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<<John W. Ransom, Analyst, Raymond James & Associates>>

Good afternoon. Welcome today to one of the Raymond James Conference. I'm John Ransom. I'm here to introduce Doug Coltharp, CFO. We're going to do – 10 minutes with Doug by himself and then I'm going to fire off some really brilliant questions that you guys are going to love. So, I'll start – let Doug start. Thank you.

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

Thank you, John. Over here and get the clicker. As John said, I'd like to spend just a few minutes on the front end, giving you a little bit of a sense as to where HealthSouth is positioned today and then also a sense as to where we think we're headed in the immediate future [Multiple Speakers] (0:43) you could have told me that before.

Alright, start right here, so this is how our Company is positioned today. We are a leading provider of post-acute services. We operate two business segments. The larger of our two business segments is in the Specialty Hospital business, we operate specifically inpatient rehabilitation hospitals. It's about a $3 billion year in revenue business and it's a business that generates adjusted EBITDA of about $800 million.

Our second business segment, we believe it's highly complementary to the first is Home Health and Hospice. In 2016 that segment generated just under $700 million in revenue, about $680 million in revenue and adjusted EBITDA for that segment of just over $100 million.

I say that the two business segments are highly complementary because about 55% to 60% of the patients who get discharged from one of our inpatient rehabilitation hospitals require follow on home healthcare. Both of our business segments are focused on the Medicare beneficiary population, which means we treat an older patient.

The average age of patient for both of our segments is in excess of 70 years old. And we feel that these businesses are well positioned because of the demographic trend that our country is experiencing right now and largely fueled by the aging of the baby boomer population. The segment of our population aged 65 and older is growing more rapidly than our overall population.

As the population ages, these individuals are going to be in need of the services that we provide. You get a sensor to the geographic footprint for our two businesses. I mentioned that our inpatient rehab business and inpatient rehabilitation hospitals go by the acronym IRF, which is for inpatient rehabilitation facilities. I mentioned that our IRF is the largest segment.

It's in fact – we are the largest operator of IRF services in the U.S. and we have a market share in excess of 20%. To give you further sense there, there are two types of inpatient rehabilitation facilities that are operated in the U.S. There are freestanding units and then there are units that are housed within an acute care hospital.

Our business is solely focused on freestanding units. We currently operate 123 freestanding hospitals. In the U.S. in total, there are roughly 250 to 260 freestanding hospitals and the next largest aggregation beyond us and any single competitor is about 19. Home health, we're positioned as the fourth largest Medicare provider of those services.

Each of our businesses is characterized by being the most cost-effective, high-quality producer in its particular segment. We've got some data that we'll show on each one of two segments and speak to the cost effectiveness. We're also focused on the higher acuity patients, the patients that are more medically complex in each of the two segments. And again, this is part of the reason that we see them as complementary.

So lot of data up on this chart, but I'll draw your attention over here. This is a measure of acuity, the very top of the chart shows the average acuity for our hospitals, as you move down you'll see the average acuity for other freestanding hospitals, not including HealthSouth and then down at the bottom is the data for the units that are housed within acute care facility.

A higher number for acuity means that it is a higher acuity and more medically complex as you can see we're treating the more medically complex Medicare patients, but we're able to do that at an average lower costs and the fact that we're able to do it more cost effectively is attributable to establish clinical protocols, economies of scale and technology.

And as a result, we're able to treat those patients at a price tag that is lower than you see for the other providers in our space. So, we actually cost the Medicare trust program, less money than to our competitors. Data is arranged in the similar fashion for our home health business and you really get to the same conclusion. We're able to treat a higher acuity patient. We do it more cost effectively and it also contributes to the superior margins that we exhibit in both of our two segments versus the peers.

Want to touch a little thought, a bit upon where we see the environment going and how we feel we're positioned for that. The change in the administration notwithstanding, we believe that the movement that was set a foot by CMS under the previous administration towards more value-based payments, more integrated delivery models will continue. We don't know the specific pace, the modality may change some under the new administration, but we believe the direction will remain the same.

And as we do that, we believe that we will move from a highly siloed environment today, where patient criteria and the requirements of care are established for each post-acute

setting by Medicare regulations will move to an erosion and an eventual elimination of those site-specific criteria and regulations. And so that to be able to serve a Medicare post-acute patient you want to be positioned with a high quality, inpatient post-acute setting that is capable of treating the full spectrum of patients requiring post-acute inpatient care from those that are currently serviced in the LTAC setting, to those that are currently serviced in the SNF setting, and you want to be able to pair that with a high quality home health provider that can again address a broad spectrum of acuity.

We believe that, that positioning will allow us to minimize costly readmissions over a longer episode into the acute care hospital setting. And so this is a very complicated chart, but this is one that we use to validate our strategy of continuing to invest in our two existing segments and not looking to diversify outside of that. And that is when we look at our portfolio of IRFs, we believe that as those regulations that are specific to each site breakdown, the IRFs are going to be better positioned to pivot from the center to address that full array of inpatient post-acute acuity, and I say that because of both the physical construct of our facilities and the staffing that's in place.

From the fiscal construct, if you've never been in an IRF before, it looks vastly different from a SNF or from an LTAC. An LTAC looks predominantly like a mini acute care facility without the trauma center, without the operating rooms, but you got a patient that is not looking to be very mobile, there's not much of an emphasis placed on things like the therapy gym. At the other end of the spectrum, SNFs are setup predominantly to accommodate patients in long-term convalescent type care. Again the emphasis around a quality therapy gym and so forth is not there.

With minimal CapEx we could convert a wing most of our hospitals, really just putting in medical gases to accommodate an LTAC patient and no CapEx at all would be required for us to address SNF patient. As a matter of fact, we operate SNF units in three of our hospitals currently. I think even the larger hurdle would probably be from a staffing perspective.

All of our facilities are required to be licensed as acute care hospitals and as such we're required to provide 24 hours a day, 7-day a week nursing. We have the full complement of skill sets from nurses. We have RNs, LPNs, CRRNs, et cetera. If you look upscale to an LTAC, their license is the hospital, but their nursing orientation tends to be on critical care nurses, look downstream to a SNF and SNFs are not required and do not provide that level of nursing service. They have much more sporadic nursing coverage.

Same thing can be said from the therapy perspective. We employed full-time therapists that are multi-discipline, physical occupational and speech. If you look upstream to an LTAC, you may have some respiratory therapists, but downstream to a SNF and is predominantly contract therapy. So again, we feel like if and when these barriers get lowered, we're going to be in a great position to capitalize on that.

John, now open it up for questions.

Q&A

<Q>: What – as you work with your partner hospitals, could you sort of describe the extremes on both ends of the spectrum, with respect to how their discharge behavior has changed since CJR and BPCI. What are the most aggressive hospitals billing versus, I assume some hospitals have not done a thing, and how would you roughly allocate, if you have 400 referring hospitals so they can number – how many of them have really aggressively moved into the new world and how many of them are just kind of overwhelmed with the complexity and not doing much of anything?

<A – Doug Coltharp>: Sure, there is a lot to that question, centered around the bundled payment pilots that were initiated under the previous administration. And just to give a little bit of level setting, BPCI is an acronym for voluntary bundled payment initiative. Voluntary, meaning the participation in the program by both acute care hospitals and also by a post-acute provider, we're completely voluntary or discretionary.

CJR is an acronym for the first mandatory bundled payment initiative and that was significant because a mandatory initiative was only allowable under the auspices of CMMI, which was the Centers for Medicare and Medicaid Innovation, and that was an agency that was established under the Affordable Care Act and there is some contesting as everyone goes through the discussions on appeal and replace right now about whether the role for CMMI will change going forward or is there a possibility, it will be eliminated altogether.

Our participation in BPCI is very limited. I would say that in terms of how it has changed the behavior of acute care hospitals, it also has been very limited. I think everyone is very much in a wait and see and learning mode, really just trying to gather additional information about whether this collaborative arrangement is moving the needle at all in terms of patient outcomes. There was an anticipation when CJR was implemented that it was going to have a more profound impact particularly on our business.

And CJR is targeted at lower extremity joint replacements, it's mandatory in 67 geographic markets for all of the acute care hospitals that are participating in those markets. I should note, because I didn't do so in my overview, but more than 90% of the patients who come to our inpatient rehabilitation facilities come to us after an episode has landed them in an acute care hospital.

So, this concept of a relationship with an acute care hospital is very important. In fact, 37 of our 123 IRFs are owned in a joint venture relationship with an acute care hospital in that market. CJR was implemented on April 1 of last year. Most of the CJR patients would be at the lower end of the acuity that we service in our facilities and particularly in a lower extremity joint replacements that weren't precipitated by a fracture, but instead were the result of wear and tear as we all get older, that had been a category of business that have been declining rapidly for us for a number of years, for more than eight years and it was really result of our emphasis.

Again, we have placed our emphasis on more complex patients, such as those recovering from a stroke and other neurological disorders. We have seen no impact from CJR on our volumes since it was implemented. We've seen very little change in the behavior of the participants in CJR. We think that is a result really of two things that came together.

First is under the previous administration specifically coming out of CMS, the acute care hospitals were hit with a wide array of new initiatives related to quality reporting metrics and other regulatory aspects and they have been working hard just to respond to those. CJR was a kind of a pile on to that and in the first year it carried absolutely no financial penalties regardless of the results that were produced under the program.

As we move into the second year of the program, there is a phased in risk color that measures sharing or penalties based on the performance of a particular episode of care for a specific CJR patient versus a target price. Heading into this year, we had anticipated that the program will remain in its current form and that hospitals will begin to direct their attention to the fact that they were now at risk for certain dollars.

And so we stated beginning in the third quarter of last year that we were going to proactively begin approaching the acute care hospitals in these markets with a proposal to serve as what is called a collaborator, which is a defined term under the CJR program. The collaborator allows a post-acute provider to participate in the risk and the gain share and with the acute care hospital subject to certain parameters.

It's legally complex, but we specifically identified after we reviewed trove of Medicare data that was made available by CMS that inversely all of the markets that we were looking at, we consistently exhibited a cost advantage and an outcome advantage versus other post-acute providers in that market for lower extremity joint replacement patients, where it was precipitated by a hip fracture.

So beginning in December, we began having meetings with acute care hospitals proposing to serve as a collaborator. What we have found is with the new administration having been elected and many of the acute care hospitals as many Americans were somewhat surprised by the results of the election, there is an anticipation that CJR is going to be made voluntary versus mandatory and this is based on some comments that have been made by HHS Secretary Tom Price.

As a result of the relatively low penalties and risk sharing that are available to acute care hospitals and the belief that it will become voluntary, we're finding much less of the sense of urgency on behalf of the acute care hospitals with whom we are meeting to actually enter into a risk-sharing arrangement. What we are finding though is that these meetings are serving as a great opportunity to bust the myth that SNFs are as effective as IRFs and can do so – and can treat these patients more cheaply. The data simply does not support that contention and so we're having positive results coming out of these meetings even if they're not leading to sign collaborator agreements.

<Q – John W. Ransom>: As a follow on to that, Tom Price is an orthopedic surgeon, the smoke signal suggest he is very physician friendly and one of the things that could happen with the stroke of the pen is that he could designate ASCs to be providers of lower hip and knee – to perform those for Medicare beneficiaries in an outpatient setting. So, if that were to happen we would expect some volume to migrate from the hospital to ASCs. How does HealthSouth follow that referral into ASCs if that would occur?

<A – Doug Coltharp>: I really don't think it changes the picture very much for us. As I mentioned, in most of those instances you're going to be dealing with the lower extremity joint replacements that are not precipitated by fracture, because the fracture adds a whole degree of medical complexity to it. The fractures also tend to occur in the more aging portion of the population.

As I mentioned previously that category of patients for us has been deemphasized and has been shrinking pretty significantly. All of the patients coming into our facilities today still have to meet a couple of different criteria. One is, they have to meet medical necessity criteria, which is a judgment by an independent physician that the patient can both benefit and can tolerate the intensive therapy regime that is administered in a nurse setting, and that therapy regime which is regulatory is on average three hours of therapy, five days a week and the preponderance meaning more than 50% of it has to be administered in an individual versus a group setting.

In almost all cases too, when the physician is making the determination that a patient should be directed to an IRF, they're making a determination that that patient really needs the 24/7 nursing that I mentioned is a regulatory requirement for us and an additional regulatory requirement is that in one of our facilities, you're required to see the attending physician face-to-face at least three times a week.

So if the patient – even if they're starting off at an ASC, upon completion of the procedure is demonstrating those types of medical complexities, either doing – owing to something that was specific to that condition or a comorbidity, we think we'll still capture that same share. But it's a small percentage of the overall patients we treat, and it's not growing to the extent our presence in, for instance stroke in neurological is.

<Q – John W. Ransom>: You have – your Company got markedly more aggressive obviously with M&A, Encompass deal, Cardinal Hill, Reliant. How would you – I think we all know the home health deal is doing great with your captured volumes, but give us an update on the other two and also, a kind of a follow-on to that is, it appears to us that a large deal probably is less likely in the cards just given away you are restricting yourself and where EBITDA multiples have gone for large home health platforms, is that a fair assumption to make?

<A – Doug Coltharp>: Yes. So John is referencing the fact that following the acquisition of Encompass, which really established our footprint –our initial footprint in home health and that's transaction that closed on the last day of 2014, we made two significant

acquisitions during 2015. At the end of the third quarter in 2015, we bought a portfolio of 11 rehab hospitals, a company called Reliant.

And then a month later, we closed on a $175 million acquisition of the home health provider called CareSouth. There was uniqueness to each one of those. I mentioned previously, in my remarks that the market for freestanding inpatient rehabilitation facilities gets very fragmented below us. There are 19 each, I believe, contained within select and within Kindred and then beyond that portfolio numbers get thin.

So, the opportunities to buy a portfolio of other rehab hospitals, particularly one that gives us a good geographic overlay with our facilities is pretty limited. Reliant had been owned by a private equity firm, they have done very well it. In terms, it was time to monetize it and we were a likely acquirer for that business.

CareSouth had somewhat of a similar story as well. CareSouth was private equity owned as well. It gave us a unique overlay with our Encompass business. One of the things that we are really trying to do is to increase the number of markets in which we operate, both in IRF and our home health business. I mentioned that these two business segments were highly complementary.

I told you earlier that about 55% to 60% of the patients who get discharge from our IRF require home health. We currently have a home health presence in 60% of the markets in which we operate in IRF. The CareSouth acquisition added 14 new overlap markets, when we were able to make that and the residual markets that it brought along were highly complementary or added market density to the existing Encompass footprint.

It's also the case that home health acquisitions of this size are not readily available and it's a good size for us. We have no interest in acquiring one of those larger national players because that would provide us with a network of home health services that far exceeds our IRF footprint and that's not the business we're looking to build. Each one of these acquisitions was integrated during the course of 2016. We're very pleased with the progress we've made and as a matter fact, at the end of 2016 we declared those acquisitions that were fully integrated and are running according to our respective standards for both Encompass and in HealthSouth.

To John's other point, if another portfolio of inpatient rehab facilities became available, would we be a likely pursuer of that transaction? I think the answer is yes. With regard to home health expansion, it's likely to be more on the smaller side. It's still a highly fragmented business there as well. There are currently about 12,500 home health agencies operating in the U.S., more than 95% of them have annual revenues of less than $5 million.

So, it's a little bit more of a ground game. We're out there looking to acquire agencies in markets where we have an IRF, but don't have a home health presence and we're targeting this year for example that we would make between $15 million and $100 million of home health and hospice agency acquisitions.

<Q – John W. Ransom>: Great. MedPAC, for those of you don't know healthcare, MedPAC is an advisory committee set up 15 years ago to advise Medicare on rate setting, pretty big shot across the value this year with recognition of 5% rate cut. It's been 10 years really since the Medicare has gone after IRFs. IRFs have pretty good margins for Medicare business, especially compared to say dialysis or some other things.

So what's the latest and greatest in your lobbying efforts? How much support are you getting from the acute care hospital industry, which has a lot of in-house IRFs? Do you think it would ever be possible they have a different reimbursement schemes for freestanding versus hospital base, anything else you want to share on that point?

<A – Doug Coltharp>: It's interesting how John gets to qualify these as a single question. I think there were about 15 in there, but let me try that…

<Q – John W. Ransom>: How about this mess I…

<A – Doug Coltharp>: I think John mentioned that MedPAC was formed as an advisory committee to Congress about 15 years ago and to my recollections it's been a little over 16 years since Congress actually took advice from MedPAC. It is true that some of the rhetoric regarding IRFs and IRF margins has heightened with MedPAC, over the course of the last two years. They've been relatively consistent in recommending rate cuts for the IRF segment as they have perversely every other segment. There's an unknown unwritten rule that you get into MedPAC's target sites, if as an industry your margin creeps north of 10% and IRFs as a whole now have a margin that's in the low teens, so we're in that category.

What's interesting is, if you look back at some of the interaction that Tom Price had with MedPAC during the hearings when he was a member of Congress, he was pretty opposed and pretty taken back about the fact that they focused on the margins of providers instead of things like just the effectiveness of the outcomes and the relative value that the Medicare program was getting on per setting basis.

So, we don't know if there is a whole lot of love amongst the HHS secretary for measuring things on volumes. I think perhaps important – more importantly in terms of why the IRF segment may not be in the target size for additional cuts is, if you look at the aggregate level of Medicare spend for IRF segment, it's less than 1.5%, and the growth in that line has been relatively flat. They have been charted on our investor reference book that shows what the growth over the last 10 years has been for each one of the post-acute segments and which you could see, is that the cost curve for the IRF segment has already flattened out.

So, it doesn't suggest that there is a runaway train year based on either utilization or based on gaming the system in some other way that needs to be addressed. They are just on a lot of dollars that play there. We also think that there is kind of a heightened awareness about the effectiveness of IRFs versus other post-acute settings and a very

specific example is that in May of last year, the American Heart Association together with the American Strokes Association published a white paper and specifically recommended guidelines to providers that highlighted the efficacy and the preference for the IRF setting versus SNF setting in terms of recovering stroke patients.

So, there's more and more independent data that's out there that I think helps to underscore the veracity of the IRF setting.

<Q – John W. Ransom>: You said it publicly that your goal is to get 80% overlap with some help, up from 59% or 60% now. So for SEC graduates, could you put that – what would that mean in terms of revenue margin, revenue and EBITDA, if you were to hit that level of overlap?

<A – Doug Coltharp>: Look, we've have got a lot of moving pieces because none of the two pieces are going to be segment as we look stagnant, as we look to increase the degree of overlap. So, again as a starting point, 123 rehab hospitals today, we've got an active portfolio of 10 or 11 hospitals. We said we're going to try to add about 46 new freestanding units per year.

So, that suggest we got about a two-year backlog on hospitals there as well. And then a pipeline defined by dollars versus the number of agencies on home health with $50 million to $100 million of home health and hospice, I would break that down as being roughly two-thirds home health and the third hospice. Right now in the overlap markets that we have – so we have a home health presence in 72 markets in which we have an IRF.

The clinical collaboration rate, which is the term that we use to describe when a patient has been discharged from our IRF and gone to our home health, in the fourth quarter, in the overlap markets it was about 28%, that was up more than 700 basis points over the fourth quarter in the previous year. And again, just to be clear, what we're saying is when we look at all of the patients in a particular market in which we operate both business segments, that went through our IRF and got discharged to home health; what percentage of that population came to our home health provider, it was a little bit less than the third.

In terms of a near-term, we said that we would like to see that move up over the next three years in the overlap markets to between 35% and 40%. And at the same time, would like to move the number of overlap markets up from 60% to more like 80%, so they're both going to be progressing. You'll have to make your own assumptions regarding the rate of progression in each of those two metrics to give a little bit further information to work with.

I believe on average a patient and they tend to be highly therapy intensive patients being discharged from one of our facilities into our home health provider, requires about 1.4, 1.5 episodes of home health and the average Medicare revenue per episode for those types of patients is about $3400.

<Q – John W. Ransom>: Alright.

<A – Doug Coltharp>: That gave you all the pieces.

<Q – John W. Ransom>: Perfect. Last question, just between you and me, nobody else look at this, but…

<A – Doug Coltharp>: I think Alabama get some next year – repeat against Clemson will be the tie break.

<Q – John W. Ransom>: So in your subjective judgment, how successfully is the home health lobby working against pre-claims review and how would you handicap that and what's the – what are your thoughts about the potential downside of that?

<A – Doug Coltharp>: It's difficult for me to speak of the effectiveness of the lobbying efforts. What I do know is that the pre-claims review demonstration exists in only one state right now, Illinois, and I believe that there is a lot of information to suggest that it has been very difficult administratively for the government and its max to contend with. Florida is a larger volumes state, that is set to go live on April 1. There is some talk that it may be delayed. I think if it goes live, the administrative burden is going to increase dramatically and it may collapse under its own weight.

<<John W. Ransom, Analyst, Raymond James & Associates>>

Got you. Well that's a pretty – usually a little more wishy washy. That was a stronger statement. I'm – thank you.