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HealthSouth

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MANAGEMENT DISCUSSION SECTION

Jon A. Langenfeld, Head of Global Equities & Director of Equity Research, Robert W. Baird & Co., Inc.

Good morning. I'm Jon Langenfeld, Head of Equities and Director of Research here at Baird. Thank you for joining us for our annual Healthcare Conference.

Couple thoughts for you, just on Baird, before we get started. I just want to leave you with two things. One, we've been around a long time and we're a very stable company. And two, we are focused on content and we're focused on being the best at what we do to drive our investor results. You can see some of the notes here that will give you a Baird at a Glance. But we're coming up on our 100th year anniversary, privately held, employee owned. And again, why are these important? Because we attract and retain the best people on the street here at Baird. We're very proud of our team. We're proud of what we do on the research side. If you look at Greenwich Associates, which goes out and surveys the portfolio managers, every year for the last 12 years, we've been here in its upper right-hand quadrant, which is the best in research and the best in sales and corporate access. We like that spot and we intend to keep it. We're going to work hard and we have a great team to do so.

And finally, Fortune 100 Best Places to Work, 14 consecutive years. And I think that really talks about the stability of who we are and what we do. And we love to align ourselves with great people, but also great company then – and great clients.

So, with that, I'm going to turn it over to Whit, and we'll get started today.

Whit Mayo, Analyst, Robert W. Baird & Co., Inc.

Great. Good morning, everyone. I'm Whit Mayo, the senior analyst covering healthcare facilities and services. It's my pleasure to have the management team from HealthSouth with us this morning. Representing the company, we have President and CEO, Mark Tarr; and Executive Vice President and Chief Financial Officer, Doug Coltharp.

And I think, with that, Mark, you have...

Mark J. Tarr, President, Chief Executive Officer & Director, HealthSouth Corp.

Sure.

Whit Mayo, Analyst, Robert W. Baird & Co., Inc.

...a couple slides that we are going to go over. And if anyone has any questions, I don't have the laptops or – I'll – just yet, but we'll work on that. But...

Mark J. Tarr, President, Chief Executive Officer & Director, HealthSouth Corp.

Well, good morning, everyone. So, it's great to be here. We do have some prepared slides that I think will help to give just a brief profile of the company, as well as give you some insight in terms of our corporate initiatives that we have underway.

First, the comments. And it's pretty early in the morning to read this kind of language, but I have to draw your attention to the comments on the forward-looking statements.

From a profile standpoint of the company, we are one of the nation's largest post-acute providers. The company is made up of two business segments: one facility-based, one home-based. The facility-based segment includes 125 IRFs or inpatient rehabilitation facilities for those of who you that may not be familiar with that term. It accounts for 80% of the company revenues. We operate in 31 states and have two sites in Puerto Rico. Within the IRF sector, we are the largest in terms of revenues, licensed beds and patients served.

As noted there, you'll see that 39 of our 125 IRFs operate as joint venture hospitals with acute care systems. The patients treated in our hospitals are medically fragile. They suffer from conditions such as stroke and other neurological. We have traumatic, non-traumatic conditions such as hip fracture, brain injuries and spinal cords. I think it's important to note that our patients are of a status that's non-discretionary. So, these are not elective procedures. All of these patients would need to be in an inpatient setting as opposed to having home health as an option on the initial onset of their injury or condition.

Our Home Health and Hospice segment accounts for the remaining 20% of our revenues and is the fourth largest provider of Medicare home health services. We have 193 locations providing home health. We have 35 locations providing hospice. We are spread across 25 states. Like the inpatient rehabilitation hospitals, the Home Health segment provides highly specialized clinical programs provided by nurses, physical, occupational/speech therapists as well as social workers and home health aides.

From a strategic standpoint, we are positioning our company for the future of the payment mechanisms that are out there relative to alternative payment models, that places a premium on integrated care. Our growth strategy is to build out both of our segments either through de novos or acquisitions, placing a priority on creating what we call overlap markets where we have a hospital and a home health agency within a 30-mile radius of each other. So, we are able to provide that continuum of care, creating these overlap marketplaces.

At the end of June, we had 60% of our markets and what we refer to as these overlap markets, where we have both a hospital and a home health location. So, why HealthSouth? It's because we execute in those areas that are critical to our business. We have a strong track record of execution and results. For us, it all starts with people. Our focus on recruitment retention of nurses and therapists. We put a high priority

on our ability to retain highly effective clinical staff. We also provide a lot of clinical education opportunities and training opportunities for our staff, both in-house and externally where necessary, that plays a big part in terms of the clinicians' interest and wanting to be in a HealthSouth or in an Encompass setting.

If you have the right people in the right place, it goes a long way in helping to produce quality outcomes. And we're very proud of the quality that we produce in both of our business segments. When you look at the Home Health segment, when you compare where we are on the national Star Ratings, we have 95% of our agencies excel at a three-star rating or higher.

When you look at our rehabilitation hospitals, we have over 100 of our hospitals have the accreditation through The Joint Commission for stroke accreditation which is very important in our ability to go out and continue to grow our stroke programs. Both of our segments place a high priority on the ability to get the patient to a home setting and eliminate the potential for the need for readmissions back to the acute care hospitals. So, both of those hospitals and home health agencies are very focused on keeping the cost of care as efficient as possible, and that starts with keeping them in the lowest cost setting which is home.

I mentioned earlier the fact that 39 of our 125 rehabilitation hospitals are set up as joint ventures. We think that that positions us well from a strategic standpoint in those marketplaces where integrated coordinated care is now at a premium. This is not a new strategy for our company. Our first joint venture hospital was established in 1991, so we know how to be a good partner.

We think that we've done an extremely good job making sure that the mission of both our company and our partner are bound to be taken into account. And we're very proud that we've never had one of our partnerships unwind in the history of the company.

One of the facets that is driving the need for our services is the demographic trends that we see in United States. Our average age patient in our hospital is 76. Our average age patient in our home health agency is 77. So, it's this aging of the population that continues to drive the need for our services.

If you look at the CAGR for Medicare beneficiaries, Medicare enrollment is 3%. If you look at the CAGR for our particular age range over the next 10 years, it's between 4.5% and 5.5%, as the aging bolus of the baby boomers age out into our age range.

Our company generates strong cash flow. We have one of best balance sheets in healthcare with leverage of 3.3 times and flexibility in our debt instruments. Our company generates high levels of free cash flow, which allows us to not only fund our growth, but also provide shareholder distributions. And I will add that another important part of our balance sheet is, in fact, that we own 70% of our real estate. So, we like that in an environment that has pricing pressures that we don't have to face increasing – escalating lease costs from our hospitals.

In both of our segments, we are the most efficient provider in the industry and have the ability to manage our staffing costs through management information systems that we invested heavily in to provide our managers onsite as well as our regional managers to provide oversight in making sure that the staffing levels are appropriate but most efficient. We also benefit from the efficiencies gained through our supply chain and scale on both of our business segments.

We've also invested heavily in technology over the years. And technology through our Cerner platform with our EMR that we develop and have rolled out in our rehabilitation hospitals, our home health agencies are the super user of Homecare Homebase which is the IT system – industry-standard IT system in the home health and hospice industry. And both of these have allowed us to become a very effective partner within the marketplaces when you start thinking about integrated care, you start looking at bundled services where there is a premium placed on working with acute care hospitals, and then downstream into post-acute.

Another thing we're very proud of is our proven track record over the years. If you look back at the last 35 quarters, we have shown adjusted EBITDA growth in 34 of the last 35 quarters. So, we're very happy and pleased with our track record and believe we'll be able to carry that forward. And before I go back to Whit, also I want to talk a little bit about our branding process.

In July, we announced that the company would undergo a branding initiative that would include a name change. This name change is effective January 1st, we'll become Encompass Health. We will brand under one name for both of our business segments. The new symbol letters will be EHC for Encompass Healthcare. And like I said, that takes place in January 1.

So, with that I'll turn it over to Whit.

Whit Mayo, Analyst, Robert W. Baird & Co., Inc.

Great. Thank you. And I found the iPad, so if anybody has questions, you can send an e-mail to session1@rwbaird.com.

QUESTION AND ANSWER SECTION

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Mark, let's stay on that last point for a minute. Can you provide a little bit of the back story around the process, how you went through the evaluation and maybe just how you came to the conclusion, why this is the right name, what the feedback has been from field?

<A – Mark Tarr – HealthSouth Corp.>: Sure, sure. When we made the commitment to acquire Encompass Home Health and Hospice in 2014, it was at that point that marketplaces have became mostly more difficult to hold ourselves out as an integrated provider network with two different names.

As we would go in, whether it was development presentations or even internally, our staff informed us and became evident to us that supporting two brands, the Encompass Home Health and the HealthSouth brand was becoming more and more difficult.

So, we brought in a branding consultant, Prophet, and really worked with them almost a year as they did the research in terms of how much brand equity was out there for either one of the brands. They had over 2,500, what I would call, touch points where they spoke with physicians, referral sources, case managers, patients, people in the communities and where we do business to get feedback in terms of their thoughts on the brand.

Ultimately, it came down to, from a management perspective, whether we wanted to go forward and try to support two brands, did two brands fully articulate our strategy going forward. And we decided that it was much better to incorporate under one name or rebrand going forward. As Prophet walked us through that process, they made us aware that it just so happened that we happen to have the rights to a good name that fit our strategy when you think about Encompass, and having the name Encompass Health incorporates Encompass from Encompass Home Health and Hospice and Health from HealthSouth. It also eliminated the south-centric component within the name HealthSouth. When you look at our geographic spread across the United States, if you are in Portland, Maine or if you are in Tustin, California, you wonder why you have south in your name. And so, we felt like this was the best opportunity going forward and it was going to be a good investment for the company to move forward with this name change.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Helpful. Maybe just to go back to the clinical collaboration model, I think you've made a lot of really strong progress over the past 18 months. And I guess I'm just really curious more from the field level and from the physicians and from the patients what the feedback has been about the strategy.

<A – Mark Tarr – HealthSouth Corp.>: The feedback has been very positive. But first of all, in the provider network whether its HealthSouth or otherwise, making successful transitions from one patient care setting to the next is wrought with difficulties relative to anything from communication or what the follow-up procedures are with future physician appointments, education on medications, and the whole medication administration and education with the families and the patients. Coordinating that care has been a challenge.

Part of our clinical collaboration, we've made great strides at better coordinating that transition as our patients transition from our rehabilitation hospitals to a home health. We've put the patient choice first, but we've also prioritized ways to streamline communication and make sure that the communication is tight and do this in the most effective and efficient way of moving the patient through the system, but yet have that patient experience that the patient benefits from it as well.

We've gotten really good feedback from physicians. We've gotten feedback from the patients, patient families. For our patients, I mentioned earlier, they're 76 and 77 years old, so you have a lot of involvement from the family and the caregivers. So, having this clinical collaboration has been particularly acceptable from them.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: When you approach health systems about partnerships today, how many of the conversations are exclusively focused on building out a freestanding inpatient rehab hospital versus building an integrated post-acute care offering through your clinical collaboration model?

<A – Mark Tarr – HealthSouth Corp.>: The vast majority of the conversation we're having now are developing a more collaborative comprehensive post-acute strategy which would include not only the IRFs, but a home health component in that. So, yes, that is one of the changes we've seen. Now, it could be where we have certain conversations where healthcare system already has their own home health and they want to incorporate that in. But even when they have their own home health, they are looking for ways, that we have learned in other markets, to better coordinate that care.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: HealthSouth is focused on data and building a data repository for years, and I think it's probably been underappreciated among the investor community. And then, the BPCI program comes along, you have access to more and more Medicare information. Can you maybe talk a little bit about the cost-effective nature of combining rehab and home health services, and what you've learned and how differentiated it is among other post-acute care alternatives across your markets?

<A – Mark Tarr – HealthSouth Corp.>: Yeah. When you start looking at the information that's been provided by CMS, which is quite often there is a year-and-a-half or two-year lag period on it. So, we've really tried to reach out to, not only information that's provided by CMS, but information that's provided by other data systems. And one of the things that we've been able to show is we've gone out and consolidated some of the cost reports and information, and then data that's out there is to help to provide accurate information relative to the cost of care.

Historically, IRFs have been seen as being a high cost of care area or that was the perception compared to a nursing home setting. That plays out really in a lot of typical diagnoses such as joint replacements where if it's a simple joint replacement, IRFs aren't the lowest cost of care. If it is a joint replacement that involves a fracture that led to that need for that joint replacement, it absolutely is a cost-effective site of care when you factor in all the total costs and you also start looking at it from an episodic standpoint or 30-day to 60-day time period versus just a per diem rate that you would compare of an IRF versus SNF. So, there are a lot of diagnostic categories that the information that we've been able to gather now, whether it's CMS related or otherwise, that show that IRFs are the most cost-effective setting of care when all the costs are included over an episodic period of time.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Last year – I think it was last year, last summer, last fall, American Heart Association, Stroke Association came out and endorsed inpatient rehabilitation as the preferred setting of care for the treatment of stroke patients. I think you have always had a strategy around growing your stroke mix, perhaps it's accelerated a little bit. Can you just talk about some of the initiatives that you have underway to whether get all of your facilities accredited as of – a stroke center of excellence?

And maybe, is there any way to size up the opportunity? I mean, some of the numbers that we've seen, and maybe [indiscernible] (20:33) look at me if I'm doing something wrong. But maybe 40% of the patients are in nursing homes today, something in that ballpark. And rehab might be somewhere in the teens, somewhere in that ballpark. So, is there any way to maybe think what the penetration of that population can be?

<A – Mark Tarr – HealthSouth Corp.>: Well, I think [indiscernible] (20:51) Crissy, we have about a 4% of the total stroke that's out there, is that correct?

<A – Crissy Carlisle – HealthSouth Corp.>: [Inaudible] (20:58).

<A – Mark Tarr – HealthSouth Corp.>: Yeah, [indiscernible] (20:59).

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Just in your [indiscernible] (21:00).

<A – Mark Tarr – HealthSouth Corp.>: [indiscernible] (21:01) data.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Yeah.

<A – Mark Tarr – HealthSouth Corp.>: So, you have to take into consideration that we're not in all marketplaces. But we do think the stroke program not only is an area that we excel in our outcomes and our ability to get almost 80% of the patients back home to the home setting, but it's an area that we have developed clinical expertise in our hospitals. We have equipped our hospitals. We've staffed our hospitals. We've gone out and brought in the medical oversights through neurologists or internal medicine. We've provided ample opportunity for the training and competencies of our therapists and nurses all around the stroke programs.

As Whit said, we have over 100 of our hospitals now are accredited through The Joint Commission for stroke designation. And that plays an important part with acute care hospitals that have done the same and have sought out to have this stroke designation for their certification to be able to hook up with the rehabilitation hospital that has a similar accreditation. It plays a big part in our overall credibility. And it helps us to show what we can do from a quality standpoint.

So, we have put a lot of resources into development of stroke program over the past six years or seven years. We continue to do that and seek out opportunities to coordinate that care. That's one of the areas that we've coordinated tighter as we've done the Encompass acquisition back in 2014.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Still at scalable growth around [ph] that opportunity (22:38)?

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

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Yeah.

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

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: CMS has been encouraging this idea around site neutrality for some period of time, and we're moving closer and closer to this. And just sort of curious, I don't know, maybe Doug or Mark, whoever wants to take this, just as you think about your hospitals, how they are configured either favorably or unfavorably for the transition towards the site-neutral model.

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

<A – Doug Coltharp – HealthSouth Corp.>: Yeah. It's our intention that eventually we will progress to the point where you'll have a single post-acute inpatient facility that can handle the full spectrum of the acuity from what is currently handled in LTAC to what is currently handled in the SNF with the IRF being kind of the center point from that. And if you look at the physical configuration of IRFs generally and more specifically the IRFs that we're building right now and also the staffing composition of the IRF model that's necessitated by regulation requirements of care, that is the model that is best positioned to pivot from the center, if you will, and treat the full spectrum of acuity. And we say that begin with just the physical composition of the facilities. If you go into an IRF, you see that there is a strong emphasis that is placed on the rehab gym, so it's large and it can accommodate a lot of patients. You tend to have centralized nursing stations that can adequately service all of the patient rooms. And you have to do that because it's a requirement of care that in the IRF setting, you provide 24 hours/7-day-a-week nursing coverage.

You tend to have centralized dining facilities, so that not all of the dining is done in-room, which encourages socialization and is part of the rehabilitation of the patients and so forth. If you do a comparison there and move upstream and look at an LTAC, most LTACs are multi-leveled facilities which is not conducive to moving patients to and from their rooms to areas like a therapy gym, and that's

because those patients aren't very mobile. I mean a high percentage of the patients in an LTAC are on a ventilator. They're not spending a lot of time in the therapy gym.

The nursing stations and the patient rooms are organized in a way that reflects that. Inversely, all the dining, again because the patients aren't mobile, is done in the room. So, they try to reconfigure an LTAC, so that it can accommodate the types of rehabilitation needs for a patient who is today going into an IRF or the higher acuity patients going into a SNF would require a very, very substantial CapEx. For an IRF to be able to accommodate an LTAC patient, there is no more CapEx required than to add medical gas capabilities in a certain number of the patient rooms. And otherwise, the rest of it fits right in.

And a similar argument can be made in terms of a SNF trying to move up, and SNFs are not required to provide 24 hours/7 nursing. They don't put the heavy orientation on the gym. Much of the nursing that they provide can be done on a contractual basis, and the same thing for a therapy. And they certainly don't have the medical gases installed in their rooms. So, for a SNF to try to convert itself into a hospital-type setting to accommodate either an IRF or an LTAC patient would require a very substantial capital expenditures.

The bigger hurdle might actually be on the nursing side. If you look at how our hospitals are staffed, and again it gets back to the requirements of care, we do have full-time nurses on 24 hours/7, and there's a pretty good spectrum of nursing licenses that make up our nursing workforce. And then, obviously the stars of the show in an IRF setting are the therapists. So, we have full-time physical therapists, occupational therapists, and speech therapists on staff.

Go upstream to an LTAC and there is much less therapy that's provided overall, and the therapy that is provided tends to be respiratory therapy and that tends to be done on a contractual basis.

Go down to a SNF, and again, much of the therapy that's provided there is on a contractual basis. So, for either one of those settings to say they were going to become a full-spectrum acuity post-acute box, they'd have to go out and recruit, train and hire all of the staffing that would be required to do that.

So, we think as we progress in that direction, the total addressable market for IRFs generally and for HealthSouth specifically increases dramatically, and that we are well positioned to be able to capture a share there.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Got it. I feel like every year or so, we have maybe some pressure [ph] on the fringe (27:20) with some of your Medicare audit contractors. Any update around any progress that you guys are making or anymore pain points that you're feeling with respect to those audits?

<A – Doug Coltharp – HealthSouth Corp.>: I think a recent positive development, and it's very early here, is that we understand that CMS has issued to some of the MACs who have been engaging in a lot of the pre-claims reviews and the pre-claims denials or prepayment denials, some additional guidelines under the acronym TPE initiative. And so, the instructions that they have now issued to the MACs is it is no longer suitable for you to decide without good statistical underpinnings that you're going to do a widespread probe and begin denying a lot of claims without engaging in very active dialog with the providers about the nature of the problems that you're finding and providing an adequate opportunity for the provider to remediate that.

So, the TPE initiative now states that for a provider to first make a denial of the category of claims, they have to have a statistically valid reason for denying those specific categories of claims for a specific provider. And then, they can engage in a targeted probe. And a targeted probe is defined as they can look at 30 claims to 40 claims in that particular category. If in that review of 30 claims to 40 claims, they find a problem, they are now required to go back and educate the provider on what they found. And that has to involve clinician-to-clinician discussions where they go through and they say, these are the specific difficulties we have found with regard to the charts that we reviewed on the patients passing through your facility that are leading to our recommendation that this claim being denied.

They then have to provide an opportunity for the provider to remediate. And if they subsequently determine that it hasn't been appropriately remediated, they can repeat the cycle of the targeted probe and educate up to three times, and each time that targeted probe is limited to an incremental 30 claims to 40 claims. If after three cycles of the targeted probe and the education, they still believe that the provider has not remediated the difficulty, it remits back to CMS for CMS to weigh in on what should be done next. That is a far different situation...

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

<A – Doug Coltharp – HealthSouth Corp.>: ...from what we have seen today. So, now this is relatively new. It does nothing to address the backlog, the very substantial backlog of the previously denied claims that are awaiting adjudication. But it potentially has a very significant impact on the amount of new denied claims that are getting added to that balance sheet item on a quarterly basis.

<Q – Whit Mayo – Robert W. Baird & Co., Inc.>: Got it. I want to spend just a minute on the home health proposal, the group remodel. What feedback are you hearing from key policy makers, staff? Or was just curious, what you've learned since the proposed rule was issued a few months ago?

<A – Mark Tarr – HealthSouth Corp.>: We're very active in Washington in terms of working with the Partnership for Quality Home Healthcare. It's the primary trade association that is working from a lobbying front. From our own company front, we are certainly working to educate the various offices of the members of Congress in which the markets which we deal with, making sure that they are aware of the potential impacts that can be out there and some of the major changes that would be included in the proposed rule. So, the environment that we've seen certainly from CMS's is one that, with the new administration, they are certainly showing signs of more willingness to listen from the provider network. I think the most recent proposed rule on the IRF side was an indication of that, when they went back in and added back some of the codes that had been erroneously left out as they did the crosswalk from ICD-9 to ICD-10.

So, I think that overall there is certainly a willingness to listen to provider network about the concerns and proposed rule. And we're confident that we'll be able to continue to message that, so that there will be some serious consideration for changes before it gets to the final rule stage.

Whit Mayo, Analyst, Robert W. Baird & Co., Inc.

Uh-huh, well, we've got 12 seconds left. So, I think I'll just leave it at that. Guys, all right, as always, I appreciate it. Crissy, thank you for coming.

Jon A. Langenfeld, Head of Global Equities & Director of Equity Research, Robert W. Baird & Co., Inc.

Thank you, all, [indiscernible] (32:07).

Mark J. Tarr, President, Chief Executive Officer & Director, HealthSouth Corp.

Thank you.

<<[05F40C-E Doug Coltharp]

Thank you [indiscernible] (32:08) HealthSouth. We're Encompass, I got to use to it.