PARTICIPANTS

Corporate Participants

Crissy Buchanan Carlisle – Chief Investor Relations Officer, HealthSouth Corp.
Jay F. Grinney – President, Chief Executive Officer & Director, HealthSouth Corp.
Douglas E. Coltharp – Chief Financial Officer & Executive Vice President, HealthSouth Corp.
Mark J. Tarr – Chief Operating Officer & Executive Vice President, HealthSouth Corp.
April K. Anthony – Chief Executive Officer, Encompass Home Health & Hospice

Other Participants

Whit Mayo – Analyst, Robert W. Baird & Co., Inc. (Broker)
Sheryl R. Skolnick – Analyst, Mizuho Securities USA, Inc.
Gary Lieberman – Analyst, Wells Fargo Securities LLC
Frank Morgan – Analyst, RBC Capital Markets LLC
A. J. Rice – Analyst, UBS Securities LLC
Chris Rigg – Analyst, Susquehanna Financial Group LLLP
Joshua Raskin – Analyst, Barclays Capital, Inc.

MANAGEMENT DISCUSSION SECTION

Operator: Good morning, everyone, and welcome to HealthSouth's Third Quarter 2016 Earnings Conference Call. At this time, I would like to inform all participants that their lines will be in a listen-only mode. After the speakers' remarks, there will be a question-and-answer period. [Operator Instructions] You'll be limited to one question and one follow-up question. Today's conference call is being recorded. If you have any objections, you may disconnect at this time.

I will now turn the call over to Crissy Carlisle, HealthSouth's Chief Investor Relations Officer.

Crissy Buchanan Carlisle, Chief Investor Relations Officer

Thank you, operator, and good morning, everyone. Thank you for joining HealthSouth's third quarter 2016 earnings call. With me on the call in Birmingham today are Jay Grinney, President and Chief Executive Officer; Doug Coltharp, Chief Financial Officer; Mark Tarr, Chief Operating Officer; Patrick Darby, General Counsel and Corporate Secretary; Andy Price, Chief Accounting Officer; Ed Fay, Treasurer; and Julie Duck, Senior Vice President of Financial Operations.

April Anthony, Chief Executive Officer of Encompass Home Health & Hospice, also is participating in today's call via phone from Texas. When possible for future calls, April will join us in Birmingham. Finally, in addition to those I've already mentioned, Barb Jacobsmeyer, current President of HealthSouth Central Region and soon to be Executive Vice President of Operations, is with the team in Birmingham today.

Before we begin, if you do not already have a copy, the third quarter earnings release, supplemental information and related Form 8-K filed with the SEC are available on our website, at www.healthsouth.com.

On page two of the supplemental information, you will find the Safe Harbor statements, which are also set forth in greater detail on the last page of the earnings release. During the call, we will make forward-looking statements which are subject to risk and uncertainties, many of which are beyond our control.

Certain risk, uncertainties and other factors that could cause actual results to differ materially from management's projections, forecasts, estimates, and expectations are discussed in the company's SEC filings, including the earnings release and related Form 8-K; the Form 10-K for the year ended December 31, 2015; and the Form 10-Q for the quarters ended March 31, 2016, June 30, 2016 and September 30, 2016, when filed. We encourage you to read them.

You are cautioned not to place undue reliance on the estimates, projections, guidance and other forward-looking information presented. Statements made throughout this presentation are based on current estimates of future events and speak only as of today. The company does not undertake a duty to update these forward-looking statements.

Our supplemental information and discussion on this call will include certain non-GAAP financial measures. For such measures, reconciliations to the most directly comparable GAAP measure is available at the end of the supplemental information, at the end of the related press release, and as part of the Form 8-K filed yesterday with the SEC, all of which are available on our website.

Before I turn it over to Jay, I would like to remind everyone that we will adhere to the one question and one follow-up question rule to allow everyone to submit a question. If you have additional questions, please feel free to put yourself back in the queue.

With that, I'll turn the call over to Jay.

Jay F. Grinney, President, Chief Executive Officer & Director

Great. Thank you, Crissy, and good morning to everyone joining this morning's call. We obviously have a lot to cover today, so we'll jump right in and review the results of the quarter first and then discuss management succession.

We are very pleased to report that the third quarter was another strong quarter for HealthSouth. The operational trends we experienced in the first half of the year, solid volume, top line and earnings growth in both segments continued in the third quarter as net operating revenues increased 19% to $926.8 million, adjusted EBITDA increased 20% to $198.4 million and adjusted earnings per share increased 20.4% to $0.65 per diluted share.

Importantly, we generated $139.8 million of adjusted free cash flow and reduced our long term debt by approximately $76 million, which, coupled with the growth in our adjusted EBITDA, reduced our leverage ratio to 3.8 times.

One of this year's key strategic imperatives has been to strengthen the clinical collaboration between our hospitals and Encompass Home Health agencies. And I'm pleased to report we continued to realize the benefits of this collaboration in the quarter.

An important component of this effort has been to place Encompass care transition coordinators, or CTC's, in our overlap market hospitals. These highly skilled professionals collaborate with clinicians and case managers in our hospitals to assess patients who may require home health services, facilitate patient choice and prepare these patients for the care they will receive at home. They also work with patient's families to ensure that they are prepared to bring their loved ones home safely obviating the need for an interim stay at a nursing home.

While we are still in the early stages of fully integrating CTC's at all of our overlap market hospitals, there have been some very encouraging early results.

To gauge the impact of this strategy, we compared 30-day and 60-day readmission rates during the 18 months prior to the introduction of the CTC, with these rates during the following 10 months at one of the first hospitals to embrace CTCs. The results were very impressive.

30-day acute care readmissions declined by approximately 470 basis points, while 60-day readmissions declined by approximately 410 basis points. Additionally, the number of patients discharged to SNFs dropped 400 basis points to an average of approximately 8% per month, once the CTC was integrated into the team, compared to approximately 12% per month prior to the CTC's arrival.

Importantly, patient satisfaction also improved significantly at both the hospital and the Encompass agencies. We believe results like these clearly define the value proposition of our facility-based and home-based post-acute strategy.

By reducing acute care readmission and SNF discharge rates, we can meaningfully impact 90-day episodic Medicare spending per beneficiary cost, a metric we believe will become more important as the healthcare delivery system continues to evolve. That we can achieve these results and see meaningful improvement in patient satisfaction is an added benefit that will position the company to be competitive in a value-based purchasing environment.

In the near-term, we believe this value proposition will be appealing to acute care hospitals participating in the CJR bundling program. As Doug will elaborate later, we've spent a good part of this year developing a risk-sharing model for the CJR bundled pilot, and we'll approach acute care hospitals in approximately 20 markets with this model over the next several quarters.

Based on preliminary feedback, we believe this model will provide acute care hospitals with an attractive solution to their CJR obligations. The basic framework of this model also will help us to explore risk-sharing with commercial payers, specifically Medicare Advantage plans. As we have reported previously, there has been a steady increase in the number of MA patients treated in our hospitals over the past several quarters.

In the third quarter, same-store MA discharges grew 3% and are up 4.8% on a year-to-date basis. Longer-term, we believe we can market our low-cost, high-quality value proposition to these plans and increase our market share even further.

As noted on page 9 of the supplemental information, the early successes we'd experienced with the CTCs, coupled with other initiatives, contributed to an 820 basis point year-over-year increase in the clinical collaboration in our overlap markets. To ensure we are optimizing all of the opportunities that exist through enhanced clinical collaboration, we are launching a teamwork best practices initiative in 2017 that will focus on this key strategic imperative.

We believe this will help us achieve a clinical collaboration of 60% or more in our overlap markets over the next several years. Another strategic imperative has been to prioritize the investment of our free cash flow into growth opportunities. To that end, we opened three new hospitals in the quarter that created two new overlap markets, acquired one home health agency in an overlap market; and acquired three hospice locations that complemented existing home health agencies, two of which are in overlap markets.

We also have another 11 IRF projects underway that will contribute to future growth, with other development projects, hospitals, home health, hospice in the pipeline. Finally, I want to address a question I know many of you have, and that's if we are seeing any impact from the CJR bundling initiative. The short answer is no for both segments. It's instructive to keep in mind that this program covers both hip fractures and lower extremity joint replacements.

With respect to the former, the percent of hip fracture discharges in our CJR markets has remained fairly stable. In fact, there was a slight uptick in the number of these patients on a sequential quarterly basis. With respect to LEJR discharges, we have seen no change to the trend line for these types of patients. As you know, the number of our LEJR discharges has been declining steadily for several years, as we focused on treating higher acuity stroke and neurological patients following the reinstatement of the 75%, now 60%, rule.

As we have previously stated, we believe our 90 day Medicare spending per beneficiary cost advantage in treating hip fractures will provide long-term upside opportunities to treat more of these types of patients, while the number of LEJR patients will, in all likelihood, continue to decline and will level off at some point.

Moving to guidance, based on the strong year-to-date results, and taking into consideration the items on page 15 of the supplemental information, we are updating our guidance as follows. Full-year net operating revenue guidance is between $3.65 billion and $3.7 billion. Full year adjusted EBITDA guidance is between $785 million and $795 million. And full year adjusted EPS guidance is between $2.50 and $2.56 per share.

With that, I'll turn the agenda over to Doug.

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

Thank you, Jay, and good morning everyone. As Jay just outlined, we had another very solid quarter, characterized by strong performances in both of our business segments. During Q3, our net operating revenues increased by 19%, and adjusted EBITDA grew by 20%. Adjusted EPS for Q3 also increased by approximately 20%.

We continued to evidence the strong cash flow generating capacity of our business, with adjusted free cash flow in Q3 of $139.8 million, an increase of 5.9% over Q3 2015. On a year-to-date basis, adjusted free cash flow of approximately $385 million increased by approximately 26% over the prior-year period.

As can be seen on slide 16 of the supplemental information, we have revised our working capital range for the full year, so that we now expect adjusted free cash flow for 2016 to be between $425 million and $485 million.

Consistent with our established priorities, we have used the free cash flow generated over the first nine months of this year to support discretionary growth-related CapEx of $88.5 million; a reduction of approximately $161 million in funded debt, the payment of approximately $62 million in dividends on our common stock, and the repurchase of approximately $24 million of common stock.

During Q3, we completed the retirement of our 7.75% notes due in 2022, the most expensive debt instrument in our capital structure. Our leverage ratio at the end of the quarter was 3.8 times, down from 4.6 times at the beginning of the year, and placing us ahead of schedule in achieving our objective of being below four times by the end of 2016. Both Moody's and S&P have acknowledged our progress on de-levering, by revising our ratings outlook from negative to stable.

I will now turn to the segment results, beginning with inpatient rehabilitation. IRF segment adjusted EBITDA for Q3 was $198.6 million, an increase of 19.5% over Q3 2015. For the first three quarters of 2016, IRF segment adjusted EBITDA was $599.6 million, an increase of 19.7% over the prior-year period. The growth in Q3 adjusted EBITDA was driven by a combination of revenue growth and expense leverage.

Net operating revenues increased 15.4% over Q3 2015, driven by discharge growth of 12.6%, and a 2.9% increase in revenue per discharge. The discharge growth of 12.6% includes a same-store increase of 1.9%, which was against a 3.9% increase in Q3 of last year. The 1.9% is consistent with the level of same-store growth experienced in the first two quarters of this year, when adjusting Q1 for the estimated impact of leap year.

As we have discussed on previous calls, we believe there has been some trade-off between same-store and new store volumes in the Reliant overlap markets. Effective October 1, the former Reliant hospitals moved into the same store base. Our pair mix for Q3 was in line with that exhibited in the first half of the year, and patient acuity was similar to Q3 2015.

Approximately 60 basis points of the increase in revenue per discharge was attributable to an approximately $4 million, one-time, indirect medical education, or IME, adjustment associated with the former Reliant Hospital in Woburn, Massachusetts. This adjustment was retroactive and included years 2015 and 2014.

Our reimbursement department discovered that the Woburn hospital had met the requirements of a teaching hospital for those periods, thereby entitling it to a higher Medicare reimbursement, but the previous owners had failed to make the requisite filings.

The IME adjustment also had a favorable impact on IRF segment expense ratios for the quarter. SWB for Q3 2016 was 49.4% of revenues, an improvement of 80 basis points from Q3 last year. In addition to the IME adjustment, Q3 SWB benefited from an approximately $700,000 year-over-year reduction in group medical costs, due primarily to favorable claims trends.

Labor productivity, as measured by EPOB for Q3 2016, was relatively flat with Q3 last year. The staffing model revisions to former Reliant hospitals were completed by the end of Q3. As a reminder, the year-over-year increase in IRF segment occupancy costs, as a percent of revenue, stems from the acquisition of Reliant with its portfolio of leased hospitals.

IRF segment bad debt expense for Q3 was 1.8%, up 20 basis points over Q3 last year. The increase was primarily due to aging base reserves, resulting from the continuation of administrative payment delays at Cahaba. We did see some progress on these administrative delays in Q3, but the issues have yet to be fully resolved.

As can be seen on slide 19 of the supplemental information, we saw a decline in new prepayment claims denials in Q3, both from the level experienced last quarter, and in Q3 of last year. Although, this is two consecutive quarters of decreasing levels of new denials, it's too early to call it a trend.

We also saw an increase in the collection of previously denied claims in the quarter. This improvement was attributable to the successful resolution of claims in the documentation that is pre-ALJ phase. We have seen little progress on resolving the backlog of claims in the ALJ adjudication progress. We had only 48 hearings in Q3 as compared to 72 in Q2, and the backlog remains at roughly four years.

Before turning to our Home Health and Hospice segment results, I'll provide a brief update on the risk-sharing strategies we are pursuing that Jay mentioned in his comments, and that we touched upon briefly in our second quarter call.

Our initial foray into risk-sharing will be via the collaborator role defined in the CJR pilot programs. The collaborator role allows certain designated providers, including IRFs and Home Health agencies, to enter into risk-sharing agreements with acute care hospitals participating in the CJR pilot. A description of the CJR model and the collaborator role is included on slides 26 and 27 of our supplemental information.

Historical data supports the superior value proposition for our IRFs, as compared to SNFs for hip fractures over a 90-day episode in many of the CJR markets. We believe we can further this advantage with enhanced clinical protocols and our partnership with Encompass. We intend to support this value proposition by approaching certain, specifically targeted acute care hospitals in CJR markets with risk sharing proposals via the collaborator role.

Our near term goal is to approach approximately 20 to 25 acute care hospitals located within 18 to 20 CJR markets, with such a proposal between now and the end of Q1 2017, with the objective of having four to six collaborator agreements in place during the first half of 2017.

Of the 20 to 25 acute care hospitals that we will initially approach with the collaborator proposal, we currently estimate that approximately 50% of those will be existing HealthSouth IRF joint venture partners, and approximately 60% will be in markets in which Encompass also has a presence.

The limiting factor on rolling this out more quickly is the competing demands of the acute care hospitals, which are currently dealing with a myriad of new reporting and other regulatory requirements, many of which are more imminent and larger than CJR. Nonetheless, the CJR program is expanding, as are the risk-sharing corridors, so we believe it is important to begin these efforts now.

Given the size of the overall CJR pilots, the limitations imposed on risk-sharing, and the number of collaborator agreements we are targeting, the financial risk to HealthSouth is expected to be immaterial. But the lessons learned both for us and our acute care partners will be very important.

A second risk-sharing initiative involves the development of bundled payment products for commercial payers, specifically targeting Medicare Advantage. We continue to make progress in demonstrating our value proposition to commercial payers, including MA plans, particularly for conditions such as stroke and neurological impairments.

We have also seen a willingness of these payers to move from per diems to case rates. We believe we can make further advances with these plans by developing bundled payment products for managed care patients, where we are unencumbered by rigid Medicare fee-for-service and regulatory structure.

This might involve developing care plans that combine a short length of stay in the IRF with home health follow-up for patients that are presently being directed to a SNF, and offering this plan of care at a fixed rate.

We hope to begin piloting commercial bundles during 2017. We will be deliberate and measured as we do so, and again believe the financial risk to HealthSouth will be immaterial, but the lessons learned will be substantial.

Moving now to our Home Health and Hospice segment, we posted another strong quarter, as segment adjusted EBITDA of $25.8 million increased by approximately 25% over Q3 last year. Home Health segment adjusted EBITDA for the first nine months of 2016 of $74.4 million increased approximately 31% over the same period last year. The growth in Home Health and Hospice segment adjusted EBITDA for Q3 was attributable to a 37.9% increase in net operating revenues, driven by higher volumes.

Home Health admissions for the quarter increased by 50.7%. That included 15.3% in same-store growth, and episodes increased by 39.7%, including 13.6% same-store growth. Approximately 440 basis points of the same-store admissions growth in Q3 was attributable to the clinical collaboration with HealthSouth IRFs.

We now have an Encompass presence in 59% of the markets in which we operate an IRF, and as can be seen on slide nine of the supplemental information, the clinical collaboration rate in these markets for Q3 improved 26.8%, an increase of 820 basis points over Q3 last year. The effect of the volume growth was partially offset by a 2.9% decline in revenue per episode, resulting from the reduction in Medicare reimbursement rates that became effective January 1, 2016, as well as the patient mix at the former CareSouth agencies.

Home Health segment operating expenses, as a percent of revenue for the quarter, increased by approximately 150 basis points over Q3 last year, due primarily to the pricing decline against which we incurred merit and benefit increases, and expenses related to the integration of CareSouth.

As a reminder, and as noted in our guidance considerations on slide 15 of the supplemental information, based on the proposed 2017 rule for Home Health and we expect the final rule any day now, we are anticipating a Medicare reimbursement rate cut of approximately 4% for all episodes beginning after November 3, 2016. The specific components of the 2017 rate reduction were discussed in detail on our Q2 call and are outlined on slide 21 of the supplemental information.

Needless to say, the 4% Medicare rate reduction creates a significant challenge for Encompass in 2017, as growth in adjusted EBITDA will be dependent on volume gains and expense leverage. We also will be adjusting to the pre-claims review demonstration, although implementation has been postponed in four of the five states including the three states, Florida, Massachusetts, and Texas that comprise approximately 50% of Encompass Medicare claims.

As we stated on the Q2 call, while we remain confident in our ability to fully comply with all the provisions of the demonstration, we will need to invest in additional administrative resources.

If the pre-claims review process ultimately were to be implemented system-wide, it is possible this would obviate the claims audits currently being done under programs such as ZPIC and RAC. Under such a scenario, we should be able to reduce or eliminate the redundant administrative expenses required during the time these programs coexist.

The good news is that 2017 is the last year of the healthcare reform rebasing adjustments for home health. As we look beyond 2017, we should begin to see Medicare home health reimbursement rate changes moderate. We also expect to be a beneficiary of the home health value-based payment initiatives, beginning in 2018, and we anticipate continuing home health volume gains resulting from increased clinical collaboration with our IRFs, the expanded CJR programs, and continued industry consolidation.

And I will now turn it back to Jay.

Jay F. Grinney, President, Chief Executive Officer & Director

Great. Thank you, Doug. Before we take questions, I'd like to talk about the planned transition that will take place at the end of the year. Our board has overseen a formal management succession process for the last 10 years that includes emergency short-term and long-term succession plans for all members of senior management. Obviously, this process included CEO succession.

As I approached the age of 65, they began a comprehensive evaluation of internal and external candidates and after a thorough assessment unanimously selected Mark Tarr to succeed me as President and CEO.

I am delighted for Mark and confident he will do an excellent job of leading the company forward. He has extensive knowledge of the healthcare industry and after 23 years of service at HealthSouth knows this company from the inside out.

As Chief Operating Officer, he was responsible for overseeing the challenging transition to the new patient criteria, resulting from the 60% rule and reengineering our clinical focus away from treating simple orthopedic conditions toward treating higher acuity stroke and neurological conditions.

At the same time, he was a major architect of our Beacon Management reporting system, played a pivotal role in identifying the need for an electronic medical records system and managed its implementation across our portfolio.

Additionally, all of the company's teamwork initiatives, sales and marketing, care management, patient experience, were developed and launched under his leadership and serve as a foundation of our high quality cost effective operating platform.

He also has played a major role in the growth of our in-patient segment, ensuring these new hospitals were successfully integrated into our operating model. When he took over as Executive Vice president of Operations in 2007, we had 91 in-patient rehabilitation hospitals. Today, we have 123. Finally, Mark is well-known and respected in the industry. He serves on the boards of the Federation of American Hospitals and the American Medical Rehabilitation Providers Association and has extensive experience lobbying members of Congress and their staffs on behalf of our patients.

He is admired and respected in our hospitals and corporate office and has developed a strong rapport with the leadership at Encompass. He will be enthusiastically received by all employees as the company's next CEO, and I look forward to watching HealthSouth grow under his leadership.

One of the accomplishments I am most proud of during my 12-year tenure is the exceptionally strong and talented management team we have assembled. While we have different backgrounds and different personalities, we are all committed to the success of this company and honoring our culture of quality, integrity, compliance, and mutual respect.

And although one member of the team will be retiring, this change creates opportunities for some remaining team members to assume new responsibilities and for new members to be added to the team, making the team even stronger. Doug Coltharp will step up as the number-two person and will be a strong partner for Mark.

Mark has asked Doug to assume expanded responsibilities for our Information Technology Group and managed care contracting function, both of which will play important roles in the development and roll-out of our bundled payment and Medicare Advantage strategies. This is in addition to the responsibilities for development and strategic planning that Doug assumed last year.

Stepping into the lead operational role is Barb Jacobsmeyer, who is currently the President of our Central Region. Barb has been with the company for nine years and has distinguished herself during her tenure with solid operational and financial performance and the successful management of some of the company's largest joint venture partnerships. Barb will be promoted to Executive Vice President of Operations, and the Company's In-Patient Regional President will report to her. A search is underway for Barb's replacement, and we are considering both internal as well as external candidates.

All of these management responsibility changes will be effective January 1, 2017. On a personal level, while my decision to retire from HealthSouth is extremely difficult, because I truly love this company, this transition comes at a perfect time. Our strategy of being a facility-based and home-based post-acute provider is set. We have best-in-class people, management, and assets.

We are delivering solid, consistent operational and financial results. Our balance sheet is among the strongest in the healthcare industry. We are generating significant amounts of free cash flow

that can continue to fund our growth, debt repayment; and shareholder distribution strategies; and we are extremely well-positioned to thrive in the evolving coordinated payment, value-based purchasing delivery system. I had always hoped I would be able to retire on a high note, and I am pleased that I have been able to achieve this objective.

I am extremely proud of what we have accomplished during the 12 years I have had the privilege of being part of this great company, and I look forward to remaining a HealthSouth shareholder and to participating on these calls on a listen-only basis from a variety of exotic locations.

With that, we will now open the lines for questions.

QUESTION AND ANSWER SECTION

Operator: [Operator Instructions] And your first question comes from the line of Whit Mayo with Robert Baird.

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Hey, thanks. Best of luck to everybody. Jay, very well deserved. I guess first question over the summer the American Heart and Stroke Associations recently issued some guidance around in-patient rehab as perhaps the preferred setting for stroke patients. Just curious on your thoughts there and what percent of patients in the market are stroke patients are treated in rehab facilities versus other post-acute care facilities? Thanks.

<A – Jay Grinney – HealthSouth Corp.>: You know we don't have data on what that percent is. We do know because we are obviously in the markets and we compete with skilled providers who sometimes do receive stroke patients.

We do believe that there is significant long-term upside as those guidelines get into the DNA if you will of the delivery system. We are certainly promoting those guidelines as we talk with patients who are recovering from a stroke in the acute care hospitals.

We are certainly promoting that to the case managers, the physicians in those acute care hospitals. We are promoting that differentiation to managed care plans. And in fact, I think that will continue to enhance the acceleration of our ability to treat stroke patients who are MA patients, Medicare Advantage patients.

As I mentioned earlier, we are seeing really nice increase in our Medicare Advantage patient, number of patients that we are treating and a good number of those are indeed stroke patients. So while we don't have specific data Whit, we do believe that there is tremendous upside. And it's not going to be flipping a switch. It's going to take some time for these guidelines to be promulgated and accepted and then acted upon.

<A – Mark Tarr – HealthSouth Corp.>: Whit, this is Mark. I will add that that information has been very well received in our market places as their CEOs and sales and marketing teams literally saturate this information among the potential referral sources and physicians in the community. As you note, it's really the first independent survey and research in this area that clearly differentiates the value of a stroke patient being treated in an IRF setting versus a SNF setting.

<Q – Whit Mayo – Robert W. Baird & Co., Inc. (Broker)>: Thanks. Maybe just a follow-up question for April. Just curious to hear a little bit more around the pre-claim and what's going on with CMS and I think Doug alluded to some investments and resources to prepare for that rollout. Maybe just any more perspective on what you see developing with the pre-claims?

<A – April Anthony – Encompass Home Health & Hospice>: Happy to do so, Whit. We are not a participant in Illinois. So we are not having to personally experience any of the Illinois situation. But obviously through our role with the Partnership for Quality Home Healthcare we get to be involved with providers who are in those states. I would say we have seen some moderate improvement over the course of the last four to six weeks. Medicare has issued some data suggesting that improvement. The concern that we continue to have is that Medicare tends to look at both the denials, excuse me, both the affirmations and the partial affirmation as being considered a positive. So they are sending out data that suggests that things are much better than perhaps they really are because I would say a partial affirmation is a partial denial.

And so we've got some challenges. So we have been prepping obviously Florida, Texas, and then Massachusetts are all meaningful markets for Encompass. And so we have been prepping our organization not only with ensuring that we do everything we can to ensure that our technology

platform helps us bolster the quality of our clinical documentation so that we're prepared. But also working with the homecare home based team to insure that we ease the administrative burden by creating as many automated processes to submit the data to Medicare which is taking up to an hour per submission for the folks in Illinois who don't yet have that functionality to do that.

And so we think between the technological advancements that we can make before Florida kicks off, we believe, that we'll be able to do this with a relatively moderate increase in cost. Most of that increase being in the form of additional reviewers, clinical reviewers to actually review that clinical documentation and make sure every I is dotted and every T is crossed.

Operator: Your next question comes from the line of Sheryl Skolnick with Mizuho.

<A – Jay Grinney – HealthSouth Corp.>: Good morning, Sheryl.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Good morning. And I'll add my best wishes, but I – and thank you to Jay and everybody for making this company quite frankly a pleasure to follow for so many years and one of the best companies – best managed companies we've – I've seen in a long time. So thank you for that. And actually, interesting lead positions going forward.

So I guess where I'd like to start is, on the – and I apologize if you've touched on this already. But on the CJR issue, I guess, the real question is why are we not seeing more interest in using home health and discharges to home health. Especially in view of the fact that CJR really is pretty much an extension of BPCI.

So for those hospitals that haven't been under a rock for the last several years, it would seem to me they could learn from other experience. They could see what's happened there and translate it. But maybe I'm just over estimating the ability of hospital managers to look beyond their four walls. But essentially the question is, so how worried should we be that home health isn't going to see the benefit of CJR that we thought that it could?

<A – Jay Grinney – HealthSouth Corp.>: Well, let me answer part of that and then I'm going to ask April to elaborate. First of all, I think that CJR will indeed benefit home health. I think what we're seeing, Sheryl is a reflection of the super saturation of new regulatory requirements and reporting requirements that have been imposed on the acute care hospitals.

At a recent Federation meeting it was noted by I think, Mil Johnson, at HCA that, the message to Washington is, stop. This is just too much too fast for even what I would argue to be the best acute care company out there, HCA to absorb, let alone the rest of the industry.

And so, I don't think that the lack of movement in CJR and remember it's only two quarters in, I don't think not seeing a big change anywhere is a reflection of what's going to happen long-term. I think it's more a reflection of they've got other things that they have – the acute care hospitals have other things that they have to focus on today and the upside and risk sharing doesn't really happen until next year. They'll start dealing with that them.

But I do think going back to the initial point and then I'll ask April to elaborate. I do believe that our home health partner will indeed see some very significant benefits long-term and it's not going to be just CJR, I think long-term we're going to see a whole lot more patients get treated in the home setting rather than in an institutional setting. If they need an institutional care, I think it's going to be a higher level of care, which we believe we can provide in our hospitals. April, do you want to elaborate any on that.

<A – April Anthony – Encompass Home Health & Hospice>: Yeah. And Sheryl I would say that it's really – it's not a matter of is there a trend that home health is not going to be the answer, it's a

matter of whether or not these hospitals have acknowledged an area of focus in this. And when we see our voluntary BPCI programs where there is truly an engaged set of partners who are looking at that BPCI data, we've seen terrific outcomes with our partnerships there where when there is an engaged involvement, there's a clear evidence that the expansion of home care is a solution that could help drive that cost down.

I think as the hospitals as both the reward and the penalty grows in those CJR programs over time then their attention will shift to those programs and as they do, just as we've seen with the orthopedic BPCI programs that we've got in place, we'll see that same level of increase happen for home health. I think the hospitals are just saying with everything else on my plate right now, there's just not enough meaningful reason to focus here.

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: Yeah they're not at risk.

[indiscernible] (41:55-42:02)

<Q – Sheryl Skolnick – Mizuho Securities USA, Inc.>: April it's wonderful to have you on the call. Thank you so much for doing this today. But if I could just ask a follow-up to that, are [ph] loopers (42:07) having much of an impact do you think either in BPCI and what you're seeing or in what little you're seeing from CJR?

<A – April Anthony – Encompass Home Health & Hospice>: When the BPCI program just first began, we saw a lot of people kind of take this knee-jerk reaction of we'll use home health, but we'll only use it for four visits and it will be a cheaper answer that way. That was a pretty short-lived strategy in the voluntary BPCI programs because it became evident very quickly that four visits, frankly if you were going to do four, you might need to do zero. But you really weren't going to accomplish the outcomes for the patient in that short period of time, particularly for these elderly Medicare patients, keeping in mind that home health the average patient age is between 79 and 80 years old. So four visits is simply not sufficient, and so we definitely saw a little bit of that sort of knee-jerk reaction, but we saw that moderate very quickly, and I don't think that has – we haven't seen a significant rise in [ph] loopers (43:01) across an extended period of time.

Operator: Your next question comes from the line of Gary Lieberman with Wells Fargo.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Good morning. Thanks for taking the question.

<A – Jay Grinney – HealthSouth Corp.>: Good morning, Gary.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Just to echo all the sentiments, Jay, thanks very much for a job well done and a well deserved retirement.

<A – Jay Grinney – HealthSouth Corp.>: Thank you. We've got a great team and I'm confident the future is going to be even brighter than the past.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: A question maybe for April. Just to get a sense of continued consolidation in the home health market and kind of the pace that you guys expect to be able to increase the overlap with the remaining IRFs where there isn't?

<A – April Anthony – Encompass Home Health & Hospice>: Well, we've got a, obviously, a targeted list, right now we're at a 59% overlap where we have home health within 30 miles of 59% of the IRF facilities, and we definitely have a desire and intent to expand that significantly. Some of our IRF facilities do have restrictions in their JV partnership that would restrict home health, but that only represent about 18% of the universe.

And so still have the opportunity to pick up another 20% or so of overlap. Some of those markets are CON markets for home healthcare and that definitely slows the pace of opportunity in that there are only so many CON's to pursue and often times they are owned by our large competitors who are not sellers, but in each market there are a handful of opportunities.

And so I think we will certainly see that this last 20% or so is going to come a bit slower for us but there are some very targeted opportunities that we're pursuing, our business development team is working closely with the HealthSouth team as well to make sure that we are prioritizing those markets which have the greatest opportunities for the clinical collaboration model to work.

And so I think that we'll get up to the 80% threshold within the next 12 to 24 months pending those CON markets where we may just have a handful of markets we simply can't get to until an opportunity goes on the market.

<A – Mark Tarr – HealthSouth Corp.>: Gary, this is Mark. I might add that some of our existing joint venture partners that have home health and are experiencing this very difficult operating environment they are starting to show some interest in wanting to reach out and maybe have some initial discussions with Encompass as well. So, that should also lead towards additional overlap markets.

<Q – Gary Lieberman – Wells Fargo Securities LLC>: Got it. And then maybe just to go back to questions around the CJR. Can you maybe give us a little bit more color about the discussions with the hospitals that you potentially partner with and what are their concerns and how do those conversations evolve and what are you guys looking for in a partner?

<A – Mark Tarr – HealthSouth Corp.>: Gary this is Mark again. So we have reached out to a number of our joint venture partners right now just having initial discussions on the topic of this working together and in a risk sharing model it's been mostly educational up to this point. But I can tell you that they are very interested in continuing to have these discussions, continuing to play a role as this process evolves.

As we've said early on, a lot of this education comes about as the hospitals are going to be in a penalty state coming up this next year with CJR. So it's starting to work up their priority list. They are starting to understand the opportunities and what may be at risk from a cost standpoint and looking for opportunities to work collaboratively with post-acute.

<A – Doug Coltharp – HealthSouth Corp.>: Gary, just to elaborate on that. We have not yet approached any of those hospitals specifically with a proposal on serving as a collaborator. We expect to begin doing so shortly after December 1st. To put some specifics around this idea that it's not currently a prioritization for the acute care hospitals we have mentioned that in this first year there's no downside risk, there's only the ability to participate to a modest extent to the tune of 5% in the upside.

Remember as well another significant component that will shift the hospital's prioritization is that in this first year the target price is based 100% on that individual hospital's historical experiences. As you move forward in CJR, the blend on the regional basis starts to come in which ought to increase their focus on trying to get improved outcomes. That will begin again in 2017.

So the other thing that has happened is that the cost data that we were initially dealing with to determine where we had the greatest advantage on things like hip fractures was based on 2012. Very recently here the 2015 data became available from Medicare. Once again it was given to us in very raw form. We are in the process of assimilating that data into our proposals but we do think we will have much more traction on this by the time we convene for our Q4 call.

Operator: Your next question comes from the line of Frank Morgan with RBC Capital

<A – Jay Grinney – HealthSouth Corp.>: Good morning, Frank.

<Q – Frank Morgan – RBC Capital Markets LLC>: Good morning. A couple of questions real quick. You had mentioned the growth that you are seeing in your Medicare Advantage book, and I was just curious where that is as a percentage of your total discharges today and where you really see that going, where do you think that actually ultimately stabilizes out?

<A – Jay Grinney – HealthSouth Corp.>: I don't know that it will stabilize and I'm, we're looking for where that is how much is Medicare Advantage. In the past it's been about half of the commercial book. What do we have here?

<A – Mark Tarr – HealthSouth Corp.>: So of our discharges, it's 9.3% Medicare Advantage.

<A – Jay Grinney – HealthSouth Corp.>: And what two years ago it was 8%? Maybe a year ago it was about 8%. I don't know that's going to level off. And I think that to the extent that the MA plans continue to expand their enrollees, I think that that will certainly expand the addressable market.

Frankly we think that there's a lot of untapped potential in the MA plan market. Because historically number one they were looking at a very narrow view of their spend, they are now starting to think about things in terms of 90 day episodes, readmission rates, obviating the need for skilled stays et cetera. Utilizing home health more judiciously. We can partner with them in that regard.

You throw on top of that the AHA/ASA guidelines. Certainly their medical directors are going to be able to promulgate those across their platforms more readily. You think about even the MA plans from a risk standpoint, they are not going to want to have to defend litigation where they've placed a stroke patient in a nursing home and had a bad outcome where you've got these guidelines out there for the plaintiff bar to use. So I think that there is no upper limit. I don't see that leveling off. I think that there's a very nice set of opportunities for us in the future.

<Q – Frank Morgan – RBC Capital Markets LLC>: Got you. And then really over on the cost side now two items. Just curious if you could give us and update on what you are seeing with your wage and labor inflation really both on the IRF and the home healthcare side.

Obviously that's a big topic right now with most providers. And then secondarily maybe a Doug question. Just the benefit that you saw in your group medical cost declining in the quarter. Is it fair to say that that is will now stay in the run rate of the Company, there's nothing there that was one time that that's sort of in the run rate going forward. Thanks.

<A – Jay Grinney – HealthSouth Corp.>: We ask Doug, I mean, Mark to talk about the labor pressures in IRF and then April if you could respond for home health and then Doug will respond to the group medical.

<A – Mark Tarr – HealthSouth Corp.>: Yeah. Frank, we continue to stay ahead of the labor markets. We have seen certain markets that have had more pressure than others. The pressure that we have seen is more concentrated in our nursing ranks specifically for RNs. We have seen some therapy pressure specifically for occupational therapists. But this is an area that we have spent a great deal of effort and resources in the past several years to improve our retention programs to improve our education our on-boarding efforts. So with the philosophy that if you are not turning them over you are not having to hire new individuals at the higher rate. So we've not seen across the board pressure but we have certainly seen it in certain markets and we are staying ahead of that.

<A – April Anthony – Encompass Home Health & Hospice>: On the home health side I think we really haven't seen much change in that area. It's always been a bit of a challenge to find clinicians in certain markets physical therapists in some of our rural markets are hard to find. But generally speaking there hasn't been anything we haven't seen an increase in our number of days to fill open positions as a matter of fact we have actually seen that number come down of late. And so we feel like we have been able to manage the staffing needs pretty efficiently.

<A – Doug Coltharp – HealthSouth Corp.>: And Frank, on the group medical you may recall that in 2015 it was a bit of a tough year for us in group medical as we saw an acceleration in that expense attributable to both an increased utilization of specialty Pharma and then a higher incidence of large claims. As we came into 2016, our assumption was that we would see a leveling off of those specific increases and thus far in 2016 it has played out exactly that way on specialty Pharma.

However, we did see and it was evident in the Q3 number a reduction in the incidence of high dollar claims. It's a little hard to say whether or not that benefit we saw, a year-over-year reduction in Q3 will extend into Q4 because a very small number of high dollar claims can change the picture very quickly and for instance if you have an accident involving someone who is a hemophiliac or you have a premature birth, the cost can escalate pretty quickly.

Having said that, we are pleased with the trends that we are seeing. We have taken other measures like putting a stop-loss policy in place. So right now we think that the assumption that group medical expenses have moderated is a valid one for Q4.

Operator: Your next question comes from the line of A. J. Rice with UBS.

<Q – A. J. Rice – UBS Securities LLC>: Hello, everybody. Congratulations Jay and best wishes, and congratulations to Mark and the rest of the team for the additional responsibilities.

<A – Jay Grinney – HealthSouth Corp.>: Thank you.

<Q – A. J. Rice – UBS Securities LLC>: First of all, real quick on the collaborator and the bundled payment discussions with the commercial guys. On the collaborator, is that, are the discussions strictly around CJR or is the discussion more broad about potentially being their collaborator for all post-acute care for all the bundles as they come down. And then on the commercial side, are you talking to them specifically about post-acute care as a bundle or more broadly taking responsibility for the episodic care?

<A – Doug Coltharp – HealthSouth Corp.>: So, A. J., it's Doug. And on both, we're going to start with the more narrow construction. So recognize when we use the term, collaborator, we're using that term specifically as it is defined in the CJR program. And that's where the focus of the acute care hospitals is going to be here in the near-term. So the discussions I referenced in my comments are going to be very specific about serving as the collaborator for those DRGs and really starting with a focus on hip fracture that are part of the CJR program.

In a similar vein, we are going to start on the commercial bundle with a targeted program for certain MA plans in certain markets and we are likely to start with some of the same DRGs that are in a CJR -- that are in the CJR pilot. There what we'll be doing is essentially building a bundled program from the ground up. So clinicians from both our IRF side and the home health side will be working together looking at something like a hip fracture and saying for the MA population can we more effectively treat that patient with let's call it I'm making up a number here, four or five days of intensive therapy in an IRF and then 1.5 episodes of home health.

We can figure out what that cost on a market by market basis, put a reasonable profit margin on top of that and take it as a fixed payment proposal to an MA plan in a particular market. That

dramatically changes the discussion from one that we are having in a lot of markets right now, too many markets right now about can we get a 2% or a 3% increase to the per diem.

<A – Jay Grinney – HealthSouth Corp.>: Okay. And I think that with that does A. J. is, it establishes a base of understanding of our ability to manage that. We are very confident in our ability to do so and it also then opens the door for us to longer term to expand particularly on the MA side, the bundled payment for other conditions. We think, for example, stroke and neurological conditions are in our sweet spot. And we believe that that's going to be a longer-term opportunity.

And underpinning all of this is our ability to use the vast data sources that we have as a result of our investment in our electronic medical record system and coupling that with the huge trove of data that April has at Encompass to start over time establishing standardized clinical protocols for how we treat these patients.

A stroke patient that we admit in Bakersfield, California is really not going to be a whole lot different than one that we admit in Miami, Florida. And yet there is, as we know, in our industry, not just in our company, but in our industry, there's a tremendous amount of variability in treatment protocols.

What we hope to do, and this is long-term, this is not, okay, tell us how you're doing in 2017. And this is going to be something we're going to do from here on out. Five years from now, 10 years from now, 15 years from now we're going to be working on this.

But we're going to harness what we have which is very unique to reduce that variability and to then – in those protocols and outcomes, and then move everybody to best of class. And I think that that's going to be the real game changer for healthcare going forward.

And in the post-acute environment, we are the only company that has that kind of information at our fingertips, because we made the investment when everybody was asking why are you doing this? Why are you spending $250 million? You're not getting any benefit. Are you really making the right investment?

Here it is, 2016, and saying, damn right it's the right thing to do. And we were thinking about where the industry was going and are really extremely pleased that we made that investment so that we can differentiate ourselves in this evolving delivery system. So I'll get off my...

<Q – A. J. Rice – UBS Securities LLC>: I remember the discussion about the spending health on the IT as well.

<A – Jay Grinney – HealthSouth Corp.>: Yeah. So everybody who asks those questions, I just answered you.

<Q – A. J. Rice – UBS Securities LLC>: Exactly.

<A – Jay Grinney – HealthSouth Corp.>: A. J., related to that tune, another I think very compelling opportunity that will play out over the intermediate term is on an increasing basis, both with some of our existing JV partners on the IRF side and perhaps as interesting in some of the development opportunities that we're pursuing with new JV partners we are hearing requests to come in and serve in those markets as the full post-acute coordinator.

<Q – A. J. Rice – UBS Securities LLC>: Right.

<A – Jay Grinney – HealthSouth Corp.>: I think that that request is borne by the myriad initiatives that are being placed on the shoulders of the acute care hospitals as well quite frankly with the frustration they have experienced in the lack of favorable results as they have used some other

entities out there that have touted decision-making modules that would help direct patients to the appropriate setting.

And so one of the initiatives we have underway is to specifically develop the role and understand the capabilities that will be required to step into a market to do that even when we don't own the full spectrum of providers on a post-acute basis. I don't have a specific timeframe for when we will be piloting that, but again I think it would be our informal objective here to have that kind of role in place in at least a couple of markets by the time we exit 2017.

<Q – A. J. Rice – UBS Securities LLC>: Okay. Thanks a lot.

Operator: Your next question comes from the line of Chris Rigg with Susquehanna Financial.

<A – Jay Grinney – HealthSouth Corp.>: Good morning, Chris.

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Good morning, Jay. And I know it's been several times but best wishes in your retirement. And congrats to the rest of the team.

<A – Jay Grinney – HealthSouth Corp.>: Thanks.

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: So just -- you made several comments on Medicare Advantage today. Can you give us a sense for are there any significant differences between how the MA plans pay you versus fee-for-service and is there a material difference in sort of length of stay, do you get paid on a per diem versus a per discharge and just any color on that would be helpful.

<A – Jay Grinney – HealthSouth Corp.>: The payments for Medicare Advantage have been migrating over the last several years towards a case rate type of payment and away from a per diem type arrangement. And that's I think in large part a reflection of the payors understanding that it's better to pay us a case rate and put the risk onto us, if you will, to manage the patient effectively.

Now, getting that patient in still requires certification and authorization. The patients that we do get tend to be higher acuity and as I mentioned earlier on the call, certainly we are seeing in 2016 a big part of that increase in our MA plan patients is in the area of stroke.

<A – Mark Tarr – HealthSouth Corp.>: And Chris this is Mark. And along with that, many of these patients -- these MA patients, particularly the stroke patients, we have gotten referred in the past have been referred to us. What we are starting to see and have seen now for the past four quarters or so is a better what we call conversion rate. In other words, we get the referral the pre-cert process they are more willing to approve a stroke patient to be admitted into our hospitals now then in the past environment. And we think that is just part of this continued acknowledgment of the value proposition and the willingness to look at things from more of a longer-term perspective than just a per diem rate in comparison of IRF versus SNF. So we think that has led to some of this growth in our stroke programs from these MA plans.

<A – Doug Coltharp – HealthSouth Corp.>: And Chris, just to give you some specifics. On average the MA plans are paying us about 14% less than we get on a comparable case for Medicare. The length of stay has historically been just a little bit higher because we do get some of their more severe patients. But we are seeing a convergence on both the rate and the length of stay with our traditional Medicare population. I think that's likely to continue as we undertake some of the initiatives that both Jay and Mark suggested.

<Q – Chris Rigg – Susquehanna Financial Group LLLP>: Got you. Okay. That's good color. And then just changing gears here on the placement of the CTCs and the care coordination generally I

mean, Jay obviously you talked about the $250 million. But is there any incremental capital costs that you guys are asked to bear from your partners on the acute care side to say if you, do they come to you and say if you want to do this we are already burdened you've got to put in X million dollars or whatever of systems or is there anything like that that's notable? Thanks.

<A – Jay Grinney – HealthSouth Corp.>: You mean on the management of the CJR patients? Is that what you are referring to? Because the care transition coordinators are incremental employees incremental costs that Encompass is incurring in order to facilitate the care continuum in our hospitals and then through to the home setting. So if you are referring to this, that element, yes that is an additional cost. But it's an investment in that clinical collaboration that Encompass is making in order to as I said facilitate that care across the continuum. So, I don't know if I was answering your question or not.

<A – Doug Coltharp – HealthSouth Corp.>: I think as we talk about the broader role if you are referencing this of serving as a post-acute network coordinator, I think there will when we get to the point there will be an additional investment almost exclusively just in SWB because we will have to get the right person in that market. As Jay alluded to in his previous comments, the great news and what really places us in a unique position is we already have the systems capabilities based on the rollout of our EMR and also based on home care home-based which now has a direct interface to our EMR. So we have all of the systems and technology components already in place to be able to serve in that capacity.

<A – Jay Grinney – HealthSouth Corp.>: Did that answer the question, Chris? We'll assume that it did.

Operator: Your next question comes from the line of Josh Raskin with Barclays

<Q – Josh Raskin – Barclays Capital, Inc.>: Hi. Thanks. I'll...

<A – Jay Grinney – HealthSouth Corp.>: Good morning.

<Q – Josh Raskin – Barclays Capital, Inc.>: Good morning, Jay. I'll echo the congratulations to yourself and Mark and Doug and Barb and everybody as well.

<A – Jay Grinney – HealthSouth Corp.>: Thanks.

<Q – Josh Raskin – Barclays Capital, Inc.>: Question just on the IRF and home health collaboration that you guys have been working hard at and it was good to hear the statistics around some of the clinical improvements.

And I think it's intuitive to me why saving SNF days would be a value creating savings in the system. But I'm curious what do you think is driving the reduction in readmissions. Why is home health more effective than SNF in terms of reducing that number of readmits?

<A – Jay Grinney – HealthSouth Corp.>: Well, I'll ask April to respond on why she believes Encompass is uniquely positioned to be able to do that. And frankly, I wouldn't take the results that I talked about and assume that that's a result that you are going to see across the industry outside of the relationship between our hospitals and Encompass Home Health agencies.

And I say that in part because in large part because I truly believe based on all the data we've seen that Encompass really does differentiate themselves from the quality of care that they can provide particularly to the higher acuity patients, who are precisely those who are more at risk for readmissions.

But I do believe that on the hospital side, a reason for that is because of that collaboration and the coordination of that care. The patients who are in our hospitals who need home health are starting to think about and being educated on what they are going to experience once they get home, the family members are, there's an assessment of the home environment making share it's set up properly.

It's a I think a result of a focused coordinated effort to ensure that that patient, A, leaves our hospitals fully recovered and B, goes to the home environment with the safety net, if you will, and the support that Encompass can provide. So, April, I don't know if you want to elaborate on that?

<A – April Anthony – Encompass Home Health & Hospice>: Well, I would just say that it is really that transition into home. And whether you make a stop from the IRF to the nursing home essentially you get back into a home environment that doesn't meet those same kind of generic standards you find in a building, smooth even floors, no throw rugs, no stairs, no dietary concerns. And so when you bring a patient back home with the home health component, you can really deal with all those home safety issues. You can deal with the nutritional issues. You can deal with the medication management and none of those things can happen really in that facility setting.

You've got to really understand the dynamics in that home, the caregiver dynamics, the environmental dynamics. And that's what home health really brings to the table is the ability to look at the total situation in a way that no one else has seen it before because of not being physically present in that home and then make sure that we build a care plan to address all of those issues. Regarding that home environment. If they've got an issue getting their medications, if they've got an issue with a family member supporting helping them manage those medications, being able to train to that and then building customized care plans, that really match up against the needs of each individual patient.

And I think that's what home health in particular can do that really no other setting can and at Encompass, as Jay said, we certainly have an emphasis on trying to drive that to even the next level of quality by building frontloaded care plans, by integrating our care management services and a calling component to verify that even if we are not physically visiting the patient, we have many touch points with them. So all those things combine to create that higher outcome and improved result.

<Q – Josh Raskin – Barclays Capital, Inc.>: I mean, it's interesting, you know, you are getting better outcomes with theoretically constant supervision at the SNF. One more quick one just on...

<A – Jay Grinney – HealthSouth Corp.>: Well, I think that that constant supervision at SNFs, when was the last time you have been in a SNF.

<Q – Josh Raskin – Barclays Capital, Inc.>: Right. I know what you mean.

<A – Jay Grinney – HealthSouth Corp.>: There is no constant supervision in SNF. In fact that's one of the great weaknesses is that they don't have the staff. They don't have the clinicians. They don't have the 24/7 nursing care. So the constant supervision in SNF is an oxymoron.

<Q – Josh Raskin – Barclays Capital, Inc.>: Yes, I know, I was just [ph] supposing... (1:11:00)

<A – Jay Grinney – HealthSouth Corp.>: It does not exist. It does not exist.

<Q – Josh Raskin – Barclays Capital, Inc.>: Okay. Second one, just on LTCH criteria, are you seeing any impact? Are there any patients that maybe have been going to LTCHs that are sort of skipping that and heading to IRFs at this point, as that sort of comes through the market this year?

<A – Mark Tarr – HealthSouth Corp.>: Yeah, this is Mark. We're not hearing that anecdotally. I'm sure that there may be some pockets and some LTCHs in certain areas that maybe took a lower acuity patient that now are starting to find their way into the IRFs. But it's not in a material manner.

Operator: Your next question comes from the line of Kevin Fischbeck with Bank of America.

<A – Jay Grinney – HealthSouth Corp.>: That's an excellent question, Kevin. Operator, I'm not sure that anyone is on.

Operator: Kevin, your line is open. You may be muted.

<A – Jay Grinney – HealthSouth Corp.>: Let's go ahead and close out – yeah, let's just close it out.

Operator: Yes, sir. We've reached the allotted time for our question-and-answer session. I will now turn the conference back to Crissy Carlisle for closing.

Crissy Buchanan Carlisle, Chief Investor Relations Officer

Thank you. If anyone has additional questions, I will be available later today and next week. Please call me at 205-970-5860. Thank you again for joining today's call.

Operator: This concludes today's conference call. You may now disconnect.