows you the Medicare enrollment. It shows you that starting in 2011, the baby boom generation started reaching Medicare eligibility age, and then you see the CAGR increasing, the trend line increasing from 2% to 3% down in the census data, down below.

Keeping in mind, I gave you the average age of our patients between the 76 and 77 number, and if you go across in those areas, those boxes that we've highlighted, you can see where the actual CAGR is somewhere between 4.5% and 5.5% as these patients age out. And the last area I want to draw your attention to on this particular slide is on the right-hand side, you'll see down the home health column, as the patients get older, there's actually an increase in the need for home health coverage for these patients. So, we believe that this is a significant driver of the future need of our services. These patients are not discretionary in nature. The vast majority of the conditions we treat are not from elective procedures, and that this is really an important part of our strategy that will drive the need for the services we provide as a company.

One of the areas that we put a lot of focus on is our strategy to integrate our two business segments. We believe that in spite of the change in the administration that will take place very soon, CMS will continue to have its focus on the value-based purchasing that as providers, our future lies in the ability to provide high quality outcomes and in addition to able to do that in a very cost effective manner. And I've shared with you the information, we have to show that we are industry leading in both of those areas.

We also believe that with time, some of the artificial regulatory barriers that limit the types of patients that are seen in certain areas, such as the differences between an IRF or long-term acute care or skilled nursing facility, over time, we believe that CMS is likely to eliminate those silos that exist around those three different areas of care. And that what you'll see is more of a site neutral environment, where CMS becomes indifferent to where the patient goes, they will have a payment for the care of the patient. Then it's up to the provider to make sure that they put the patient in the right area of their facility and provide the right level of care to achieve the outcomes and to provide the quality that they're paying for.

We believe that we are uniquely positioned to take advantage of that in the future. Our rehabilitation hospitals are licensed as acute care hospitals. They are a specialty track of acute care hospitals. But if you look at the comparisons on our hospitals versus those other siloed areas, between the SNFs and the LTACs, we believe that we're very favorably positioned to, as we refer to here, pivot from the center.

It's fairly easy to go down the acuity continuum and treat patients that perhaps are less acute than what we're currently seeing, but we also feel that going up the acuity continuum is an area that we're uniquely qualified as well. Given the construct of our buildings with our med gases, with our in-house pharmacies, with our nursing staff, many of them are trained in providing critical care nursing, we have full complement of physician, medical staff in our hospitals. We're also capable of going in and converting rooms to treat more of what you'd see from an ICU-level patient, perhaps a chronic illness that we put a patient on a ventilator from a long-term perspective. So, we think that we are in a unique position to pivot from the center, given the construct of our buildings and the existing staff that we have in our hospitals currently.

2016 was a really strong year for HealthSouth. We're very proud of our accomplishments, given the objectives that we set out going in the 2016 fiscal year. Among those accomplishments, we put a high priority first on the full integration of Reliant and CareSouth as part of our growth initiatives. These are two large acquisitions we had going in 2015. We want to make sure that 2016 was a year that we made great advancements on the integration of both of those. The Reliant hospitals are near fully integrated and we've made great strides in integration of CareSouth home health locations that exist primarily in the Southeast and the Mid-Atlantic states.

We're able to – we opened or acquired four new hospitals in 2016. I mentioned earlier that we have 10 new projects that have – are currently underway. We expanded our existing hospitals by 83 beds. And then we acquired or opened 10 home health locations and eight hospice locations this last year. So, it's a very strong year in terms of achieving our growth initiatives.

We had a number of operational initiatives that we sought out for in 2016. One was to begin to collaborate to a greater degree on our clinical programs between our rehab hospitals and our home health. So, we started the process of creating best practices with regard to clinical protocols. I mentioned earlier, our focus on creating a process for clinical collaboration that would advance the coordination of our patients as they're discharged from our rehab hospitals into our Encompass Home Health sites.

And then we also started to use some of the data from our EMR in our hospitals that we began investing in some five years ago or six years ago as one of the few post-acute providers to have Electronic Medical Record, [ph] our vendor Cerner. (17:22) We're now starting to capture some of the data from that. And in this case, we're starting to apply it to predictive modeling to help identify patients that may be at a risk of acute care transfer, so that we can take earlier advance clinical intervention to prevent those patients from being readmitted.

It was also a year that we continued to participate in alternative payment models. One of which was starting to develop a template in agreement for – to participate within CJR as a collaborator. There is specific language within CJR that allows acute care hospitals, acute care systems to engage with and partner with other providers that would allow the other providers in a coordinated fashion to take a risk. And that quite frankly is something that we're willing to do, it's something that we think that the fact that we have 37 joint ventured hospitals, we're ideally suited to go out and participate in these mandatory bundles, in CJR particularly, and work collaboratively with the acute care hospitals coordinating our care up to and involving the acceptance of risk. Albeit, in a way that the programs are set up, [ph] you're limited (18:48) 25% of the penalty risk that acute care hospitals may have on those particular cases. But nonetheless, we put this format in place that we think will ultimately also allow us to go out and coordinate, and it'll be an attractive part of our offerings to Medicare Advantage plans and other commercial plans in the future.

It's also a year that we continued to make significant progress on our capital structure. Very proud that we had revised ratings from S&P and Moody's on the outlooks of our debt. We also increased

shareholder distributions. We repurchased $1.7 million (sic) [1.7 million shares] (19:32) of our common stock as well as raised our dividend from $0.23 to $0.24.

All this momentum that we've had in 2016, we think will carry over in 2017 in strong fashion. We'll continue down the growth platform, the opportunity to continue to build out our IRF platform with the 10 hospitals that I mentioned between – that will come online between 2017 and 2018. We will continue to expand out our home health platform, prioritizing those opportunities to create those overlap markets. I also want to note that you see here, we have marked $50 million to $100 million worth of capital for these acquisitions which would be twice what we had in 2016. We believe that we can accelerate the potential to go out and acquire these additional home health or hospice locations to expand that network.

We also have operational initiatives that I think are very complementary to what we're trying to do with our strategy. I mentioned earlier the collaborator role, we think that we'll have a number of these collaborator agreements signed by the end of the first half of the year. We want to continue to make strides in enhancing our clinical collaboration with the team work standardization effort that we've applied in other aspects of our business, we'll be applying that this year to the collaboration – the clinical collaboration between our hospitals and our home health locations, so that we can standardize this process that we believe will help us achieve that 35% to 40% collaboration rate in this next year.

Within our guidance, we do have included the outcomes of the two final rules, the one final rule for inpatient segment as well as the final rule for home health. The final rule for the inpatient or the IRF sector this year is fairly straightforward. You can see that they implemented a net – Medicare implemented a net 1.65% market basket increase. We think that the impact for our hospitals this year will be a total of 1.9% for Medicare pricing. The difference between the two is that we're having a positive swing on the wage index in a disproportionate number of our marketplaces that would put us up from that 1.65% to this 1.9% level. Relative to the additional quality metrics that required for quality reporting, we believe that we'll be able to accommodate that in our existing systems, many of which, we're now able to capture through the use of our EMR. We've had to add a few FTEs at our hospitals to also help to capture some of this quality reporting data.

On the home health side, it's a little bit more involved, I want to take some time here to cover the impact of the final 2017 rule on this. We will be disproportionally impacted from this rule in a negative way. The types of patients that we treat – in this case, the higher acuity patient – put us

at a disproportionate impact from the recalibration of the case-mix weights as well as the conversion of the outlier payments to a cost per unit methodology. And we have estimated this will create about $21 million headwind for 2017. Relative to the quality reporting, much the same as on the IRF side or hospital side. We'll be able to accommodate this within the existing structure and supplement the procedures and processes we currently have in place to capture the quality reporting data.

We offered guidance for 2016. For adjusted EBITDA of $785 million to $795 million, and then for the preliminary guidance on 2017, for adjusted EBITDA would come in at $800 million to $820 million. Try to bridge this to make it clear in terms of the bridging between the 2016 endpoint and the 2017 guidance, you walk from left to right, you'll see that we had the benefit in 2016 of $4 million of a retroactive indirect medical education, IME, benefit that we actually had from one of the Reliant hospitals that we put forth in 2016 that won't be reoccurring in 2017.

If you go across, you'll see the growth from operations that we estimate between $32 million and $62 million. The $21 million headwind from the change in the propose to the final rule for home health. And then we had the sale of the pediatric home health business that was a one-time benefit, but we won't have the ongoing EBITDA in 2017 of $2 million. So, those items are outlined at the bottom of this chart.

The guidance considerations for 2017. We talked quite a bit about the pricing impact on both. We put forth the salary, estimated salary increase of [ph] right at (25:30) 3%. And then we listed out a number of the other items as part of the consolidated impact. We are a company with a strong ability to produce free cash flow, you can see here, estimated cash flow of $245 million to $370 million for 2017. I will remind you that we will have a tax impact for that this year. You see our cash flow priorities. We offer our business outlook for the next three years with the emphasis on adjusted EBITDA CAGR of 5% to 9%, annual discharge growth of 3% and 10%, and then our final number for our salaries and other costs.

So, with that, we'll move to Q&A.

QUESTION AND ANSWER SECTION

<Q>: Great. Thanks for coming to HealthSouth breakout. I don't currently cover the company, so I've a few questions. So, please don't be shy. I hope you guys' fire away get questions that you really want to answer. Maybe one I'd start with is, when you look at the current mix of the business that exists today, look at the development and the acquisition plans that you have, what

do you think about – what do you think the company looks like over three years to five years top-line EBITDA growth? What is the growth outlook of HealthSouth?

<A – Mark Tarr – HealthSouth Corp.>: Doug, do you want to take that?

<A – Doug Coltharp – HealthSouth Corp.>: Yeah. Well, I think, that's largely borne out by the business outlook slides that cover a three-year look forward that Mark referenced at the very end of his presentation. And if you look at those slides, what you can see is our anticipation that home health revenues will grow faster than the IRF side. And that's really a function of, a, our objective of creating more overlap between the home health business and the IRF. So, we've got to fill in that 41% of the markets. We won't get to 100%, but our objective is to have complete overlap, and we'll do that predominantly by acquisitions.

It's also a function of two other things at least – and then I'm going to ask April to comment on this as well. One is, what we see is the growing demand for home health services and the role it plays in providing the solution to cost effectiveness across the spectrum and to doing things like reducing hospital readmissions. It's also the fact that the rate cut that we talked about, although it impacts it disproportionally, it's been a multi-year rebasing that is taking a financial impact on many of the smaller operators in the business. And recall that the home health industry is one that is highly fragmented.

Even today, there remain in excess of 12,000 home health agencies in the U.S., and approximately 95% of those have revenue of less than $5 million. So, when they see rate cuts or when they see programs like pre-claims demonstration that is coming forward or the increase in quality reporting requirements, it becomes very difficult for them to compete. They don't have the resources to be able to deploy to compete effectively and that creates more acquisition candidates for us.

So, again, over time, we would expect that in terms of the composition of our business, you're going to continue to see solid growth in the IRF business. More rapid growth, meaning that from a revenue and EBITDA perspective, you'll see an increasing percentage from home health. And we also have a focus on growing our hospice business as well. It's probably fair to say that up until the last couple of years, our hospice strategy had been one of a little bit to borrow from [ph] retail or

the (2:04) gift with purchase, which is we had gotten into hospice when we acquired a home health agency that also happened to be in hospice business.

And April and her team want to study that business for a period of time to determine if it was one where you could successfully manage it to a reasonable margin, and therefore, reasonable return on investment. I think April and her team have made the conclusion that you can do that, if you do it in the right way, and that we now have as an additional growth objective, ultimately expanding in the hospice in as many markets where we currently have a home health agency as we can.

<A – April Anthony – Encompass Home Health & Hospice>: Absolutely. There's not too much to add to Doug's comment there, other than we absolutely believe the market is right for further consolidation in both the home health and the hospice area. And that as a margin leader and a volume leader in the industry that we are uniquely positioned to take advantage of some of the stress that's inherently coming from the outside sources, particularly in the reimbursement area, and maximize the benefit of that stress for our organization as we grow.

<A – Mark Tarr – HealthSouth Corp.>: And it's worth noting that both of our segments, not only the home health, but inpatient side as well, both of these segments are very fragmented, which present an opportunity for market consolidation. I think it's also one of the reasons that you see from our development pipeline for the hospitals, it's very much dominated by joint venture partnerships, where the acute care hospitals have a rehab unit that is either not ran as efficiently as they potentially could or they see a greater growth opportunity in working with the HealthSouth.

<Q>: [indiscernible] (3:42) in the last couple of minutes of the presentation, you missed actually two very detailed slides about your three-year outlook [indiscernible] (3:50)

<A – Mark Tarr – HealthSouth Corp.>: Yeah. No. I apologize for that. I got overenthusiastic about other slides. But we'd encourage you to look at our business outlook slides that make up the last three slides of our presentation.

<Q>: Audience, anyone? One question I had on the labor costs, the 3% labor costs [indiscernible] (4:13) how does your workforce breakdown now in terms of PT, RNs, LPNs, home health AAS. Can

you give us a rough breakdown and is there any material difference in how that blended 3% works out?

<A – Mark Tarr – HealthSouth Corp.>: I'll answer to the hospital side and let April answer the home health side. On the hospital side, about [ph] 60% (4:37) of our total FTEs involve some nursing component, whether that's RN, LPNs or nursing assistants. So, it is nursing dominated. When we look at our overall salary environment, we had not seen pressures across the board. We have seen certain pressures in selected markets. There are some markets in Texas, the Houston markets that are high-growth markets. But we're very confident in our ability to continue to keep our turnover rate down and our recruitment and retention at a degree that helps us to balance out some of the staffing pressures.

<A – Mark Tarr – HealthSouth Corp.>: And I don't have the exact percentages on the home health breakdown, but better than half of our total field staff is in the nursing disciplines, both RNs and LPNs. And so, certainly, that's our major focus. We have the greatest success in retention with our physical therapy discipline. And so, it's both the smaller portion and the lesser churn portion of our organization. And so, maintaining therapists has not been as challenging as maintaining nursing has been. So, we certainly put a lot of our focus as it relates to recruitment and retention on the nursing side to make sure that we can manage through challenging situations there.

<Q>: [indiscernible] (6:10) home health care, are there opportunities for telemedicine?

<A – April Anthony – Encompass Home Health & Hospice>: The questions regarding telemedicine in the home health care arena – two different ways to think about that. There is the telemonitoring component, we see that being viable in our space where we're providing additional monitoring capabilities to particularly high risk patients and utilizing our nursing force to really coordinate the care of those patients using the monitoring as a trigger. We've found that in some of our acquisitions that they're utilizing telemonitoring devices. We have rarely found that we've been able to sustain that at scale and really create a differentiated value from those services. And so, we have not deployed telemonitoring broadly as an organization.

When you speak more specifically of telemedicine, the more physician-based house call through a device, with our average patient being in their later-70s, and 50% of our patients being north of 80, we don't find that to be a terribly effective tool either. And so, at the moment, that's a very limited use component that occasionally works out, but by no means a standard.

<A – Mark Tarr – HealthSouth Corp.>: Yes.

<Q>: What about testing the patient at the home, instead of drawing blood and sending the blood to the hospital?

<A – April Anthony – Encompass Home Health & Hospice>: Actually, completing the lab in the home and use...

<Q>: [indiscernible] (7:30) lab in the home, point of care.

<A – April Anthony – Encompass Home Health & Hospice>: We are not doing any point of care lab testing at the moment. So, we're always drawing the blood and then sending it to the lab.

<Q>: Could you talk about hospice expansion? Is that entirely an M&A effort? And then, what kind of synergies are there between the home health and the hospice business?

<A – April Anthony – Encompass Home Health & Hospice>: The hospice growth will come both through M&A as well as through de novo startups. The de novo startups are a bit slow. Ideally, we frankly would prefer to acquire in the hospice arena. There are nearly 5,000 hospices nationwide, and so there is a pretty right field for acquisition. So, priority number one is to look at acquisitions. If we can't find an acquisition opportunity in a market that either meets our diligence criteria or is available for purchase, then we are not opposed to go in the de novo route. We've done a few de novos in the last couple of years on the hospice side. And certainly, they can be done; they're just a little bit more laborious and take a bit more time upfront.

As far as the synergies between home health and hospice, we find those to be significant. And as you heard Mark mentioned, our strategy is to put home health everywhere that we have IRFs, and to put hospice everywhere that we have home health, and sort of in that order of priority. And so, we have a significant opportunity, which is 35 hospice locations, a significant opportunity to expand our hospice. We absolutely see that the ability to share back-office resources. We believe a dedicated clinical team on the hospice side makes sense.

But there is certainly the opportunity to share facilities, share administrative support staff, and share a lot of costs that allow us to have a very low [ph] census (9:11) in hospice and still a nice profit margin on that segment, because of those synergies that you simply couldn't do if you were stand-alone hospice with some 40 patients, it's hard in many cases to break even. In our case, we can break even in those hospice locations at about half of that [ph] census, (9:27) because of the synergies we can get from existing administrative supports – capacity and resources on home health side.

<Q>: [indiscernible] (9:36-9:56)

<A – April Anthony – Encompass Home Health & Hospice>: I'm not sure I'm going in the right direction with your question, but I think what we see is the ability to enter a market from a hospice perspective and get to a acceptable margin level sooner. Once you hit sort of a point of economies of scale, once you're north of 50 patients, 60 patients, 70 patients on your hospice [ph] census, (10:15) that overlap and that sharing of expenses mitigates its relative value, because you're really getting the greatest value of that at the beginning, where you're not having to double down on facilities and conference rooms and phone systems. Once you've realized that and you get up to a more substantive [ph] census (10:31) level, then we tend to find that that margin expansion is relatively small beyond that initial first 25 patients or 30 patients.

<Q>: [indiscernible] (10:42-10:49)

<A – April Anthony – Encompass Home Health & Hospice>: In the home health space?

<Q>: Yeah. And consolidated.

<A – April Anthony – Encompass Home Health & Hospice>: Consolidated home health and hospice, do want to [ph] give the details? (10:57)

<A – Mark Tarr – HealthSouth Corp.>: I think, I mean, you can get some of those from the business outlook slides as well. Obviously, 2017 is going to be a difficult year from a margin

perspective, because of the extent of the rate reduction that we're facing for Medicare home health. That said, on a consolidated basis, we've been a kind of low- to mid-20% adjusted EBITDA margin. The higher margin is in the IRF segment. Home health margins have been under pressure for a multi-year period based on the rebasing.

The good news is that we believe that in home health, once we move beyond 2017, we start to see a more normalized pricing environment both, based on what's included in the Affordable Care Act as it stands today, and then also based on things like the Value-Based Payment initiative which will start to redistribute certain Medicare patients to those agencies that are providing or producing the best outcomes and we fall into that category. I don't view this as being, in aggregate, a margin expansion story for the near term. I think we'll be working hard to kind of hold margins in.

<Q>: Your payer mix, can you comment [indiscernible] (12:07) I think it's pretty steady now for couple of quarters. And then related to that, on MA – I know in Medicare fee-for-service [indiscernible] (12:15) what's your guys view on like the MA plans? I know they've been part of the [indiscernible] (12:21) you wish you could get through that more or is it just not worth it? Just kind of your general thought on [indiscernible] (12:27)

<A – Mark Tarr – HealthSouth Corp.>: Over on our payer mix, I think what you've seen in 2016 is kind of our go for run rate, it's been pretty consistent relative to MA plans, willingness to use rehabilitation hospitals. We've actually been very successful over the past couple of years in articulating and showing our value proposition, particularly for stroke patients. And I think that they realized that working with HealthSouth in inpatient rehab hospital versus sending the patient to a skilled nursing facility, where there might be a likelihood of return to acute care hospital, I think that they're starting to now realize that looking at the total cost of care from more of an episodic standpoint is more beneficial to them in the long run and we play right into that.

<A – Doug Coltharp – HealthSouth Corp.>: And then as Mark mentioned in his presentation, one of the initiatives that we have underway for 2017 is to take some of our initial learnings from CJR and to expand that into a bundled payment program that would be targeted at the Medicare Advantage providers. Now, we'll do that in a very limited way initially, but we think that that could be a compelling approach from both our perspective and from the MA plans perspective in looking at the relationship around these patients differently.

<A – Mark Tarr – HealthSouth Corp.>: Any other questions?

<Q>: [indiscernible] (13:58) can you talk about BPCI a little bit, what visibility you're having, et cetera? So, we – number of companies [indiscernible] (14:05) what we're generally hearing is that we don't know when we're going to get paid, how we're going to get paid, when CMS is going to calculate the savings, a lot of uncertainty around it [indiscernible] (14:16)

<A – Mark Tarr – HealthSouth Corp.>: We participate in both segments. In BPCI, I would say that we have more experience on the home health front. We have eight hospitals that have participated in the last three years on BPCI, but it's been primarily not from a financial exposure, it's been more from an experience, opportunity to go in and just see if that platform when rolled out on a larger scale, what we would need to make sure that we do as a provider to accommodate that. But, overall, we have been very enthusiastic embracing any of the programs that would tie quality with our payment.

<Q>: Have you seen any financial reconciliation [indiscernible] (15:04)

<A – Mark Tarr – HealthSouth Corp.>: April, do you want to comment on that?

<A – April Anthony – Encompass Home Health & Hospice>: Yeah. In the home health side, we have had some interim reconciliations that are not yet finalized. And so, we really hate to respond on those, because they've still got data coming in. So, they do give you some interim reporting, but we've not had any finalized done deal, and certainly, no payments coming through the system yet that are backing those up.

<Q>: Time for one more? Nobody is taking that one.

Mark J. Tarr, President and Chief Executive Officer

If not, well, thank you very much for joining us today.

Douglas E. Coltharp, Chief Financial Officer & Executive Vice President

Thank you

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