PARTICIPANTS

Corporate Participants

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

Other Participants

David Breadon Common – Analyst, JPMorgan Securities LLC

MANAGEMENT DISCUSSION SECTION

David Breadon Common, Analyst, JPMorgan Securities LLC

Okay, folks. Well, welcome to the last session, at least, for today's healthcare line-up. Thanks again for all your interest. I think this is now being webcast. So, for the webcast, my name is David Common, healthcare analyst in JPMorgan's High Yield Research Group. And it's my pleasure to welcome Doug Coltharp, the Chief Financial Officer from HealthSouth. And we thought we jazz it up a little bit and instead of doing the formal presentation, I've got a dozen or so questions and we'll see where this takes us. And if we have time left at the end, we'll take questions from the audience as well.

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QUESTION AND ANSWER SECTION

<Q – David Common – JPMorgan Securities LLC>: So, Doug, I sort of divided my questions up, not surprisingly to start with your all-important inpatient rehab business. And so, as I was collecting my thoughts, I realized I couldn't explain if asked the full gamut of impact that having a JV with a local hospital company, a brand, does for you with respect to referrals, with respect to reimbursement rates, staffing, and occupancy, really, anything that comes to your mind?

<A – Doug Coltharp – HealthSouth Corp.>: Yeah. So, just a couple of distinctions here. First is there are two types of inpatient rehabilitation facilities in the U.S. There are freestanding units and there are units that are housed within an acute care facility. Across the U.S., the combination of the two, there are roughly 1,200 units or so, and the majority of those are units within an acute care hospital. About 250 of the total 1,200 are in free-standing IRFs and that's the business that we are in.

We have 123 freestanding IRFs, more than a third of those or more than 35 are operated in joint venture relationships with acute care partners. And our joint ventures, some have a very long track record. We have joint ventures that have been in place for more than 20 years. We have never had a joint venture that once put in place subsequently unwound, and that includes joint ventures that survived through the aftermath of the substantial fraud that the company experienced in 2003, which I think speaks to the strength of our partnerships and the importance that our acute care partners see in a relationship.

We see now more than ever that our development pipeline is heavily oriented towards joint venture opportunities. As a matter of fact, more than two-thirds of the current pipeline involves joint venture opportunities in terms of developing new IRFs. The primary reasons that we do that, there are really two or three reasons, and David touched upon some of these in his question.

First, it is a fact that about 90% of the patients who are admitted into an IRF, not just ours but into any IRF, are admitted from an acute care hospital. And that's not surprising when you look at the types of conditions that are treated in an IRF. As an example, a little bit less than 20% of the patients that we treat in our IRFs are patients who were recovering from stroke. And so, in many instances what happens is a patient suffers a stroke, they're admitted into an acute care hospital, they spend three to five days in that setting, they get medically stabilized, but they suffered some ongoing impairment, perhaps a partial paralysis, loss of some of their ability to speak, so they're not quite ready to return home and into their former life.

The patient can be admitted to one of our facilities. They'll spend on average a little bit less than two weeks. They receive round-the-clock nursing coverage while they're in our facility, that's a requirement for all of our hospitals. And they'll also receive a very intensive therapy regime. We are required and we do provide, on average, three hours of multi-disciplined therapy, five times a week to patients in our facility. The multi-discipline includes physical occupational and speech therapy. So, it's a very intensive program. So, certainly that relationship from a referral perspective is very important to us. And as we're entering a new market, a joint venture is extremely attractive to us because it essentially allows us to derisk that market entry as we go in having an established referral source. That doesn't override Medicare beneficiary patient choice.

The increased emphasis that we've seen recently I think is a result of the progression that we are making. And even though it was started predominantly under the former administration, I really don't think that the trajectory and the direction change much with the new administration towards more collaborative care market – models, towards integrated payment models, and all of the progression towards just more integrated and collaborative care.

<Q – David Common – JPMorgan Securities LLC>: Okay. Just following up, I guess there's no real control in the experiment. But what would you think it would be doing to your occupancy rates or reimbursement rates having the JV versus being on your own branding at HealthSouth?

<A – Doug Coltharp – HealthSouth Corp.>: It has no impact on reimbursement rates. So, we are – about 80% of our payer mix is in Medicare. That includes probably 8% Medicare Advantage. So, the vast majority is Medicare Fee-for-Service and that is a scheduled reimbursement rate that's not impacted by whether or not we're operating in a JV or not in a JV. I mean, some of the other advantages that do come out of that is in most instances when we set up a joint venture, we build our new IRF either on the hospital campus or very approximate to it. And since the physicians who are overseeing many of our patients are also physicians who were associated with the acute care hospital from a logistics perspective, it makes very easy for them to flow back and forth and that increases our interaction with the patients. And when that happens, you produce better patient outcomes.

<Q – David Common – JPMorgan Securities LLC>: Okay. Fair enough. Moving on to the different payer classes. I thought I'd post this as, if you had – I'm looking here for a difference in reimbursement rates. So, if you had a hypothetical 64-year old with a stroke and you were paid under commercial, how much different would it be if it was a 66-year-old Medicare reimbursement patient?

<A – Doug Coltharp – HealthSouth Corp.>: Yeah. So, just to – I'll do this more than specific to the stroke patient, but more on the average patient we get from each one of the payers and I'll do it in terms of discounts. So, the highest level of reimbursement we get for any payer category is this Medicare Fee-for-Service. At roughly a 14% discount to that based on 2016 results was our Medicare Advantage book of business. At about a 24% discount to the Medicare Fee-for-Service is our Managed Care book of business. And then at about a 34% discount to that Medicare Fee-for-Service is Medicaid. And Medicaid is a very small piece of our overall business at less than 5% of revenues.

I'll note two important trends though particularly within that Medicare book of business and that is we have seen the gap between Medicare Fee-for-Service and Medicare Advantage narrow in each of the last four years. And it's also the case that we've seen an increasing percentage of our Medicare Advantage contracts transition from a per diem to a case-rate basis. And we ended 2016 with approximately 56% of our Medicare Advantage contracts on a case-rate basis. We think both of those, the narrowing of the gap and the progression of case rates are indicative of the fact that Medicare Advantage is increasingly seeing our value proposition.

We have some great ammunition to go out with during the course of 2016, incremental ammunition that is. And that's because in May of last year, some of you may have seen the American Heart Association, together with the American Stroke Association, issued some new guidelines based on an extensive study that they had commissioned that demonstrated that the results for stroke patients receiving rehab in an IRF setting were substantially better than if they received rehab in a SNF setting. And so, those two bodies endorsed stroke patients receiving their rehabilitation in an IRF setting wherever possible. We've carried that out to all of our payers and referral sources and specifically, we've seen an increase in Medicare Advantage stroke penetration.

<Q – David Common – JPMorgan Securities LLC>: Well, actually, I'm going to pull forward on a question I had planned for later and that is, anecdotally, I'd heard that cases where commercial just didn't want to pay for inpatient rehab even when the patient's family felt that was indicated, and maybe even the doctor as well. I assume you've heard such anecdotes and is that something that you have to chip away out and help facilitate so that the same patient doesn't go to a nursing home?

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<A – Doug Coltharp – HealthSouth Corp.>: It's definitely a bias we face and it's more prevalent – it's much more prevalent in the Managed Care book of business, which I'm differentiating now from Medicare Advantage. It is one where we try to make the argument with a lot of empirical data.

It's been difficult to get great cost by cost comparisons. One of the silver linings in the CJR program that rolled out recently is Medicare made it available to us and to all other providers, a significant amount of data [ph] that here before (9:50) we did not have visibility into. And so, previously before the data was released for CJR, we could see data about what was happening for the Medicare beneficiaries who are going through our facilities. But we really didn't have any visibility into what happened to those beneficiaries after they left our facilities. And we didn't have any visibility as to what was happening to comparable patients utilizing other post-acute facilities in that market.

Out of CJR, we were able to see and track our patients over a full episode and also see how those similar patients had progressed through other settings. And what we found and this was looking specifically at CJR data for instance, is that if a joint replacement was precipitated by a fracture, that we consistently demonstrated superior results both in terms of quality of outcomes and the cost over the episode. Now, that's not directly translated into the commercial book of business. But the more we can get our arms around data like that and we are working hard to do so and carry empirical evidence into those discussions, I think the more successful we'll be.

I think also as we move down the road, one of the things that we've talked about in some of our recent conference calls, and it will start with Medicare Advantage, is we believe we're in a position to begin piloting on a limited basis, risk-sharing arrangements with the MA plans. And the advantage of starting with MA versus thinking about this in the Medicare book of business is because we're not subject to all of the regulations around requirements of care that really don't build many flexibility from the cost side of the market for us.

So, we can do things like work with a shorter length of stay in the inpatient facility, still administering a very intensive therapy regime. And then engage in perhaps a longer episode of home health, home health always being less expensive than an inpatient setting, to see if we can create a more favorable outcome in a more cost effective way, put a fixed price on that and offer that to an MA plan provided that they give us a certain number of patients within that category. If we get it right there, we think it's got potential extension capabilities into the general managed care market as well.

But we'll start slowly on that, I don't want anybody to think that we're immediately going to change our business model and jump into big extensive risk-sharing arrangements without having experimented and conducted very, very thorough analysis around these arrangements.

<Q – David Common – JPMorgan Securities LLC>: A couple of observations, I mean, correct me if I'm wrong. I think you have – let me get this right. The hospitals have the lower acuity, I think, in general, for their IRF patients and I think you have a disproportionate number of Medicare patients. Is that right?

<A – Doug Coltharp – HealthSouth Corp.>: Versus?

<Q – David Common – JPMorgan Securities LLC>: Versus the hospital units.

<A – Doug Coltharp – HealthSouth Corp.>: Yes and let me see, I think I've got a – I can get to a certain slide here, I bypassed it – I'm sorry. So, this is a slide that's also been included in our Investor Reference book. My colleague, Ed Fay is here in the audience as well so while I'm giving this answer, I'll ask him to note for those who are on the webcast, what page it is in the Investor Reference book, and then we'll cite that for you. But it shows a number of key statistics for our

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HealthSouth IRFs versus other freestanding IRFs and the units within an acute care hospital. And I think this gets to some of the distinctions that David was pointing to in his question.

First, you can see in the middle of this chart that relative case mix index for each of those categories of providers. And here, a higher number indicates a higher acuity of the average patient. And at 1.25, HealthSouth is higher than those other categories. But if you move a column to the right, you see that our average cost to treat those patients is actually lower. And it's lower because we have more well-developed clinical protocols. And this is on page 21 of the current version of the Investor Reference book which is posted to the Investor Relations section of our website.

So, we're able to treat those patients on a more cost-effective basis because of the effectiveness of our clinical protocols. We simply see more of these patients across our hospital base than any other IRF providers because of our significant market share advantage. And it's also the case that we enjoy substantial economies of scale. You can see those economies of scale if you move back to the left and just look at the average size of the facility and see that we have more average beds per facility than to the others. We're also able to leverage our central infrastructure.

And as a result of that, we have a very small percentage of outlier payments. And the fact that we don't have much in the way of outlier payments means that if you move all the way to the right, that even though we're treating a higher acuity patient and the Medicare Fee-for-Service schedule is scaled to move up with patient acuity, we actually receive less on average than do these other categories of providers and the differential is a lack of outlier payments.

We're so cost-effective we don't qualify for outlier payments. Outlier payments for our IRF business are less than 0.5% of revenue and that keeps the cost to the Medicare program down. So, what this represents is that we are a great value for the Medicare trust fund. They should send all of their IRF eligible patients to us because we can take those sick patients and we can produce positive outcomes at a lower cost per beneficiary.

<Q – David Common – JPMorgan Securities LLC>: Okay. That's great. That was helpful explanation. Switching to the way the industry is viewed in Washington, who advocates for the inpatient rehab? Is it just the two hospital associations or do you have your own subcategory lobby or industry association?

<A – Doug Coltharp – HealthSouth Corp.>: So, we do have the American Hospital Association. There is also a body called [ph] AMPRO (16:21), which is specific to the rehab hospitals. And go back to the beginning of our conversation when I discussed the composition of the industry, you can start with an assumption that would be an erroneous one to say will the acute care hospitals really don't have a dog in the pipe when it comes to inpatient rehabilitation.

But because so much of the industries actually found in the form of units within an acute care hospital, more than 50% of the overall industry are the units within the acute care hospitals from a volume perspective. They do have a vested interest in what happens with regard to inpatient pricing and inpatient rehabilitation. And so, they do lobby on our behalf and we're a very active participant there.

But we also recognize that we are the only publicly-traded company whose primary business is inpatient rehabilitation facilities. And to some extent, the burden of leading lobbying efforts and leading innovation efforts around regulation here falls upon us.

We do have full-time government affairs folks who reside in Washington. We have two such individuals and we spent a lot of time as a management team engaged in discussions with our congressional representatives.

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<Q – David Common – JPMorgan Securities LLC>: Okay. As I recall, MedPAC proposed most recently a pay cut. Could you speak to their logic and review if there's a recommendation?

<A – Doug Coltharp – HealthSouth Corp.>: Speaking to MedPAC's logic would imply that there is some, which I'm not sure is the case. First of all, I think the history of congress actually adopting MedPAC's proposals is limited to non-existent. We have seen any number of proposals come out of MedPAC over the course of the last five-plus years. They always recommend price cuts. Their rationale for those price cuts kind of varies from year to year. Last year, they made an implication in their December comments, say the rhythm is typically a MedPAC meeting with transcripts, prepared scripts published in December, and then followed by a written report in March that looked at the margin differential between freestanding units and hospital units and suggested that it was coming more from coding differences and it was from actual cost and efficiency differences.

Well, the fallacy in that report and what they specifically cited was that they looked at how acuity was scored or the average acuity that was embedded in the coding for a patient upon admittance to an IRF and said that that appeared to be higher than the acuity that was coded for the patient when they were discharged from an acute care facility.

What they didn't discuss is that the coding systems are very, very different and that the requirements for coding upon discharge from an acute care facility don't include provisions such as assess the patient for cognitive impairments or other types of impositions that would be treated in an IRF, which are required to be assessed and coded upon admission to an IRF. So, that rumor was somewhat [ph] dispelled (19:34).

The 5% cut doesn't have a lot of rationale behind it other than it suggest that, overall, the industry margins are too high. Without rhyme or reason, MedPAC has historically focused on industry segments that have double-digits margins. And the IRF segment currently enjoys an industry margin of about 13%. So, that puts us a little bit in a crosshairs with that particular body.

Interestingly enough, if you go back and look at some of the transcripts for dialogue that Tom Price had as a member of congress with MedPAC as they were providing some of their reports, he was appalled by their focus on margins solely for the fact that the margins were higher, and made some comments to the effect of if you're looking to just the target the most efficient providers of services, that's not sufficient rationale to recommend a price cut.

So, we are optimistic that as it relates to all forms of ongoing regulation coming out of CMS at the presence of somebody like Tom Price who is an orthopedic surgeon, who has what we think is a great deal of empathy for the provider community, will only prove to be helpful.

<Q – David Common – JPMorgan Securities LLC>: Okay. Well, since you've mentioned Tom Price's name, you've gotten us to the next stage which is where you explain what healthcare reform is going to look like. Do you think post-acute reform slows down under the current administration? Does it accelerate?

<A – Doug Coltharp – HealthSouth Corp.>: So, we're looking at another slide right now and this slide really has kind of two components to it. The top slide are some of the specific goals that were enumerated by CMS albeit under the prior administration related towards the movement towards value-based purchasing and episodic payments and collaborative care models. We believe that the change in administration notwithstanding this direction remains intact.

And in fact, there may be some minor modifications to the goals but this is the direction that the system is moving at. What that system is driving, right now, if you look at the lower left-hand portion of this page, you see that based on the current regulations, in the post-acute sector, each setting is required to operate within their swim lanes, and that makes it very difficult. The site specific patient

criteria, the site specific regulations per requirements of care and even things like Medicare beneficiary patient choice, make it very difficult for the providers to work together in a way that will accomplish the CMS goals that are enumerated at the top of this page.

So, we believe as we evolve from left to right on this spectrum, that by necessity, there will be a loosening of some of these standards, the swim lanes will begin to evaporate, if you will, and then over time, what we will progress to in post-acute is a single inpatient, post-acute provider that is capable and has the regulatory ability to serve the full spectrum of post-acute inpatient acuity from that which is currently addressed in an LTAC setting, to that which is done in a SNF.

And I don't want – this slide can be a little bit misleading. I don't want to imply that we believe that that's going to be in place by 2019. If 2019 really applies to the upper end of the graph, it's going to take some time to get there and it will probably be a gradual process.

And with that in mind and again, we don't think that that direction changes. Some of the specific modality and some of the timing may be altered based on the current administration. But we think the train has started ahead in that direction and it is not going to reverse.

With that in mind, we think that it underscores our strategy of continuing to invest in inpatient rehabilitation and home health and getting the two paired up in as many markets as we possibly can. And we say that because we think it's a perfectly hedged strategy. But so long as we stay in our swim lanes, we believe that the IRF segment will continue to benefit from increasing demand for the services that are provided in an IRF today based on the aging of the population and a very favorable demographic trend that will likely extend over at least the next 15 years. Patients are going to continue to have strokes. They're going to suffer the neurological disorders that go along with aging. Somebody is going to have to treat those patients and we've demonstrated consistently that we are very effective in doing so.

If we move more towards this broader-based, site-agnostic, post-acute facility, then we believe IRFs are best positioned to make that transition, both in terms of the physical construct of our facilities and the current staffing arrangements. And we say that if you think about [ph] an IRF, if you've (24:32) not been in one, we have a heavy orientation towards the therapy gym because we're licensed as hospitals and are required to provide 24-hour, 7-day a week nursing. You see the prominence of the centralized nursing stations. The rooms look like hospital rooms. To be able to address LTAC patients, really, all that would be required is for us to add gases to a number of those rooms and basically set up an LTAC wing. We've operated LTACs previously. So, we have the clinical knowledge about how to do that.

No modifications from a CapEx perspective would be required to take in SNF patients. I'm specifically thinking about the higher end of the SNF acuity right now. And in fact, we operate three SNF units today. If you think conversely about the CapEx that would have to be applied by either and LTAC or a SNF, to be able to have this full acuity spectrum and provide the therapy and the types of nursing, it would be extensive and very difficult if it could be done at all.

The bigger hurdle may actually be from a staffing perspective. If you look at where IRFs begin – again, because we're required to provide 24-hour, 7-day-a-week nursing, we're fully staffed from a nursing perspective. And we've got the full spectrum of nursing licenses in place. So, we have RNs, we have LPNs, we have CRRNs in place. If you go up to an LTAC, an LTAC is also going to offer 24/7 nursing, but their nursing is going to be heavily oriented towards critical care nurses, which is a very different orientation. And then look down at SNFs and obviously the provision of nursing services and SNF where it's not required is fairly de minimis.

Same comments can be made regarding therapy. Because of the extensive therapy regime that we are required to administer in our facilities, we are already staffed with full-time therapist specializing

in occupational therapy, speech therapy, and physical therapy. Move upstream to an LTAC and they are going to have it if they offer any full-time therapist at all. There's going to be a respiratory therapist. If you go down to SNF, most of the therapy is provided on a contract basis. So, I think it would be very difficult for them to recruit and train the staff and get the staffing in place in a market, we're frankly competition, for clinical workers, is only increasing.

And so, this is the way we see things playing out over the next several years, and we believe that we're extremely well-positioned for it. We think our position is even more enhanced by the fact that even though we weren't required to do so, we began in 2010 with the roll-out of an EMR. And you may recall that the Affordable Care Act mandated that all acute care hospitals adopt an EMR. And provided they met certain milestones along the way, those were the meaningful use standards you may recall, they were provided pretty significant subsidies for implementing the EMR under the high-tech provision . No such mandate existed for post-acute providers and no subsidy was available. Nonetheless, we look back to the beginning of our conversation at the fact that 90% of our patients were flowing to us from acute care providers.

We could see the writing on the wall that we were moving to more of these collaborative care markets and we felt it would be at a maximum, a ticket to admission and at least a competitive advantage in these integrated models to have the EMR that would allow us to correspond electronically with players upstream and downstream. We now have the EMR which was developed together with Cerner to be specifically tailored to the IRF setting. That is in place in 100 of our 123 facilities and we'll complete the installation of that by the end of this year.

<Q – David Common – JPMorgan Securities LLC>: Okay. I'm going to switch to a couple of your other businesses starting with home health. I'd like to ask you about a decision of buying versus building in home health, acquisition prices, barriers to entry, and what would motivate you to actually – it seems like a relatively low barrier to entry business. What would motivate you to purchase versus build?

<A – Doug Coltharp – HealthSouth Corp.>: The primary motivation is that there are moratoriums against new licenses in place. And if not, all states, then virtually all states. And so, that means if you want to expand your geographic territory, you essentially have to acquire an existing agency or an existing license.

We also – when we first entered this business in a meaningful way, we had a small [indiscernible] (29:27) and prior to the end of 2014. We did a lot of research about the business and really studied the industry and met with various players for about a three-year period from 2011 through 2014. We made the decision that we wanted to get into home health. We felt it was important for two related reasons. Most immediately and again thinking about the environment in which we currently operate. A little bit more than 55% of the patients who get discharged from one of our IRFs requires home health service and we were capturing very little of that revenue and, frankly, not providing the patients with the quality of care across a broader continuum that we thought we would be able to if we owned a home health partner.

And second, is we felt like it would be increasing importance on being able to provide the continuity of service as we moved to these more collaborative care markets. So, we had identified Encompass as the highest quality operator in the home health business run by its founder April Anthony. He remains the CEO over that business today. April had partnered with a private equity firm Cressey. They had grown the business nicely and in a high quality fashion. They decided it was time for an ownership transition, and we were fortunate enough to be acquirer of that business.

As we're growing it from that point forward, the strategy is really focused around agency acquisition. And those acquisitions that we utilized to grow the business and what we really attempting to do is we've got three areas of focus as we grow that portfolio.

The most important area of focus is to acquire agencies in those markets in which we currently operate an IRF but don't have home health. And so, right now we've got about 60% overlap and we define overlap as within a 30 mile radius. But to enhance our clinical collaboration efforts on a go-forward basis, number one priority is filling those markets where we don't have one.

The second priority is that there are very substantial economies of scale benefits that can accrue if you got density in an existing home health market. So, where we have presence with home health but don't have market density, we'll look to increase that.

And then the third is, we're fortunate to have multiple growth opportunities. There are any number of attractive Medicare beneficiary markets where we don't currently have a home health agency. So, we'll look to fill in there.

The levels, the types of acquisitions can be all over the board. From time to time, we will find what is effectively a small mom-and-pop operation that has a license [ph] or a CON (32:09) in an attractive [ph] market for us but (32:10) it's underproductive and producing very little in EBITDA. You're really paying for the right to do business in that particular market. So, the multiple on trailing EBITDA may look very high. When you do it on a pro forma basis, it's not so high.

And then there are some regional players that could be attractive to us. A good example is in the fourth quarter of 2015, we bought a company called CareSouth. That was about $175 million acquisition, and it immediately brought with us 14 incremental overlap markets. Now, we have said this year, we'll target $50 million to $100 million in home health and hospice agency acquisitions. About two-thirds of that will be home health and about a third will be hospice.

<Q – David Common – JPMorgan Securities LLC>: I've only surprisingly got two more minutes left. But since you're in front of credit audience and we think of things that can go wrong. I've never really been able to get my head around how you mitigate the risks in the hospice business where both doctors and patients are motivated to liberally interpret the criteria for hospice admission. So, could you just address?

<A – Doug Coltharp – HealthSouth Corp.>: No. First, let me say that I empathize with you because I spent my first 10 years as a banker. So, I've never taken off my credit hat and I brought it to this position. I hope that's reflective in how we manage our balance sheet and our capital structure.

Hospice, it's interesting. Right now, hospice is a very small piece of our overall business. We got into it initially, I should say April got into it initially with what I'll call the [ph] old provider (33:44) retail base, which was the second phase of my career, to get with purchase strategy, which is when she was buying home health agencies that were attracted to her, they sometimes had a small piece of hospice attached to them.

And even as we were in the courtship process with April to acquire Encompass, she said at that time, we're taking time to learn the hospice business to make sure that we can manage the risk appropriately and to make sure that as we manage it appropriately, we feel that an appropriate margin can be earned on this business which will give us an acceptable return.

Really about by the end of 2015, I think she and her team had made the termination and had convinced us that you could answer yes to all of those questions. And so, we agreed that we would start expanding a little bit more rapidly, but not overly rapidly in the hospice business with an emphasis on adding hospice into those markets where we have home health but don't currently have hospice. We're going to do it very deliberately.

Specific to your question, the regulations are actually pretty clear. And so, the way that you manage your risk is you don't tolerate any deviation from the regulations, and you monitor the statistics around your patients, and you look for any outlier activity.

David Breadon Common, Analyst, JPMorgan Securities LLC

Okay. I think the beep indicates our webcast is over. So, the pinpoint landed.

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

Outstanding.

David Breadon Common, Analyst, JPMorgan Securities LLC

Doug, thank you very much for being here. The audience didn't get an opportunity to ask questions, but I imagine you'll stick around for a few minutes.

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

Absolutely. I'd be delighted to answer any questions.

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